GME FINANCING AND REIMBURSEMENT:  NATIONAL POLICY ISSUES

Tim Johnson, Senior Vice President
Association of Hospital Medical Education (AHME) Institute
May 18, 2016
Greater New York Hospital Association (GNYHA) is a membership organization comprising approximately 140 voluntary and public hospitals and health systems.

Members are located in the various regions of New York, as well as northern New Jersey, Connecticut, and Rhode Island.

GNYHA’s main mission is to develop and analyze policy proposals and advocate for its member hospitals at the State and Federal levels.

GNYHA also provides technical assistance on regulatory and policy matters to hospital staff and sponsors multi-institutional collaboratives.

GNYHA’s core expertise is in graduate medical education, health care financing, regulatory affairs, quality improvement, and other areas.
Presentation Outline

Definitions, Formulas, and Examples
- Direct GME
- Indirect Medical Education
- Didactic and Research

Resident Caps
- Current Data
- Triggering the Cap
- Adjustment Opportunities
- Rural Areas

Policy Issues
- Interested Parties
- Legislative Activity
- President's Budget
Direct GME (DGME) Costs

Easy to identify, education-training costs

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

Policymakers don’t generally question the principle behind these costs and the legitimacy of these costs

- Occasional question: why is the Federal government paying for the training of physicians but not other professionals?
- Another question that comes up: why reimburse the hospitals for these costs?

Congress needed to identify the direct costs to teaching hospitals and create a rational means to compensate them for these costs
Medicare DGME Payment Formula

“PRA” is per resident amount for the hospital, set in base year and updated by inflation since then.

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

“Medicare share” is hospital’s proportion of Medicare inpatient days compared to all inpatient days.
Hospital DGME Payment Example

Assume:

- 10 residents and 10 fellows*
- Per resident amount in base year = $75,000
- Cumulative inflation since base year = 30%
- Medicare share of inpatient days = 40%

Direct GME Payment Calculation

- □ 10 residents* × $75,000 × 130% × 40% = $390,000
- □ 10 fellows × $75,000 × 130% × 40% × 50% = $195,000
- □ So total annual DGME payment = $585,000

* Reminder: residents training beyond initial Board eligibility are counted for DGME at 50% (counting the fellows that way gives a “resident weighted count”)
Indirect Medical Education (IME) Costs

Teaching-related patient care costs

- Label ("medical education costs") is a misnomer given Congressional intent

Congress believed that payment system would not fully account for additional costs

"Proxy" was needed for additional payment

Meant to account for and compensate for characteristics or practices that generally increase costs at many teaching hospitals

- Examples: ER stand-by costs, larger uncompensated care, high-tech services
- The formula was not meant to tie directly to specific costs at every teaching hospital
Medicare IME Payment Formula

\[ 1.35 \times \left( \frac{(1 + \text{Count of Residents})^{0.405}}{\text{Count of Beds}} - 1 \right) \]

- Known as “indirect teaching adjustment factor” or “the multiplier”
- Multiplier and formula specified by Congress
- Quotient in middle is “intern and resident-to-bed” (IRB) ratio
- Count of residents is UNWEIGHTED (all treated the same)
- Count of beds is “available beds”
1. Using the total resident count and bed days available in the year, determine the IRB ratio

- Resident FTE count (for the year) = 291.27
- Total bed days available in a year = 224,243
- Average bed days available = 224,243 ÷ 365 = 614.36 per day
- IRB ratio = 291.27 ÷ 614.36 = 0.4741

2. Use IME formula and IRB ratio to calculate adjustment and percentage for this hospital

- 1.35 × \((1 + 0.4741)^{0.405} - 1\) = 0.2297
- 0.2297 \times 100 = 22.97% Just converting to a percentage
3. Now, let’s look at a particular case and payment amount to the hospital

Example (pulled from a particular hospital)

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

4. Apply the IME percentage to the base amount

- Base amount × IME % = IME payment
  - $26,940.96 × 22.97% = $6,189.57

So that is the IME payment for that one case
Type of Activity and Practice Setting

Patient care activities vs. educational activities

Patient care activities vs. research activities

Hospital setting

Outside the hospital

Medicare’s “default” for GME: inside the hospital engaged in patient care activities
## Counting Time for Didactic Activities

ACA established new rules for counting didactic activities in most cases.

