

CHAPTER

10

**Treatment of the initial residency
period in Medicare's direct graduate
medical education payments**

R E C O M M E N D A T I O N

The Congress should eliminate the weighting factors that currently determine Medicare's direct graduate medical education payments and count all residencies equally through completion of residents' first specialty or combined program and subspecialty if one is pursued. Residents training longer than the minimum number of years required for board eligibility in a specialty, combined program, or subspecialty should not be included in hospitals' direct graduate medical education resident counts. These policy changes should be implemented in a budget-neutral manner through adjustments to the per resident payment amounts.

***YES: 12 • NO: 0 • NOT VOTING: 0 • ABSENT: 4**

***COMMISSIONERS' VOTING RESULTS**

Treatment of the initial residency period in Medicare's direct graduate medical education payments

In this chapter

- Medicare's payments for direct graduate medical education costs for residents
 - Programs with training beyond the initial residency period
 - Revising the initial residency period
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Medicare makes direct graduate medical education payments to hospitals that operate residency training programs based on predetermined per resident amounts. Hospitals' receive a full payment for residents who are within the initial residency period for their specialty—the minimum number of years required to qualify for board certification up to five years—but only half for residents training past the initial period. The Balanced Budget Refinement Act of 1999 required the Medicare Payment Advisory Commission to make recommendations on the appropriateness of the initial residency period, especially whether it should be changed for combined residency training programs or those that require preliminary years of training in another specialty. The payment differentials between training programs may influence hospitals' decisions on the types of residents they train. The Commission believes, however, that Medicare should not be involved in setting health workforce policy and therefore recommends that these weighting factors be eliminated in a budget neutral manner. If this policy were adopted, Medicare's direct graduate medical education payments would cover the minimum training period for the first specialty residents plan to complete, and, if chosen, that for the first subspecialty.

A well-trained supply of physicians and other health care professionals is essential to providing high-quality care for Medicare beneficiaries. This raises the question of what role the Medicare program should play in ensuring an appropriate supply and distribution of health care professionals. The Commission has concluded that although Medicare spending for health care services influences the health workforce in many ways, hospital payment policy is too blunt an instrument on which to rely to achieve specific workforce goals.

In our August 1999 report to the Congress on Medicare's payment policies for graduate medical education and teaching hospitals, we concluded that residents bear the cost of their training by accepting lower wages than they might otherwise earn and, therefore, that Medicare payments for direct graduate medical education (GME) costs should be considered patient care expenses (MedPAC 1999). Consequently we recommended folding costs for inpatient direct GME into prospective payment system rates through a revised indirect medical education (IME) adjustment to teaching hospitals' payments (MedPAC 2000). We also recommended that federal policies intended to affect the number, specialty mix, and geographic distribution of health care professionals be implemented through specific targeted programs rather than through Medicare's payment policies.

For this report, the Congress asked the Medicare Payment Advisory Commission (MedPAC) to examine only one aspect of Medicare's current payment policies for direct GME costs: whether the initial residency period should be extended for residencies requiring prerequisite years of training or for combined programs. Because we believe the broader question of whether Medicare's payment policies should be used to influence the specialty

distribution of residents is the key to considering the Congress's question, this chapter presents a brief discussion of both issues.

Medicare's payments for direct graduate medical education costs for residents

Medicare currently provides over \$2 billion in direct GME payments to hospitals for training allopathic, osteopathic, dental, and podiatry residents. The program provides payments to hospitals for residents in approved training programs, regardless of specialty or whether the residents' care is for Medicare beneficiaries. Direct GME payments are based on hospital-specific per resident costs in a base period, updated for inflation. A hospital's payment is the product of three factors:

- its per resident payment amount,
- a weighted count of full-time equivalent (FTE) residents training in the facility, and
- the hospital's Medicare patient share; the ratio of Medicare patient days to total patient days in the acute inpatient setting.¹

The weighting of FTE residents is based on the length of a resident's initial training period. A full-time resident in the initial residency period is counted as 1.0 FTE, whereas any resident training past this period is counted as 0.5 FTE. These weighting factors, though, do not apply to the resident counts used for calculating Medicare's IME adjustment. Because many residents train beyond the initial residency period, a weighting factor of less than 1.0 may influence hospitals' decisions on the types of residents they train.

The initial residency period

The Accreditation Council for Graduate Medical Education (ACGME) is responsible for accrediting post-MD medical training in the United States. In concert with individual specialty boards, the ACGME defines the minimum training standards, including minimum length of training, for the different allopathic specialties and subspecialties. Medicare uses these published standards to establish the length of the initial residency period for particular specialties. Similar processes exist for accrediting and setting training standards for post-doctoral training programs in the osteopathic, dental, and podiatric medical professions, which the Health Care Financing Administration (HCFA) uses to determine the initial residency period for the various residency programs in these medical professions. The accrediting and approval bodies for these residency training programs are the Council on Postdoctoral Training of the Bureau of Professional Education of the American Osteopathic Association (AOA), the Commission on Dental Accreditation (CODA), and the Council on Podiatric Medical Education (COPME).

