



Graduate Medical Education Reimbursement

March 6, 2009

Ohio University College of Osteopathic Medicine,
Centers for Osteopathic Research and Education

Today's Agenda

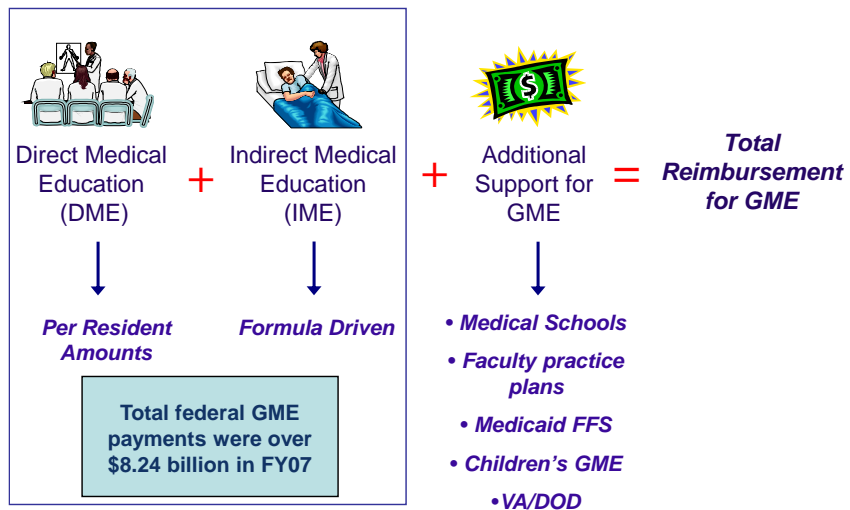
- The financing of Graduate Medical Education
 - Brief overview of the basics
 - Children's Hospitals funding
- Payment impacts, including relationship of disproportionate share to indirect medical education
- How to assess the GME bottom line
- The strategic value of residency training
- Q&A

GME Reimbursement

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The GME payment methodology was enacted in 1983, replacing reimbursement based on “reasonable cost”.



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DME payments represent reimbursement for the direct costs of medical education.



DME payments are meant to cover items such as:

- Salary and fringe benefits paid approved residents and fellows
- The portion of teaching physician salaries and fringe benefits associated with teaching and supervision of residents and fellows
- Other direct costs that can be attributed to medical education (clerical salaries, telephone, office supplies, etc.)
- Allocated costs through the Medicare cost report "step-down"

All of these costs are/were used as the basis to arrive at a hospital's specific per resident amount.

IME payments are made to cover the additional costs teaching hospitals incur to maintain approved educational programs.



The Costs of Maintaining Educational Programs

Increased Operating Costs

- Increased use of supplies and tests
- Additional exam rooms
- Severity of cases greater

Loss of Productivity

- Slower evaluation
- Consultation and supervision
- Volume reductions

Lower Revenues

- Reduced payment from insurers for education costs

DME and IME payments are specific to each hospital, and are tied to the portion of Medicare patients seen.

DME Payments

- Based on a per resident amount, varies greatly
- Multiplied by **Medicare utilization** percent
- Weighted by half if resident exceeds IRP (e.g. fellows)

IME Payments

- Based on a regulatory factor, which has been steadily declining since 1996
- Incorporates level of teaching intensity
- Multiplied by total DRG and Medicare Managed Care payments

Because of the payment methodology for DME, often times IME is used to offset total reimbursement shortfalls.

Medicare only pays hospitals for its share of patients, so DME payments are almost always less than total direct costs.

$$\begin{array}{ccccccc}
 \$100,000 & * & 50\% & * & 1.0 \text{ FTE} & = & \$50,000 \\
 \uparrow & & \uparrow & & \uparrow & & \uparrow \\
 \text{Hospital} & & \text{Medicare} & & \text{Resident} & & \text{DME} \\
 \text{Specific DME} & & \text{Utilization} & & \text{FTE's} & & \text{Payment} \\
 \text{Rate} & & & & & &
 \end{array}$$

Per FTE Direct Costs

• PGY Salary =	\$40,000
• Benefits =	11,600
• Administrative Costs =	9,000
Total Per FTE costs:	\$60,600

DME Shortfall:

(\$10,600)

DME reimbursement can be significantly worse for trainees who go beyond their initial residency period, such as fellows.

$$\begin{array}{ccccccccc}
 \$100,000 & * & 50\% & * & 1.0 \text{ FTE} & * & 50\% & = & \$25,000 \\
 \uparrow & & \uparrow & & \uparrow & & \uparrow & & \uparrow \\
 \text{Hospital} & & \text{Medicare} & & \text{Resident} & & \text{IRP} & & \text{DME} \\
 \text{Specific DME} & & \text{Utilization} & & \text{FTE's} & & \text{Weighing} & & \text{Payment} \\
 \text{Rate} & & & & & & & &
 \end{array}$$

Note: Neither of these examples include the costs of teaching.

