Conference Report

Medicare graduate medical education law, regulations, and legislative proposals

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In 1995, Congress considered significant changes in the Medicare system. Of most significance to postdoctoral dental education were proposed changes in Medicare Graduate Medical Education (GME) reimbursement. Historically, Medicare GME has supported hospital dental residency positions along with other medical residency positions. Because of the breakdown in budget negotiations between the White House and Congress, Medicare GME proposals in budget reconciliation legislation were not signed into law in 1995. This issue was not reconsidered by Congress in 1996. The AADS has worked to assure that any of the proposals considered in Congress to reduce Medicare GME support did not adversely or disproportionately affect dental residency training. The AADS has also examined the options for including support of dental school-based residents under Medicare GME in situations where the university hospital/academic health center incurs the costs of such training.

The term "GME" encompasses both Medicare Direct Graduate Medical Education (D-GME) payments (begun in 1965 and operating in its current form since 1985) and Medicare Indirect Medical Education (IME) payments (created in 1983). Hospitals have been reimbursed for residency training costs from the inception of Medicare in 1965. Medicare has shared in the cost of approved education activities that take place in teaching hospitals, as described in the legislative history of the original law:

"Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program."[1]

As medical residency programs grew in number and duration during the subsequent years, interns and residents became increasingly important to the services delivered and became an increasingly significant part of teaching hospitals' budgets. Originally, the basis of Medicare reimbursement for residency training was a direct or reasonable cost basis, which is the forerunner of today's D-GME. The original Medicare D-GME has been modified several times; most recently COBRA 1985 changes brought D-GME under a new payment methodology, replacing reasonable cost basis with formula payments based on each hospital's per resident costs.[2]

Medicare Direct Graduate Medical Education (D-GME)

Medicare D-GME payments cover costs directly related to the training of residents, such as residents' stipends and fringe benefits, salaries and fringe benefits for supervising faculty, and allocated overhead for direct (malpractice costs) and institutional (maintenance and utilities) items. The D-GME payment formula is calculated as follows:

1. Figure hospital specific per resident cost using FY 1984 or FY 1985 costs and the base year number of residents (for that time period)
2. Update base year per resident amount for inflation (using consumer price index for urban consumers)
3. Multiply the updated per resident amount by the number of full-time equivalent (FTE) residents in the payment (current) year
4. Determine Medicare's share based on the proportion of hospital inpatient days used by Medicare patients in the particular hospital (this is overall hospital usage and is not related to extremely limited dental benefits coverage under Medicare).

Dental residents in accredited programs are counted in the formula in the same manner as medical residents, and are in fact covered under the definition of "approved medical residency programs" in the regulations.[3] Off-site residents in ambulatory or community clinic settings can also be counted if the hospital incurs all or substantially all of the costs of such training.[4]

However, none of these dollars are "earmarked" for dental residency positions. Hospitals may claim Medicare GME for any eligible program, but these funds do not obligate them to support dental programs. It may also seem ironic that dental training can be supported by Medicare despite the lack of Medicare benefits coverage for nearly all dental care. In reality, this turns out

to be quite a bonus for the Medicare program. While Medicare does not have to pay for dental procedures, the presence of dental residency training in the hospital allows for consultations and oral health care for medically compromised patients that otherwise would be less likely to happen without such training programs. Therefore, it is extremely important for the survival of dental residency programs that support under Medicare GME be continued.

D-GME payments to hospitals currently total approximately $2 billion per year, according to fiscal year 1995 estimates, with an average per resident amount of $65,000 and amounts ranging from $20,000 to over $200,000 (as described in the D-GME formula, this is not the actual amount a hospital receives per resident).[5] In 1993-94 health care reform deliberations, the Department of Health and Human Services (D-HHS) had assumed a per resident amount of $58,000.