For most specialties, the initial residency period is the minimum number of years of formal training necessary to satisfy the specialty's requirements for board eligibility, up to five years.² The initial residency period is determined based on the specialty program a resident first enters after completing medical school. For example, the initial residency periods for residents entering internal medicine and general surgery programs are three and five years, respectively. (See Appendix C for information on the lengths of initial residency periods for other specialties.) Residents who pursue subspecialty training (such as cardiology or vascular surgery) or training in a second specialty, are considered to have completed their initial residency period.

1 The Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 made several changes to Medicare direct GME payments that affect both the per resident payment amounts for individual hospitals and the resident counts used to determine total payments in a given year. Hospitals currently face hospital-specific caps on the number of allopathic and osteopathic residents Medicare will support and the resident count used to calculate payments is based on a three year rolling average instead of a single year resident count.

2 Before July 1, 1995, the initial residency period was one year longer than the minimum training period, also up to a maximum of five years.

The Health Care Financing Administration adjusts the initial residency periods to reflect changes in training requirements adopted by the different approving bodies (ACGME, AOA, CODA, and COPME).

Development of and modifications to the initial residency period

In enacting current policy, the Congress directed that Medicare would pay its full share for a resident's first program, but not a second one. Some members of the Congress also wanted to encourage training in primary care and discourage subspecialization. (At the time, an overwhelming majority of residents in internal medicine subspecialized, today it is about half.) The Congress also limited the total amount of training fully supported for any individual to five years, discouraging specialties from lengthening training periods and residents from pursuing more than one specialty.

The Congress has made several exceptions to the initial residency periods for specific specialties. In the 1986 legislation establishing the current payment system, up to two years of training in approved geriatric residency and fellowship programs were exempted from the initial residency period. In 1993, a similar exemption was extended to residents pursuing additional training in approved preventive medicine training programs. Residents in approved geriatric or preventive medicine programs who have completed their initial residency period, therefore, continue to be counted as 1.0 FTE for up to two years of training, so long as the minimum period for board eligibility is two years.

The Balanced Budget Act of 1997 extended the initial residency period for combined primary care programs (such as internal medicine / pediatrics) by one year, to cover the full length of training required in such programs. (Primary care specialties include allopathic and osteopathic family practice, general

internal medicine, general pediatrics, preventive medicine, and geriatric medicine.) The Balanced Budget Refinement Act of 1999 changed the initial residency period for child neurology training programs to the number of years for pediatrics plus two years, lengthening the initial residency period to cover the full training period required in this specialty.

The Congress also enacted policies differentiating payment rates based on residents' specialties. In the Omnibus Budget Reconciliation Act of 1993, it updated the per resident payment amounts for 1994 and 1995 only for residents in primary care and obstetrics and gynecology training programs. As a result, per resident payment amounts are about 6 percent higher for these specialties.

Programs with training beyond the initial residency period

Three types of residency programs may require training beyond the initial residency period (see text box, p. 158). These programs include:

- programs with prerequisites requiring one or two years of prior training in another specialty;
- combined programs, which allow residents to be certified in two specialties; and
- subspecialty programs, in which residents who have completed training in a specialty are trained further in one aspect of that specialty (for example, gastroenterology or vascular surgery).

Hospitals receive lower direct GME payments for at least a part of the training period for residents in most of these programs. For programs with prerequisites, the initial residency period varies depending on how the preliminary

year of training is accomplished. For combined programs in which the specialties are not both primary care, the initial residency period is that for the specialty that has the longest training period. All subspecialty training takes place outside of the initial residency period.

The initial residency period definitions and weighting factors also affect payments for residents pursuing a second specialty or those who switch specialties during training. Residents pursuing a second specialty are counted as 0.5 FTE in the second specialty. The initial residency period for residents who change their specialty is based on the specialty they first entered after medical school. For example, residents who switch from general surgery to internal medicine after two years of training would have three years remaining in their initial residency period and would be counted as 1.0 FTE throughout this training. On the other hand, residents who switch from internal medicine to general surgery after two years would have only one more year in their initial residency period and thus would be counted as 0.5 FTE for the last four years of general surgery training (assuming five years to complete the new program).

Revising the initial residency period

As discussed in detail in MedPAC's August 1999 report on Medicare's payment policies for graduate medical education and teaching hospitals, we believe that Medicare's payment policies should not be used to influence the specialty mix of the physician workforce. However, the current set of weighting factors for direct GME payments may do just that. We believe these differential weighting factors are inappropriate, and therefore recommend that they be eliminated.

Specialties with training beyond the initial residency period

Three types of specialties require training beyond the initial residency period.

