GME Update: Payment and Policy

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AGENDA

- Background & Context
- GME Payment Mechanics
- Community Support & New Program Issues
- Counting Resident Time
- Other Funding Opportunities
- Developments & Trends

BACKGROUND & CONTEXT

The Funding Landscape

- Federal/State funding for graduate medical education goes to over 1,000 hospitals for 115,000 resident positions (100,000 capped number).
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  -
  - Medicare: $9.35 billion
  - DGME – just under $2.7 billion
  - IME – just under $6.7 billion
  - Medicaid: $785 million
  - Children's Hospitals GME: $265 million

GME on the Chopping Block?

- MedPAC's June 2010 Report to Congress:

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GME on the Chopping Block?

- National Commission on Fiscal Responsibility and Reform—"Simpson-Bowles" Plan (Dec. 2010)

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  - Recommended reducing IME adjustment by 60% and capping DGME payments at 120% of national average resident salary ("in 2010

Reduction ("supercommittee") proposed GME

  - Estimated to save $6B in 2015, $60B through 2020

GME on the Chopping Block?

- Proposed Cuts in President's FYs 2013 – 2016 Budgets
  - **Indirect Medical Education (IME) for Acute Care Hospitals**
    - 2013 Budget: IME ↓ by 10% ($830M) beg. 2014 (↓ $9.7B over 10 years)

  - **Indirect Medical Education (IME) for Acute Care Hospitals**
    - 2013 Budget: IME ↓ by 10% ($830M) beg. 2014 (↓ $9.7B over 10 years)

    - 2015 Budget: IME ↓ by $960M in 2015 (↓ >$14.6B over 10 years)

    - **Children's Hospital Graduate Medical Education**
      - 2013 and 2014 Budgets: CHGME ↓ >65% ($177M) from 2012 funding levels; would have eliminated IME funding for children's hospitals
      - 2015 Budget would have funded new slots ($530M in 2015; $5.2B ov years) to train ~13,000 primary care and high-need specialty residents;
      - This figure included a $100M set-aside to fund pediatric training in children's hospitals in

IOM Report

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  -
    - Cap total GME spending at current levels (adjusted for inflation)
    - Carve out up to 30% of all GME funding for new

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Congressional Climate

- GME, went into effect on April 1, 2013, and will remain in effect until 2024
- Sustainable Growth Rate (SGR) replacement?
- UPSHOT: Health care reform remains in the national spotlight
  - Congress is focused on cost-cutting
  - Proposed GME changes will not disappear

GME PAYMENT MECHANICS

GME Payment Mechanics

- **Direct Graduate Medical Education (DGME)**
  - Per-resident payment

    of MS-DRG

    DGME)

    ~~of Medicare separate pass-through payment~~, independent payment
  - Roughly 1/3 of total GME (almost $) in 2012)

    IME) DRG
  - Not paid on a per-resident basis

FTE Cap

- In the Balanced Budget Act of 1997, Congress capped the number of residents for which a hospital can claim DGME/IME reimbursement
  - In the Balanced Budget Act of 1997, Congress capped the number of residents for which a hospita can claim DGME/IME reimbursement
    Hospitals are capped at the number of "full-time equivalent" (FTE) residents reported in the hospital's
    - subject to the FTE Cap
    - FTE Cap is statutorily limited to "allopathic and

DGME Payment Formula

DGME payments are intended to compensate hospitals for the "direct" costs of graduate medical education programs —*e.g.*, residents' stipends & benefits, teaching physician salaries, administrative costs, and allocated overhead

$$\text{DGME} = \text{Hospital's "per-resident amount" (PRA)}^{*} \times \text{FTE resident count}^{**} \times \text{Hospital's Medicare patient load}$$

* PRA is hospital-specific; once established, it is updated annually for inflation, but cannot be reset

** "Weighted" number of full-time equivalent residents, subject to 3-year rolling average and the FTE cap

Weighted Resident Count

- Applies only to DGME (not IME)
- Residents training beyond their "initial residency period" (IRP) count as 0.5 FTEs
- IRP = the minimum number of years required for specialty Board eligibility

3-Year Rolling Average

- Also enacted in the Balanced Budget Act of 1997, for both DGME and IME…
  - The total number of FTE residents for payment purposes is equal to the average of the actual FTE resident counts from the current cost reporting period and the preceding two cost reporting periods
- Dental residents are subject to the 3-year rolling average
- Effect is to delay the full realization of additional reimbursement for new residents by "phasing in" the FTE increase over 3 years

