Federal Funding of GME

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Presentation to the: Ohio University Center for Osteopathic Research and Education

Finance Workshop

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Financing of Resident Education and the Special Missions of Teaching Hospitals Comes from Multiple Sources

- Medicare (largest explicit payer)
- Medicaid
- Private patient care revenues
- VA/DoD
- Other Federal and state programs

Medicare

Medicare Makes 2 Specific Payments With an "Education" Label

Direct GME Payments (DGME)

- Partially compensates for residency education costs

Indirect Medical Education (IME) Payments

- Partially compensates for higher patient care costs due to presence of teaching programs

DGME and IME Payments are Not Inconsequential

Estimated Federal Fiscal Year 2008:

DGME Payments	=	$2.70 billion
IME Payments	=	$5.74 billion
Total	=	$8.44 billion

Source: CMS Office of the Actuary, July, 2008

Medicare DGME Payments

What Are DGME Payments Intended to Cover?

Compensate teaching institutions for Medicare's share of the costs directly related to educating residents:

- Residents' stipends/fringe benefits
- Salaries/fringe benefits of supervising faculty
- Other direct costs
- Allocated overhead costs

Residents must be in approved programs

What is the Basic Methodology Underlying DGME Payments ?

Step 1: Determine hospital-specific per resident base year cost amount (generally 1984)

Step 2: Update (to current year) base-year per resident amount (PRA) for inflation

Step 3: Multiply the updated PRA by the number of residents in the current year (this amount capped by BBA resident limits)

Step 4: Multiple by the hospital's ratio of Medicare inpatient days/total days

Not Every Resident Counts the Same

Residents in their "initial residency period" (IRP) are counted as 1.0 FTE

Residents training beyond the IRP counted as 0.5 FTE

IRP determined at the beginning of the residency and DOES NOT CHANGE

Physicians who decide to retrain in another specialty are counted as 0.5 FTE

Per Resident Amounts (PRAs)

In FFYs 94 and 95, PRAs updated only for primary care; frozen for other specialties.

- Consequently, PRAs for primary care residents are slightly higher than nonprimary care residents.

In 2002, PRAs for hospitals with low PRAs were raised to 85% of a "locality-adjusted" national average PRA.

Hospitals with PRAs greater than 140% of the national average receive no increases until 2014.

Medicare Only Pays Its "Share" of Resident "Costs"

Medicare Share * Per Resident Amount = Medicare Payment Per Resident

40% x $80,000 = $32,000 payment per primary care resident

40% x $75,000 = $30,000 payment per all other residents

(40% x $75,000) ÷ 2 = $15,000 payment for fellow

Medicare IME Payments

Medicare Payments with an Education Label: IME

Compensates teaching hospitals for higher inpatient operating costs due to:

- unmeasured patient complexity not captured by the DRG system
- other operating costs associated with being a teaching hospital (lower productivity, standby capacity, etc)

Percentage add-on payment to basic Medicare per case (DRG) payment

Calculating the IME Adjustment Factor

The IME adjustment is based on statistical analysis using intern and resident-to-bed ratios (IRB)

% per case add-on =

$$\textbf{Multiplier X } ((1 + IRB)^{0.405} - 1)$$

For FFY 2009, multiplier is 1.35

Short hand for IME: Hospitals get about a 5.5% increase in DRG payments for every 10- resident increase per 100 beds

Calculating the IME Payment

Step 1: Determine the IRB ratio:

Chicago Hope = 170 residents/ 666 beds = 0.255 = IRB
(Note: IME resident counts do NOT reflect weighted amounts)

Step 2: Use statistical formula and IRB to calculate IME%

$1.35 \times ((1 + 0.255)^{0.405} - 1) \times 100 =$ 13.00%

Step 3: Calculate the IME payment for each case
(Payment for DRG 547 x IME %) = IME Payment
$31,321.91 x 13.00%) = $4,071.85

IME Adjustments Over Time

	Adjustment	Multiplier
FY 1997	7.7%	1.89
FY 2002	6.5%	1.5
FY 2003	5.5%	1.35
10/01/03 to 3/31/04	5/5%	1.35
4/1/04 to 9/30/04	6.0%	1.47
FY 2005	5.8%	1.42
FY 2006	5.55%	1.37
FY2007	5.35%	1.32
FY 2008 and Beyond	5.5%	1.35

Medicare Resident "Caps"

Medicare Resident Limits: 1997 BBA (P.L. 105-33, Sections 4621 and 4623)

Generally speaking, the number of FTE allopathic and osteopathic residents that a hospital may count for DGME and IME payments is limited to 1996 Medicare cost report count.

