



## GRADUATE MEDICAL EDUCATION FUNDING IN CALIFORNIA

# Medicare GME Funding 101

**M**edicare accounts for over 70% of the total federal investment in graduate medical education (GME) nationwide.<sup>1</sup> In California, Medicare funding accounts for roughly four times the amount of all of other state and federal funding sources combined. In 2014, the Institute of Medicine (IOM) released a 210-page report describing the current Medicare payment system as “inflexible, inequitable, inscrutable, and illogical.”<sup>2</sup>

## Medicare and GME: How Does It Work?

California has 119 teaching hospitals, which are hospitals that offer one or more accredited residency or fellowship programs and are therefore eligible to receive Medicare GME payments from the Centers for Medicare & Medicaid Services (CMS) with minimal reporting requirements. Medicare GME payments comprise two distinct funding mechanisms, each of which is based on a formula set in statute in the 1980s. These antiquated formulas rely heavily on the number of Medicare patients in the hospital and have no relation to the actual costs of a GME program.

**Direct GME payments (DGME).** DGME provides funding to teaching hospitals to cover the types of costs directly incurred by GME programs, such as trainee stipends, supervisory physician salaries, and administrative expenses. Actual costs are not used. As part of the DGME funding formula, CMS assigned each hospital a per resident amount (PRA), calculated by dividing a hospital’s allowable training costs of GME by its number of residents in a base period. The base period is, for most hospitals, the hospital’s cost reporting period beginning in fiscal year (FY) 1984, though for newer programs, it is set

### ABOUT THIS SERIES

Graduate medical education (GME) — also known as residency and/or fellowship — is the final training that physicians undergo after graduation from allopathic or osteopathic medical school, domestically or internationally. GME, and how it is funded, determines the number and specialty types of practicing physicians in the workforce.

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when the first resident begins and is the lower of either the hospital's costs per resident or the regional average. The PRA can vary widely between hospitals and, once established, is permanent and cannot be modified or reset, other than annual updates for inflation.

Each hospital has a separate PRA for primary care residents and non-primary care residents. The California hospitals with the highest and lowest primary care PRAs in 2015 are listed in the table.

**Indirect medical education payments (IME).** IME provides funding to teaching hospitals to cover the types of costs indirectly associated with residency programs, such as higher patient care costs from additional diagnostic testing that residents may order, or the longer time spent by residents in interpreting test results. Again, actual costs are not used.

Between 1965 and 1997, Medicare GME payments to teaching hospitals did not limit the number of residents trained. The Balanced Budget Act of 1997 limited, or "capped," Medicare GME payments for each teaching hospital to the number of full-time equivalent (FTE) residents and fellows that it had in training in 1996. This limit on Medicare FTE positions is referred to as the 1997 Medicare GME cap. The cap essentially freezes the geographic and financial distribution of Medicare-supported GME positions without regard for future changes in local or regional health workforce priorities or the geographic distribution and demographic makeup of the US population. As a result, the highest density of Medicare-supported positions and Medicare GME funding remains in the northeastern United States.<sup>3</sup>

### Highest/Lowest Primary Care PRAs, California, 2015

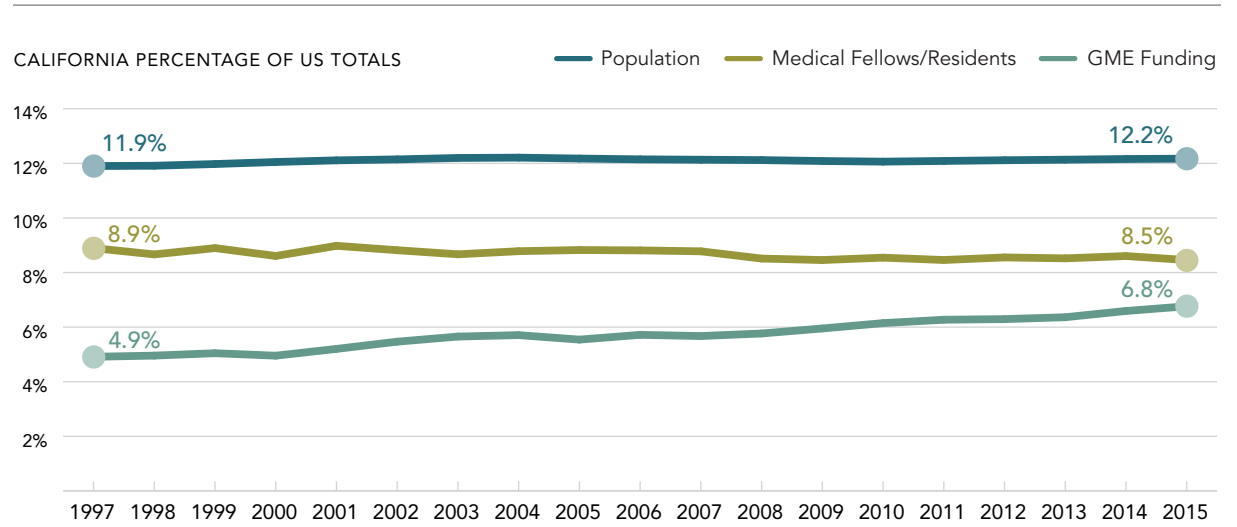
Highest PRA	
UCLA Medical Center, Santa Monica	\$186,565
UCSF Childrens Hospital, Oakland	\$181,169
UCLA Medical Center, Olive View	\$163,801
Good Samaritan Hospital	\$160,625
Glendale Adventist Medical Center	\$159,330
Lowest PRA	
St. Bernardine Medical Center	\$39,750
St. Josephs Medical Center	\$44,192
Saddleback Memorial Medical Center	\$48,337
Desert Hospital	\$54,771
Kaiser Hospital Foundation Manteca	\$86,508