IME Payment Formula

IME payments are intended to compensate hospitals for the "indirect" costs of graduate medical education—higher patient care costs due to more complex patient population and increased costs of specialized services

$$\text{IME} = \text{Multiplier}^{*} \times \left[\left(1 + \text{Resident-to-Bed Ratio}^{***} \right)^{0.405^{**}} - 1 \right] \times \text{DRG Pmts}$$

* Multiplier is 1.35 for FY 2015 (42 C.F.R. § 412.105(d)(3)(xii))
** Effect of teaching activity on inpatient operating costs (42 C.F.R. § 412.105(c))
*** Lesser of current or previous year's "resident-to-bed" ratio (the "IME lag")

"IME Lag" (or IRB Ratio Cap)

- Also in the Balanced Budget Act of 1997…
  - A hospital's resident-to-bed ratio (IRB ratio) for payment purposes cannot exceed the prior year's IRB ratio
- Effect is to delay the IME benefit by 1 full year
- It would require a legislative fix to eliminate the 3-year rolling average and the IME lag

COMMUNITY SUPPORT & NEW PROGRAM ISSUES

Community Support Principle

- "Since Inception" Rule
  - "A hospital must continuously incur costs of direct GME of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents...."42 C.F.R. § 413.81(b) (emphasis added), *see also* 68 Fed. Reg. 45346, 45434, *et seq.* (Aug. 1, 2003).
  - For residency programs in nonhospital settings, only those programs funded by a hospital since their inception are eligible for a hospital to receive DGME and IME funding.
- Community support is forever!

Community Support Principle

- A word about grants:
  - "Community support" generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations
  - Community support does not include grants, gifts, and endowments that are not required to be offset against a hospital's operating costs
  - Take-away: Supporting grants do not necessarily create a community support disallowance if a hospital continuously incurs the required direct program costs

New Programs

- Scenario: There has been a community support disallowance with respect to a particular residency program, and a decision is made to close the program that has become ineligible for GME reimbursement. The hospital and dental school want to partner to establish a different dental residency program that will be GME-eligible.
- Key Consideration: In order to ensure that the hospital will be permitted to count the new resident FTEs for purposes of GME reimbursement, the program must qualify as a "new program," under CMS guidance.

New Programs

- Accredited on or after January 1, 1995
- In determining whether a particular residency program is truly "new," CMS looks at several factors:
  - Whether the program director is new
  - Whether the teaching staff is new
  - Whether there are only new residents training in the program
  - Whether the hospital operating the program also operates another program in the same specialty
  - Relationships between hospitals operating similar programs
  - Whether the program has been relocated from a hospital that closed (and whether the program was part of that hospital's cap)
  - Whether the program is part of any other hospital's FTE cap determination

See 74 Fed. Reg. 43754, 43908-17 (Aug. 27, 2009).

New Programs

- New teaching hospitals and rural hospitals can receive a permanent FTE cap adjustment to accommodate FTEs of allopathic and osteopathic residents training in "new programs" they establish
- However, some background rules to keep in mind:
  - Dental residents training in "new programs" cannot trigger an FTE cap adjustment
  - But, dental residents *will* trigger the establishment of a new teaching hospital's PRA
  - Unlike allopathic and osteopathic residents, dental residents participating in "new programs" *are* subject to the 3-year rolling average and the IME lag

COUNTING RESIDENT TIME

CMS Rules for Counting Resident Time

- Factors affecting how resident time may be counted include:
  - Costs hospitals must bear to count resident time in nonhospital sites
  - Activities in which the resident participates —*e.g.*, patient care, didactic, research, approved leave
  - Documentation requirements

Counting Resident Time in Nonhospital Sites

- Costs Hospital Must Incur
  - **Pre-Affordable Care Act: "Substantially All"** Hospital had to incur 90% of sum of resident stipends & benefits AND supervisory teaching costs
  - **Post-ACA: Residents' Stipends and Benefits** Hospital must incur only the costs of residents' stipends & benefits during the time the residents spend at nonhospital sites; hospitals are no longer required to pay faculty costs at the nonhospital site

Counting Resident Time in Nonhospital Sites

- Impact of hospitals not being required to pay faculty costs:
  - Most hospitals will refuse to pay faculty costs
  - More hospitals better able to afford financing new dental programs in nonhospital sites

