Financing a Training Program

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Disclosure

- I have no relevant financial relationships or affiliations with commercial interests to disclose

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True or False?

- GME funding was designed to be a permanent part of Medicare/Medicaid legislation.
- CMS payments for Direct GME (DME) are greater than payments for Indirect GME (IME).
- Both DME and IME directly support resident and GME expenses.
- All residents in a 6-year urology training program get the same amount of funding.

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Information Sources

Perspective
JUNE 19, 2014

The Economics of Graduate Medical Education
Amitabh Chandra, Ph.D., Dhruv Khullar, M.D., M.P.P., and Gail R. Wilensky, Ph.D.

BACKGROUNDER
No. 2983 | DECEMBER 29, 2014

Reforming Graduate Medical Education in the U.S.
John S. O'Shea, MD

Accreditation Council for Graduate Medical Education

The Basics of GME Finance for Program Directors February 26, 2015

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GME Funding
Financial Implications of Curriculum Design

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Finances of Graduate Medical Education
New Program Directors
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Medicare Payments for Graduate Medical Education:
What Every Medical Student, Resident, and Advisor Needs to Know
January 2013

Brief History of GME Financing

- First Surgical Residency Programs (1889)
  - Most surgeons simply "put up a shingle"
    - Training consisted of
      - Apprenticeships
      - European tours
      - Short courses
      - Performing progressive more complex operations on their patients

John S. O'Shea, "Becoming a Surgeon in the Early 20th Century: Parallels to the Present," *Journal of Surgical Education*, Vol. 65, No. 3 (May–June 2008), pp. 236–241, http://www.jsurged.org/article/S1931-7204(07)00292-9/pdf

http://www.medicineatmichigan.org/sites/default/files/archives/winter2002.pdf

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Brief History of GME Financing

- Early 20th Century: Reformist Era
  - AMA establishes Council on Medical Education (1904)
  - Abraham Flexner Report (1910)
    - Sweeping changes/standardization of Medical School Education

Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching* (New York: Carnegie Foundation, 1910), http://archive.carnegiefoundation.org/pdfs/elibrary/Carnegie_Flexner_Report.pdf

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Brief History of GME Financing

- Pennsylvania 1st State to require one-year rotating internship for licensure (1913)
- Specialty Boards Proliferate (1920-1940)
  - American Board of Urology (ABU)
    - Organized in Chicago (1934)
    - Incorporated in Delaware (1935)
    - First Official Meeting in 1935
- WWII: Board-certified physicians/soldiers
  - High rank, better pay, better assignments

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Brief History of GME Financing

- Pre-1940
  - Hospitals paid for physician internships & residencies: no government subsidies
  - Cost passed onto patients through higher fees
- Robert P. Dobbie, MD: U of Michigan, 1953
  - Married Reed Nesbit's head nurse
  - "I got $25 a month and paid back the hospital $18.75 for room, board and laundry."

http://www.medicineatmichigan.org/sites/default/files/archives/winter2002.pdf

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Brief History of GME Financing

- First Government Support for GME: VA (1944)
  – Living expenses of Veterans reimbursable under the GI bill
- Hill-Burton Act (1946)
  – Increased the size and number of hospitals and available internships and residencies

- John S. O'Shea, "Individual and Social Concerns in American Surgical Education: Paying Patients, Prepaid Health Insurance, Medicare and Medicaid," *Academic Medicine*, Vol. 85, No. 5 (May 2010), pp. 854–862, http://journals.lww.com/academicmedicine/Fulltext/2010/05000/Individual_and_Social_Concerns_in_American.34.aspx

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Brief History of GME Financing

- Medicare/Medicaid created (1965)
  - "Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent be the hospital insurance program."

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S. Rep. 404, 89th Cong., 1st Sess., p. 36 (1965), and H.R. 213, 89th Cong., 1st Sess., p. 32 (1965).

