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Medicare Funding of Graduate Medical Education – Fundamentals and the Future

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Lori Mihalich-Levin, J.D.
Health Care Affairs
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Financing of Resident Education and the Special Missions of Teaching Hospitals Comes from Multiple Sources

- Medicare (largest explicit payer)
- Medicaid
- Children's GME program
- Private patient care revenues
- VA/DoD
- Other Federal and state programs

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Medicare

Medicare Makes 2 Specific Payments With an "Education" Label

Direct GME Payments (DGME)

- Partially compensates for residency education costs

Indirect Medical Education (IME) Payments

- Partially compensates for higher patient care costs due to presence of teaching programs

DGME and IME Payments are Not Inconsequential

Estimated Federal Fiscal Year 2010:

DGME Payments	=	$3.0 billion
IME Payments	=	$6.5 billion
Total	=	$9.5 billion

Source: CMS Office of the Actuary

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Medicare DGME Payments

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What Are DGME Payments Intended to Cover?

Compensate teaching institutions for Medicare's share of the costs directly related to educating residents:

- Residents' stipends/fringe benefits
- Salaries/fringe benefits of supervising faculty
- Other direct costs
- Allocated overhead costs

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What is the Basic Methodology Underlying DGME Payments?

Step 1: Determine hospital-specific per resident base year cost amount (generally 1984)

Step 2: Update (to current year) base-year per resident amount (PRA) for inflation

Step 3: Multiply the updated PRA by the number of resident FTEs in the current year (this amount capped by BBA resident limits)

Step 4: Multiply by the hospital's ratio of Medicare inpatient days/total days

Note: Teaching hospitals receive DGME payments associated with both FFS and managed care patients

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Fellows Counted Differently from Residents

- Residents in their "initial residency period" (IRP) are counted as 1.0 FTE
- Residents training beyond the IRP counted as 0.5 FTE
- Physicians who decide to retrain in another specialty are counted as 0.5 FTE

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Medicare Pays Its "Share" of Resident "Costs": EXAMPLE

Medicare Share * Per Resident Amount = Medicare Payment Per Resident

40% x $100,000 = $40,000 payment per primary care resident

40% x $90,000 = $36,000 payment per all other residents

(40% x $90,000) ÷ 2 = $18,000 payment for fellow

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Medicare IME Payments

Medicare Payments with an Education Label: IME

Compensates teaching hospitals for higher inpatient operating costs due to:

- unmeasured patient complexity not captured by the MS-DRG system
- other operating costs associated with being a teaching hospital (lower productivity, standby capacity, etc.)

Percentage add-on payment to basic Medicare per case (MS-DRG) payment

Calculating the IME Adjustment Factor

The IME adjustment is based on statistical analysis using intern and resident-to-bed ratios (IRB)

% per case add-on =

Multiplier X $((1 + IRB)^{0.405} - 1)$

For FFY 2011, multiplier is 1.35

Short hand for IME: Hospitals get about a 5.5% increase in MS-DRG payments for every 10-resident increase per 100 beds

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Calculating the IME Payment

Step 1: Determine the IRB ratio:

Chicago Hope = 170 residents/ 666 beds = 0.255 = IRB
(Note: IME resident counts do NOT reflect weighted amounts)

Step 2: Use statistical formula and IRB to calculate IME%

$1.35 \times ((1 + 0.255)^{0.405} - 1) \times 100 =$ 13.00%

Step 3: Calculate the IME payment for each case
(Payment for MS-DRG 227 x IME %) = IME Payment
($29,002 x 13.00%) = $3,770.26

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Medicare Resident "Caps"

Medicare Resident Limits: 1997 BBA (P.L. 105-33, Sections 4621 and 4623)

Generally speaking, the number of FTE allopathic and osteopathic residents that a hospital may count for DGME and IME payments is limited to 1996 Medicare cost report count.

- Limits may be different for DGME and IME

* The Medicare statute provides very few exceptions to the caps

Changes re: Cap Slots in the Affordable Care Act (ACA)

- Unused slot redistribution program
- Closed hospital slot redistribution program

Note: Final regulations on these programs were published in the Outpatient PPS Final Rule in the *Federal Register* on November 24, 2010 (75 *Fed. Reg.* 71800, 72133)

Resident Caps and Teaching Hospital Closures

If a teaching hospital closes, regulations provide for "temporary" cap increases for those hospitals that take on and complete the training of the displaced residents

After displaced residents complete training, the temporary cap increases end and hospitals revert to original caps

But now, under ACA, the cap slots are ultimately redistributed on a *permanent* basis (with geographic preference, and preference for hospitals that took displaced residents)

Counting Resident Time

Resident FTE count is a major factor in determining both IME and DGME payments and Medicare has lots of regulations governing this!

Counting Residents, Some Examples

Cannot count time spent in PPS-excluded units (rehab, psych, SNF)

As of FY 1998, can count time in nonhospital, clinical settings if meet the requirements

Payments for Residents in Nonhospital Settings: Background

Hospitals may include residents training in non-hospital settings in their resident counts, as long as the hospital pays "all or substantially all" of the training costs at that site and the residents spend their time in patient care activities.

ACA: "All or Substantially all" defined as resident stipends and benefits.

"Nonhospital site" defined as a CLINICAL setting; does not include medical schools

Training in non-hospital sites: what if the hospital is over its resident cap?

"[A] hospital may choose not to pay for the costs relating to the training of residents in a nonhospital setting if it is training FTE residents in excess of its caps, and therefore, would also not include those FTE residents training in nonhospital sites in its FTE counts."

"[A] hospital may only claim residents training at nonhospital sites on its cost report if the hospital would, in the absence of the FTE caps, be permitted to count those FTE residents for direct GME and IME payment purposes, even if those residents would be over its caps."

Source: 72 *Fed. Reg.* 26975 (May 11, 2007)

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Changes re: Counting DGME/IME Time in the Affordable Care Act (ACA)

- Counting time in nonhospital sites
- Counting time for didactic, research, approved leave

Note: Final regulations on these programs was published in the Outpatient PPS Final Rule in the *Federal Register* on November 24, 2010 (75 *Fed. Reg.* 71800, 72133)

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Resident Time Counted and Not Counted for Medicare DGME and IME Payments (§5505)

DGME

Hospital	Non-Hospital
Patient Care	Patient Care
Vacation/Sick	Vacation/Sick
Didactic	*Didactic (July 1, 2009+)*
Research	NOT Research

IME

Hospital	Non-Hospital
Patient Care	Patient Care
Vacation/Sick	Vacation/Sick
Didactic (Jan. 1, 1983+)	NOT Didactic
*NOT Research (Oct. 1, 2001+)**	NOT Research

Note: Text in italics indicates language in the Affordable Care Act.

* The ACA clarifies that IME research time does not count after October 1, 2001. It does not answer the question of whether IME research time counted prior to this date (the section states that the research provision: "shall not give rise to any inference as to how the law in effect prior to such date should be interpreted").

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The future of Medicare funding of Graduate Medical Education?

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What does the future hold?

- MedPAC recommendations
  - Focus on accountability
    - E.g., Congress should authorize the Secretary of Health and Human Services (HHS) to establish a "performance based" GME program.
- President's Fiscal Commission Report (December 2010)
  - Limit DGME payments to 120% of 2010 national average resident *salaries*
  - Reduce IME from 5.5% to 2.2%
- AAMC Advocacy

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