GME FINANCING AND REIMBURSEMENT: NATIONAL POLICY ISSUES

Presented to Association of Hospital Medical Education
Tim Johnson, Senior Vice President
May 13, 2015
Presentation Outline

- Direct GME Costs
- Indirect Medical Education Costs
- Didactic and Research Time
- Resident Caps
- Current GME Policy Discussions
- Teaching Health Center GME Program
Direct GME (DGME) Costs

DGME costs are the “easy to identify” costs

- Resident salaries (stipends) and benefits
- Supervising physician salaries and benefits
- Other direct costs (e.g., classroom space)

These costs are generally viewed by policymakers as educational costs

- Costs that a hospital would not otherwise incur except for the fact that it is training residents
Medicare DGME Payments

“PRA” is per resident amount for the hospital and “share” is proportion of Medicare inpatient days

“Count of residents” is number of residents training in hospital and qualifying nonhospital settings

Count is based on number of full-time equivalents (FTEs), not the number of residents (people) in programs.
“Weighting” and the IRP

“Weighting” of residents is one way Congress applies policy decision to incentivize training of certain specialties.

Idea also recognizes that residents that receive more advanced training are probably more valuable to the hospital.

Concept: teaching hospitals are reimbursed for DGME at a higher level for residents training in core specialties vs. subspecialties.

Difference is based on the Initial Residency Period (IRP), minimum number of years required for initial Board eligibility.
Weighting of Residents

Resident training within the IRP is valued at 100%; resident training beyond the IRP is valued at 50%.

Example: resident trains in IM, then goes into ID fellowship

<table>
<thead>
<tr>
<th>IM, PGY-1</th>
<th>IM, PGY-2</th>
<th>IM, PGY-3</th>
<th>ID, PGY-4</th>
<th>ID, PGY-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 FTE</td>
<td>1.0 FTE</td>
<td>1.0 FTE</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
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</tbody>
</table>
Example: hospital is training 80 residents within the IRP and 60 residents beyond the IRP

Hospital receives Medicare DGME reimbursement on behalf of 110.0 FTEs (subject to cap)

<table>
<thead>
<tr>
<th>Trainee Type</th>
<th>Actual Count</th>
<th>Weighting</th>
<th>Weighted Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents</td>
<td>80</td>
<td>100%</td>
<td>80.0</td>
</tr>
<tr>
<td>Fellows</td>
<td>60</td>
<td>50%</td>
<td>30.0</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td></td>
<td>110.0</td>
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</table>
Indirect Medical Education (IME) Costs

Teaching-related patient care costs

- Label is a misnomer

Congress believed that DRG payment system would not fully account for additional costs incurred by teaching hospitals

- ER stand-by costs, larger uncompensated care, high-tech services
- Also, now: emergency preparedness

“Proxy” was needed to account for and compensate for factors that increase costs at many teaching hospitals

- Not all teaching hospitals incur every one of these costs
Medicare IME Payment Formula

1.35 * (((1 + \frac{\text{Count of Residents}}{\text{Count of Beds}})^{0.405}) - 1)

Quotient in middle is referred to as the “intern and resident-to-bed” (IRB) ratio

Count of residents is UNWEIGHTED

* Formula and specific multiplier included in Federal law; multiplier for Federal Fiscal Year 2015 is 1.35
Determine the resident to bed ratio for a hospital

- Resident FTE count = 291.27
- Total beds days available = 224,243
- Average bed days available (bed count) = $224,243 \div 365 = 614.36$
- IRB ratio = $291.27 \div 614.36 = 0.4741$

Use IME payment formula to calculate adjustment %

$$1.35 \times \left( (1 + 0.4741)^{0.405} - 1 \right) \times 100 = 22.97\%$$
Apply that percentage to the base amount for each particular DRG and each particular case

Example (pulled from a particular hospital)

• DRG 227 Cardiac Defibrillator Implant base amount = $26,940.96

So what is the IME payment for that one case?

• Base amount × IME adjustment %
  $26,940.96 × 22.97% = $6,188.34
Didactic and Research Activities

Direct GME is education payment
• CMS will support almost all approved activities

IME is patient care payment
• CMS takes a stricter view

Hospital setting
• Generally willing to support activities

Nonhospital (nonprovider) setting
• Stricter view since payment is still going to hospital
ACA defined “nonprovider setting that is primarily engaged in furnishing patient care”

- Private physician’s office - yes
- Community health center - yes
- Medical school – no
- Patient home – no
- Research lab – no
- Hotel (for conference) – no
- Dental school – no … but
- Dental clinic in the dental school - yes
## Counting Time for Didactic Activities

ACA established new rules for counting didactic activities

<table>
<thead>
<tr>
<th></th>
<th>Direct GME</th>
<th>IME</th>
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</thead>
<tbody>
<tr>
<td>Hospital setting</td>
<td>Countable</td>
<td>Countable</td>
</tr>
<tr>
<td>Nonprovider setting</td>
<td>Countable, but only if the setting is primarily engaged in furnishing patient care</td>
<td>Not countable</td>
</tr>
</tbody>
</table>
ACA also confirmed rules for disallowing nonclinical research activities.

