GME FUNDING: THE BASICS

Fellowship Directors’ Forum
PAS 2014
• None of the panelists has any conflicts of interest to disclose.
GME funding

• How much do you know about GME funding? (thanks to Franklin Trimm and the LEAD Council for MCQs)
• A bit of history
• Where are we now?
• Future of GME funding
Medicare supports GME through a direct payments (DME) methodology that pays for which of the following?

A. Offset for teaching institution with disproportionate share of indigent patients
B. Subsidies to lower the cost of care at teaching hospitals
C. Subsidies to offset cost of longer inpatient stays at teaching hospitals
D. Resident salaries and supervising physician’s time
Medicare supports GME through an indirect payments (IME) methodology that pays for which of the following?

A. Subsidies to offset cost of longer inpatient stays at teaching hospitals
B. Offset for teaching institution with disproportionate share of indigent patients
C. Resident salaries and supervising physician’s time
D. Subsidies to lower the cost of care at teaching hospitals
The amount Medicare pays to an individual GME program is MOST dependent on which of the following?

A. The annual number of Medicare patients admitted
B. The annual number of Medicare plus Medicaid patients admitted
C. The proportion of Medicare plus indigent patients admitted
D. The proportion of Medicare patients admitted
Which of the following determines the number of GME positions at an institution that is eligible for Medicare funding?

A. Ratio of Medicare inpatients days to total number of inpatient days
B. Predetermined federal cap originally determined by ratio of Medicare inpatients in 1996
C. Predetermined federal cap originally determined by number of GME position in 1996
D. Ratio of number of GME positions to number of Medicare inpatients
Which of the following would NOT typically be eligible to receive 0.5 FTE equivalent funding?

A. Second year resident in a Pediatric Hospitalist fellowship
B. Third year fellow in Pediatric Emergency Medicine fellowship
C. Third year Pediatric resident who had previously completed 1 year of Family Medicine residency
D. Fellow in subspecialty program who spent five years in pediatric practice after residency
Children’s Hospital Graduate Medical Education funding through HRSA has resulted in all of the following EXCEPT?

A. Improved GME funding in children’s hospitals
B. Increased number of pediatricians and pediatric subspecialists entering the workforce
C. Improved geographic distribution of pediatricians and pediatric subspecialists
D. Decreased projected shortfalls in pediatric subspecialists
Brief History of GME funding

• Prior to 1940’s-costs were low and built into hospital charges
• 1940-1960-six-fold increase in GME positions; costs built into insurance charges
• 1965-public funding of GME
  • Incorporated into Medicare “reasonable costs” payments to teaching institutions
• 1982-IME payments
• 1986-DME payments
• 1997-BBA resident caps
• 1999-CHGME
Current Funding

- Medicare
- Commercial insurers, managed care plans
- State and local appropriations
- Foundation and federal grants
- VA
- Department of Defense
- Patient care revenues
- CHGME
- THCGME
Medicare

- Largest funder of GME
- $8.8 billion in 2007
- Provided to teaching hospitals that operate an ACGME approved residency program
- Medicare pays based on hospital’s proportion of Medicare patients
Medicare payments

- DME-supports resident salary, benefits, faculty salary and program support. It is a fixed amount based upon number of residents, and proportion of Medicare patients.

- IME-supports higher costs associated with teaching hospitals (longer stays, higher illness severity), some of which goes to GME; payment is dependent upon the number of residents and a congressionally determined IME multiplier.
DME: more detail than you need

- Resident FTEs:
  - Each resident in an Initial Residency Period = 1 FTE
  - Each resident beyond Initial (fellowship) = 0.5 FTE
- Resident caps set in 1997 Balanced Budget Act: limit hospital reimbursement for teaching support by Medicare (based on # in training in 1996); Adjusted in 2002 and 2005
- Per Resident Amount (specific to hospital and specialty)
- Medicare Utilization Ratio (Medicare inpatient days/total inpatient days)
- DME = FTE (capped) x PRA x MUR
- DME payments to hospitals, not training programs
IME

- Compensates teaching hospitals for higher patient care costs at academic centers (not just GME)
- IME surcharge = intern and resident/bed ratio, cost multiplier percentage (complicated formula)
- Hospitals have wide latitude in how IME payments are spent
Medicare payments: Bottom Line

DME & IME payments: estimates for fiscal year 2010

<table>
<thead>
<tr>
<th>Payments</th>
<th>Amount</th>
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<tbody>
<tr>
<td>DME Payments</td>
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<tr>
<td>IME Payments</td>
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<tr>
<td>Total</td>
<td>$9.54 billion</td>
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CHGME

• “Freestanding” children’s hospitals are not eligible for Medicare funding for GME
• Administered by the Health Resources and Services Administration (HRSA)
• Funded by appropriations under the Labor-HHS-Education appropriations bill to support the training of residents in freestanding children's hospitals.
• Authorized by the Health Research and Quality Act of 1999 and announced in a June 19, 2000, Federal Register notice.
Why Did Congress Enact CHGME

• Surprised that freestanding children’s hospitals didn’t get Medicare GME (children’s hospitals were receiving only 0.05% of the federal GME support that other teaching hospitals received)
• Positive response to the “equity” principle – bipartisan support, whether pro or con GME
• Concern about unintended consequences of federal GME policy and impact on freestanding children’s hospitals and pediatric workforce
  ❖ Congress appropriated over $300 million dollars for ONE year of GME funding including DME/IME

❖ The amount of money appropriated to CHGME is debated by congress and “at risk” every year.
Successes of CHGME

• 55 independent children’s hospitals in 29 states and DC (<1% of all hospitals nationally)
• Supports the training of > 6,000 residents annually
• Freestanding children’s hospitals increased their training capacity by 35%
• Increase of 74% in new pediatric specialists being trained nationwide
• Positive impact on pediatric workforce
  • 49% of pediatric residents (from 30% in 1999)
  • 51% of pediatric subspecialists
  • Nearly 100% of pediatric rehabilitation specialists
• But still inadequate pediatric subspecialists
CHGME-Challenges

- Annual congressional appropriation

- Difficult budget climate – current CHGME funding down 21% from FY 2010 levels

- In FY2002, CHGME per resident = 86% of Medicare GME, in FY2011 68%
President Signs Legislation Supporting Funding for Pediatric Residency Training

- April 8, 2014 President Obama signed into law S. 1557, the Children’s Hospital GME Support Reauthorization Act of 2013.
- $267.3 million yearly
- CHGME funding through FY 2018
- Bi-partisan bill: Reps. Joseph Pitts (R-PA) and Frank Pallone (D-NJ), and Sens. Robert P. Casey Jr. (D-PA) and Johnny Isakson (R-GA)
Public Funding for GME

• Is the education of future physicians and the sustainability of teaching hospitals a public good?
• Should this training be publicly funded?
• Should funding align training with workforce needs (specialty and/or geographic)?
• Should funding be used to improve access for children with public insurance?
• Should funding be used to enhance services for the underserved?
• Should program or resident outcomes be used to justify funding?