Per FTE Direct Costs	
• PGY Salary =	\$50,000
• Benefits =	14,500
• Administrative Costs =	9,000
Total Per FTE costs:	\$73,500

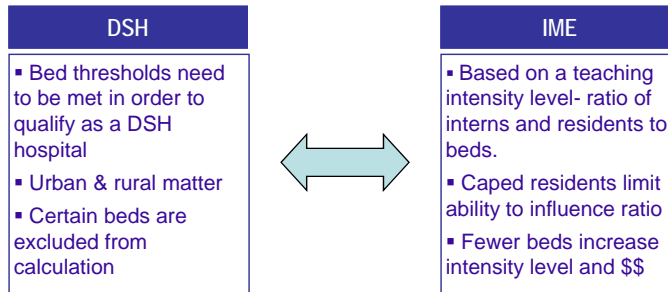
DME Shortfall:
(\$48,500)

Hospital payments are influenced by certain factors, with “add-ons” for teaching hospitals (IME) and hospitals serving a disproportionate share of low-income patients (DSH).

Core Elements of a PPS Payment

- Standardized amounts, or basic payments amounts
- Wage index, to account for differences in hospital labor costs
- DRG relative weights, accounting for case mix
- Add-on payments for hospitals serving a disproportionate share of low-income patients
- Add-on payments for hospitals that incur indirect costs of medical education
- Outlier payments for cases that are unusually costly

In general, IME and DSH reimbursement has been at odds as it relates to the counting of beds (which can be pretty complex).



Hospitals engaging in a high proportion of uncompensated or poorly compensated care tend to be urban hospitals, where most university and major affiliated teaching hospitals are located.

IME reimbursement is influenced by two main factors: a hospital's level of teaching intensity, and a factor decided upon and set by Congress.

$$\text{IME Payment} = \left(\left(\frac{\# \text{ of IME Residents}}{\# \text{ of Beds}} \right)^{0.405} - 1 \right) * \text{IME Factor} * \text{DRG \& Medicare Advantage Payments}$$

Teaching Intensity
The ratio of interns and residents to the number of beds in a hospital

Congressional Factor
Has varied over the past several years, going back to FY96

** Keep in mind, IME is not intended to reimburse hospitals for their direct costs, but higher patient care costs.*

It is this component of IME reimbursement that has seen the most changes.

The regulatory factor for IME has dropped by approximately 30% from when the resident caps were set to the last fiscal year.

Fiscal Year	Factor
1996	1.89
1997	1.89
1998	1.72
1999	1.60
2000	1.47
10/1/00 - 4/1/01	1.54
2002	1.60
10/1/02 - 4/1/04	1.35
4/1/04 - 10/1/04	1.47
2005	1.42
2006	1.37
2007	1.32
2008 +	1.35

MedPAC's empirical analysis suggests this factor should be cut in half.

Children's hospitals, with low Medicare utilization, have been receiving appropriated funds to allow for the funding of residency training.



- The Children's Hospital GME Medical Education Payment Program was authorized in 1999 to bridge the funding gap, and has been reauthorized through 2011
- Health Resources and Services Administration makes IME (2/3) and DME (1/3) payments to ~ 60 eligible hospitals
- Unlike Medicare GME funding, Congress must appropriate funds annually and the total amount of funding has varied from year to year:
 - In past five years, total GME payments have been ~ \$300 million per year into the pool
 - Since inception of program ~ \$1.1 billion in support has been made

Approximately 4,100 residents train at these hospitals, about 30% of the Nation's pediatricians and half of the pediatric sub-specialists. PPS hospitals still play an important role.

How to Assess the GME Bottom Line

Let's take a look at how the direct costs are allocated.

