Dominant GME Funder

In Federal fiscal year 2011, Medicare paid teaching hospitals

• Approximately $3.2 billion in DGME payments

• About twice that amount in IME payments
Other Sources of Funding

• Medicaid
• Veterans Administration
• Children’s Hospital GME (HRSA)
• Teaching Health Center GME (HRSA)
• National Institute for Occupational Safety & Health (NIOSH)
• Military
Direct Graduate Medical Education (DGME)

- Payment for Medicare’s share of the costs of training physicians (resident salaries & benefits, faculty compensation, administration & overhead costs)

- Product of the hospital’s per resident amount (PRA), Medicare utilization rate & number of full time equivalent (FTE) residents
Per Resident Amount

- PRA varies widely from hospital to hospital
- For most hospitals: set in 1984 & updated for inflation
- New teaching hospitals: set at lower of costs of establishing the program or the regionally adjusted national average
Initial Residency Period

• Minimum number of years required for board eligibility in resident’s specialty

• DGME: Resident counted as 1.0 FTE during IRP, up to a maximum of 5 years, & as 0.5 FTE thereafter (no time limit)

• If resident changes specialty, IRP = minimum number of years for first specialty
Indirect Medical Education (IME)

- Recognizes higher patient care costs in teaching hospitals when compared to nonteaching institutions (treating sicker/more complex patients, more tests & services, standby capacity)

- Product of hospital’s teaching intensity (IRB ratio), DRG payments & IME adjustment factor for current year
FTE Resident Cap

• Limits number of residents Medicare will pay for

• For most hospitals: Based on resident count in cost reporting period ending on or before 12/31/96

• New teaching hospitals: Cap set at highest number of residents in any program year in the 5th year (10/1/12)
FTE Resident Cap(s)

For most hospitals with GME since the 1990s there are multiple caps

• 2 for DGME purposes (primary care & non-primary care)
• 2 for IME purposes (primary care & non-primary care)
• Separate cap for 1st resident redistribution
3 Year Rolling Average

• Reduces cap over time if hospital fails to fill all of its Medicare-funded positions

• In conjunction with cap, may reduce – but not increase - number of residents Medicare will pay for

• Average of the hospital’s FTE resident count in the current cost reporting period & those in the two preceding periods
Transferring Residents

• General Rule: Residency programs can’t be transferred from one hospital to another.

• Program closure: Displaced residents can finish training in another hospital if certain requirements are met (then slots revert).

• Hospital Closure: Closed hospital redistribution process authorized by ACA.
“New” Teaching Hospital

- Hospital that starts training residents for the first time on or after January 1, 1995
- Doesn’t include hospital that is accredited & begins training after 1/1/95 if the program previously existed at another hospital
- Cap based on number of residents in all programs in 5th year after training starts
“New” Teaching Hospitals

- Once caps are set, urban hospitals can’t add Medicare-funded positions.
- Rural hospitals can’t increase existing programs but can add new specialties.
- Can share rotations with existing teaching hospitals (each hospital counts time training residents, up to its cap).
“New” Teaching Hospitals

• Beware: Rotating residents to nonteaching hospitals will generate caps & PRAs in those hospitals, whether or not they seek or receive Medicare payment
Medicare GME Affiliation Agreements

• Allow hospitals that share resident rotations to aggregate their caps & receive payment per the agreement

• Provide relief to hospitals under cap & at risk for losing FTEs

• Number of FTEs in aggregate cap cannot exceed the combined caps of the individual hospitals
Medicare GME Affiliation Agreements

- Allows nonteaching hospital that enters into agreement with existing teaching hospital to receive Medicare payment without generating cap
- Doesn’t work for new teaching hospital, which can’t enter into an agreement until cap is set
Non-Hospital Training

- **DGME**: Hospital can count all time residents spend training in nonhospital settings (e.g., physician offices & clinics) if it pays resident stipends & benefits.

- **IME**: Hospital can count the time residents spend **in patient care** activities if it pays resident stipends & benefits.
What’s New – FY 2013

Final Rule –

• Increases cap-building period from 3 to 5 years

• Specifies new methodology for apportioning residents when they rotate to more than one hospital during 5-year period
What’s New – FY 2013

• Methodology for apportioning residents that rotate during cap-building period

• Clarifies Section 5503 “primary care average” & “75% threshold” requirements

• Includes labor & delivery beds in “available bed” count for IME purposes
Any Questions?

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