Counting Resident Time in Nonhospital Sites

- **Recordkeeping Requirements**: Hospitals must maintain certain data on the time residents spend in nonhospital sites
- **Written Agreement Requirements**:
  - No written agreement is required between the hospital and nonhospital training site as long as the hospital incurs the costs of residents' stipends & benefits within three months following the rotation month
  - If multiple hospitals share stipend & benefit costs of training at a nonhospital site, then the hospitals must have a written agreement with one another ensuring that each hospital counts its proportional share of time

Counting Resident Time for Didactic Activities

- **Post-ACA**, certain didactic time (*i.e.*, lectures, conferences, seminars) can be counted for GME reimbursement purposes:
  - Didactic time occurring in a hospital counts for both DGME and IME
  - Didactic time occurring in a dental or medical school clinic counts towards DGME only
  - Didactic time occurring in a dental or medical school auditorium or other classroom never counts

Counting Resident Time for Didactic Activities

- To count didactic time that occurs outside the hospital, training must occur in a "nonprovider setting that is primarily engaged in furnishing patient care"
  - Hotels and convention centers? *Not OK.*
  - Dental and medical schools? *Not OK.*
    - CMS's position: medical and dental schools are primarily engaged in education, not patient care
  - Dental and medical school clinics? *OK!*
    - CMS was persuaded by ADEA's argument that dental and medical school clinics are primarily engaged in furnishing patient care (CY 2011 Hospital OPPS Final Rule)

Didactic Activities
Former "One Workday" Rule

- The "one workday rule" effectively permitted programs to count didactic time in nonhospital settings unless the didactic activity encompassed the entire workday:

  ". . . [A]s long as an *entire* workday is *not* scheduled for didactic activities, then for documentation purposes, that day may be recorded as spent in patient care activities."

  71 Fed. Reg., 47870, 48091 (Aug. 18, 2006).

- **CMS eliminated the "one workday rule" effective January 1, 2011**

CMS Rule on Research Time

- In a hospital setting, research that is "not associated with treatment or diagnosis of a particular patient" can be counted for DGME only
- In a nonhospital setting, however, such "bench research" activities cannot be counted at all
  - Only patient-specific "research" that is focused on establishing a diagnosis or furnishing therapeutic services for a particular patient can be counted

What Resident Time Counts for Medicare DGME and IME Payments?

	Hospital		Nonhospital	
Time	**DGME**	**IME**	**DGME**	**IME**
Patient Care	Yes	Yes	Yes	Yes
Vacation/Sick	Yes	Yes	Yes	Yes
Didactic	Yes	*Yes*	*Some**	No
Research	Yes	*No*	No	No

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

* To count didactic time in nonhospital settings, didactic training must occur in dental clinic and not in dental school

Foreign Dental Graduates

- Graduates of foreign dental schools that are not accredited by CODA cannot be counted for GME purposes
- Graduates of foreign dental schools may be counted fully for IME purposes

OTHER FUNDING OPPORTUNITIES

Teaching Health Centers GME Program

- HRSA-administered grant program under the Public Health Service Act, established under Affordable Care Act (§ 5508)
  - Provides per-resident payments to "teaching health centers" (THCs) that establish and/or expand primary care residency training programs, including programs in general and pediatric dentistry
  - THCs are community-based, ambulatory patient care centers—including, *e.g.*, FQHCs and RHCs—that operate a primary care residency program
- Funded at $230M over 5 years (FYs 2011 - 2015)
  - But, no grant competition is planned for FY 2015 (AY 2015-16)
  - THC GME will expire this year, but other grant opportunities may exist…

Examples of Other Potential Grants

- **Predoctoral Training in General Dentistry, Pediatric Dentistry, and Dental Public Health and Dental Hygiene**—Funds the planning, development, operation of, and participation in approved professional training programs in general, pediatric, or public health dentistry and dental hygiene.
- **Postdoctoral Training in General, Pediatric and Public Health Dentistry**—Funds the planning, development, operation of, and participation in approved professional training programs in general, pediatric, or public health dentistry for dental residents, practicing dentists, or other approved primary care dental trainees.
- **Faculty Development in General, Pediatric, and Public Health Dentistry and Dental Hygiene**—Funds the planning, operation of, and development in programs for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry or dental hygiene.

