Graduate Medical Education
Financial Support

Ron Grouskey
Vice-Chair, Revenue Cycle
Medicare Strategy

Mayo Clinic
Medicare Graduate Medical Education Reimbursement

Annual Funding Levels

- **Direct Graduate Medical Education (DGME)**
  - $3.0 billion

- **Indirect Medical Education (IME)**
  - $6.5 billion
### Medicare DGME and IME Payments by State

<table>
<thead>
<tr>
<th>State</th>
<th>Funding</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>$180,500,000</td>
<td>1.9%</td>
</tr>
<tr>
<td>New York</td>
<td>$1,870,000,000</td>
<td>19.7%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>$969,000,000</td>
<td>10.2%</td>
</tr>
<tr>
<td>39 others</td>
<td>$6,480,500,000</td>
<td>68.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$9,500,000,000</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Other Federal Funding for Graduate Medical Education

• Medicaid - approximately $3.8 billion / year (Minnesota: $40 million / year)
• Tricare - $1.2 billion / year
• CHGME - $320 million / year
• Teaching Health Centers GME
  • ACA section 5508
  • community-based ambulatory settings
  • $230 million / 5 years (2011-2015)
Other Funding Sources

- Special state appropriations (e.g. MERC)
- Commercial payers
- Provider revenues
- Physician practice plans
- Philanthropy
Direct Graduate Medical Education

- Includes payment for direct GME costs:
  - resident stipends & benefits,
  - teaching physician salaries & benefits,
  - other administrative and overhead costs associated with the residency program

- Reimbursed as a pass-through payment calculated within the Medicare cost report
Residents

• Medicare Definition of “Resident”
  • An intern, resident, or fellow who is formally enrolled in an approved medical residency program in order to become certified by the appropriate specialty board
  • Unaccredited fellowships not included and are not funded under DGME and IME

• Approved residency programs include:
  • ACGME
  • American Board of Medical Specialties
  • American Osteopathic Association
  • American Dental Association
  • American Podiatric Medical Association
Direct Graduate Medical Education

- Reimbursement is affected by several factors:
  - Program accreditation
  - Training setting
  - “Per Resident Amounts”
  - Initial residency period
  - Weighted resident counts
  - Full Time Equivalent resident cap (1996)
  - Additional redistributed cap add-ons
  - Prior year and penultimate year FTE counts
  - Primary Care versus other programs
  - Medicare utilization (patient days)
  - Inpatient / outpatient splits
Direct Graduate Medical Education

• Medicare payment is made only for the time that residents in accredited programs spend in the hospital

• Exceptions are made when the hospital incurs substantially all of the cost for resident time in a non-hospital setting such as a clinic or nursing home
Direct Graduate Medical Education

• Since 1989, payment is based on a hospital specific “per resident amount”

• The payment is determined by multiplying the per resident amount by the weighted resident count and then applying the resident caps

• This amount is multiplied by the Medicare utilization percentage (ratio of Medicare days to total days)
Indirect Medical Education

• IME is intended to compensate teaching hospitals for the extra costs incurred due to the presence of the graduate medical education program. For example:
  • the added costs of additional tests ordered by inexperienced residents;
  • higher staff to bed ratios;
  • higher costs related to care of sicker patients;
  • other costs unique to teaching hospitals
Indirect Medical Education

• The IME payment is an add on to the inpatient DRG payment

• The IME payment amount is driven by a formula based on the ratio of residents to beds
  • \(((1 + (\text{Residents}/\text{Beds}) \text{ raised to the exponential power of } 0.405) - 1) \times 1.35\)
Resident Caps

- The BBA of 1997 imposed caps on both DGME and IME
- Based on 1996 resident levels
- No adjustments to the caps are permitted (limited exception for rural hospitals)
- Unused cap redistributed under the MMA and ACA
- GME affiliation agreements permitted
Threats to Medical Education

• IME already reduced by 88 percent since 1984, from a multiplier of 11.59 to 1.35

• Reductions to DRG rates also reduce IME over and above specific IME cuts

• Per MedPAC, IME is overfunded by $3.5 billion / year

• New proposals to cut IME by 10 to 60 percent and to reduce DGME
Threats to Medical Education

• The President’s budget called for reducing IME by 10 percent
  • impact of $9 billion over 10 years

• Simpson-Bowles deficit commission proposed cutting IME by 60 percent and limiting DGME payments to 120 percent of the national average salary paid to residents in 2010
  • impact of $60 billion over 10 years
Threats to Medical Education

• Medicare sequestration adjustment reduces IME and DGME by $1.7 billion through 2021
  • NIH and other GME funding reduced

• Medicaid funding of GME decreasing due to state budget cuts

• MERC funding also unreliable due to state budget issues

• Resident caps limit the number of residents trained despite estimates of a 130,000 physician shortage by 2025
Threats to Medical Education

• Commercial payers likely to negotiate lower payment rates in ACA exchanges
  • eliminates the opportunity to include GME costs in a teaching hospital’s fee structure

• CHGME - 67 percent cut proposed

• Many teaching hospitals also receive disproportionate share (DSH) payments
  • to be cut by 75 percent beginning in 2014 and additional cuts proposed
Additional Impacts of Reductions in Medical Education Funding

• According to a study conducted for the AAMC:
  • For every $1 the federal government cuts GME payments, the hospital’s state economy loses $3.84
  • A 60 percent GME reduction would result in a loss of more than 72,600 jobs and a loss of $653 million in state and local tax revenue
Questions

Contact Information:
Ron Grouskey
Mayo Clinic
(507) 284-4627
grouskey.ronald@mayo.edu