- Limits may be different for DGME and IME

The Medicare statute provides very few exceptions to the caps

Rural Teaching Hospitals

- cap = 130% of 1996 count (BBRA)
- cap can be adjusted for new programs

Rural Training Track Programs

- Urban hospitals can get cap adjustment to accommodate first year of these programs

GME Resident Limit Affiliation Agreements (sort of)

New Teaching Hospitals

- Get 3 years to start any and all residency programs; cap attaches in 4th year

Temporary Adjustments Associated with Closed Hospitals and Programs

New Teaching Hospitals: Receiving DGME and IME Payments

Defining "new" teaching hospitals:

- Had no allopathic or osteopathic residents reported on most recent Medicare cost report ending on or before 12-31-1996 (42 CFR §413.79(e)(1))

Keys to receiving payments:

- Establishing the per resident amount (PRA) for DGME payments
- Establish resident caps (for both DGME and IME)

Establishing PRAs for New Teaching Hospitals

The PRA equals the LOWER of:

The new hospital's actual GME costs

OR

The average of the teaching hospitals in the same geographic wage area (if less than 3, then census region)

Once the PRA is established, it is permanent

Source: 42 CFR § 413.77(e)

New Teaching Hospitals: Establishing a Resident Cap

3 year window to establish the cap:

- Window starts when the hospital begins to train residents in the first NEW program started
  - -- relocating an existing program, or adding the hospital as a new training site for an existing program DOES NOT COUNT!
- Window closes at the end of the 3rd program year of the first new program started
- Permanent caps are effective as of the first day of the 4th program year of the first new program started

Source: 42 CFR §413.79(e)(1)

Establishing a Resident Cap: 3 Year Window, Cont.

Cap equals the sum, for all programs, of:

The highest number of FTE resident counts in any program year multiplied by the initial residency period, subject to the number of accredited slots for that program

- If a resident does a rotation at an existing teaching hospital, thenew hospital cannot claim that time as part of the FTE count andthe existing hospital CANNOT claim the new rotation as part of its cap

Remember, this calculation occurs in the 3rd year of the first program's existence

Source: 42 CFR § 413.79(e)(1)(i)

Temporary Resident Cap Increases and Closed Hospitals/Programs

If hospital or residency program closes, hospitals that take on the displaced residents may have their caps increased until the residents complete their training

For program closures, the original hospital must agree to temporarily reduce its cap

Additional residents not included in 3-year rolling average (IME: 42 CFR 412.105(f)(1)(v); DGME: 42 CFR 413.79(d)(6))

Resident Caps and Teaching Hospital Closures

If a teaching hospital closes, regulations provide for "temporary" cap increases for those hospitals that take on and complete the training of the displaced residents

After displaced residents complete training, the temporary cap increases end and hospitals revert to original caps

Result—A permanent reduction in aggregate teach hosp resident cap slots

CMS does not believe it has the legislative authority to permanently distribute the closed hospital's cap slots to other hospitals.

Resident Training At Nonhospital Sites

Payments for Residents in Nonhospital Settings: Background

Hospitals may include residents training in non-hospital settings in their resident counts as long as the hospital pays “all or substantially all” of the training costs at that site and the resident spends their time in patient care activities.