	Family Practice	Internal Medicine	Med Peds	Pediatrics	Orthopedics	Surgery
Personnel Expenses						
Faculty salaries and contracts	\$ 807,734	\$ 1,231,311	\$ 378,715	\$ 1,635,891	\$ 985,538	\$ 947,335
Faculty fringes	148,658	221,014	69,297	329,749	119,757	142,596
Faculty Costs	\$ 956,391	\$ 1,452,325	\$ 448,012	\$ 1,965,640	\$ 1,105,295	\$ 1,089,931
Staff salaries	420,623	238,411	133,542	660,202	179,839	137,599
Staff salaries - open positions	0	1,560	0	0	90	100
Staff overtime	7,770	8,464	655	7,667	3,020	4,229
Staff temporary services	0	12,580	4,147	11,810	16,455	0
Staff fringes	108,686	75,566	39,272	196,036	51,739	29,600
Staff Costs	\$ 537,079	\$ 336,582	\$ 177,616	\$ 875,714	\$ 251,144	\$ 171,528
Resident salaries	834,240	1,427,183	652,559	636,294	394,200	471,954
Resident fringes	234,550	398,887	174,152	192,021	116,655	121,822
Resident Costs	1,068,790	1,826,070	826,712	828,315	510,855	593,776
Total Personnel Expenses	\$ 2,562,260	\$ 3,614,977	\$ 1,452,340	\$ 3,669,669	\$ 1,867,293	\$ 1,855,235
Operating Expenses						
(Office supplies, dues, travel, recruiting, conference, etc.)						
Total Operating Expenses	\$ 185,177	\$ 234,656	\$ 61,716	\$ 271,855	\$ 118,351	\$ 125,485
Overhead charges						
Overhead - clinical	\$ 358,150	293,765	138,757	500,859	389,458	285,965
Overhead - billing	43,765	35,899	16,956	61,204	47,591	34,943
Overhead - administrative	93,268	72,479	33,911	125,350	95,756	69,890
Total Overhead	\$ 495,183	\$ 402,143	\$ 189,624	\$ 687,413	\$ 532,805	\$ 390,798
Total Expenses	\$ 3,242,620	\$ 4,251,776	\$ 1,703,680	\$ 4,628,937	\$ 2,518,449	\$ 2,371,518

So, how do we offset these costs?

Direct Only

	Family Practice	Internal Medicine	Med Peds	Pediatrics	Orthopedics	Surgery
Number of Residents	17	29	13	13	8	9
Revenue						
DME	\$ 551,600	\$ 943,655	\$ 431,473	\$ 420,718	\$ 260,645	\$ 312,056
IME	-	-	-	-	-	-
Net Clinical Revenue	-	-	-	-	-	-
University Support	-	-	-	-	-	-
Grants	-	-	-	-	-	-
Total Revenue	\$ 551,600	\$ 943,655	\$ 431,473	\$ 420,718	\$ 260,645	\$ 312,056
Total Expenses	\$ 3,242,620	\$ 4,251,776	\$ 1,703,680	\$ 4,628,937	\$ 2,518,449	\$ 2,371,518
Revenue (Loss)	\$ (2,691,020)	\$ (3,308,121)	\$ (1,272,207)	\$ (4,208,219)	\$ (2,257,804)	\$ (2,059,461)

So, how do we offset these costs (continued)?

IME, DME and Other Funding

	Family Practice	Internal Medicine	Med Peds	Pediatrics	Orthopedics	Surgery
Number of Residents	17	29	13	13	8	9
Revenue						
DME	\$ 551,600	\$ 943,655	\$ 431,473	\$ 420,718	\$ 260,645	\$ 312,056
IME	1,779,909	3,044,996	1,392,281	1,357,578	841,053	1,006,947
Net Clinical revenue	875,293	717,941	339,114	1,224,062	951,807	698,877
University Support	75,000	75,000	-	75,000	-	24,000
Grants	-	-	-	-	-	-
Total Revenue	\$ 3,281,802	\$ 4,781,592	\$ 2,162,867	\$ 3,077,358	\$ 2,053,506	\$ 2,041,879
Total Expenses	\$ 3,242,620	\$ 4,251,776	\$ 1,703,680	\$ 4,628,937	\$ 2,518,449	\$ 2,371,518
Revenue (Loss)	\$ 39,182	\$ 529,816	\$ 459,187	\$ (1,551,579)	\$ (464,943)	\$ (329,638)

What about DSH? What if we cut IME in half?

Things to consider when we look at the costs:

- How do we treat teaching costs?
 - Remember, the per resident amount is supposed to capture just the teaching costs (our example shows full costs)
- What are the faculty compensation arrangements?
 - Are there expectations or incentives in place to generate more clinical revenue to offset costs?
 - Protected time, core faculty
- What are the opportunity costs?
 - How many rotations are not claimable, either through rotations to other providers or activities not meeting regulatory approval?
- How do you stand vis-à-vis your caps?
 - What are the number of funded residents compared to claimable FTEs?
- Replacement costs- what if you get out of the GME business altogether?

Because DME is based on Medicare utilization, we need to consider the impact of indirect reimbursement and other subsidies.