SOURCE: http://bhpr.hrsa.gov/grants/dentistry/index.html

DEVELOPMENTS & TRENDS

Staying Power?
MedPAC's June 2010 Report to Congress

- Greater accountability and transparency for GME payments
- Incentivize programs to focus on teamwork, quality, and cost containment
- Performance-based incentive program with payments contingent on reaching desired educational outcomes and standards
  - *E.g.*, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice
  - Finance incentive payments with $3.5B reduction in IME payments (>50%), which would be redistributed to high-performing institutions as additional DGME payments
- Increase nonhospital, community-based rotations
- Increase diversity of residents
- Analyze/compare costs and optimal GME payment levels for programs in various specialties
- Study workforce needs by resident specialty

IOM Report

- Would effectively cut total GME payments for existing residency slots by 35% by Year 5
- Proposals include:
  - Cap total GME spend at current levels (adjusted for inflation)
  - Create a single GME payment stream based on a national per-resident amount (geography adjusted); eliminate separate IME payments
  - Make GME payments directly to program sponsors and delink from Medicare patient volume
  - Allocate up to 30% of all GME funding to "Transformation"
  - "Modernize" GME payment methods based on performance, innovation, oversight, accountability
  - Create new bureaucracy

IOM Report (cont'd)

- Two New GME Funds
  - **Operational Fund** (70 – 90%): Ongoing payments to GME program "sponsors
  - **Transformation Fund** (10 – 30%): New slots in priority areas/ specialties, innovation initiatives, development of performance measures, alternative payment demonstrations
- New bureaucracy:
  - **GME Policy Council**: Strategic GME plan, research and policy development, inter-agency coordination, annual reports to Congress
  - **GME Center**: Operations management, payment demonstrations, data collection and reporting

Legislation in the 113th Congress

- **Resident Physician Shortage Reduction Act of 2013** (S. 577 and H.R. 1180)
  - Would have increased funded resident positions by 15%—adding 3,000 new slots/year between 2015 and 2019 for a total of 15,000 new slots, half of which would be reserved for "shortage specialties"
  - Similar legislation was introduced in the Senate in 2011 and in the House in 2012; neither ever emerged from committee

Legislation in the 113th Congress

- **Training Tomorrow's Doctors Today Act (**H.R. 1201)
  - Transparency—Would have required CMS to report annually on GME payments
  - Accountability—IME Performance Adjustment:
    - Would have reduced IME payments to hospitals whose residency programs fail to achieve performance standards
    - Up to 2% of IME payments at risk
  - Performance Standards would assess resident training in, *e.g.*:
    - Coordination of patient care across various settings
    - Cost and value of various diagnostic and treatment options
    - Inter-professional and multidisciplinary care teams
    - Methods for identifying system errors and implementing system solutions
    - Use of HIT
- Similar legislation was introduced during the previous session (GME Reform Act of 2012), but died in committee

Performance-Based Accreditation

- ACGME's Clinical Learning Environment Review (CLER) Program, a component of its Next Accreditation System
  - Announced March 2012; fully implemented July 2014
  - Requires semi-annual reporting on "educational milestones"
    - 30 to 36 specialty-specific dimensions representing educational achievements of residents
    - *E.g.*, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice
  - Emphasis on responsibility of sponsoring institutions for quality and safety of the environment for learning and patient care

Single Accreditation System

- ACGME, AOA, and AACOM have announced a planned "merger"
  - Beginning July 2015, AOA programs may apply for ACGME accreditation
  - By July 2020, ACGME will accredit all osteopathic GME programs currently accredited by AOA
- The organizations will collaborate to form a single accreditation system for all allopathic and osteopathic residency programs nationwide
- All residency programs and residents will be evaluated according to the same common Milestones and competencies as under the Next Accreditation System

SOURCE: https://www.acgme.org/acgmeweb/tabid/445/GraduateMedicalEducation/SingleAccreditationSystemforAOA-ApprovedPrograms.aspx

ADEA Commission on Change and Innovation in Dental Education

Core Principles

1. Critical Thinking
2. Lifelong and Self-Directed Learning
3. Humanistic Environment
4. Scientific Discovery and the Integration of Knowledge
5. Evidence-Based Oral Health Care
6. Student Assessment
7. Faculty Development
8. The Health Care Team (interprofessional education)

SOURCE: http://www.adea.org/adeacci/about-adea-cci.aspx

Questions

THANK YOU

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