The magnitude of D-GME payment for dental residents is a difficult figure to estimate accurately, since dental residents are just a small part of a medical residency count that exceeds 100,000 residents nationwide. In 1995 the AADS was awarded a Health Resources and Services Administration (HRSA) contract to determine Medicare's share of support for dental education. This has never been done in the past, partly because of lack of information maintained by the Health Care Financing Administration (HCFA), which only started to compile more detailed GME information four years ago. This project will help to determine if hospitals are counting all eligible dental residents. Initial analysis indicates that not all eligible hospitals are counting their dental residents, at least for the 1990-91 cost year examined. The AADS recently mailed 1991 HCFA Medicare GME data to dental schools and affiliate member hospitals. This data included the total Medicare GME funds received per hospital for that year, and indicated the number of dental residents (by program) included at each hospital as part of the hospital's total full time equivalent (FTE) count. An estimate of the "dental share" at any given hospital could be made by simply dividing the total dollar figure by the dental FTE figure. The AADS has also shared pediatric residency program information in this data set with the AAPD.

In recent years the D-GME formula counted a full-time resident for the time spent in a basic training period **plus one year** Basic training period means the time required to be eligible for board certification. There is an exception to this rule for General Dentistry residencies, so that such residents are counted in the formula even though the training is not required for board certification. The preamble to HCFA regulations (p. 40294, September 29, 1989 Federal Register) recognizes that General Dentistry residents should be counted as 1.0 FTE for one or two years, depending on the length of the program. This time does count against the basic training period if the resident were to later enter a specialty program.

Due to a legislative change, after July 1, 1995, the basic training period for all residents was limited only to the **actual length** of the residency period (not to exceed 5 years), rather than the residency period plus one additional year under previous law. Residents within this period count as 1.0 FTE, and beyond this period count as .5 FTE. **For dental residents, this means they count as 1.0 FTE during the following years**

General Dentistry- 1 or 2
Dental Public Health- 1
Endodontics- 2
Oral Pathology- 3
Oral Surgery- 4
Orthodontics- 2
Pediatric Dentistry- 2
Periodontics- 3
Prosthodontics- 3
Prosthodontics/Maxillofacial Surgery- 3

This is based on recently issued HCFA regulations on initial residency periods under Medicare D-GME (*Federal Register*, August 30, 1996).

The Budget Reconciliation Law of 1993 (OBRA 1993) made some changes in the Medicare D-GME formula. It defined primary care residencies as family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. This medical-only definition reflected a goal to steer more physicians into primary care. The law provided that only these primary care residency positions would receive an annual inflationary update of the per residency amount in the D-GME formula. Since dental residents were in the non-primary care group, this meant that Medicare D-GME still continued support for dental residents, but at a flat rate. However, this freeze on inflationary updates for non-primary care residency positions was limited only to cost reporting periods beginning in fiscal year 1994 or 1995. Therefore, unless Congress affirmatively acts to extend this legislative authority, which has not happened, the provision has expired for fiscal year 1996 and beyond. Dental residents in the count are once again eligible for the inflationary update. The AADS is concerned, of course, about any future efforts to target funds to primary care training that would exclude any dental training from a primary care definition.

To receive D-GME payments for residents, a hospital must furnish the following information to its fiscal intermediary[6] for Medicare:

1. Name and social security number of each resident
2. Type of residency program, and number of years each resident has completed in all types of residency programs
3. Date resident is assigned to the hospital and any hospital-based providers
4. Date resident is assigned to other hospitals or other freestanding providers, and nonprovider setting during the cost reporting period, if any

5. Name of the medical, osteopathic, dental, or podiatry school from which the resident graduated and the date of graduation
6. Name of the employer paying the resident's salary.

The major issue each year influencing changes in a hospital's reimbursement under Medicare D-GME is the number of residents.

