

U.S. Physician Residency Funding:

Unravel the Mystery, Participate in the Conversation

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Introduction

The American public supports post-graduate physician residency training with approximately \$15 billion in taxes annually, primarily via Medicare payments to teaching hospitals. Government and private agencies alike have challenged the amounts, sourcing, transparency, accountability, and efficacy of that investment. The Institute of Medicine (IOM) published a study entitled [Graduate Medical Education That Meets the Nation's Health Needs](#) which recommends to Congress and other decision makers that graduate medical education (GME) payment models be modernized; that funds be more actively directed towards office-based training (where most healthcare is delivered - rather than being almost entirely allocated to teaching hospitals); and that payments be contingent upon outcomes, such as fulfillment of geographic need, community-based training expansion, and diversity. The IOM also calls for improved incentivization for primary care training, arguing that the current GME funding model has led to an overproduction of physician specialists which undermines higher quality, cost-effective care.

In order for us to join these conversations and begin to comprehend the downstream effects of these money flows, we physicians in practice and in training must have a basic understanding of how residencies are funded. Throughout the aforementioned study, the IOM describes GME financials as daunting, complex, largely undocumented, opaque, and incomplete. The authors denounce the lack of oversight, accountability, and stewardship of the public's investment in resident training. Few physicians, and certainly fewer public representatives, are aware of the economics surrounding GME, how and to whom these tax dollars course through teaching hospitals to their final destinations, or how certain outcomes and consequences have been incentivized (perhaps unintentionally) through these payment schemes. In researching these

topics, I found several helpful sources: the above referenced IOM [study](#), the Association of American Medical Colleges (AAMC - in particular its series of short [videos](#)), an American Academy of Family Physicians (AAFP) [presentation](#) entitled “Medicare GME Payments - Background and Basics,” and a Macy Foundation [paper](#) - “Ensuring an Effective Physician Workforce for America.”

Background

The [Medicare Act](#) of 1965 established the basis for current GME funding. Along the way there have been several legislative adjustments, perhaps most notably to adjust the calculation of various payments (COBRA in 1985) and to place a “cap” on the number of funded residency positions (part of the 1997 Balanced Budget Act). Medicare, which is administered by the Center for Medicare and Medicaid Services (CMS, an agency within the Department of Health and Human Services) contributes about \$10B, or $\frac{2}{3}$ of the \$15B annual tax-funded GME expenditure. Roughly \$3B of that amount is provided in Direct Graduate Medical Education (DGME) payments and \$7B in Indirect (IME) payments. The remaining \$5B of tax supported sources are derived from varying state Medicaid, Veterans Affairs and Children’s GME funds. Teaching hospitals themselves, insurance payers and other private entities are minor funding sources.

Focusing on the primary funder, CMS makes DGME payments to teaching hospitals to cover Medicare’s share of the direct expenses of training residents, to include their salary and benefits, faculty support, and program accreditation costs. This payment to hospitals is in the \$30,000 range per resident annually (with average stipends paid out to residents in the \$50,000s each year). Additionally, Medicare IME payments compensate the hospitals for indirect (if not somewhat ambiguous and theoretical) costs of resident training, like increased patient testing, less efficient care, and longer hospital stays at teaching facilities. IME is typically about twice as much as the DGME payment, such that a teaching hospital likely collects over \$100K in total Medicare revenue for each resident in training per year. Federally legislated formulae are used to calculate these payments which take into consideration the number of interns and residents training at a given hospital, the hospital’s percentage of Medicare patients, and case complexity. Some have claimed that IME payments may be excessive in comparison with the actual indirect costs of resident training. In particular, [MedPAC](#) (the Medicare Payment Advisory Commission) has estimated that the “IME adjustment is twice its empirically justified level.”

Implications

An interesting condition placed on DGME funding is its limitation to the number of years of duration of the first program that a resident matches into - the Initial Residency Period (IRP). For example, if a resident matches into a 3-year family practice residency, she is “funded” for 3 years. If she decides to switch into a 5-year general surgery residency after one year of FP, there will only be 2 years of full DGME funding remaining for her. Any subsequent years beyond the IRP will be partially covered at a discounted 50% DGME rate. (IME payments continue unaffected.) The DGME rule is also true for all accredited fellowship positions. They are only covered at a 50% rate since all fellowships are beyond the IRP. This can introduce some interesting considerations when switching or prolonging residencies, especially at smaller programs that have fewer residents and less overall funding to absorb a partially-funded resident.

Despite the reduced GME distribution provided to hospitals for residents who are training beyond their Initial Residency Period, per MedPAC there are about 19,000 residents completing training without being fully funded. What’s more, about $\frac{2}{3}$ of the nation’s teaching hospitals have taken on additional residents for whom there is no Medicare GME funding at all – to the tune of approximately 11,000 trainees. These hospitals are operating “above cap.” It is unclear how hospitals pay for these partially and unfunded positions. However, it stands to reason that the revenue a resident generates through increased billable services, decreased alternate employee costs, and add-on IME payments to the institution must generally exceed the cost of training. Otherwise, these many positions would not exist.

Conclusion

GME funding is an enigma for most. Multiple public and private organizations seek to understand these issues, to drive down costs, and to remodel the system to meet myriad goals. If we physicians desire to influence integral aspects of our profession, it is imperative that we understand these details, outcomes, and money flows.

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