Graduate Medical Education
Federal Funding: CMS and HRSA

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Agenda

- Medicare Reimbursement of Graduate Medical Education – How teaching hospitals are paid by Medicare
- Overview of Teaching Health Centers and the ACA expansion
- Interplay between Traditional Graduate Medical Education and Teaching Health Centers
- ADDED – The Institute of Medicine, August 2014 Report: *Graduate Medical Education That Meets the Nation’s Health Needs*
FP and NP Pipeline

- Residency: 3 years
- M.D./D.O.: 4 years
- BA/BS: 4 years
- MCAT
- MSN: 1.5-3 years
- BA/BS*: 4 years
- GRE or NCLEX-RN

11 years

5.5-7 years

*While a standard 4-year degree, preferably a BSN, is recommended, alternate pathways exist for an RN without a bachelor’s degree to enter some master’s programs.

AAFP, 2012
Medicare Payments for Graduate Medical Education

PAID TO “TEACHING HOSPITALS”

PAID UNDER MEDICARE COST REPORTING/SETTLEMENT SYSTEM

WHAT IS A MEDICARE TEACHING HOSPITAL?

A MEDICARE CERTIFIED HOSPITAL IN WHICH RESIDENTS ARE PRESENT AND IN TRAINING IN AN APPROVED GRADUATE TRAINING PROGRAM – NO APPLICATION NEEDED, THE CONCLUSION FOLLOWS ONLY THE FACTS OF THE RESIDENT TRAINING

IF THE RESIDENTS ARE PRESENT AND IN TRAINING IN THE HOSPITAL OR ANY PROVIDER BASED LOCATIONS OF THE HOSPITAL, IT IS A TEACHING HOSPITAL – AND MANY GOOD AND POTENTIALLY TROUBLESOME RESULTS FOLLOW
Medicare Payments for Graduate Medical Education

THE RULES ARE COMMONLY DESCRIBED AS **BYZANTINE**

(OF A SYSTEM OR SITUATION) EXCESSIVELY COMPLICATED, TYPICALLY INVOLVING A GREAT DEAL OF ADMINISTRATIVE DETAIL
Traditional GME Model

- Accreditation
- Medicare GME $
Traditional GME: Two Payment Components and Methods

• Direct Graduate Medical Education (DGME):
  – Purpose: offset direct costs of educating residents, including salaries/benefits of residents and teaching physicians
  – The FTE Cap and the PRA are CCN number attributes

• Indirect Graduate Medical Education (IME)
  – Purpose: offset higher cost of running a teaching hospital, including increased number of tests ordered by residents as opposed to experienced physicians and higher level of care needed by patients at teaching hospitals
DGME Payment Formula

• DGME Payment
  – PRA x three-year rolling average of # of FTE residents, subject to the FTE cap x Medicare patient load

• DGME is an annual payment settled in the Medicare Cost Report

• PRA: Per Resident Amount –Now, lower of actual DGME costs per resident in the base year or weighted average of PRAs of surrounding teaching hospitals
  – Original base year 1984, or determined when first resident rotates in, whether or not hospital intends to seek DGME or IME payments for that resident
  – Triggered whether the resident is in a new program or an old program
  – The PRA is permanent unless re-audited by CMS or the contractor –which can occur at any time
DGME Payment Formula (con’t)

• **FTE Cap**: For most teaching hospitals, based on the number of residents training in the hospital in 1996-1997, created by the Medicare Balanced Budget Act of 1997: separate caps for IME and DGME
  
  • New teaching hospitals: Based on number of resident FTEs in most populated training program five years after that program/hospital starts if first resident rotated in after October 1, 2012
    – FTE cap is set three years after the start of the first program if before October 1, 2012
    – Cannot be permanently moved by contract but can be “affiliated” to another hospital or moved through merger or CHOW/assumption of the provider number
    – The hospital need not sponsor the program to trigger the FTE cap
DGME Payment Formula (con’t)

