History of Graduate Medical Education (GME) Funding

- Pre 1965 – House Officers were given room & board for work/training
- 1965 – The Department of Health, Education & Welfare created the Social Security Act that included Medicare & Medicaid (and GME funding)
  - Why? Education improves quality of care, and should be an element in the cost of care to be borne partially by the hospital insurance program, “until the community bears the cost in some other way”.
- 1980’s – Hospitals found this was a way to pay for hospital-based indigent care & teaching hospitals/residents became the soul source of care for poor populations. Disproportionate Share Hospital funding (DSH) was developed to account for this phenomenon.
- 1997 – Residency spots or Intern & resident per bed ratio (IRB) at each hospital were capped retroactively to December 1996 (Exempted - dentists & podiatrists) 1996 levels. First allowed payment for time spent in clinic (non-hospital setting)
- 2005 – GME redistribution of 3,000 residency positions (added many EM spots)

Center for Medicare & Medicaid Services (CMS) Financing

Direct Graduate Medical Education (direct GME) – reimbursement to hospitals for costs such as resident salary, benefits, and faculty and hospital overhead expenses directly related to graduate medical education. (2008 – $3 billion)
- Things that are paid for:
  - “…pay for time spent in hospital and “non-provider setting” that are ‘primarily engaged in furnishing patient care’ & for didactics.”
    - Must pay for “substantially all (90%) of the cost of the residents salary & benefits while they are at a non-hospital site, and the portion of the teaching physicians salary & benefits that are attributable to GME”
    - Must have a written agreement with the teaching physicians
  - Leave and vacation time that do not prolong the resident’s training

Indirect Medical Education adjustment (IME) – higher operating cost to the hospitals from teaching activities including increased lengths of stay & higher acuity patients. (2008 - $6.5 billion)
- Things that are not paid for
  - Time spent in medical school setting without a hospital
  - Research activities that “are not associated with the treatment or diagnosis of a particular patient”
  - Time spent on international rotations
• Reporting
  o IRIS (Intern Resident Information System)
  o Many hospitals that ‘share’ residents between sites have had to account for their residents’ time by the hourly logs.
• To most successfully play “the game” to get maximum GME funding, a program needs residents “above the cap” for times that don’t count for each resident.

Calculating the GME finances
Direct Graduate Medical Education
• 1983 – Prospective Payment System – broke GME into DME & IME
  o DME remains tied to 1984 cost-based reimbursement for salaries, benefits, faculty and hospital overhead directly related to GME (office space) – this led to significant differences in payments across the country – per resident amount (PRA) ranging from $43,000 to $172,000 (2001). Still, CMS only pays for Medicare proportion of hospital cost, presuming the other insurance, Medicaid & local indigent care funds pay for the rest.
  ▪ Increases are based upon consumer price index & primary care was allowed more some years so the PRA is different for specialties.
  ▪ Full payment to only the initial residency training period (based on 2nd year of training) & those training further are limited to 0.5 FTE.
  o E.g. Each resident DGME cost is $100,000, you have 30 EM residents & 35% inpatient beds utilized by Medicare = $1,050,000

Indirect Medical Education
• IME is not different between primary care or adjusted for length of training.
• IME adjustment payment over the past 10 years this has significantly decreased (1997 =7.7% to now = 5.5%). IME adjustment is calculated using:
  o IME multiplier for FYE 2009 = 1.35
  o Formula (from Gentile reference) to calculate IME
    ▪ Adjusted ratio = IME multiplier\{1 + (#residents/#beds)\}^{0.405} -1
    ▪ IME adjustment = Adjusted ratio x (%Medicare pts.)(DRG payment) (Case mix ratio)
  o E.g. 2008 IME Adjustment = 5.5% increase in DRG payment for every 10 resident increase per 100 beds

Medicaid GME Funding
• Most states (not IL) provide some monies for GME training; CMS provides ~50% of their GME cost obligation so they can match these funds – 2008 - $3 billion

Fellowship funding
• ACGME approved – Treated as a resident in all federal registry language
  o Can’t bill for Medicare/Medicaid patients if in the same specialty – PedsEM
  o Only count as 0.5 FTE for direct GME funding in IRIS report
  o Can work & bill as ED attendings if not in same specialty - Tox, Hyperbarics
• Non-approved –work shifts in ED (80 hours/month average) - EMS, Education
Creative financing

- Maximize use of current residency spots
  - Move rotations to hospital with higher PRA for DME
  - Move rotations to hospital with higher % Medicare patients
  - Move rotations to hospital with DSH funding (minimal now)

- Government funding opportunities
  - VA hospital funding – no caps
  - Develop affiliations with hospitals that have never before had residents
  - Rural hospital affiliation – 50% of training must take place there to increase caps
  - Possible increase in cap numbers for a state through CMS (Louisiana?)
  - Resident closures – take on additional residents from hospitals that closed and the new hospital has a temporary adjustment up in their caps.

- Hospital/group private reimbursement
  - Payment for use of residents in ED instead of mid-levels
  - EM residents can provide in-house Code coverage,
  - EM resident external moonlighting increases rural referral patterns

- International residents who pay for direct costs of rotation
  - George Washington University - $85,00 administrative fee/resident
  - [http://www.gwumc.edu/imp/education/internatres.cfm](http://www.gwumc.edu/imp/education/internatres.cfm)

- Educational courses taught by residents (ACLS, simulation, procedure courses)
- Residents help with coding EM charts
- Research/grant money

Typical EM Residency Budget

<table>
<thead>
<tr>
<th></th>
<th>Standard Fixed Costs</th>
<th>Standard Variable Costs</th>
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</thead>
<tbody>
<tr>
<td>Resident costs</td>
<td>Salaries &amp; Benefits</td>
<td>Educational course (ACLS, ATLS, etc)</td>
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<tr>
<td></td>
<td>Medical Liability cost</td>
<td>Professional Society membership/dues</td>
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<tr>
<td></td>
<td>Resident meeting allowance</td>
<td>Resident educational supplies (books, computers)</td>
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<td></td>
<td></td>
<td>Meal reimbursement</td>
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<tr>
<td>Program costs</td>
<td>Annual accreditation cost</td>
<td>Recruiting/Interview season</td>
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<tr>
<td></td>
<td>Residency management system</td>
<td>Food costs (journal club &amp; other events)</td>
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<td></td>
<td>In-training exam</td>
<td>Visiting speakers</td>
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<td></td>
<td></td>
<td>Research expenses</td>
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<tr>
<td></td>
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<td>Welcome party/picnic</td>
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<td></td>
<td>Graduation celebration</td>
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<td></td>
<td></td>
<td>Office supplies</td>
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<tr>
<td>Other Possible Costs</td>
<td>Coordinator salary &amp; benefits</td>
<td>Faculty Protected time salary</td>
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<tr>
<td></td>
<td></td>
<td>Travel reimbursement (Residents, Faculty)</td>
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<tr>
<td></td>
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<td>Other celebrations</td>
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</tbody>
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References:


