Graduate Medical Education Financing (Made Less Complex)

Jed Magen, DO MS
Madhvi Richards MD
Alyse Ley DO
College of Human Medicine
College of Osteopathic Medicine
Michigan State University

- Medicare
- Veterans Administration
- Health Resources and Services Administration
  - Children's Hospital's GME
  - Teaching Heath Centers GME
- Department of Defense

- Medicaid
- Private insurers (a few)

As the above formula indicates, the hospital's PRA, weighted count of residents, and ratio of Medicare inpatient days to total inpatient days together determine the amount of DGME funds that each institution receives. Table 3-2 shows the average of each component of the DGME formula for different categories of teaching institutions based on geographic area, the number of residents on staff, and the low-income patient percentage (LIPP). On average, hospitals are paid 37 percent of their PRA for each ("adjusted") resident FTE. However, there is considerable variation in the percent of Medicare bed-days across hospitals and this factor significantly impacts an institution's aggregate DGME funding. Safety net hospitals (i.e., those with a high LIPP), for example, tend to have relatively low Medicare ratios and, thus, low Medicare DGME PRAs. In 2008, the average Medicare PRA for safety net hospitals with the highest LIPP (65 percent or greater), was only $25,306, while for hospitals with a 15 to 25 percent LIPP the average was $46,857, more than 85 percent higher.

IOM GME report 2014

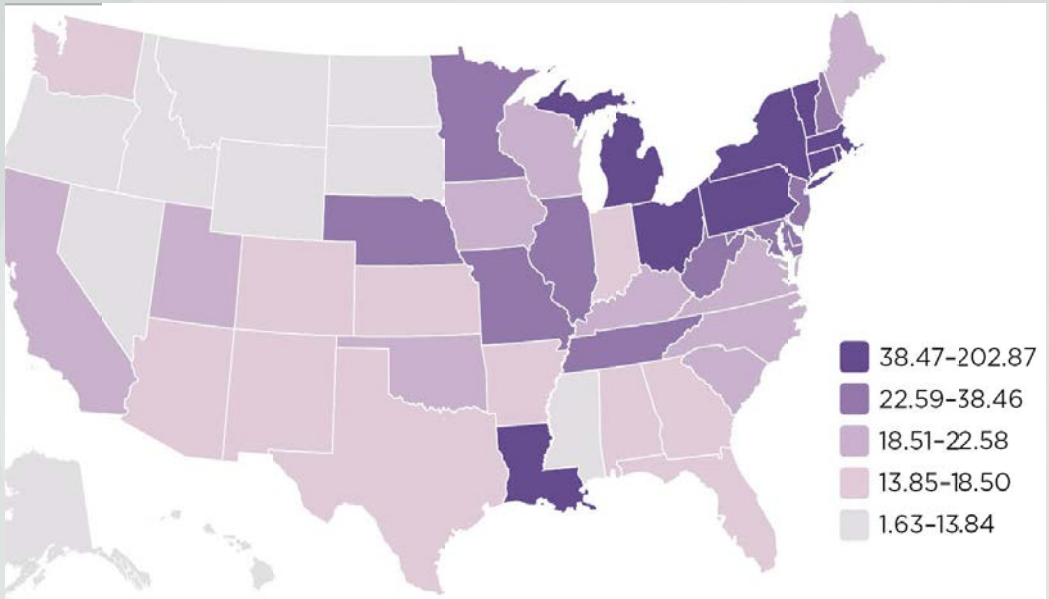

FIGURE 3-2 Number of Medicare-funded training pos tions per 100,0C0 population, 2010.

SOURCE: Mullan et al., 2013.

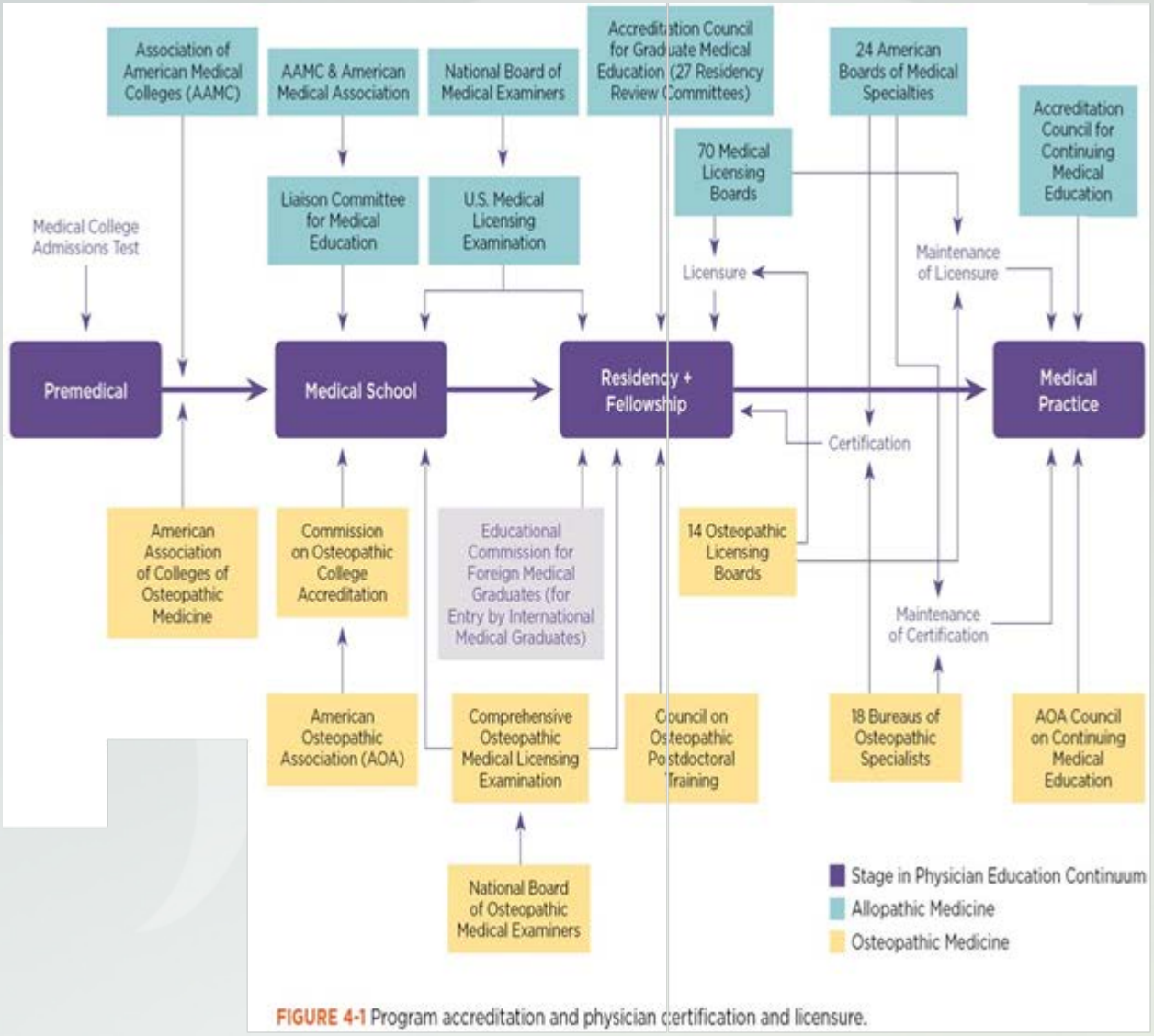

FIGURE 4-1 Program accreditation and physician certification and licensure.

