The Balanced Budget Act of 1997 and continuing changes put into place by the Educational Commission on Foreign Medical Graduates (ECFMG) are altering the environment for graduate medical education (GME) in ways that threaten osteopathic graduate medical education in particular.

Hospital revenue is decreasing due to declines in Medicare GME and patient-care reimbursements. The new 3-year rolling average methodology for counting “house staff” makes it likely that unfilled positions will be eliminated. With osteopathic GME positions unfilled and financial resources decreasing, osteopathic medical programs may shrink further.

Additionally, the ECFMG has put into place policies that may restrict the number of international medical graduates entering the United States. Approximately 25% of all allopathic GME positions in the United States are filled by international medical graduates. If this applicant pool decreases, allopathic medical programs may turn to osteopathic medical graduates as the only other available pool of individuals to fill program positions. At a time when allopathic internship positions are already unfilled and 30% of osteopathic medical graduates enter allopathic first-year programs, further inroads by allopathic programs could severely impact osteopathic GME efforts.

(In Key words: Balanced Budget Act of 1997, BBA, Clinical Skills Assessment, ECFMG, graduate medical education, J-1 visa, Medicare, osteopathic medical education)

Any discussion of current trends in graduate medical education (GME) must acknowledge both the fiscal constraints and general uncertainty under which we presently labor. In the osteopathic medical profession in particular, GME training is changing due to internal and external pressures. This article discusses the external threats to the osteopathic GME enterprise and some protective strategies.

In recent years and to its great credit, the osteopathic medical profession has increased the number of osteopathic medical internship and residency positions in response to significant increases in the number of students entering colleges of osteopathic medicine (COMs). Since the 1993–1994 academic year, the profession has approved 352 new internship positions but had a shortfall in funding for 90 existing positions, for a total of 1796 internship positions—of which only 1502 were filled.1 It further funded 220 new residency positions in the years 1996 through 2000 for a total of 4304 positions—of which only 2928 were filled.1

Even these strides have not kept pace with new student enrollment, however. In 2000, COMs graduated 2270 students resulting in 474 fewer osteopathic medical internship positions than graduates.1 This mismatch between graduates and postgraduate positions will increase as COMs graduated approximately 2500 students in 2001.1 To provide residency positions for all of its graduates, the osteopathic medical community would have to create an additional 2000 residency positions.1

The only reason the osteopathic profession does not have a severe shortage of internship and residency positions is that significant numbers of osteopathic medical students enter allopathic programs in the first and subsequent training years. The availability of these positions represents a “safety valve” that allows COMs to continue to increase class sizes without working to increase numbers of osteopathic GME positions. This state of affairs could continue indefinitely if not for two primary external forces affecting GME. The Balanced Budget Act of 1997 (BBA) affects Medicare GME funding. Additionally, recent actions by the Educational Commission on Foreign Medical Graduates (ECFMG) will potentially cause severe dislocations in osteopathic GME.

Balanced Budget Act of 1997 (Public Law Number 105-33)

Since the Medicare Act of 1965, no single piece of legislation is responsible for more changes in GME funding than the Balanced Budget Act of 1997.2 The provisions of most concern to the medical community are as follows:

- Freezing intern/resident reimbursable numbers as of 1996,
- The 3-year rolling average for “house staff” counts,
- Decreases in GME funding through the indirect medical education adjustment (IME) and the disproportionate share hospital payment (DSH), and
Decreases in patient revenue due to Medicare reimbursement cuts.

Medicare now will provide GME reimbursement funding only for the total number of interns and residents in any hospital as of the last cost-reporting period of 1996. Until 1996, hospitals were free to increase house staff numbers secure in the knowledge that Medicare GME reimbursement dollars would automatically be paid for all residents and interns, regardless of how many of these workers the hospital added in any given year.

Except for rural hospitals, the BBA freezes house staff numbers at those reported by the hospital in the Intern Resident Information System (IRIS) count as of the last cost-reporting period of 1996. Medicare will not fund any house staff positions over this “cap number.” However, there is one provision allowing for changes to house staff numbers within individual programs; a hospital could increase a family practice program by five positions per year, for example, if it also decreased other programs by a total of five positions per year. Alternatively, hospitals are also free to increase intern/resident numbers over the cap number by finding alternative funding for these positions.

In addition to the cap on house staff numbers, for GME payment purposes, Medicare will now calculate house staff numbers based on what is known as a “3-year rolling average.” Hospitals now report the average of the last 3 years of house staff numbers (2 years for 1996) to Medicare and payment is made on this average—regardless of the actual house staff count for that fiscal year (Table). The IME adjustment is an important component of GME payments to hospitals. The general rule of thumb is that IME is one and one-half to two times the amount of the direct GME payments to hospitals. The general rule of thumb is that IME is one and one-half to two times the amount of the direct GME payments.

The DSH payment is not a factor for the financing of osteopathic medical hospitals, as it exists to compensate hospitals—usually inner-city hospitals—that have large proportions of patients for whom uncompensated care is provided. Decreases in IME adjustments and DSH payments will continue through 2002 and are a major reason why academic medical centers are encountering severe budget problems.