- As MedPAC notes, IME payments “reflect the higher costs per case observed in teaching hospitals that cannot be allocated specifically to residency programs.”
- From a contribution margin standpoint, is it fair, accurate, or acceptable to include all of the IME reimbursement received but not include any assumptions for indirect costs?
 - Question then becomes, how much IME can be estimated and allocated as an indirect cost to my programs?
 - Aren't these hospital costs?
- At the end of the day, recognition must be made that both DME and IME is generated based on Medicare business, but residents train through the entire hospital and care for non-Medicare patients.
 - Must look to the overall mission, and reason why we are in the GME business

What is the Strategic Value of GME?

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How do we redefine the future in a complex environment and proactively manage limited resources?

- Teaching was perceived as a profitable venture before the BBA, and in many instances is still perceived as such today.
- This perception, before the BBA, presented programs and hospitals with an incentive to grow their programs.
 - The higher the teaching intensity, the more IME received
- Many teaching hospitals need to look inward to reassess their mission.
 - How do you define value, and how do you fund the enterprise and adopt to lower payments?

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Redefining the mission with a more explicit focus on broader value can have many benefits, as well as barriers.

Benefits

- Optimal sizing and deployment of residents
- Appropriate sizing and faculty activity focus
- Improved integration with clinical operations
- Increased benefits to community through physician manpower retention
- Higher return on the OGME investment

Obstacles

- Lack of organizational alignment
- Change in role and responsibility of physicians
- Impact on operations and core processes
- Difficulty achieving consensus on appropriate benchmarks and performance thresholds
- Inability to access needed data in a timely and consistent manner due to disparate systems

A framework to consider assessing the value of OGME consists of four general areas.

- Strategic
- Operational
- Financial
- Programmatic

Framework to assess OGME value: Strategic

- Strategic
 - *How well does the program support community needs and referrals?*
- Operational
- Financial
- Programmatic

Framework to assess OGME value: Strategic

Areas of Analysis:

- Evaluate the community need for physician training in the geographic area and the rest of state.
- Examine the placement patterns of hospital program graduates.
- Analyze the impact on physician succession planning.
- Calculate the loyalty and strength of program graduate's referral patterns.

Framework to assess OGME value: Operational

- Strategic
- Operational
 - *How well is the training model aligned with clinical operations?*
- Financial
- Programmatic

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Framework to assess OGME value: Operational

Areas of Analysis:

- Calculate resident needs based on clinical volume.
- Identify resident staffing support required to support case and visit volume across areas of service.
- Document overall staffing model (by service area) of faculty, residents, fellows, other physicians and physician extenders.
- Differentiate between provider-based and freestanding sites to determine documentation requirements.
 - ◆ Can some freestanding sites become provider-based?
- Do residents rotating in require a payment/residents rotating out receive payment?
- Compare variable costs of teaching and non-teaching cases within a specific illness.
- Identify the degree of duplicative staffing across different programs.

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Framework to assess OGME value: Financial

- Strategic
- Operational
- Financial
 - *What is the net investment in the academic infrastructure?*
- Programmatic

Framework to assess OGME value: Financial

Areas of Analysis:

- Examine the incremental revenues and expenses related to teaching and potential improvement opportunities.
- Quantify the contribution margin of trainees to the organization:
 - ◆ Are you profitable or do you require a subsidy?
 - ◆ If a subsidy is required, where will it come from, and what is the rationale for providing it?
- Indirect revenues such as ancillaries, X-rays, lab, etc., and allocation of indirect costs.
- Evaluate faculty teaching payments relative to industry benchmarks.

Framework to assess OGME value: Financial

Areas of Analysis (continued)

- Evaluate the model for physician teaching arrangements (faculty vs. independently contracted services) relative to other industry practices.
- Compare resident salary levels to outside benchmarks.
- Evaluate current resident rotation affiliation arrangements.
- Evaluate both the level and type of external funding support for research, if applicable.

Framework to assess OGME value: Programmatic

- Strategic
- Operational
- Financial
- Programmatic
 - *How well does the program meet AOA requirements and individual trainee needs?*

Framework to assess OGME value: Programmatic

Areas of Analysis:

- Review program status, quality and strength.
- Analyze Board passage and match rates relative to national averages.
- Review market trends regarding specialty and subspecialty enrollment.
- Analyze the level of care for the medically indigent.
- Understand the programs impact on the ability to recruit and retain quality medical staff.
- Analyze the programs impact on research and clinical trials.

What is the burning platform to consider program value?

- Economics have changed so radically that the traditional mission is no longer affordable.
- The mechanics are complicated, misunderstood and are often executed incorrectly exacerbating financial constraints (leaving \$ on the table).
- The mission needs to be broadened to include explicit organizational and community value.
- If you accept the notion of a revised mission, there is a need to redesign the delivery of teaching to realize greater value from the investment in OGME.

Additional Questions and Answers

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