HSCRC Direct Medical Education Policy
Final Adopted Recommendations
June 2002

Introduction

A primary social cost funded in Maryland's rate-setting system is the cost of graduate medical education (GME), generally for interns and residents trained in Maryland hospitals. Both direct and indirect costs are built into hospital rates through the rate-setting system. Because the hospital is the setting for a substantial portion of medical training, it is both appropriate and necessary for the Health Services Cost Review Commission (HSCRC or Commission) to provide for the funding of these costs.

In recent years, however, the cost of these programs has grown as hospitals have requested recognition of larger numbers of interns and residents as part of their GME costs. These requests have routinely been granted, contributing to a substantial rise in reimbursement to hospitals with large teaching programs. While the Commission's commitment to funding GME is appropriate, that commitment need not be open-ended. The Commission does, however, have the responsibility to establish reasonable provisions in hospital rates for the funding of GME.

The purpose of this paper is to re-articulate the Commission's policy on the amount of GME recognized in Maryland's rate-setting system and to propose a process for consideration of changes in a given hospital's number of approved interns and residents. The paper begins by reviewing current Commission policy on GME and showing the magnitudes currently in rates for direct and indirect medical education costs. The paper then proposes a specific policy for recognizing appropriate levels of GME funding.

Description/Background

Graduate medical education is generally defined as the clinical training following graduation from medical school. This clinical training, which ranges from three to seven years in length (internship and/or residency), has traditionally taken place in teaching hospitals or academic medical centers (AMCs). Graduate medical education costs are traditionally divided into direct medical education (DME) and indirect medical education (IME) components for identification and reimbursement purposes. Direct medical education costs are those directly incurred in the operation of teaching activities and consist of salaries and fringe benefits of residents and interns, faculty supervisory expenses, and allocated overhead. By contrast, indirect medical education expenses are generally described as those additional costs incurred as a result of the teaching process (e.g., extra tests ordered by interns/residents or the extra costs of supervision).

In Maryland, both indirect and direct graduate medical education expenses are financed through hospital rates paid by patients treated at teaching hospitals, and both are affected by the Commission's DME policy. For example, IME costs are calculated, in part, by including the resident per bed ratio in the IME regression calculation. The reasonable cost of graduate medical education was included by the Commission in teaching hospitals' rates at their original rate settings, and are inflated each year through the annual update factor. For DME, the reasonable

cost is defined as 75% of the statewide average of the direct costs of training a resident.[1] In the past, each hospital's total count of qualified, paid interns and residents in approved programs was limited to the total count reported by the HSCRC in the September 1990 screens, or the relevant cap established for a hospital.[2] For rate year 2002, the number of qualified residents and interns included in hospital rates was 1,557, or $78.6 million in approved revenue for direct medical education. Inpatient estimated IME costs in Maryland was $168 million (*for intern/resident count by hospital, please see* Attachment I).

The Commission utilizes an annual hospital intern and resident count to assist in quantifying the direct and indirect costs of medical education in physician training programs, and recognizes only the interns and residents included on the survey up the hospital's cap. On the survey, each hospital reports, by program, the count of qualified, paid interns and residents in approved physician training programs treating patients at their hospital on a particular survey date – the first Tuesday following Labor Day of each year. Because the Commission methodology limits inclusion to qualified and paid interns and residents only, the following definitions apply:

1. Interns/residents are qualified if they are prior to their first specialty board eligibility, up to and including five years of postgraduate medical school training (*please see* Attachment II, *which lists the required years for certification by program*).

2. Non-qualified interns/residents are defined as: residents/fellows in or beyond their first year of specialty board eligibility; interns/residents/fellows past their fifth year of training; or residents/fellows in a sub-specialty, after their first specialty board eligibility.