Medicare indirect medical education (IME)

Medicare indirect medical education reimbursement (IME) was created by Congress in 1983 as part of the Prospective Payment System (PPS).[7] While D-GME remains separate from PPS, IME is part of this system that reimburses hospitals and physicians based on diagnosis-related groups (DRGs). DRGs represent an average charge for discharges in specific diagnosis categories (rather than specific procedures), compared to the national average for all Medicare hospital discharges. IME was created to compensate for factors that increase teaching hospitals' costs, such as: treating a more severely ill patient population; offering a wider range of services and technology; providing more diagnostic and therapeutic services to certain types of patients; and allowing clinical inefficiencies as residents learn their profession (such as the ordering of more tests than the norm). IME is calculated as a percentage add-on to teaching hospitals' prospective payments. The IME adjustment increases as the ratio of residents-to-beds[8] at a hospital increases. Currently, this is a 7.7 percent increase for each 10 percent increase in a hospital's intern/resident to bed ratio, after twice being reduced from the original level of 11.59 percent. Dental residents are part of the IME resident count.[9]

Medicare IME is more limited in terms of support for residents outside of the hospital compared to D-GME: IME only applies to the inpatient setting (PPS portion of a hospital) and the hospital outpatient department. Residents in community health centers may be counted under IME if the residents are under the hospital's ownership or control and the hospital incurs all or substantially all of the costs of services furnished by the residents. However, because of this "ownership and control" restriction, this provision in reality has had little impact since community health centers are usually self-governed and independent of hospitals.

As noted above, the D-GME formula factors in the component of a hospital's Medicare inpatient population. Since Medicare IME represents an adjustment in payments for DRGs, a hospital's Medicare population affects its funding amount under the IME formula. Unlike D-GME however, IME has no limitation on the number of years of residency training supported. Under IME, residents were formerly counted on one day (September 1). However, for cost reporting periods beginning after July 1, 1991, hospitals count the number of residents on hand for the entire year.

In fiscal year 1995, IME payments amounted to $3.8 billion to hospitals. Dentistry's "share" of IME is also difficult to estimate for the same reasons stated above in reference to D-GME. However, AADS analysis of HCFA data has already produced some useful comparisons. The information recently distributed on total Medicare GME received per hospital in 1991 includes both D-GME and IME payments. As indicated above, each hospital listed in these data would be able to perform a simple estimate of its "dental share" of these, albeit not broken out between D-GME and IME. The AADS plans to make similar calculations based on more recent HCFA data.

Eligibility of residents trained in dental school clinics

Current law and Medicare D-GME regulations provide that training at outpatient or hospital off-site clinics can also be counted if the hospital incurs all or substantially all of the costs of such training. This means that hospitals may count residents based in dental school clinics for purposes of Medicare GME support, provided that certain conditions are met. The AADS has advised dental schools that their clinic might be considered an "off-site facility" affiliated with a hospital under Medicare D-GME (but not Medicare IME), or might be considered part of a hospital for both Medicare D-GME and IME purposes where the school clinic is an integrated, although physically separate, component of the hospital. It is clear that hospital-based residents who rotate through dental school clinics should be "counted" for this time under D-GME, provided that the time is spent in patient care activities and there is a written agreement with the hospital.

In the area of dental school based postdoctoral residency programs and the relationship to Medicare GME, there are several important points:

1. If the dental school clinic is considered part of the hospital complex (or under the same corporate structure), there may be no need to treat the dental school clinic as "off-site", as noted above.
2. It must be remembered that the hospital is the only entity that actually receives Medicare GME funds. Therefore, a key point is the relationship of the dental school to the university teaching hospital. This helps determine whether a school may, within the academic health center, seek Medicare GME inclusion as a free-standing affiliated clinic or an actual component of the hospital. The author of this article should be contacted for more information on some of the legal and regulatory issues relevant to this relationship.
3. A critical point in this analysis is to have a discussion with the hospital's financial reimbursement officer (titles may vary) who is responsible for dealing with the hospital's Medicare reimbursement, specifically GME.