GME Financing

- major funding mechanism for graduate medical education in U.S.
- rules are complex
- ignorance is dangerous
- knowledge is power

GME Financing

Federal Financing Mechanisms

GME Financing

Federal Mechanisms

- Dept. of Veterans Affairs

  10,300 (2012)

- Dept. of Defense

  5,000

- HRSA

  556-700 “primary care” positions

GME Financing

Federal Mechanisms

- Medicare

  funds virtually all other positions

GME Financing

Federal Mechanisms

Medicare

Direct Medical Education Adjustment

Indirect Medical Education Adjustment

(Disproportionate Share Adjustment)

GME Financing

Federal Mechanisms

- Direct GME Reimbursement

  intended to pay Medicare's share of residency program costs out of Federal Medicare budget

GME Financing

Federal Mechanisms

Direct Medical Education Reimbursement Calculation

start with calculation of cost/FTE resident

- stipend and fringe benefits
- overhead costs for education office

1. GME Financing

Federal Mechanisms

Direct Medical Education Reimbursement

- some salaries for teaching physicians
- 1984 “base year”

GME Financing

Example

St. Elsewhere General Hospital

- 600 beds
- 400 house staff

GME Financing

Direct Medical Education Reimbursement

St. Elsewhere General

1. Cost/FTE resident x number of residents = "total cost"

$60,000 x 400 = $24,000,000

GME Financing

Medicare only pays costs for proportion of Medicare patients in hospital

(Medicare Utilization Rate)

GME Financing

2. “total” program costs x Medicare Utilization Rate = DME Payment

$24,000,000 X 0.46 = $11,040,000

This hospital receives $11,040,000 from Medicare in direct GME reimbursement.

GME Financing

Important Points!

Residents count as 1 FTE until:

- board eligibility
- a maximum of 5 years
- thereafter count as 0.5 FTE.

GME Financing

Important Points!

Residents in primary care fields receive slightly higher GME payments.

GME Financing

Federal Mechanisms

- Medicare
  - Direct Medical Education Adjustment
  - Indirect Medical Education Adjustment
  - (Disproportionate Share Adjustment)

GME Financing

Indirect Medical Education Reimbursement

- % add-on to DRG payment
- compensates hospitals for “added costs” of medical education

GME Financing

Indirect Medical Education Reimbursement

- becomes part of hospital revenues, not education funding

GME Financing

IDME Calculation

Start with basic DRG payment of $10,000:

1. Calculate resident/bed ratio

    400 house staff/600 beds = 0.6

GME Financing

IDME Calculation

2. Use chart to determine % add-on for ratio of 0.6, in this case 27.59%
3. $10,000 x 27.59% = $2,759

GME Financing

IDME Calculation

4. $10.000 + $2,759 = $12,759 total DRG payment

St. Elsewhere makes an extra $2759.00 because it has residency programs.

GME Financing

IDME Increases

- % increase for each 10% increase in house staff/bed ratio
- increase in ratio=increase in IDME amount

GME Financing

Federal Mechanisms

- Medicare
  - Direct Medical Education Adjustment
  - Indirect Medical Education Adjustment
  - (Disproportionate Share Adjustment)

GME Financing

Disproportionate Share Adjustment

- to compensate hospitals for caring for patients without means to pay
- percentage add-on to DRG payment
- important to many urban teaching hospitals, rural hospitals

GME Financing

- DSH funding decreases as result of ACA
- especially problematic in states that did not expand Medicaid

GME Financing

Important Over-All Point

- IDME income for any hospital is generally 1 ½ to twice DME amount
- vital to many teaching hospital's bottom line

GME Financing

Special Psychiatry Issues

psychiatry units now reimbursed via Prospective Payment System for Psychiatry

GME Financing

State Funding Mechanisms

GME Financing

State Mechanisms

Medicaid

- usually pays a per resident amount to hospitals (some states)
- states can obtain waivers to use Medicaid GME dollars in innovative ways (leveraging Medicaid funds)

Faculty Billing

GME Financing

Faculty Billing

Medicare Regulations

- no billing for time resident spends with patient

GME Financing

Faculty Billing

Medicare Regulations

- teaching physician may bill for services if documents personal interaction with patient and critical component of exam and discussion with resident and review of note.

GME Financing

Faculty Billing

- BUT, private insurers have own regulations.
- need to know specific regulations for each insurer

GME Financing

BBA Refinement Act (2001)

- mean 2001 Adjusted National Per Resident Average approximately $76,888
- If PRA is less than 85% of adjusted national average, hospital PRA will be increased to 85%
- if PRA is over 140%, hospital PRA will not be updated for inflation

House Staff Caps
And
The Rolling Average

GME Financing

House Staff Caps

- applies to hospitals, not programs
- applies to both DME and IDME numbers

(but they can be different)

GME Financing

House Staff Caps

- residents post-first year board eligibility are still counted as 1.0 for IDME, 0.5 for DME

GME Financing

The “Rolling Average”

	# house staff positions	# filled positions	3-year average
2012	100	80	85
2013	100	85	85
2014	100	98	87

GME Financing

Claiming out-of-hospital rotations

- pay the cost of resident salary and fringe benefits
- claim the amount of time in the out-of-hospital setting

Counting Resident Time for Didactic and Scholarly Activities

GME Financing

Counting didactic time

- setting must be one “where primary activity is care and treatment of particular patients”
- settings where primary activity is NOT patient care do not qualify
- count for IDME only if in hospital

GME Financing

Allowed

- hospitals, doctors offices, community health clinics

Not Allowed

- medical schools, hotels, convention centers

GME Financing

Research

- must be associated with treatment or diagnosis of a particular patient

GME Financing

Leave and vacation

- now countable for DME and IDME

GME Financing

Experimental “Downsizing” Program Failed

- house staff are still less expensive than adding non-terminal degree health care providers

GME Financing

Reduction in FTE Caps (three rounds so far)

- hospitals that are under cap lost 65% of unfilled positions

GME Financing

Positions redistributed:

- 70% to hospitals in states with resident-to-population ratios in lowest quartile”
- 30% to hospitals in states in top ten among ratio of population living in health profession shortage areas

GME Financing

Teaching Health Center Provision of ACA

GME Financing

Allows applications for new or expanded “primary care” residency programs in cooperation with FQHC or RHC

- includes psychiatry
- appropriation for 5 years

Politics!

- Medicare Payment Advisory Commission
- Advisory Committee on Health Workforce \ Evaluation and Assessment
- Institute of Medicine Committee on GME

GME Financing

MedPAC

- decrease IME
- put savings in fund for quality payments to GME programs

GME Financing

GME funding is given for increased value provided for higher value of patient care services provided in teaching hospitals

GME Financing

Advisory Committee on Health Workforce/

Evaluation and Assessment

- develop and commission evaluations of education and training activities

GME Financing

- identify barriers to improved coordination at the federal, state, and local levels and recommend ways to address them
- encourage innovations that address population needs, changing technology, and other environmental factors.

Institute of Medicine Report

- no physician surplus
- combine IME and DME
- build administrative structures to monitor and to make GME policy
- take $$$ from current GME to fund administration and “innovation fund”
- accountability

GME Financing

The Near Future

- physician payments will decrease
- ACO's
- physician shortages
- increased numbers of graduates, no increase in residency positions

GME Financing

- decrease in uncompensated care
- falling patient and GME reimbursement
- more people covered

Single Accreditation System For GME

- AOA, AACOM join ACGME
- DO residencies apply for ACGME accreditation
- RRC membership
- two matches maintained for present time
- DO’s still take COMLEX

Medical Education Administration

When you discover that you are riding a dead horse, the best strategy is to dismount. In health care, we often try other strategies with dead horses, the most common being:

Medical Education Administration

- Change riders
- Buy a stronger whip
- Appoint a committee to study the dead horse

Medical Education Administration

- Arrange a visit to other sites to see how they ride dead horses
- Conduct a training session to increase our dead horse riding ability
- Harness several dead horses together to increase speed

Medical Education Administration

- Provide performance based incentives for the dead horse
- Purchase a horse information system
- Revisit the horses performance requirements

Medical Education Administration

- Define ownership of a dead horse as a core competency