Programs with prerequisites

A number of specialty programs require one or two years of prior general training in another specialty before receiving training in the specific specialty; these include anesthesiology, dermatology, pathology, radiology, child neurology, and ophthalmology. Prerequisite years of training can be taken in a preliminary program in another specialty (such as internal medicine or general surgery), in a one-year transitional program, or in the actual specialty if a first-year position is offered. If the preliminary year or years of training are taken in another specialty, the initial residency period is determined based on the training required to become board eligible in the preliminary specialty. Residents therefore will not be in the initial residency period for the final year(s) of training if the initial residency period for the preliminary specialty is shorter than the training period required in the final specialty. (See Appendix C, Table C-1, for more detail on the different specialty programs with prerequisites.)

A similar issue pertains to osteopathic training. All specialty programs in the osteopathic profession require completion of a one-year internship as a prerequisite for entering osteopathic residency. However, when an osteopathic physician seeks to enter an Accreditation Council for Graduate Medical Education (ACGME)-approved residency program, the ACGME-approved program frequently does not recognize the American Osteopathic Association internship year as a requirement for the first year in that residency program. Therefore, under present policy, the osteopathic physician would be counted as 0.5 FTE for the last year of the training program.

Combined programs

Combined programs allow residents to seek certification in two specialties, such as internal medicine and psychiatry. Residents cannot become board certified in either specialty until they complete the combined program. The total length of training in combined programs generally is less than if the two programs were taken separately, but at least one year longer than the training required in the longest of the specialties. The initial residency period for combined programs is based on the

training period required for the longest of the two specialties, although when the programs are both in primary care specialties (or primary care and obstetrics and gynecology) the initial residency period is extended by one year to cover the full length of training. Residents in combined programs that are not both primary care specialties are counted as 0.5 FTE during the one or two years of training beyond the initial residency period. (See Appendix C, Table C-2, for more detail on the different combined training programs.)

Subspecialty programs

Subspecialty programs require residents to complete training in a specific specialty, such as internal medicine, pediatrics, or general surgery, before starting the subspecialty program. Examples of subspecialty programs include cardiovascular disease, critical care medicine, gastroenterology, hand surgery, and thoracic surgery. Because residents entering these programs have completed their initial residency periods, they are counted as 0.5 FTE for the full length of training in the subspecialty. (See Appendix C, Table C-3, for more detail on the different subspecialty training programs.) ■

RECOMMENDATION

The Congress should eliminate the weighting factors that currently determine Medicare's direct graduate medical education payments and count all residencies equally through completion of residents' first specialty or combined program and subspecialty if one is pursued. Residents training longer than the minimum number of years required for board eligibility in a specialty, combined program, or subspecialty should not be included in hospitals' direct graduate medical education resident counts. These policy changes

should be implemented in a budget-neutral manner through adjustments to the per resident payment amounts.

The Commission recognizes that the Congress asked a narrower policy question regarding use of the initial residency period for combined programs and specialties with prerequisites. The policy changes we recommend would allow hospitals to receive full funding for residents through completion of the minimum period of training required for board certification in a specialty and subspecialty making Medicare's GME payments policy neutral.

For training programs that require preliminary years of training before residents enter the chosen specialty, the changes we recommend would provide full funding for the entire length of training. For example, a resident who completed an anesthesiology residency program after a preliminary year of internal medicine training would be counted as a full FTE for four years instead of three, as is the case under current policy.

Current policy allows for full funding of combined programs in which both specialties are considered primary care

(including in this definition obstetrics and gynecology), but the program provides only partial support for the last years of training if the combined specialties are not both primary care. The current policy therefore provides somewhat of a disincentive for dual certification in these combined programs. Our recommendation would extend Medicare's payments to cover the full training period required by all combined training programs.

Hospitals receive lower direct GME payments for residents pursuing subspecialty training. This policy may inappropriately influence hospitals' decisions on supporting such training. Our recommendation would remove this disincentive and make Medicare policies neutral with regard to subspecialty training. Residents who decide to enter an approved subspecialty training program

would be counted as 1.0 FTE for each year of approved training rather than 0.5 FTE as under current policy.

We believe Medicare's direct GME payments should be limited to the minimum training period required for residents to receive board certification in the first specialty they plan to complete, and if chosen, the first subspecialty. Training in a second specialty or second subspecialty should not be supported unless it is part of a combined training program. The additional years of training required for residents who decide to switch specialties partway through their training also should not be supported. These limitations should discourage any unnecessary lengthening of training by individual residents and residency programs as well as multiple specialization and perpetual training.

Other things being equal, eliminating the weighting factors currently in place for subspecialty training programs would potentially increase Medicare's direct GME payments by roughly 5 to 8 percent. We believe these changes should be implemented in a budget neutral manner, so that total direct GME funding for residency training does not change. Even if implemented on a budget neutral basis, our recommendation would likely have a relatively small impact on total hospital payments. Hospitals that do not have any subspecialty training would likely see a small drop in payments. Hospitals with substantial subspecialty training (those at which more than 15 percent of residents are in a subspecialty) would likely see a small increase in payments. Further research would be necessary to more accurately estimate the quantitative impact of adopting our recommendations. ■

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