Consequences

For all practical purposes, osteopathic GME positions are frozen at the levels reported in December 1996. Although rural hospitals are permitted to increase house staff positions, most osteopathic programs do not reside in rural hospitals. The osteopathic medical profession is now in a zero-sum game for GME purposes.

Any increase in house staff numbers in one hospital program must be offset by a corresponding decrease in another program—or programs. There is no mechanism in the BBA for hospitals in nonrural settings to increase internship numbers to catch up with the number of our current osteopathic medical graduates. There is no mechanism to increase numbers of family practice or other primary care positions—even if a hospital is otherwise in a position to do so. Furthermore, a hospital that does not fill its number of capped house staff positions is disadvantaged for several years because the rolling-average mechanism of the BBA makes decreasing house staff numbers more advantageous to hospitals than increasing them.

The Table illustrates a hospital that did not recruit a full intern/resident class in 1996 or 1997. As a consequence, the average number of house staff continues to be depressed for several years due to the rolling-average mechanism. As a result of this methodology, osteopathic medical hospitals that do not fill positions will lose at least a portion of the GME funding for these positions over the subsequent 3 years. Cuts in IME adjustments are further decreasing GME funding at osteopathic medical hospitals. Combined with Medicare reimbursement decreases and cuts from managed-care entities, osteopathic medical hospitals will find that essentially all revenue streams are decreasing.

The cumulative effect on GME is a certain decrease in financial and other resources. It is becoming increasingly more difficult for hospitals to promote quality and support their osteopathic GME programs. Simultaneously, the American Osteopathic Association (AOA) and COMs are changing accreditation requirements in ways that require more resources from hospitals. While these changes are in large measure important in professionalizing programs, tightening standards, and promoting quality, it is clear that this is a time of increasing scarcity of GME resources.

The cumulative effect of these changes puts increasing pressure on hospital budgets. An obvious area to examine for budget savings is GME. Generally, hospitals believe that medical interns and residents increase the cost of patient care. Under the Medicare prospective-payment system, anything
that decreases patient-care costs will increase hospital profits on patient care. In addition, the cost of teaching physicians, their secretarial support, and other GME costs are usually not fully reimbursed—especially in osteopathic medical hospitals where these costs have not been included as reimbursable costs in prior years. For all these reasons, hospital administrations may regard GME as a place to cut costs.

Educational Commission on Foreign Medical Graduates

Several examinations are available for international medical graduates (IMGs) that allow them to apply for state medical licenses in the United States. In the past, these examinations included a test of English-language proficiency and one of several written licensure examinations. Currently IMGs are required to take the United States Medical Licensure Examination. Since 1998, the ECFMG also requires IMGs to pass a practical Clinical Skills Assessment (see http://www.ecfmg.org/). This examination is expensive (currently $1200), administered only in Philadelphia, Pa, and requires an exchange visitor visa (J-1 visa) for IMGs not already based in the United States. Considerable numbers of IMGs may not be willing or able to finance the considerable costs involved. Additionally, J-1 visas for potential applicants who wish to take this examination may not be forthcoming from the Immigration and Naturalization Service, creating a further barrier to completion of medical licensure.

Out of approximately 98,000 GME positions in allopathic programs, about 25% are filled by IMGs. Data from the National Resident Matching Program indicate that, for 2001, of 20,642 first-year positions, IMGs filled approximately 23% of these positions. The number of IMGs essentially remained steady when compared with the numbers for 1998.

Consequences

If the numbers of IMGs begin to drop, some proportion of these 3500 first-year GME positions formerly filled by IMGs will be open. The obvious alternative to decreasing program size or closing programs is to attempt to recruit the only other untapped pool of potential medical residents: osteopathic medical students.

Close to 30% of osteopathic medical graduates enter allopathic programs in their first year—and most osteopathic medical residents are in allopathic programs. Bear in mind that these numbers have been achieved without aggressive recruiting tactics by allopathic programs. Such programs, especially those located in university medical centers or affiliated institutions, tend to have many more resources than comparable osteopathic medical programs. Hospitals are larger and budgets are bigger. Should allopathic programs decide to aggressively recruit osteopathic medical students to fill these vacancies, many programs could deploy larger resources than osteopathic medical programs. These programs can also offer students allopathic specialty board eligibility.


Figure. Additional resources

Judging from the popularity of dually accredited programs, this “transferability” is already perceived by medical students as advantageous. The end result could be a large decrease in the number of osteopathic medical students entering osteopathic GME programs. With the rolling-average methodology for hospital GME financing and hospital budgets under stress, internship and residency positions unfilled over time are likely to be lost permanently—resulting in fewer osteopathic GME positions, program closures, and fewer osteopathic medical training programs.

The loss of osteopathic GME training would have multiple impacts. As interns and residents do a considerable amount of teaching, their absence would necessitate increased physician resources devoted to clinical and didactic medical student teaching. It is generally acknowledged that house staff also promotes excellence in patient care and attracts high-caliber physicians to hospitals. Hospitals, osteopathic medical schools, and their students would be the poorer for this loss. And, finally, one cannot underestimate the value of osteopathic medical internships and residencies in building and cementing a junior physician’s identification with the practices of osteopathic medicine.

