FLORIDA HOSPITAL ASSOCIATION

POLICY DOCUMENT

MEDICARE GRADUATE MEDICAL EDUCATION (GME)

ISSUE BRIEF

JANUARY 2023

Summary

The number of physicians available to care for Florida's aging and growing population is insufficient. A shortage of **18,000** physicians is projected **by 2035**. Training more physicians in Florida is key to increasing the number of physicians practicing in the state. The COVID-19 pandemic has underscored the vital role that physicians and all health care providers play in our nation's health care infrastructure and has spotlighted the need for a larger physician workforce.

Medicare is the largest single program providing financial support for Graduate Medical Education (GME)–the training that occurs post-medical school graduation during primary residencies and specialty/subspecialty fellowships. However, the number of Medicare-funded GME residency slots/positions for each hospital is "capped" or limited. Medicare provides no funding for residents that exceed each hospital's cap. Today, Medicare GME payments support just **75%** of Florida's medical residents.

Typically, residency training can range from three to eight years, depending on the specialty, and the cost can range anywhere from **$35,164 to $226,331 per resident per year**. In addition, even with Medicare funding within the cap, GME payments typically do not cover all of the costs of residency training.

FHA supports increasing Medicare GME funding and lifting the 1996 cap on the number of Medicare-funded GME slots and/or extending the 5-year cap-establishment window for new GME training programs.

Background

GME includes physician residency and fellowship training after graduation from allopathic or osteopathic medical schools, domestically or internationally. Where a physician trains is highly predictive of where he or she eventually practices. Nearly 60% of medical residents and fellows continue to practice in the state where they complete their training.[1] In 2022, Florida has approximately 92.4% of their residency positions filled, compared with California and Texas whose residency fill rates are 95.8% and 95.2%, respectively.

[1] (AAMC Report on Residents , 2021) AMMC 2021 Report on Residents

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Medicare is the largest, but not sole, public funder of GME. (Please refer to our policy brief on Medicaid GME for a discussion of Medicaid funding of physician education and training). Florida currently has 281 residency programs and 4,126 residents in training. Of that number, 1,028 residents (25%) are not supported by Medicare direct GME payments. [2]I n comparison, California has currently 474 residency programs and 9,095 residents training but 1,860 (20%) of those residents are not receiving Medicare payments.

To qualify for Medicare GME payments, a teaching hospital must have an approved medical, osteopathy, dentistry, or podiatry residency program. Teaching hospitals often are affiliated with a medical school. Medicare regulations require an approved medical residency program to be accredited by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), Commission on Dental Accreditation of the American Dental Association, or Council on Podiatric Medical Education of the American Podiatric Medical Association.[3]

Medicare GME Payments

The majority of the funding for GME programs comes from the federal government. Residency and fellowship positions are supported through the U.S. Department of Health and Human Services budget (Medicare, Medicaid, and HRSA) and through the Departments of Defense and Veteran Affairs. **Medicare is responsible for approximately 75% of all federal GME spending**.[4]

Medicare provides GME payments based on several factors, including a teaching hospital's full-time equivalent (FTE) residents. However, Medicare GME funding is not tied to a specific individual resident. Instead, multiple residents may be counted as one FTE because their time may be spent in care settings that are not covered by Medicare GME (e.g., time spent at facilities operated by the VA would not be paid by Medicare).

Medicare GME payments are divided into two categories: direct graduate medical education payments (DGME) and indirect medical education payments (IME).

Direct Graduate Medical Education (DGME) payments: Medicare DGME payments cover the direct costs of operating a residency program, including resident salaries and benefits, medical malpractice insurance premiums, supervisory physician salaries, and administrative costs.

DGME payments are made as aggregate payments to hospitals based on a statutory formula: multiplying the hospital's per resident amount times the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital (and non-hospital sites, when applicable), and the hospital's Medicare share of total inpatient days.

Indirect Medical Education (IME) payments: Medicare IME payments support the indirect costs associated with residency programs, such as additional tests or procedures ordered by residents, increased record-keeping to maintain educational records for residents, and greater use of highly specialized technologies such as in burn or transplant units.