Applicable for both DGME and IME (since FY 1998) payments

Regulatory Definition of “All or Substantially All” of Resident Training Costs at Nonhospital Sites

Before 1999: resident's stipends and benefits

1999 and thereafter: “residents’ salaries and fringe benefits (including travel and lodging where applicable) **and the portion of the cost of teaching physicians’ salaries and fringe benefits attributable to direct graduate medical education**”

42 C.F.R. §413.75(b)

The Medicare DGME/IME Nonhospital Site Final Rule

Published in the Federal Register (as part of the long term care hospital final rule) on May 11, 2007

Effective with cost reporting periods beginning on or after July 1, 2007

Regulatory Definition of "All or Substantially All"

Before 1999: resident's stipends and benefits

1999-2007: "residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education"

July 1, 2007_: "at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to direct graduate medical education"

Payments for Residents in Nonhospital Sites, Cont.

Big Issue:

- How does the hospital deal with Volunteer Physicians?

Secondary Issue:

- How does the hospital determine nonhospital physician's "supervisory costs"?

Medicaid GME Funding

Federal Proposed Rule Eliminating FFP for Medicaid GME Payments

Published on May 23, 2007

Comments were due June 22, 2007

AAMC comments at http://www.aamc.org/advocacy/library/teachhosp/corres/2007/062207.pdf

Legislative moratorium in place until April 1, 2009

Federal Proposed Rule Eliminating FFP for Medicaid GME Payments, Cont.

"[T]here is no express authority in the Medicaid statute for payments to support GME programs"

"This rule proposes to clarify that, for proposes of Medicaid reimbursement eligible for FFP, GME is not an allowable cost or payment for medical assistance under the approved Medicaid State Plan."

DGME and IME Funding—Short Term Concerns

Capital IME Payments

FY 2008 IPPS final rule called for the elimination of capital IME payments:

FY 2009: 50% elimination

FY 2010: 100% elimination

Stimulus bill restored FY 2009 payments, but FY 2010 elimination is still scheduled

Estimated 100% cut to teaching hospitals would be about $360 million annually

MedPAC 2008 March Report

IME Recommendation (No. 2A-2):

"The Congress should reduce the indirect medical education adjustment in 2009 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained by reducing the indirect medical education adjustment should be used to fund a quality incentive program."

Other quote of note:

"These funds are provided to teaching hospitals with no accountability for how they are used, and a better use of the funds is desired."

MedPAC March 2008 Report, page 70

GME Funding—Longer Term Musings

Our Collective Goal

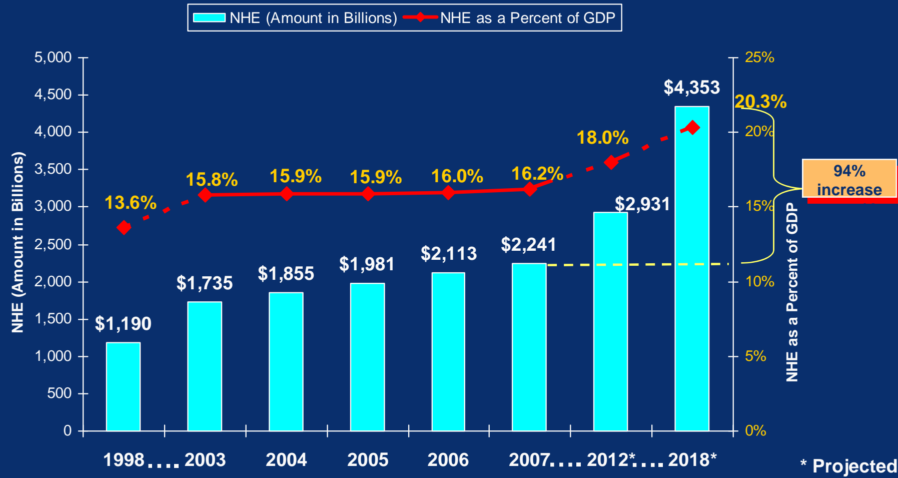
Dedicated, stable funding for the funding of physician training and the other valued contributions of teaching hospitals and their faculties.

