Guest Editorial

THE FUNDING OF GRADUATE MEDICAL EDUCATION

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The above is the short version of the title; the long one is "Reimbursement for Graduate Medical Education During and After the Medicare Program." Most of the proposals for the reform of health care delivery have focused on such issues as cost control, access, and quality; surprisingly few have addressed the education of physicians. But in the long term, the size and quality of the health care system depends on the renewal of its work force.

Whereas undergraduate medical education is supported by a variety of funding streams, graduate medical education (GME) is supported almost entirely by patient care revenues to hospitals. Given this single source of funding for GME, governmental proposals for reductions in funding from Medicare and decisions of private payers to restrict payments to "necessary" services have sent shock waves throughout academe.

Because different payers use different methods of payment, most of which do not separate patient care from education, the exact cost of GME is problematic, although it has been estimated by the American Association of Medical Colleges (AAMC) to be between 5 and 6 billion dollars annually.

Medicare is unique in that it recognizes GME costs and designates two explicit payments for education to teaching hospitals. The direct Medicare payment for GME, which compensates teaching hospitals for costs directly related to the training of residents, totaled over 1.6 billion dollars in 1994. Specific direct costs include the salary and fringe benefits of residents and supervising faculty members and allocated overhead costs, such as clerical support. The estimated median cost per resident is about $45,000 annually; it is less for academic medical center hospitals (about $40,000) and more for affiliated community teaching hospitals (about $47,000). Medicare and Medicaid provide 77% of the total direct costs for GME; 11% is from the VA and the remaining 12% is from state and local appropriations and faculty practice plans.

The current method of reimbursement for direct costs was implemented with the COBRA legislation in 1989. A prospective, capitated payment is used that bases both per resident cost and the number of residents on those that existed in 1984 or 1985. The base year, per resident cost is corrected annually for inflation and multiplied by the number of residents in the current year. Medicare's payment is based on its share of the program's inpatient days.

Beginning October 1, 1995, residents beyond first board eligibility are being counted at the 50% rate only. This change will affect medicine, pediatrics, and specialties that have an optional first year, such as radiology. Surgical specialties will see no change in payments, although subspecialties will. This provision is expected to save about 166 million dollars over 5 years.

The indirect medical education adjustment (IME) is unfortunately named, because it is not primarily for medical education; rather, it is a percentage add-on to the basic DRG payment to teaching hospitals for their higher Medicare inpatient costs due to severity of illness, operating costs of educational programs, and higher percentage of indigent patients. The IME costs were over 4 billion dollars in 1994. The IME adjustment is based on the intern and resident-to-bed ratio, or IRB. There are three steps in the determination of the IME payment for a Medicare case. First, the IRB ratio is calculated (eg, 200 residents to 800 beds is 25%). Major teaching hospitals have an IRB of 25% or greater. For each 10% in a hospital's IRB ratio, there is a 7.7% add-on. A major teaching hospital with an IRB of 25% would receive an add-on of 2.5 x 7.7% or 18%, which, in the third step,
is added to the DRG payment. Thus, a cardiac catheterization (DRG 106), in a hospital reimbursed at $20,000, would receive an additional 18%, or $3,600 for the IME payment.

**BEYOND MEDICARE**

A number of organizations, including the AAMC, have supported the creation of a national all-payer fund, separate from patient care payments, to pay the direct costs of GME. While government officials and educators agree that all payers should contribute to this fund, business has expressed concern about any corporate tax on payroll. Clearly, the business community will be difficult to convince that the education of physicians is a societal responsibility.

Because this fund would contain public dollars, with it would come accountability for the types of physicians produced. In return for creating and maintaining a dedicated fund, the government will expect to exert control over the number and specialty mix of physicians. Thus, the administration’s proposal to create a National Council on Graduate Medical Education within the Department of Health and Human Resources would, starting in 1998-99, authorize annually the number of positions in each specialty, taking into account the need for physicians in each. The percentage of individuals entering primary care training programs would not be less than 55% in the aggregate.

Establishment of this Council would create political issues relating to its composition, the degree of participation of the medical profession, the level of federal involvement (including the potential role of the states), the process for allocating residency positions (national or local), and the method for selecting positions to be funded, (e.g. if quality is a criterion, what organization will perform this function, and how will quality be stratified when currently only minimum standards exist?) The role of local educational consortia in the new system is also unclear.

Finally, the size of the fund will be controversial. Current legislation proposes $3.2 billion in (calendar year) 1996, rising gradually to $5.8 billion in 1999 and 2000, with annual inflationary adjustments thereafter. In the future, it is likely that non-hospital entities will be able to receive payment for direct GME costs to encourage training in non-hospital sites. In effect then, the dollars will travel with the resident.

Given the wide variation in costs among institutions and disciplines, the Administration has also moved toward an average rate for direct costs, often combined with a weighting scheme to favor primary care specialties. But the further one moves away from hospital-specific costs toward national average costs, the greater the need for payment adjustments to recognize legitimate differences in costs. The Medicare Prospective Payment System (PPS) is based on this principle.

One cost that the government wants to standardize is the amount paid for faculty support, which is the primary reason for the wide variation in the costs per resident. In proposed legislation, estimates were based on an average physician’s salary of $125,000 and a 10:1 resident-to-attending ratio. This proposal does not recognize differences across specialties and seniority, and there is no empirical basis for the 10:1 ratio. Most resident review committees suggest something more along the lines of 3 or 4:1.

The arguments for a separate all-payer fund are that academic health centers:

1. treat patients who are more severely ill than those in community hospitals.
2. are more likely to attract patients with greater social needs.
3. provide regional referral services, such as burn units, which require specialized equipment and personnel. They are also often the first places to acquire new technology, which requires uniquely trained personnel.
4. have educational costs.
5. provide an environment for the conduct of both basic and clinical research.
6. are often located in the inner cities where operating expenses are higher.

It seems clear then that with the decline or demise of Medicare funding for GME, coupled with increasing initiatives for primary care, funding for orthopedic GME will be curtailed. Because the orthopedic work force is in oversupply, a reduction in the number of residents trained is desirable; however, funding for even the remainder is likely to be problematic. Therefore, we must consider cutting our numbers even further, reducing the number of years of training, or lowering salaries. While none of these alternatives seems particularly attractive, obtaining additional funds from other sources may be even more problematic. The most obvious source—practice income—is shrinking. Endowments would have to be extremely large to provide permanent sources of funding. Requiring affiliated institutions to assume partial responsibility for the costs of educating residents prior to service in the affiliate is perhaps an option that should be explored: However, whether we cut costs or increase funding from other sources, stable funding for the GME enterprise must be found.