Brief History of GME Financing

- Center for Medicare and Medicaid Services (CMS) (1965-1983)
  - CMS only supports Direct GME Payments (DME)
- DME reimburses hospitals for expense directly related to GME
  - Resident salaries/fringe benefits/vacation
  - Faculty expenses
  - Overhead expenses

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Direct GME Payments (DME)

- Calculating DME
  - Per Resident Amount (PRA) set in 1984-1985
  - Increases based on consumer price index (CPI)
- Costs of GME training increased substantially more than CPI over the last 20 years
- Calculation
  - PRA $100K x 100 residents x 35% inpt Medicare beds = $3.5M

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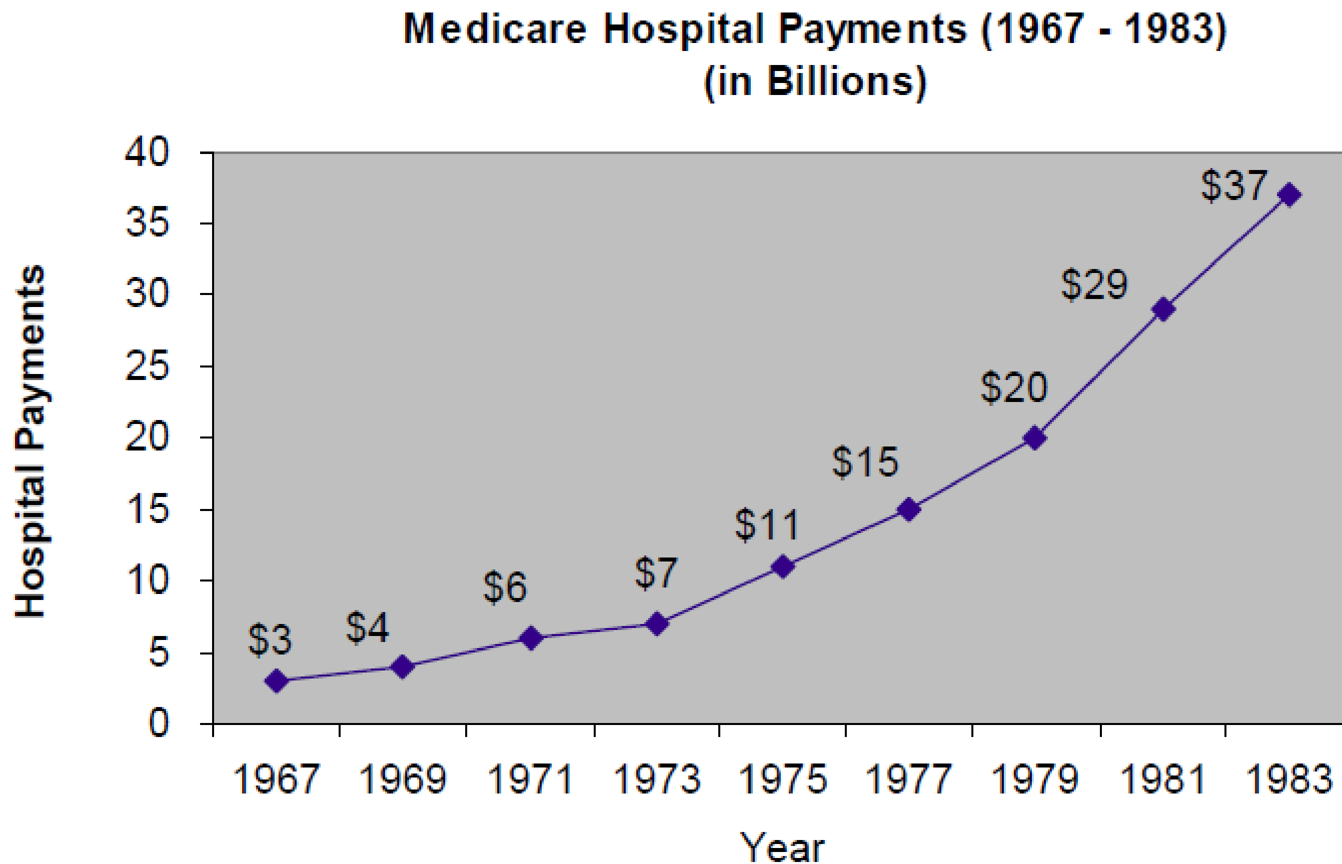
1967-1983: Good Times for Hospitals



1. Centers for Medicare & Medicaid Services, *Medicare: Estimated Hospital Insurance Disbursements Calendar Year* 1966-2000, Center for Medicare & Medicaid Services, Office of the Actuary (2000).