<table>
<thead>
<tr>
<th></th>
<th>Direct GME</th>
<th>IME</th>
</tr>
</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>
### Counting Time for Research Activities

ACA also confirmed rules for not counting nonclinical research activities in most cases.

<table>
<thead>
<tr>
<th></th>
<th>Direct GME</th>
<th>IME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital setting</td>
<td>Countable</td>
<td>Not countable</td>
</tr>
<tr>
<td>Nonprovider setting</td>
<td>Not countable</td>
<td>Not countable</td>
</tr>
</tbody>
</table>
Types of Nonprovider Settings

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

“No” means you can never count the time that the resident spends in that setting
Medicare Resident Caps

Count of residents capped as per Balanced Budget Act (BBA) of 1997

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

Principal one-time adjustments

- MMA Section 422
- ACA Section 5503

Some ongoing adjustment opportunities

- Medicare GME Affiliated Group agreement
- Rural area adjustments
- ACA Section 5506 - Closed teaching hospital program
- New teaching hospital
U.S. Teaching Hospital Resident Counts Relative to their Caps

Source: 2014 HCRIS Data (December 31, 2015 release)

62% of hospitals nationally are training above their cap.
Top Five States Training Above their Cap

CA (122 teaching hospitals) - 1,920 FTEs above cap
TX (69 teaching hospitals) - 1,557 FTEs above cap
NY (107 teaching hospitals) - 1,455 FTEs above cap
OH (67 teaching hospitals) - 1,321 FTEs above cap
PA (74 teaching hospitals) - 1,007 FTEs above cap

Source: 2014 HCRIS Data (December 31, 2015 release)
Accidently Triggering a Cap and a PRA

Nonteaching hospital

- Cap = 0 (no residents trained in base year for the cap)
- No PRA (no residents trained in base year for calculation of the PRA)

Scenario

- Nonteaching hospital has resident rotation from another hospital
- CMS: we have limited to no authority under Medicare statute to NOT consider this hospital a teaching hospital

Implication

- Cap-building period begins for rotation hospital (like it’s a new teaching hospital) even though rotation hospital did not start its own program
- PRA gets calculated for rotation hospital even though rotation hospital may have minimal (or no) DGME costs

Problem

- The rotation hospital’s cap and PRA are now set (at low levels) and can never be adjusted
Cap Adjustment #1: Medicare GME Affiliated Group Agreement

Provision included in original BBA legislation

- Congressional goal: allow hospitals cross-training flexibility
- How it works: aggregate caps and create a “group cap”
- Net effect of cap adjustments must be zero

Two or more teaching hospitals

- Same or contiguous urban or rural areas; or
- Under common ownership; or
- Not located in same or contiguous areas but jointly listed as sponsor, primary clinical site, or major participating institution

Additional requirements in all cases

- Shared rotation (one or more residents participate in training in multiple hospitals with no “breaks” in the link)
Cap Adjustment #1: Medicare GME Affiliated Group Agreement (cont.)

All hospitals must sign and submit agreement to MAC and CMS

Due by July 1st for upcoming academic year

- Must be at least one year in length and specify adjustments being made to each hospital’s caps

If agreement is terminated, hospital caps revert to existing levels

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Current Cap</th>
<th>Adjustment (Jul 1 – June 30)</th>
<th>New Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>100</td>
<td>+10</td>
<td>110</td>
</tr>
<tr>
<td>Hospital B</td>
<td>100</td>
<td>-10</td>
<td>90</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td></td>
<td>200</td>
</tr>
</tbody>
</table>

Each hospital is paid up to adjusted cap level
Cap Adjustment #2: Displaced Residents from a Closed Program

Not included in original BBA legislation

- CMS goal: protect residents who cannot easily find another training program because of hospitals being at or above their caps
- How it works: like the affiliated group agreement but without the planning

Differences from affiliated group agreement

- Available for mid-year closures/adjustments
- Not limited to hospitals in same or contiguous area
- No requirement for shared rotation

“Displaced resident”: resident who was training in the closed program up until actual date of closure
Cap Adjustment #1: Displaced Residents from a Closed Program (cont.)

