Introduction to GME Financing

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Disclosure of Commercial Relationships

- None
- No Off-Label Disclosures

(Though our residency programs are funded by almost every source we are going to talk about...)
Learning Objectives

At the conclusion of this session, the learner should be able to:

• List common Graduate Medical Education (GME) funding sources
• Describe the “CAP” on GME funding
• Compare and contrast Direct and Indirect GME funding
To understand the future...

...you need some historical perspective
History of GME funding - 1965

Social Security Act = Medicare, Medicaid & GME funding
Why?

“Education improves quality of care, and should be an element in the cost of care to be borne partially by the hospital insurance program, until the community bears the cost in some other way”.
History of GME funding – 1980’s

- Reform of GME payments
  - Direct costs (DME or Direct GME)
  - Indirect costs (IME)

- GME funding became the primary source of hospital-based indigent care & teaching hospitals/residents became the soul source of care for poor populations.
  - Disproportionate Share Hospital (DSH) funds
History of GME Funding – 1990’s

- 1994 – Full funding limited to the time of training for Initial Residency Program (IRP) per resident

- 1997 – “Cap” applied to the Intern & Resident per Bed ratio (IRB) at each hospital.

- 1997 - Funding for resident time at non-hospital training sites (clinics, nursing homes.)
History of GME Funding – 2000’s

Unfunded spots now 33%

Resident positions Redistributed

- Residency Redistribution - 2005
  - 3,000 residency spots shuffled
  - Resident Redistribution -
Historical Financing of GME

- CMS Medicare/Medicaid funding
- State Medicaid funding
- State indigent care monies
- Hospital/patient care funding
- Research & education stipends
- Private funding (Blue Cross, Institutions, Practice groups)

Residency Program funding
Center for Medicare & Medicaid Services (CMS)

- Direct Graduate Medical Education (direct GME, or DME) - $2.6 billion
- Indirect Medical Education (IME) - $6.8 billion
Direct GME

- Direct GME stipulations
  - Pays for all time residents spend at a hospital & “non-provider setting” when they are “primarily engaged in furnishing patient care” & didactics
  - Pays for vacation & leave that do not prolong resident’s training
    - If the hospital pays for:
      - “Substantially all” (90%) of the cost of the salary & benefits of the resident
      - Away rotations (some)
      - The appropriate portion of the teaching faculty salary & benefits
Calculating Direct GME (DME)

Per Resident Amount (PRA) set in 1984 – 1985

- Increases based on consumer price index
  - Cost of GME training has increased substantially more than CPI over the past 20 years
  - For the past several years, only primary care receive CPI increase, so now primary care & specialty residents are funded at different amounts.

To calculate –

PRA $100,000 x 100 residents x 35% inpt Medicare beds = $3,500,000
Two types of payments – Indirect GME

• Indirect GME…a misnomer
  • Actually used for indirect patient costs related to having a GME program and operating costs
  • Intended to pay for more complex patients, standby capacity for trauma/burn centers, & learner inefficiencies such as increased length of stay

• Things not paid for:
  o Time spent in medical school setting without a hospital (if your simulation lab or conference room is there) or away conferences for 1 day or more
  o Time spent on international rotations
    • No Medicare beneficiaries overseas to care for
Calculating the IME

• Formula to calculate IME:

Adjusted ratio =
IME multiplier\([1 + (#\text{residents}/#\text{beds})]^{0.405} - 1\]  
IME adjustment =
Adjusted ratio x (%Medicare pts)(DRG payment) (Case mix ratio)

• 2008 IME Adjustment = 5.5% increase in DRG payment for every 10 resident increase/100 beds
The Math

• Step 1: Determine the IRB ratio:
  
  Chicago Hope = 200 residents/ 500 beds = 0.40 = IRB

• Step 2: Use statistical formula and IRB to calculate IME
  
  $1.32*(((1 + 0.40)^{0.405} - 1)) *100 = 19\%$

• Step 3: Calculate the IME payment for each case
  
  (Payment for DRG 547 * IME %) = IME Payment
  
  ($30,918.31 * 19\%) = $5,874.48

From AAMC "GME Financing Primer"
Medicaid GME

- Medicare GME (2012 - $10 billion)
  - DGME & IME together

- State Medicaid GME (2012 - $3.8 billion)
  - Part of funding goes to the state from CMS
  - States can match this & some do up to 50%
  - Some states have a separate indigent care fund from their own state monies that help fund urban teaching centers
GME funding for Fellowships

- ACGME approved fellowships
  - Fellows are treated as residents for DME & IME
  - Since they are training longer than their initial residency program, they count as 0.5 FTE
  - Can’t bill Medicare for DME/IME for fellows & bill Medicare for use of them as an attending
  - Can bill for something outside their field – Toxicology, Hyperbarics vs. working as an attending in the ED

- Non-ACGME fellowships
  - Cannot get DME & IME, so they can bill attending rates
    - Typical fellowship requires 80 hours/month clinical time
Funding
Resident Research Time

- Direct GME – Research not having to do with direct patient care will be funded if done at the hospital, but not at a non-hospital setting.

- IME – Research time is not funded.

- Research must be a requirement of specialty
  - Rotations need to be very carefully designed; it helps to make sure a project that is presented/published comes from the rotation.
Reporting to CMS

- Intern Resident Information System (IRIS)
  - Must demonstrate hours – thru computerized logging
    - Submit in Medicare Cost Report (MCR)
  - In recent CMS audits, many hospitals that ‘share’ residents between sites have had to account for their residents’ time by the hour

- To most successfully maximize GME funding
  - Hospital should to keep residents “above the cap” in IRIS system due to eliminated times of reimbursement for each resident
What’s this Cap?
In practical terms...

- “Over cap” means we have more employed residents than we have slots.

- No one program is “over cap”, adding residents just reduces the per resident subsidy.
How do we count residents?

<table>
<thead>
<tr>
<th>Number of Accredited Positions</th>
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<tbody>
<tr>
<td>Number of Employed Residents</td>
</tr>
<tr>
<td>(what the hospital is paying for)</td>
</tr>
<tr>
<td>Residents on the CMS Cost Report</td>
</tr>
<tr>
<td>The “CAP”</td>
</tr>
</tbody>
</table>
Why be over cap?

• Some subsidy is better than no subsidy (no other workforce element is subsidized)

• Residents are attractive (attract faculty, provide marketing value, facilitate service lines)

• They work more than the “usual FTE”, some time twice as much (up to 80 hours)
Why do you care???

- Now you can determine how much money your residents are worth to the institution... & how much they are skimming off the top

- Things to do now:
  - Become best friends with the hospital CEO/CFO
  - Find out your institutions’
    - % Medicare beds
    - PRA (percent resident amount)
    - Resident cap number
GME Funding Summary

Questions?

FIGURE 5-1 Current flow of GME funds.
NOTE: DGME = direct graduate medical education; DoD = Department of Defense; HRSA = Health Resources and Services Administration; IME = indirect medical education.
SOURCE: Adapted from Wynn, 2012 (Committee of Interns and Residents Policy and Education Initiative White Paper, “Implementing the 2009 Institute of Medicine recommendations on resident physician work hours, supervision, and safety”).