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Brief History of GME Financing

- Prospective Payment System (PPS) (1983)
  - Reimburses hospitals fixed amounts based on diagnosis (DRG), severity of illness
  - PPS added an adjustment rate for Indirect GME payments (IME)
- IME reimburses hospitals for indirect expenses related to GME
  - Higher overall costs from teaching activities
  - Increased lengths of stay
  - Higher acuity patients

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Indirect GME Payments (IME)

- Understanding IME
  - Actually for indirect patient care costs related to having a GME program
    - More complex patients
    - Call coverage for trauma/burns/interventions
    - Learner inefficiencies, increased LOS
  - IME does not pay for
    - Time spent in medical school settings without a hospital
    - Time away for conferences or international rotations
    - Research
  - IME is more that twice the $$$ of DME

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Brief History of GME Financing

- Initial Residency Period (IRP) (1994)
  - Full funding limited to time of training for IRP per resident.
    - Additional time
      - Reimbursed at 50% DME
      - Reimbursed at 100% IME
  - IRP for Surgery programs set at 5 years
    - Urology PGY6 gets 50% DME funding

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Brief History of GME Financing

- GME Funding Supports Unfunded Care
  - Hospitals used DME & IME to pay for indigent care
    - “Teaching Services”
    - “Free Clinics”
    - Residents become primary and often sole-caregivers
  - Solution: add more residents
- Disproportional Share Hospital (DHS) funds
  - Developed to account for this phenomenon

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Brief History of GME Financing

- Balanced Budget Act (1997) sought to address
  - Perceived Physician surplus
  - Growing GME costs
- Capped Allopathic/Osteopathic GME slots
  - Residency spots or Intern & resident per bed ratio (IRB) at each hospital were capped retroactively to December 1996
  - First allowed payment for time spent in clinic (non-hospital setting)
  - Reduced DME by $1B and IME by $8B

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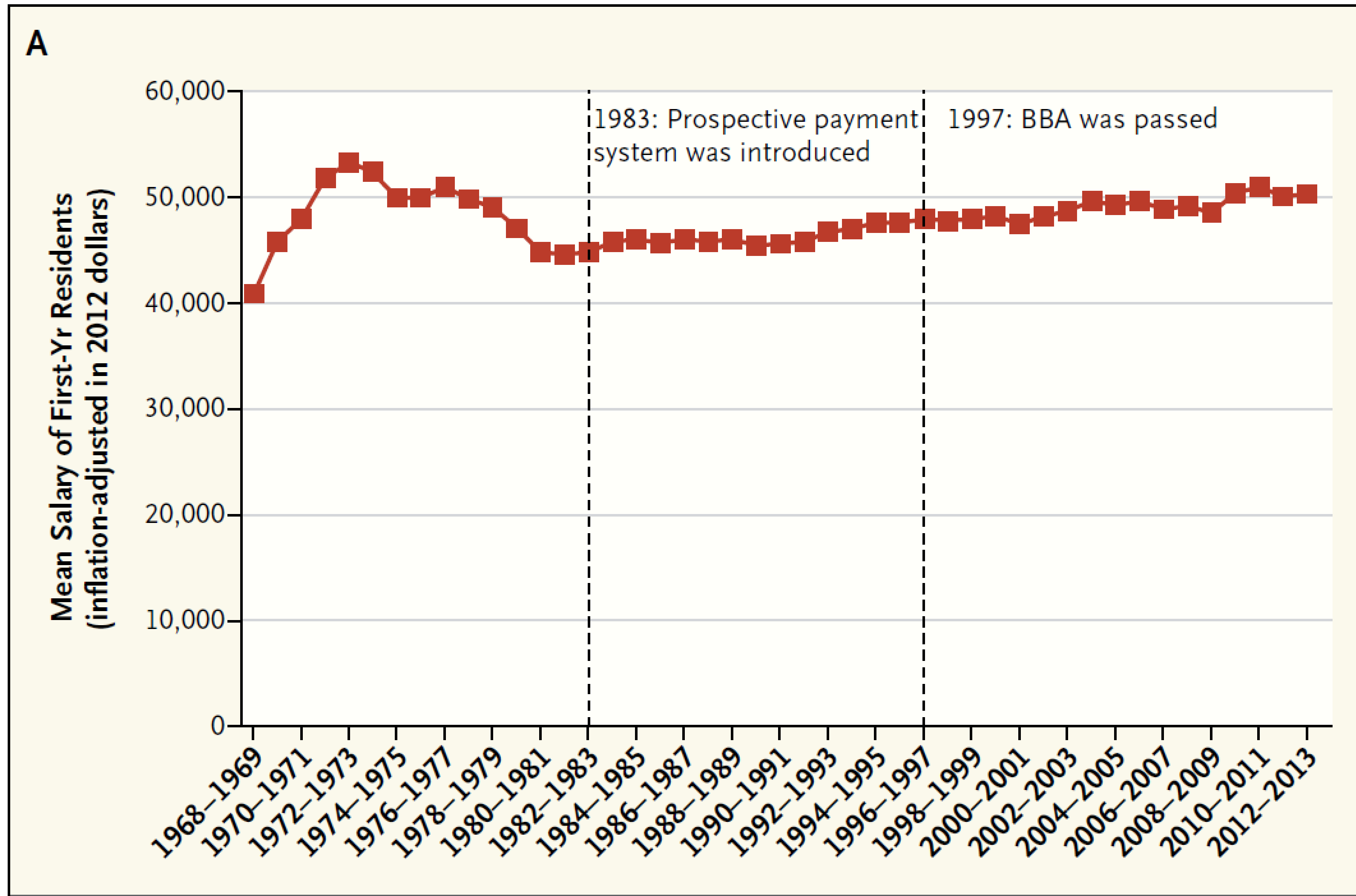
Mean Salary 1st Yr Residents