Both hospitals must sign and submit agreement to MAC and CMS

- Hospital with closed program lowering its cap
- Adjustments only available for specific trainees
- Displaced residents get named in the agreement
- Cap adjustments reflective of amount in excess of cap

Agreement due within 60 days (NOT two months!) of displaced resident beginning training in new hospital

- Net effect of cap adjustments must be zero
- Individual hospital caps revert back as the resident(s) finish
Rural GME Cap Issues

Rural area challenges

- Infrastructure for training
- Physician supply

Congress in BBA regarding caps

- “…the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas”
- Gave CMS broad authority to provide separate rules while not providing exemption from caps

Congress in Balanced Budget Refinement Act (BBRA) of 1999

- “In the case of a hospital that is not located in a rural area but establishes … rural tracks … the Secretary shall adjust the limitation … in an appropriate manner … in order to encourage the training of physicians in rural areas.”
- Further adjustment to rural teaching hospital caps
Special rule within BBA

- Cap adjustment available for establishment of new program in perpetuity
- But no ongoing cap adjustment opportunity for expansion of existing programs

Additional adjustment in BBRA

- Rural teaching hospitals provided with 30% increase in their caps
- Paid up to 130% of BBA caps
- Provides more room for growth of existing programs
- Effective as of April 2000

Also: partial exemption from redistribution programs

- No MMA or ACA redistribution of unused slots from rural teaching hospitals with less than 250 beds
Rural Residency Training Track Programs

Model

• Urban hospital and rural hospital share training of residents
• Urban hospital also eligible for cap adjustment

Cap adjustments

• Now: set after three-year cap building period
• CMS 2017 IPPS Proposed Rule would extend to five years
  • But rule would be effective for new programs begun on or after October 1, 2012

Requirement (as of October 2003)

• More than half the training must take place in rural hospital
• Had been 2/3 of training
Parties Interested in GME Policy

- President
- ACGME
- Institute of Medicine
- Medicare Payment Advisory Commission
- Federal Council on GME
- Congress
- Sponsors of accountability legislation
- Sponsors of cap relief legislation
- House Ways and Means Committee
The Resident Physician Shortage Act of 2015

- Introduced in April 2015 in both House and Senate
- Increase resident cap positions by 15,000 over five years

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)

- 121 co-sponsors as of today for House bill
- On record supporting GME and addressing cap issue
- 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>
<td>New slots paid using usual DGME and IME methodology</td>
</tr>
</tbody>
</table>
# Use and Distribution of New Slots

<table>
<thead>
<tr>
<th><strong>Nelson-Schumer-Reid</strong></th>
<th><strong>Crowley-Boustany</strong></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 <em>over five year-period</em></td>
<td>Individual hospital cannot receive more than 75 slots <em>in any fiscal year</em></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>
Other Pieces of GME Legislation

Training Tomorrow’s Doctors Today Act

• Introduced in March 2016 to increase resident cap positions
• Sponsored by Kathy Castor (D-FL)
• Includes language around accountability/performance of GME programs
  • Direct Secretary to create measures and performance standards
  • IME payment level would be tied to performance
• Also includes language to fix accidental triggering of cap and PRA

Medicare IME Pool Act of 2015

• Draft released in July 2015 by House Ways and Means staff
• Part of a larger hospital payment reform bill
• Would convert IME payments to block grants
  • Methodology would likely create major redistributions
• No accountability language
President Obama’s 2017 Budget Proposal

Released in February 2016

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

Focus on Medicare IME payments to teaching hospitals

• 10% cut over 10 years ($17.8 billion)
• “…encourage workforce development through targeted and more accurate indirect medical education payments.”
• “…[the] Secretary will be granted the authority to set standards for teaching hospitals receiving GME payments to encourage resident training in areas of emerging need…and emphasize skills that promote high-quality, high-value health care.”

Savings redirected in part to other workforce programs
Goal of Medicare IME Payment Accountability

- Identify patient care priorities that GME should focus on
  - E.g., team-based care, care coordination
- Identify appropriate measures to assess performance on those priorities
- Define performance standards for those measures
- Incentivize performance in those priorities
- Put some portion of Medicare IME payments at risk
### Outlook for the Future

- Continuing pressure for hospitals to justify and account for Medicare IME support
- Continuing interest in better linking physician training outcomes to current delivery system needs
- Pressure for general cap relief and attempts to target such relief only toward certain specialties
- Consideration of relationship of physician training to delivery system reform (ACOs, PCMHs, bundles, etc.)
- Consideration of role of primary care physician relative to other practitioners (e.g., nurse practitioners)
THANK YOU!

Questions?

Tim Johnson
(212) 506-5420
tjohnson@gnyha.org