Preventive strategies

Anyone designing preventive strategies should be mindful of the desired outcome—keeping match rates high between osteopathic medical students and osteopathic medical internships, and keeping osteopathic medical residency programs filled. Further, this goal has to be achieved in a way that promotes educational quality.

A strategy clearly not to be endorsed is that of increasing student stipends above the going market rate. An improvement to the educational quality of a program is not borne out by such
a stratagem. While this strategy may fill programs, anecdotal evidence indicates that it may not attract quality graduates.

More reasonable preventive strategies may include the following:

- **Building programmatic excellence.** Obviously, this strategy should always be a priority in any medical program. Students clearly vote on program desirability through their medical school applications. Programmatic excellence draws students and serves as a recruiting tool for teaching physicians.

- **Combining with other osteopathic medical programs.** Programs that merge are likely to be larger than either program alone—and to have more resources. There will not be competition between programs for house staff and increasingly scarce resources. Because AOA accreditation standards require a critical mass of 3 residents and 4 interns per program,10 some programs with smaller house staff numbers are already at risk. These programs may find merging more attractive than attempting to increase house staff numbers with the current legislative obstacles to growth.

- **Combining with allopathic programs.** As hospitals merge, osteopathic and allopathic medical programs may find themselves coexisting at the same institutions. Allopathic programs having difficulty attracting US-based graduates may find merging an attractive alternative. However, these programs are more likely to have quality problems and perhaps accreditation difficulties.

  Taking over or merging with substandard allopathic programs without added resources will result merely in a merged osteopathic-allopathic program with continued quality challenges. An osteopathic medical program considering such a merger should be clear about the other program’s individual situation. An important part of making such a decision is for the osteopathic program to review its potential partner’s last accreditation letter from the Accreditation Council for Graduate Medical Education, as most of these newly merged programs will seek accreditation from the AOA and the Accreditation Council for Graduate Medical Education.11,13

  Merging programs should also push for the option of excluding problematic teaching rotations. Combined resources may allow the creation of other educational settings and the addition of didactic material not otherwise available.

  Since the BBA freeze on house staff numbers, an important advantage of merging with allopathic programs is that this is virtually the only means of expanding the number of training positions. In fact, this is perhaps the only avenue open to the osteopathic profession to provide internally the number of training positions needed to accommodate the increased numbers of COM graduates. Although developing new programs in non-teaching hospitals seems an obvious strategy, the BBA prohibits—except in the case of rural institutions—GME funding for new programs. An added benefit offered by such a merger is that residents in dually accredited programs will be eligible for both osteopathic and allopathic medical specialty board certification examinations. This fact can provide a considerable recruiting draw for osteopathic medical students.

  **Hospital-affiliation agreements.** Under BBA provisions, separate hospitals may sign affiliation agreements with each other, allowing residents to rotate to each other’s institutions while continuing to obtain full DME and IME reimbursement for these residents.

  A critical advantage to this arrangement is that affiliated hospitals may aggregate their house staff numbers for purposes of the total house staff count. Thus if Hospital A has fewer residents in one year and Hospital B has an excess, Hospital A under an affiliation agreement could take the excess from Hospital B and both hospitals could potentially keep house staff numbers at or near their respective cap limits. Hospitals A and B could also have interns/residents do rotations at both hospitals, further increasing their flexibility and perhaps overall program quality.

- **Direct Medicare billing by residents.** Residents who are claimed on a hospital IRIS count cannot bill Medicare for the services they provide. Clearly, in this situation, only the teaching physician can bill for services rendered. However, in some programs, residents are not paid by an entity receiving Medicare GME reimbursement or by an entity that is reimbursed by another organization receiving GME reimbursement. These residents are not claimable on any IRIS count.

  For example, residents may rotate to a clinic setting not affiliated with a hospital. The clinic pays resident salaries directly or reimburses the home department. The clinic is not eligible for Medicare GME reimbursement. In this setting, residents who are fully licensed physicians may be able to bill Medicare directly for their services.14 No teaching physician can bill for these services and there is no “double dipping,” since Medicare is reimbursing only for patient care services. This strategy takes advantage of what may be somewhat unique circumstances for a small set of osteopathic medical programs.

  Some combination of the above stratagems should be appropriate for various hospitals. Both creativity and cooperation are going to be needed to implement these strategies. Program directors and others who understand the complex regulations around GME are going to have to work with directors of medical education, hospital administrators, financial officers, and less knowledgeable program directors.

**Summary**

We are facing a complex and unpredictable healthcare financing environment that will exist for at least several more years. As a result, osteopathic GME could become very marginalized even within the osteopathic medical profession. Leaders in osteopathic GME must carefully track the evolving rules and regulations around GME.
ment at the signing of the Declaration of Independence on July 4, 1776, might also sum up the current situation for osteopathic GME: “We must all hang together, or assuredly we shall all hang separately.”

References


