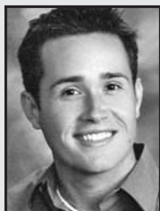

RESIDENT PRESIDENT'S MESSAGE

Healthcare in America: The True Value of Residency Education

Michael Ybarra, MD
AAEM/RSA President

As we begin a new membership year with the incoming team of leadership for AAEM/RSA, we have the opportunity to build on our past successes and implement exciting new ideas. I cannot stress enough the importance of every member to our organization – we benefit from your ideas and contributions, and your membership adds to the growing voice that AAEM/RSA has in the house of medicine and in national policy debates. You, as a resident, are extremely important to us, to your residency program, to the hospital at which you work, to the local communities you serve and to the healthcare system as a whole. The next installment in a continuing series on Healthcare in America is about you: how residency education is funded and your true value to the system!

Through college and medical school, we have already invested a tremendous amount of money in ourselves, but the government also knows the value and importance of medical education and has invested even more. The government sees a value in ensuring that our country has a steady stream of well-trained physicians and is, therefore, the primary sponsor of Graduate Medical Education.

The federal government pays for our positions as residents by reimbursing hospitals through Medicare. Additional money is available through Medicaid, but varies widely by state and is under tremendous financial pressure, as most Medicaid programs are well over budget. Medicare, which is housed in the Department of Health and Human Services, pays for costs in two categories: Direct Graduate Medical Education (D-GME) and Indirect Medical Education (IME) costing over five billion dollars annually.[1]

D-GME payments help to cover resident salaries, benefits and teaching attending physician compensation, among other costs related to resident training. IME costs are also reimbursed and include payments for extra tests that residents may order, longer patient stays and technological investments that enhance resident education. The IME is controversial; some economists argue that IME payments simply add to hospitals' revenues unjustly while others argue that residents truly add indirect costs. One study whose author argued against IME attempted to quantify the true value of a resident and argued that resident salaries are well below fair market value.[2]

The Balanced Budget Act of 1997 capped the number of funded residency training spots giving Medicare most of the power to control the number and distribution of residency programs.[3] If a hospital decides to start an emergency medicine residency program to meet the growing population demands, it has to reduce the number of residents in another specialty or fund the program without additional Medicare funds. Of note, podiatry and dentistry residency programs are not included in this cap.

Changes to these rules have occurred since 1997. For example, in 1999, rural hospitals were given the option to increase their resident cap by 30% with the hope that more rural trained residents would mean more physicians working in rural areas.

Medicare has created additional incentives to encourage growth of certain specialties. For example, reimbursement to hospitals for fellowship programs is typically half of the full-time equivalent salary for a resident, except for geriatrics and preventive medicine. This means a hospital will receive more reimbursement from Medicare for a geriatric fellow than an endocrinology fellow.[4]

D-GME payments are calculated based on a moderately complicated formula that includes variables such as number of Medicare inpatient days, the total number of inpatient days, the number of residents at the teaching hospital and an amount known as the Per Resident Amount (PRA). The PRA is a fixed annual dollar amount, unique to each hospital depending on location and local wage indices and based on a 1984 number that is increased every year to reflect inflation. The PRA is slightly higher for primary care residents to encourage hospitals to train more primary care physicians.[5]

IME costs are reimbursed to the hospital based on an adjustment percentage (again determined by a complicated formula!). For example, if Medicare typically reimburses a hospital $3,000 for a laparoscopic cholecystectomy, and the procedure is performed on a Medicare patient at a teaching hospital whose adjustment percentage is 5%, then that hospital will actually receive $3,150. The reimbursement to hospitals for Indirect Medical Education decreased sharply from 1997 to 2007, but began to increase again in 2008 after intense lobbying from hospitals. Even so, hospitals receive a lower adjustment percentage today than they did ten years ago.[6]

These reimbursements are for teaching hospitals up to their allowed number of residents. If a hospital has more residents than allotted by the Medicare cap, the additional residents must be fully funded by the institution. This sets the stage for intense debates within hospitals as to how to distribute and prioritize residency programs.

Residency education is a national priority reflected by the tremendous investment that the federal government has made. Your true value as a resident is important not only in the patient

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care and community service that you provide, but also the funding that you contribute to your hospital's bottom line.

Editor's Note: At the time of publication of this article, there are bills in the US Senate (S.973) and House of Representatives (H.R.2251), both titled "Resident Physician Shortage Reduction Act of 2009," proposing an increase in the current GME funding caps, potentially increasing the number of residents and future workforce of emergency physicians. The Association of American Medical Colleges has a very easy website portal that automates the process of sending emails supporting the bill to your representatives: http://capwiz.com/aamc/home. Show your support for increasing the Medicare caps by emailing your representatives today!

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2. Nicholson and Song (2001). "The incentive effects of the Medicare indirect medical education policy." Journal of Health Economics. 20: 909–933.
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