<table>
<thead>
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<td>Not countable</td>
</tr>
<tr>
<td>Nonprovider setting</td>
<td>Not countable</td>
<td>Not countable</td>
</tr>
</tbody>
</table>
Count of residents capped as per BBA

- Every acute care hospital has both a DGME and IME resident cap

NOTE: caps are UNWEIGHTED

Principal one-time adjustments

- MMA Section 422
- ACA Section 5503

Principal ongoing adjustments

- Medicare GME Affiliated Group agreement
- New teaching hospital
- ACA Section 5506 - Closed teaching hospital program
66% of hospitals nationally are training above the cap.

Source: HCRIS December 2014 (2013 Cost Reports)
Top Five States Training Above the Cap

Source: HCRIS December 2014 (2013 Cost Reports)
Redistribution of Slots from Closed Hospitals

Preserves residency slots from closed teaching hospitals

- Closed = retired Medicare provider number

Priority Areas

- First, same or contiguous CBSA as closed hospital
- Same state as closed hospital
- Third, same region as closed hospital
- Fourth, rest of country

Congressional goal: preserve training in the area in which the hospital was located and in the same program(s) if possible
Closed Hospital Program – Closure Rounds

Round 1

- Physicians Carraway Medical Center (AL)
- Mesa General Hospital (AZ)
- Michael Reese Hospital (IL)
- St. Joseph Regional Medical Center Mishawaka (IN)
- Touro Rehabilitation Center (LA)
- Mid-Missouri Mental Health Center (MO)
- Muhlenberg Regional Medical Center (NJ), William B. Kessler Memorial Hospital (NJ)
- Cherry Hospital (NC)
- Temple East Hospital (PA), Geisinger South Wilkes-Barre Medical Center (PA)
- Charleston Memorial Hospital (SC)
- Cabrini Medical Center (NY), Caritas Health Care (NY), North General Hospital (NY)
## Closed Hospital Program – Closure Rounds

<table>
<thead>
<tr>
<th>Round</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 2</td>
<td>St. Vincent’s Medical Center (NY)</td>
</tr>
<tr>
<td>Round 3</td>
<td>Hawaii Medical Center East (HI)</td>
</tr>
<tr>
<td></td>
<td>Oak Forest Hospital (IL)</td>
</tr>
<tr>
<td></td>
<td>Huron Hospital (OH)</td>
</tr>
<tr>
<td>Round 4</td>
<td>Peninsula Hospital Center (NY)</td>
</tr>
<tr>
<td>Round 5</td>
<td>Infirmary West Hospital (AL)</td>
</tr>
<tr>
<td></td>
<td>Montgomery Hospital (PA)</td>
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<tr>
<td>Round 6</td>
<td>Cooper Green Mercy Hospital (AL)</td>
</tr>
<tr>
<td></td>
<td>Sacred Heart Hospital (IL)</td>
</tr>
<tr>
<td>Round 7</td>
<td>Long Beach Medical Center (NY)</td>
</tr>
</tbody>
</table>
Distribution of Awards from Closed Hospitals

Rounds 1 through 7

<table>
<thead>
<tr>
<th>Round</th>
<th>CT</th>
<th>NJ</th>
<th>NY</th>
<th>Other</th>
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<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>241</td>
<td>110</td>
<td>69</td>
</tr>
<tr>
<td>2</td>
<td>25</td>
<td>46</td>
<td></td>
<td>251</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>35</td>
<td></td>
<td>69</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td>39</td>
<td></td>
<td>37</td>
</tr>
<tr>
<td>5</td>
<td>8</td>
<td>39</td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>6</td>
<td>28</td>
<td>28</td>
<td></td>
<td>28</td>
</tr>
<tr>
<td>7</td>
<td>29</td>
<td>29</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>Total</td>
<td>166</td>
<td>476</td>
<td>555</td>
<td>1,226</td>
</tr>
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Round 1: 695 Cap Slots
Round 2: 321 Cap Slots
Round 3: 69 Cap Slots
Round 4: 37 Cap Slots
Round 5: 47 Cap Slots
Round 6: 28 Cap Slots
Round 7: 29 Cap Slots
Total: 1,226 Cap Slots
Two bills introduced on April 30, 2015 to increase Medicare resident caps

Both named “The Resident Physician Shortage Reduction Act of 2015”

- S. 1148 introduced by Senators Bill Nelson (D-FL), Charles Schumer (D-NY), and Senate Minority Leader Harry Reid (D-NV)
- H.R. 2124 introduced by Representatives Joseph Crowley (D-NY) and Charles Boustany (R-LA)

GNYHA and other associations working hard to gather co-sponsors for these pieces of legislation
## Distribution Mechanism and Payment Methodologies