• FTE Cap
  – The FTE cap is set by residents in new programs only: not program expansion, not program relocation: must be “new new” to CMS
  – Once set, the FTE cap is permanent, unless Congress acts: MMA Section 422 redistribution, ACA 5503 redistribution, ACA 5506 rescuing closed hospital FTE cap
  – The FTE cap “belongs” to the Medicare provider number

• Medicare Patient Load: Measures amount of Medicare care provided versus total amount of care provided. No special rule for new hospitals.
  – Hospitals with greater Medicare percentage receive proportionally higher DGME/IME reimbursement
Medicare Payments for Graduate Medical Education

- In 2010, Medicare paid almost $10 billion for graduate medical education
  - Estimated $3.1 billion for direct graduate medical education costs (DGME) on a per resident basis
  - $6.3 billion for indirect medical education costs (IME) computed as a percentage add-on for each Medicare discharge paid
- Estimated hospitals received $30,000 in DGME and $62,000 in IME per FTE
  - Paid to over 1,000 hospitals, for about 110,000 residents
IME Payment Formula

- Formula-driven add-on payment for each Medicare discharge
- Hospital specific interns & residents to beds (IRB) ratio key individual determiner
- Also subject to separate IME FTE cap
IME Payment Formula

- **IME Adjustment Factor:** \( c \times [(1 + r) \times 0.405 - 1] \)
- \( c \) is set by Congress each year
- \( r \) is the hospital specific ratio of [residents and interns to beds]: IRB ratio
- The formula multiplier (c) of 1.35 represents a 5.5 percent increase in IME payment for every 10 percent increase in the resident-to-bed ratio
IME Payment Formula

• Very Rough Example of the Result
• 200 bed hospital
• Add 20 residents
  – 20/200 $1,600,000 in IME /20 = $80,000/FTE
• Add 2 residents
  – 22/200 $1,814,600 in IME/22 = $82,480/FTE
• IRB ratio limited to lower of this year’s or last year’s
New Teaching Hospital

• A new teaching hospital has never before had residents rotating through it/in it
• Two types of residents:
  – New program residents
  – Old program residents
• Full-time equivalent (FTE) cap is set with new program residents
  – There are separate FTE caps for DGME and IME
• Per resident amount (PRA) is set with new and old program residents
New Teaching Hospitals

• Traps to avoid – FTE cap
  – Have any “new program” residents ever rotated to your hospital? If so, did that trigger your FTE Cap? If new program residents have been present, the 3/5 year cap determination period starts
  – A “new program” is a program that began and was newly accredited after 1995 (the year the FTE cap idea began), and is now defined by CMS rule. Only “new program” residents can build a cap, and the presence of any new program residents at a hospital without an FTE cap will trigger the FTE Cap determination
New Teaching Hospitals

• Traps to avoid - PRA
  – Have residents been in the hospital on an informal basis in past years? Has that set your PRA? The absence of any prior Medicare DGME/IME payments may not matter
  – If no direct medical education costs in the PRA determination year, the PRA can be $0.00 – zero, meaning that there will be no DGME payments
GME Payment for Simulation or Simulation Center Training

- Simulation training: What kind of time is it?
  - May be classified as *didactic*, i.e. not related to the care of an individual patient – it is likely not *research*
  - CMS differentiates: patient care time, research time, didactic time

- Didactic training time can be counted towards DGME reimbursement if done on the "*hospital complex" or *non-provider sites* that are primarily engaged in patient care
  - "Hospital complex" not well defined – on campus
  - Non-provider site primarily engaged in patient care not well defined – excludes a dedicated simulation lab?