While pediatric dental residencies are usually based in hospitals, some of these hospitals are children's hospitals. Children's hospitals are eligible for Medicare GME, but receive very little in such reimbursement

because of their low Medicare inpatient costs. Therefore, the current Medicare GME system results in much more significant support of pediatric dental training where such positions are located in a university teaching hospital with a large Medicare inpatient population. As indicated in the legislative section below, this is one of the weaknesses in not having a unified "all payer" fund to support residency training costs.

Legislative update on potential Medicare GME changes

In 1995, the U.S. Congress considered significant changes in the Medicare system, including proposed changes in Medicare GME reimbursement. This was part of larger budget reconciliation legislation. This legislation was vetoed by the President on December 6, 1995. No significant Medicare GME reform was considered in the second session of Congress in 1996. Any Congressional activity in this area has been postponed until 1997.

The most significant threat to dental residencies in 1995 was a proposed residency freeze. This proposal, originating in the House of Representatives, was to limit support for each training program to the number of residents in place as of August 1, 1995. Because of AADS efforts, and with the support of the American Association of Hospital Dentists (AAHD) and the American Dental Association (ADA), dental residents were *exempt* from this "freeze" or "cap" in the final House budget reconciliation bill and the conference budget reconciliation legislation. The rationale for this dental exemption was to allow room for growth in dental residency programs, due to the need for additional primary care General Dentistry positions as noted in the IOM report on dental education. Physician residency training, by contrast, has an over-abundance of first year residency training positions compared to the number of graduates each year from U.S. medical schools. The Presidential veto ultimately made the residency freeze issue a moot point for everyone.

The Senate Medicare GME proposal made no changes to the current Medicare D-GME system, but would have reduced the IME adjustment to 6.7% in FY 1996, 5.6% in FY 1997, and 4.5% in fiscal years 1998-2002. The House Medicare proposal created a GME trust fund that would pave the way for permanent, ongoing GME support. Medicare IME and D-GME would have been reduced over seven years while new GME accounts would be created from general treasury funds, shifting the GME burden from Medicare. The best estimates were that the GME trust fund would result in a slight increase in expected GME spending over seven years (versus projected spending if Medicare GME remained unchanged), while reducing Medicare's contributions to these GME costs. Commentators suggested this could be the first step in creating a true "all payer" GME fund, which means having all insurers/third party payers who benefit from residency programs contribute to support residency training. The trust fund approach was adopted by the conference committee, but as noted above, this died with the Presidential veto of budget reconciliation legislation. The AADS and numerous health professions associations remain supportive of an "all payer trust fund" concept.

While no Medicare GME changes were made in 1995 or 1996, these Medicare GME issues have already resurfaced in the Administration's fiscal year 1998 budget request and in current Congressional deliberations on Medicare. Therefore, the threats to and opportunities for dental residency training under Medicare GME will remain a reality for dental residency programs in hospitals and dental schools.

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1. *House Report*, Number 213. 89th Congress. 1st Sess. 32 (1965) and *Senate Report*, Number 404. Pt. 1. 89th Congress. 1st Sess. 36 (1965).
2. Consolidated Omnibus Budget Reconciliation Act of 1985, passed by Congress in April, 1986.
3. Signed into law April 7, 1986, 42 CFR (Code of Federal Regulations) §413.86 (b) (1), referencing §405.522 (a).
4. §1395ww (h) (4) (E). 42 CFR §413.86 (f) (1) (iii).
5. Prospective Payment Assessment Commission. "Medicare and the American Health Care System". Report to Congress, June 1995.
6. Payment to a provider of Medicare reimbursement is commonly handled by a fiscal intermediary that is typically an insurance company, pursuant to a contract with the Secretary of the U.S. Department of Health and Human Services.
7. 98-21, making IME changes effective January 1, 1983.
8. For counting of hospital beds, adult or pediatric beds are included (a bed permanently maintained for lodging inpatients). Excluded are newborn beds, custodial beds, and beds in excluded units.
9. CFR § 412.105 (g) (1) (i) (A), referencing accrediting organizations in § 405.522 (a).