3. The Commission considers a reporting hospital's intern/resident as **paid** if the reporting hospital is covering the direct costs associated with the intern/resident. For each intern/resident reported on the survey, the hospital is required to identify the payment status on one of the following:
    - A. Payment made directly to the intern/resident;
    - B. Payment made **to** another institution (e.g., hospital retains this intern/resident under contract);
    - C. Payment made **by** another institution (e.g., another

[1] AMCs argue that the direct and indirect costs and the productivity losses associated with the presence of interns and residents constitute net costs to teaching institutions. Community hospitals, on the other hand, believe these costs may be balanced by the extent to which residents directly substitute for other health care professionals (physician assistants, nurses, and physicians). The current 75% allowance for DME reflects an HSCRC judgement about the relative size of benefits to costs at teaching hospitals.

[2] The Commission has imposed caps for administrative simplicity and to limit the amount in hospital rates from small year-to-year fluctuations in hospital intern and residency programs.

institution has contracted for this resident/intern); or

D. Payment made by another source.

4. For each intern/resident listed on the survey, the following information is used to determine qualified status:

   A. The number of years in current program;

   B. Whether the intern/resident was in any program previously; and

   C. The total number of years in previous programs.

Guideline and Time Frame for Proposing and Rationalizing Changes to Direct Medical Education Methodology

The Commission staff propose that any request for the Commission's Direct Medical Education policy relating to the process for the consideration of changes to hospital intern and resident caps should include the following:

1. **Nature of the Request**: The proposed change to the applying hospital's current resident/intern cap should represent a substantial change either in the number of residents/interns or to the hospital's teaching program structure, and must be consistent with the Commission's policy objectives for the CPC system. Evidence must be provided to show that the current hospital cap does not adequately reflect the substantial operation of the teaching program.

2. **Supporting Documentation**: It should be the responsibility of the applying hospital to provide the necessary supporting documentation. This may include, but is not limited to:

   - the clinical justification for changes to the teaching program;
   - an impact analysis on the applying hospital as well as its effect on the overall state-wide system (stating the number of cases and amount of revenue may suffice, depending on the magnitude of the proposed change); and
   - a detailed write up of the methods used in any data analysis to ensure that proposed changes are consistent with the Commission's overall goals and policy objectives for the CPC methodology.

Accordingly, each hospital's current approved resident and intern count as of May 1, 2002 is the maximum number of interns and residents for the hospital. That cap will only be reconsidered in light of a submitted application, and the burden of proof rests with the hospital to justify any increase in its current cap. The Commission staff also recommend that requests be considered once each year, and suggest that any application for a change in a hospital's maximum number of interns and residents should be filed with the Commission by the required submission date for the annual intern and resident count survey (currently July 1, 2002).

At its June 6, 2002 meeting, the Commission adopted the staff recommendations. Based on comment letters received by the Commission, the final numbers were also adjusted to reflect for intern and resident survey results that had been previously returned to the Commission with incomplete information.

Attachment I

Number of Hospital Interns/Residents

Hospital	**Number of Qualified Interns/Residents**
Johns Hopkins Hospital	464
UMMS	372.5
Sinai Hospital	125.5
Johns Hopkins Bayview	102
Franklin Square Hospital	77
St. Agnes Hospital	62
Union Memorial Hospital	58
GBMC	51
Mercy Medical Center	48.5
Maryland General Hospital	45
Prince Georges Hospital	40
Good Samaritan	38
Harbor Hospital	36
Holy Cross Hospital	30
Kernan Hospital	7
Suburban Hospital	3
Shady Grove	3
Total	**1557**

Attachment II

Residency Programs and Number of Years Required for Certification

Program	Total Years for Certification
Anesthesiology	4
Dermatology	4
Emergency Medicine	3
Family Practice	3
Internal Medicine	3
Neurological Surgery	6
Nuclear Medicine	4
Obstetrics/Gynecology	4
Ophthalmology	4
Otolaryngology	4
Pathology	4
Pediatrics	3
Physical Medicine and Rehab	4
Psychiatry	4
Neurology	4
Radiology	4
Surgery (includes Orthopedic, Plastic)	5
Urology	5