[2] AAMC State-by-State Graduate Medical Education Data
[3] (Congressional Research Service , 2013) Congressional Research Service Medicare GME Payment Overview
[4] (Congressional Research Service , 2013)Congressional Research Service Medicare GME Payment Overview, pg#1

IME payments are an add-on to each Medicare inpatient prospective payment system per-discharge payment based on statutory formula. The additional payment is based on the IME adjustment factor. The IME adjustment factor is calculated using a hospital's ratio of residents to beds, which is represented as r, and a multiplier, which is represented as c, in the following equation: c x [(1 + r).405 - 1]. The multiplier c is set by Congress. Thus, the amount of IME payment that a hospital receives is dependent upon the number of residents the hospital trains and the current level of the IME multiplier.[5]

Hospital-Specific Cap

Each hospital has a specific cap, or limit, on the number of physician residents that may be used to calculate both DGME and IME payments. DGME and IME caps are calculated separately. The caps are largely fixed, although there are a few circumstances when caps may be adjusted.

A hospital's specific cap is based on when it started training residents:

- *Residency program started 1996 or earlier*:

DGME and IME payment caps are based on the number of residents reported on the hospital's 1996 Medicare cost report.

- *Residency program started 1997 or later*:

For residency programs beginning after 1996, Medicare funds all of a hospitals' residents for either three or five years before imposing a cap.

  - *Residency programs beginning before Sept. 30, 2012*: caps are based on the number of residents in year 3 of the program. For example, a program that started in July 2010 would have its caps set based on the number of residents Medicare funded for the academic year beginning July 2012.
  - *Residency programs beginning on or after Oct. 1, 2012*: caps are based on the number of residents in year 5 of the program. For example, a program that started in July 2013 would have its caps set based on the number of residents funded by Medicare in July 2017.

If a hospital trains more residents than its cap, it must find sources other than Medicare to cover the training costs.

How are Residents Counted?

Each full-time resident is counted as 1.0 FTE at the beginning of the residency period. A hospital may count a resident's time training in the initial hospital and other training in a different hospital. If a resident rotates to any sites that the hospital cannot count, then the hospital must proportionally reduce the claimed FTE.

The residency program in which a resident begins training determines the number of years Medicare will fully fund its share of the training at 1.0 FTE. Moreover, the hospital may receive up to Medicare's payment of the hospital-specific per resident amount for training a resident within their residency period. For any additional training years, the resident will be counted by the hospital as 0.5 FTE and will receive half of the awarded payment. Only under limited exceptions can a resident be counted as a 1.0 FTE beyond the residency time frame:

[5] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Indirect-Medical-Education-IME

- A specialty that requires a broad-based clinical year
- If the first year is a transitional year
- Training in a combined residency program
- If the specialty is requiring additional training in a preventive medicine residency or fellowship

Consolidated Appropriations Act of 2021- Additional Slots

While state-specific data are not available, 33% of all hospitals in the South, which includes Florida, were considered to be over both their DGME and IME caps in 2018, meaning they used funding other than Medicare payments for resident training.

With almost 90% of hospitals nationwide having funding caps set in 1997, the majority of hospitals have had more than **25 years** of frozen Medicare GME funding. In 2021, with the passage of the Consolidated Appropriations Act of 2021, Congress recognized the need for increasing GME funding The Act provides funding from FY 2023 through FY 2031 for 1,000 new Medicare-supported GME positions with priority given to teaching hospitals in rural areas, hospitals over their caps, hospitals in states with new medical schools, and hospitals that care for underserved communities.

Starting in FY 2023, no more than 200 slots will be funded each year. Hospitals may use awarded slots to increase the resident count for an established program or for a new program. Hospitals must apply annually for slots, and hospitals awarded slots are permitted to apply for slots in subsequent years.

Policy Recommendations

- Florida GME- Naive expansion program similar to California, Georgia, and Texas
- Increasing the number of residency slots will help combat the projected physician residency shortage. Although this is a national issue, this will positively affect the state's impending physician shortage.
- Expand slots per year and an extended time of more than five years, allowing for the more significant expansion of existing programs.
- Increase Medicare funding to prevent hospital offsetting the cost for additional residents.

Resources

GAO Report: Caps on Medicare-Funded Graduate Medical Education at Teaching Hospitals
CMS: Direct Graduate Medical Education (DGME)
Section 126 of the Consolidated Appropriations Act 2021
Georgia GME-Naïve Hospitals: GME Expansion in Medicare
Congressional Research Service Medicare GME Payment Overview
1997 Bill Language
Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33
Commonwealth Report on 1997 ACT