- Didactic training is only countable towards IME payments if it occurs in a hospital setting: put the simulation center “in the hospital”?
TEACHING HEALTH CENTERS
THC: Affordable Care Act Expansion

- Five-year grant program from October 1, 2010 through September 30, 2015 designed to support an increased number of primary care physicians and dentists in community-based ambulatory care centers
- $230 million
- Spurred by projected physician shortages and a desire to improve access
- Introduce physicians to the primary care setting earlier in their careers with the goal fostering high-quality, low-cost care in the future
THC Model

Community Training Sites

Teaching Health Center
- Residency
- CHC

Hospital/AHC
- Medicare GME $

Accreditation

HRSA GME $
THC: Function

• Five-year grant period from ACA; funding ends in 2015
• To be eligible for funding, a THC must operate as a “community based, ambulatory patient care center” that “operates a primary care residency program”
• Accrediting agency’s institutional sponsor of record must be a health center or a GME consortium that includes a health center
THC: Payment

- HRSA oversees the grant program (instead of CMS for traditional GME)
- Payments made directly to the THC
  - Even in the case of a consortium, the money must go to the THC
- Payments contingent upon recording outcomes – THCs must track and report numbers and specialties of residents trained and number who go on to care for vulnerable populations
  - This type of accountability does not exist under traditional GME
INTERPLAY BETWEEN MEDICARE GME AND HRSA THC FUNDING
CMS versus HRSA
Resident Reimbursement

- Hospital must report all resident FTEs training in the hospital regardless of who is paying for the cost of those residents in Sections E and E-4 of the hospital cost report
  - Medicare will pay IME and DGME for those residents up to the FTE cap
  - HRSA will not pay for FTEs funded by Medicare
  - HRSA residents should also be reported on the IRIS report
CMS versus HRSA
Resident Reimbursement (con’t)

• HRSA residents are reported separately on the hospital cost report in Section S-2
  – Note that these same residents are reported in Sections E and E-4, but HRSA will not fund residents that Medicare has already agreed to pay for
• Hospitals likely cannot count the time a THC resident spends in a non-hospital site
Medicare GME and THCs: Takeaways

• GME and THCs work together to increase the level of funding available for residents, but there are many questions remaining for hospitals and THCs:
  – Can THC residents set the PRA for a new teaching hospital?
  – Can THC residents set the FTE cap for a new teaching hospital?
  – Must a teaching hospital be over its cap to receive pass-through payments from the THC – a pass-through of the HRSA funding?
  – There is little clear regulator guidance on any of these questions
Other GME Funding

• Federal Children’s Hospital GME: Budgeted at $265 million in 2015
• State Medicaid Programs: Currently 24 states, maybe more
• State grant programs
IOM: GRADUATE MEDICAL EDUCATION THAT MEETS THE NATION’S HEALTH NEEDS

• Culmination of a two plus year study period, requested by 11 U.S. Senators and supported by 12 private foundations

• IOM report largely reflects and reinforces key prior studies and reports of the last 10 years by organizations such as MedPAC, COGME and others
  • If what the IOM said was yet another new proposal, it would have just added another voice for reform
  • By aligning with many prior proposals it seems a wave is building

• Basic conclusion: The current system is broken and needs fundamental reform

• Significant industry criticism, however, is it right?
IOM: GRADUATE MEDICAL EDUCATION THAT MEETS THE NATION’S HEALTH NEEDS

• Recommendations:
  • Keep Federal GME funding with Medicare (tied to an entitlement for longevity) and at current support level, but modernize and improve its function
  • Build a new GME policy and financing system, including the establishment of a mechanism to have a national GME policy and a GME financing system to support: an operations fund and an innovation fund
  • De-link GME funding from teaching hospitals by changing to paying the sponsoring institutions (not hospitals or THCs, necessarily) a new national geo-adjusted per resident amount

• The goals of reform:
  • Better physicians: reform competency for the triple aim, cultural competency and diversity (population and locale)
  • Innovation in GME
  • Transparency and accountability
  • Have a GME policy and reward performance
  • Make the system rational and purpose driven
  • Mitigate the negative effects of the transition – but transform it