National Health Expenditures (NHE) as a percent of GDP, 1993-2017

*Projected

SOURCE: For 1993, data come from National Health Statistics Group, Centers for Medicare and Medicaid Services (CMS), Office of the Actuary *NHE Web tables*, Table 1 National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth by Source of Funds: Selected Calendar Years 1960-2007 (http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf)
For 2002-2017, data come from CMS, Office of the Actuary, *NHE Projections 2007-2017, Forecast summary and selected tables*, Table 1 National Health Expenditures and Selected Economic Indicators, Levels and Annual Percentage Change: Calendar Years 2002-2017 (http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf)

National Health Expenditures (NHE), and as a percent of GDP, 1998-2018



* Projected

SOURCE:
For 1998-2007, data come from Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group. *NHE Web tables,* Table 1: National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth by Source of Funds: Selected Calendar Years 1960-2007 (http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage)
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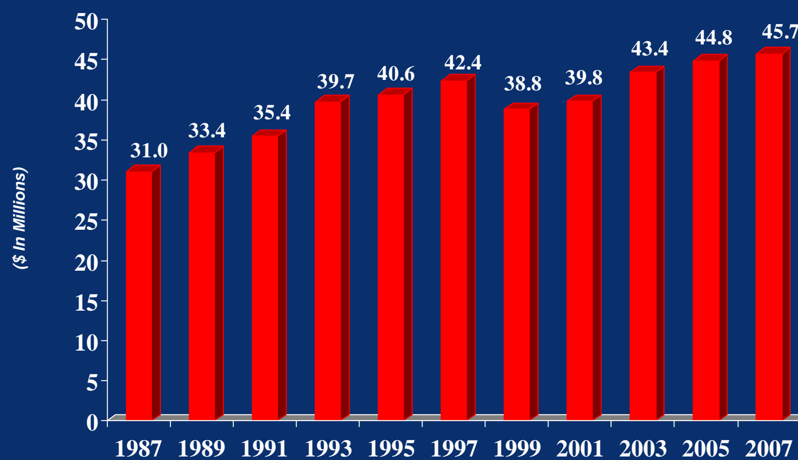
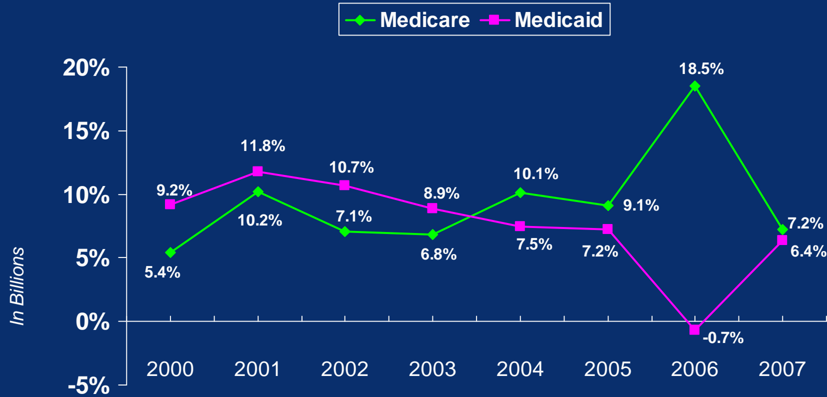
Number of People who lack Health Insurance Coverage 1987-2007



Source: US Census Bureau, *Poverty, and Health Insurance Coverage in the United States: 2007, Table C-1: Health Insurance Coverage: 1987 to 2007* (http://www.census.gov/prod/2008pubs/p60-235.pdf)

Medicare and Medicaid Spending, Annual Growth, 2000-2007



Note: Annual Growth reflects changes in Medicare and Medicaid spending from the previous year. For example, the annual growth shown for 2000, reflects growth in spending from 1999.