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Brief History of GME Financing

- Funding set as proportional to the number of Medicare enrollees being treated
  - Disadvantages Children's Hospitals
- Health Research and Quality Act (1999)
  - Free-standing Children's Hospitals receive DME/IME from Health Research & Services Administration (HRSA)

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Brief History of GME Financing

- GME funding through Medicaid
  - Voluntary, State-by-State
  - Federal match based on State per capita income
    - 50%-69% of costs covered (2014)
  - Declining due to State's growing fiscal constraints

Tim M. Henderson, "Medicaid Graduate Medical Education Payments: A 50 State Survey," 2013, Association of American Medical Colleges, https://members.aamc.org/eweb/upload/Medicaid%20Graduate%20Medical%20Education%20Payments%20A%2050-State%20Survey.pdf (accessed December 1, 2014).

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Brief History of GME Financing

- GME funding (2012)
  - Medicare DME $2.6B
  - Medicare IME $6.8B
  - Medicaid $3.9B
  - VA $1.4B
  - HRSA $251M

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Brief History of GME Funding

- Private Funding: Difficult to Quantify
  - Hospitals
  - Universities
  - Physician Groups/Faculty Practice Plans
  - Insurance Companies
    - Indirectly, through higher rates for teaching hospitals
- ACA detrimental effects on GME funding
  - Insurance companies establish narrow-networks that exclude teaching hospitals

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ACA: Resident Time Counted for DME/IME Payments

DME		IME	
Hospital	Non-Hospital	Hospital	Non-Hospital
Patient Care	Patient Care	Patient Care	Patient Care
Didactic	Didactic (2009)	Didactic (1983)	NOT Didactic
Vacation/Sick	Vacation/Sick	Vacation/Sick	Vacation/Sick
Research	NOT Research	NOT Research (2001)	NOT Research

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GME Funding for Fellowships

- ACGME Approved Fellowships
  - Fellows are treated as residents for DME & IME
  - Since they are training longer than Initial Resident Period (IRP), they count as 0.5 FTE
  - Can’t bill Medicare at all for fellowship activities
  - Can bill for moonlighting (ED coverage)
- Non-ACGME Fellowships
  - No DME & IME so can bill as attending
    - Salary/fringe, malpractice considerations: break even?

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“Over the Cap” Growth

- 2003-2013
  - Number of new programs: 16% increase
  - Number of new slots: 17.5% increase

Barbara O. Wynn, Robert Smalley, Kristina M. Cordasco, “Does It Cost More to Train Residents or to Replace Them? A Look at the Costs and Benefits of Operating Graduate Medical Education Programs,” RAND Corporation, 2013, p. 1, http://www.rand.org/pubs/research_reports/RR324.html