## California's Medicare Funding Gap

Since 1997, there have been significant and persistent gaps among California's proportion of the US population, its proportion of US GME graduates, and its proportion of CMS Medicare GME funding. Between 2008 and 2010, California was the most populous state in the nation, with 12.1% of the US population, yet ranked 26th among US states in the number of Medicare GME FTE positions (19.36) per 100,000 population.<sup>4</sup>

In 2015, California constituted approximately 12.2% of US population and trained 8.5% of GME graduates, yet only received 6.8% of the total CMS Medicare GME dollars (see the chart below).

### California's Population, Medical Residents/Fellows, and GME Funding as a Percentage of US Totals, 1997–2015



Sources: US Census Bureau; American Medical Association (AMA) Masterfile Historical Residency File, 2017; Centers for Medicare & Medicaid Services Cost Reports.

# Current Opportunities Within the Medicare Payment System

## Opportunities for GME Expansion in California

Hospitals that have never been teaching hospitals are not subject to the 1997 Medicare GME cap. These hospitals are sometimes referred to as Medicare GME “naive” hospitals and are of great interest to policymakers because of their potential for GME growth. There are approximately 260 Medicare GME naive hospitals in California, defined as not having received Medicare DGME or IME funding between 1996 and 2015. If one of these hospitals becomes a new teaching hospital, the Medicare GME cap is calculated and implemented in the fifth year of the new training program. However, CMS staff has said that a hospital is a teaching hospital (i.e., not naive) if there is training that occurs according to a planned and regular schedule (i.e., not spontaneous or random), even if the hospital is not incurring the costs of the residents’ salaries, is not the sponsor of the program, and is training only a very small number of FTEs.

Critical access hospitals, small rural hospitals with no more than 25 inpatient beds, are reimbursed for CMS Medicare DGME based on 101% of the reasonable costs incurred.<sup>5</sup> There are 34 critical access hospitals in California, none of which is considered a teaching hospital.

## Opportunities for Reform

In its 2014 report, the IOM made detailed recommendations for federal GME reform, including moving to a performance-based system and establishing a new GME Center within CMS for oversight. The new center would maintain two funds: an operational fund and a transformation fund. The operational fund would cover the direct costs of existing GME positions, paying a national PRA to the program sponsor (not to the teaching hospital). The national PRA could be adjusted for regional cost differences. Roughly 10% to 30% of the total GME funds would go to the transformation fund, which would support GME expansion and innovations. Other federal GME funding programs, such as the Teaching Health Center and Children’s Hospitals GME programs currently administered by the Health Resources and Services Administration (HRSA), would also be overseen by the new GME Center within CMS. Implementing these reforms would have many benefits, including moving from antiquated payment formulas based on Medicare inpatient days to direct support of the GME program using PRAs based on actual program costs (adjusted for regional cost of living); making the system more transparent and equitable across states; and supporting expansion and innovation, including Medicare payments to Teaching Health Centers and children’s hospitals traditionally excluded from Medicare funding.<sup>6</sup>

The Graduate Medical Education Initiative (GMEI) is an effort comprising primary care leaders, educators, and advocates — primarily from western states that traditionally have been disadvantaged by Medicare GME payment methodologies — who are working to reform GME through payment reform, strategic partnerships, state-level initiatives, advocacy, and education.<sup>7</sup>

## The Authors

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## About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit [www.chcf.org](http://www.chcf.org).

## Endnotes

1. "Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding," US Government Accountability Office, March 9, 2018, [www.gao.gov](http://www.gao.gov).
2. Jill Eden, Donald Berwick, and Gail Wilensky, eds., *Graduate Medical Education That Meets the Nation's Health Needs* (Washington, DC: The National Academies Press, 2014).
3. For more information on the history of the Medicare cap, see "Chapter 3: GME Financing," in Eden, Berwick, and Wilensky, eds., *Graduate Medical Education That Meets the Nation's Health Needs*; and "Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding," US Government Accountability Office, March 9, 2018, [www.gao.gov](http://www.gao.gov).
4. US Census Bureau 2017. [www.census.gov](http://www.census.gov); American Medical Association Masterfile Historical Residency File, 2017; and Centers for Medicare and Medicaid Services 2015 cost reports. [www.cms.gov](http://www.cms.gov).
5. Elayne J. Heisler et al., *Federal Support for Graduate Medical Education: An Overview* (report no. R44376), Congressional Research Service, February 12, 2016, [fas.org](http://fas.org) (PDF).
6. "Chapter 5: Recommendations for the Reform of GME Financing and Governance," in Eden, Berwick, and Wilensky, eds., *Graduate Medical Education That Meets the Nation's Health Needs*.
7. To learn more about the GME Initiative, go to [www.gmeinitiative.org](http://www.gmeinitiative.org).