<table>
<thead>
<tr>
<th>Nelson-Schumer-Reid</th>
<th>Crowley-Boustany</th>
</tr>
</thead>
<tbody>
<tr>
<td>15,000 in total</td>
<td>15,000 in total</td>
</tr>
<tr>
<td>No slots would come from redistribution</td>
<td>No slots would come from redistribution</td>
</tr>
<tr>
<td>3,000 distributed per year for five years</td>
<td>3,000 distributed per year for five years</td>
</tr>
<tr>
<td>Half of “available slots” must be used for shortage specialties</td>
<td>Half of “available slots” must be used for shortage specialties</td>
</tr>
<tr>
<td>New slots paid using usual DGME and IME methodology</td>
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</tr>
</tbody>
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## Use and Distribution of New Slots

<table>
<thead>
<tr>
<th>Nelson-Schumer-Reid</th>
<th>Crowley-Boustany</th>
</tr>
</thead>
<tbody>
<tr>
<td>First priority category is hospitals in states with new medical schools</td>
<td>First priority category is hospitals in states with new medical schools, or state with highest proportion of population living in HPSAs</td>
</tr>
<tr>
<td>Second priority is hospitals training residents over the cap</td>
<td>Second priority is hospitals with academic affiliation with VA hospitals</td>
</tr>
<tr>
<td>Individual hospital cannot receive more than 75 slots over five year-period</td>
<td>Individual hospital cannot receive more than 75 slots in any fiscal year</td>
</tr>
<tr>
<td>Slots cannot be used for cap relief</td>
<td>One-third of slots designated for cap relief</td>
</tr>
<tr>
<td>1,500 slots per year for specialty shortages</td>
<td>1,000 slots per year for specialty shortages</td>
</tr>
</tbody>
</table>
Policymakers and Others Calling for Action on GME (Including More “Accountability”)
What are Policymakers Trying to Address with “Accountability”?

- Identify areas that GME should focus on
- Identify appropriate measures to assess performance in those areas
- Define performance standards for those measures
- Pay (or penalize) to incentivize performance in those areas
Institute of Medicine (IOM) Report

Twenty-one person committee created in 2012 at request of Macy Foundation and seven U.S. senators

Broad testimony from many different stakeholders

Graduate Medical Education That Meets the Nation’s Health Needs

- Released on July 29, 2014
- Report focuses almost exclusively on Medicare GME support to teaching hospitals and how this funding should be restructured
Maintain Medicare GME funding at current levels

Build a GME policy and financing infrastructure

Create one Medicare GME fund with two subsidiary funds

“Modernize” Medicare GME payment methodology

Leave Medicaid GME to states’ discretion
Letter released in December 2014 - requested comments on GME financing (urban and rural, direct and indirect, role of per resident amount), distribution of training, impact on workforce, role of states

Signed by Representatives Joseph Pitts (R-PA), Frank Pallone (D-NJ), Gene Green (D-TX), Diana DeGette (D-CO), Cathy McMorris Rodgers (R-WA), Peter Welch (D-VT), H. Morgan Griffith (R-VA), and Kathy Castor (D-FL)

GNYHA and other associations provided extensive comments, including reactions to IOM report recommendations
Federal Council on GME (COGME)

Advisory body to Secretary of Health and Human Services (HHS) on GME and physician workforce

17 members (14 are appointed by HHS)

Latest report, *The Role of Graduate Medical Education in the New Health Care Paradigm*, focused on the shift towards ambulatory care training

Interplay between Federal COGME and IOM-proposed GME Policy Council is unclear
Released in February 2015

- Serves as a blueprint for budget negotiations; non-binding policy document

Proposed cut to IME for teaching hospitals

- 10% over 10 years ($16.3 billion)

Savings redirected in part to workforce programs

- $5.3 billion for “Targeted Support for GME” program
- $2.6 billion for National Health Service Corps
Sustainable growth rate (SGR) is component of Medicare physician payment system

- Essentially requires a cut in Medicare physician fee schedule to offset growth in physician volume of services

Medicare Access and CHIP Reauthorization Act of 2015

- Eliminates the SGR, creates value-based physician payment system
- Passed by House and Senate; signed into law by President Obama on April 16, 2015

No cuts to GME funding included in final bill
Teaching Health Center GME Program

Program created as part of Affordable Care Act

- Funded for up to $230 million from 2011 through 2015

Funding provided to teaching health centers to sponsor primary care residency training programs

- Funding available for usual DGME costs and “IME type” support

Challenges

- Time-limited funding
- Finding hospital training sites (no cap relief for them)

Continuing funding provided in SGR doc fix legislation
THCGME Program: Some Results

60 residency programs and more than 550 resident FTEs supported through THCGME program during Academic Year 2014-2015

88% of residents received training in a medically underserved community

77% of graduates from Academic Year 2013-2014 practicing primary care

George Washington University has contracted with Health Resources and Services Administration (HRSA) to conduct evaluation

Source for data: HRSA Justification of Estimates for Appropriations Committees for FY 2016
THANK YOU!

Questions?

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tjohnson@gnyha.org