SOURCE: Data come from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group (*NHE web tables*, Table 3: NHE, Levels and Average Annual Growth from Previous Years Shown, by Source of Funds, Selected Calendar Years 1960-2007) (http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage)

Medicare Spending, 1998-2018

SOURCE: Data for 1998-2007 come from the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group (*NHE web tables*, Table 3: NHE, Levels and Average Annual Growth from Previous Years Shown, by Source of Funds, Selected Calendar Years 1960-2007) (http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage)
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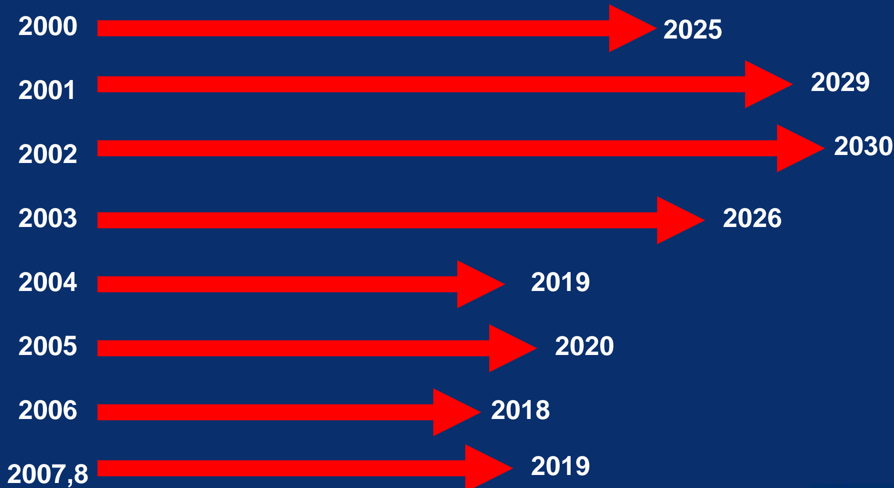
Projected Solvency of the Medicare Part A Trust Fund



Source: Health and Human Services Press Releases Announcing Release of Annual Medicare Medicare Trustees Reports, 1998 - 2005; The 2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund.

Future Health Care Spending--A Sobering Picture

"CBO projects that, without changes in law, total spending on health care will rise from 16 percent of GDP in 2007 to 25 percent in 2025 and 49 percent in 2082. Federal spending on Medicare (net of beneficiaries' premiums) and Medicaid would rise from 4 percent of GDP in 2007 to 7 percent in 2025 and 19 percent in 2082."

"The bulk of the projected increase in spending on Medicare and Medicaid is not due to demographic changes (such as increases in the number of beneficiaries) but rather to ongoing increases in costs per beneficiary."

Testimony of Peter Orszag when he was Director, CB00O before the US Senate Budget Committee, 1-31-2008

Academic Medicine and Health Care Reform

Educating physicians and other health care providers

Pushing the frontier of medical science

Providing disproportionate amount of care to the uninsured

Teaching hospitals are costly

Relationship between teaching hospitals and clinical faculties

Health Care Reform—Sen. Baucus' Views

"While the Medicare GME program has provided essential resources for training America's physicians, it needs to be reexamined"

- -- Whether changes are needed to "allowable GME training slots"
- -- Explore options to increase residency caps for certain specialties
- -- Allow training in other settings and encourage a focus on care coordination
- -- Increase accountability of IME funding
- -- Address workforce shortages and support "increased racial and ethnic diversity within the health care workforce by strengthening public health programs in these areas."

"Call to Action, Health Reform 2009"
November 12, 2008

Health Care--Views of OMB Director, Peter Orszag

The next step on health care, he said, is a set of "changes to Medicare and Medicaid to make them more efficient, and to start using those programs more intelligently to lead the whole healthcare system."

With a growing body of research finding some practices more cost-effective than others, the programs reimbursement rules can be used to force changes at those hospitals – a sort of back door to health care reform.

"Medicare and Medicaid are big enough to change the way medicine is practiced," he said.

Source: February 19 article in POLITICO.

What Has Been Said About GME and IME Funding Alternatives?

- All Payer Trust Funds
- Appropriations
- Medicare "premium" support
- Important Question: How intertwined are GME and overall Medicare/health reform?

GME Funding: Some Key Questions

Should there be public support of GME training?

What should be the source of funding?

What should be the level of funding?

What entities should receive the funding?

Should teaching institutions be held “accountable” for the GME $$ they receive (ala “pay for performance”)?