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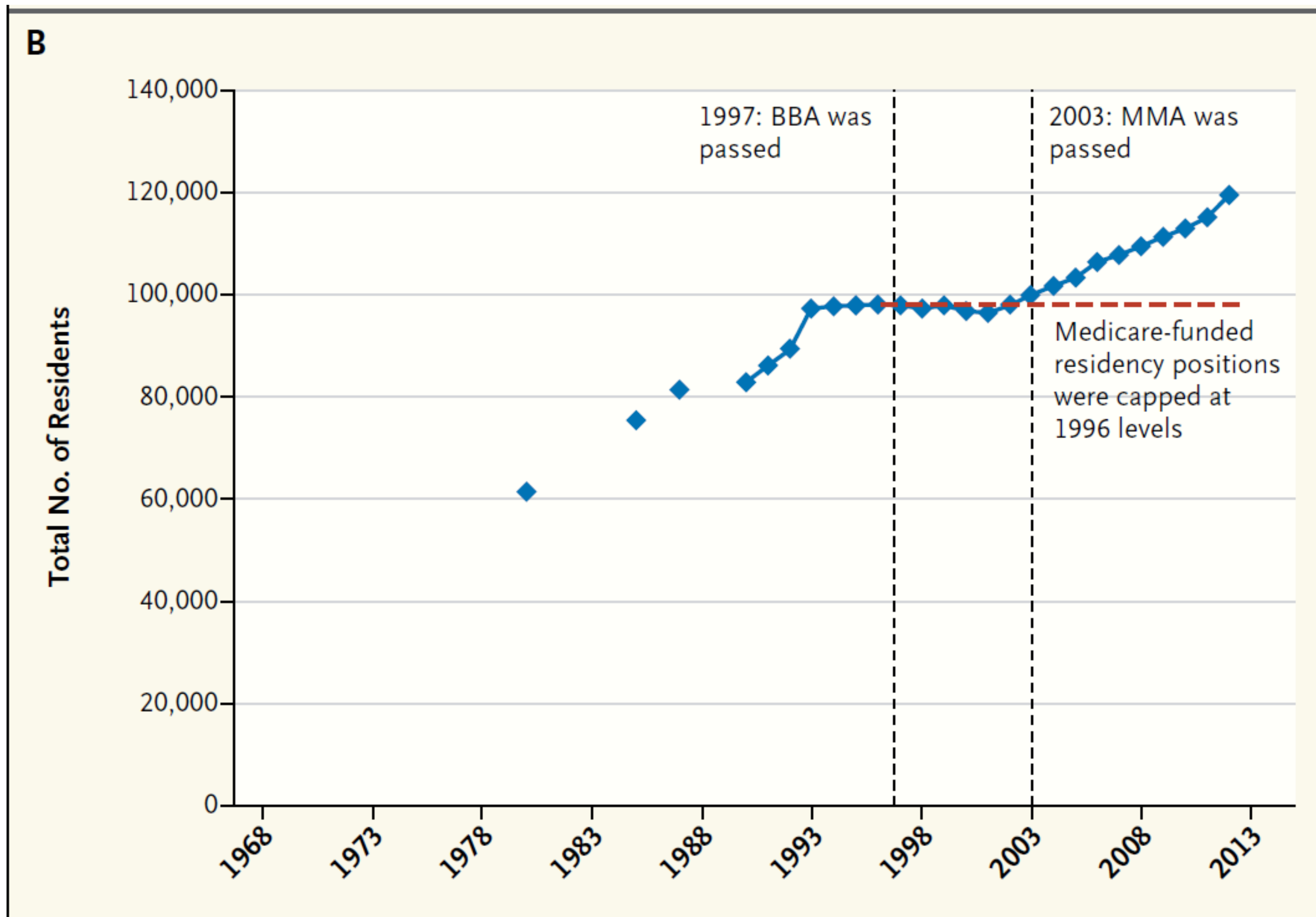
“Over the Cap” Growth



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Consequences of GME Financing

- Geographic Disparities: Funded Slots by Region
  - Funded slots per 100,000 population
    - New York: 77
    - California: 19
    - Florida: 14
    - Arkansas: 3
  - DRE/IME Rates
    - Connecticut: $155K/resident
    - Louisiana: $64K/ resident

Fitzhugh Mullan, Candice Chen, and Erika Steinmetz, “The Geography of Graduate Medical Education: Imbalances Signal Need for New Distribution Policies,” *Health Affairs*, Vol. 32, No. 11 (November 2013), pp. 1914–1921, http://content.healthaffairs.org/content/32/11/1914.full.html

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Workforce Training 1996-2011

- ABMS Approved
  - Primary Care: 8.4% increase
  - Pipeline (Standard Residencies): 10.3% increase
  - Subspecialties: 61.1% increase
- ABMS Specialties (1999-2013)
  - Total number increased from 84 to 145
    - Pediatric Urology
    - FP-MRS

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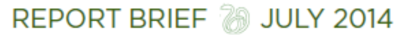
Future of GME Funding



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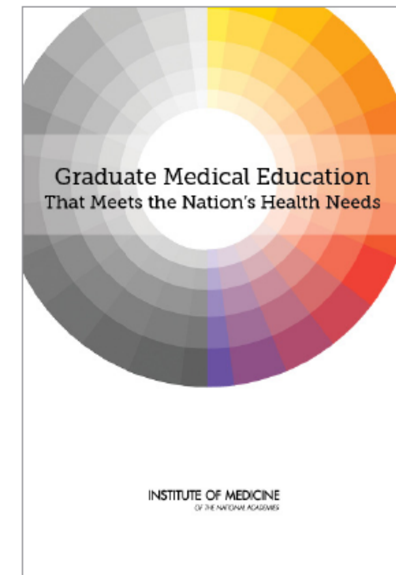

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IOM 2014 Recommendations

- Keep current funding for 10 years, phase-out CMS methodology
- New policy and finance infrastructure
- Develop separate Operational and Transformational funds
- Pay a per-resident amount based on funds
- Medicaid-funding remains a state decision

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What do I think will happen?

- Less money for GME, less per resident
- Although residency is an educational enterprise, it is mostly supported by resident servitude
  - Who else will work 80 hours/week for $50K?
- Hospital clinical revenue will make up more (or most) of the funding
  - Need to justify how residents help

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Residents circa 1950's

- "We were required to not only work up every new patient, but also do all the lab work: analyze urine, draw blood, take samples, and run them in the lab ourselves. We had to start all the IVs ourselves".

Robert P. Dobbie, MD

http://www.medicineatmichigan.org/sites/default/files/archives/winter2002.pdf

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Residents circa 2016

- No phlebotomy, no IVs, no central lines
- No primary critical care (beyond CCM residents)
- No discharge planning or social work
- Clinical documentation is often cut and paste
- All key/critical portions of surgery require an attending's presence
  - Simple procedures (cystoscopy) everything is key/critical
- Harder to argue residents are required

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Cautionary Note

Trends in 2006 to 2016:
-Average Loss per year: 13%
-Average Gain per year: 18%
-Average Forecasted Growth: 11%

*** 789 PAs**
687 NPs

Nurse Practitioner and Physician Assistant Head Counts at UPMC 2006-2016

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Budgets

- Expenses for Training Program
  - Program Director Stipend ($65K)
    - Associate Program Director ($15K)
    - Supported entirely by the Department
  - Program Coordinator Salary ($30K)
  - Resident Benefits
    - Meetings
    - Loupes/Campbell's/iPads/Jackets/Graduation Event
    - Food (Grand Rounds, Education Conference)
    - Interview Activities
    - Social Events

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Budgets

- Revenues for Residents
  - Teaching medical students (ECUs)
  - Philanthropy
  - Faculty contributions
  - Clinical revenues (limited)

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Grants

- Resident research is entirely funded by the Department, and PI grants
  - Residents work hard, “the best assistants in the lab”
- Residents need their own project
  - Align with the research time, skills of the resident
  - Goal is a research exposure, no Nobel expectations
  - Promote research experience
    - Sectional meetings, Research Awards, Visiting Professors

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Advancement for Teaching

- “Clinician Educator” category for promotion
  - Evidence of sustained and innovative teaching
    - More Medical Student/School focused
  - Annual teaching awards supportive
  - At Pitt SOM, rare to be promoted with tenure as Clinician Educator

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Conclusions

- Financing for GME will likely change
- Demonstrating the value of residents and residency programs increasingly important
- No uniform mechanism to fund the non-resident expenses in a training program
  - Requires creativity, commitment

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Questions to Panel

- Briefly describe your training program
  - Length?
  - Number of Residents?

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- How do you set the amount of the stipend or administrative supplement for your Program Director?
  - Flat rate or proportional to total compensation?

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- How do you fund resident perks?
  - Attendance at national meetings?
  - Book?
  - iPads?
  - Loupes?
  - Logo jackets?

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- How do you fund an increase in resident complement?

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- How do you fund resident research?
  - Time away from clinical activities?
  - Research supplies?

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- Do you subsidize faculty for teaching activities?
  - If so, what is the source of funding?

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