SESSION N
Graduate Medical Education:
Hospitals And Residents Feel The Pinch With Greater Funding Challenges And Increased Competition For Slots
January 25, 2013

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Disclaimer
- This program is not intended to provide legal advice. The comments of Ms. Mihalich-Levin do not necessarily reflect the official views of AAMC.
### Presentation Topics

- Physician Demand / Supply Factors
- Residency Applicants / Slots
- Financing of Resident Education
- Medicare Litigation
- Q & A

### Increased Demand For / Diminished Supply Of Physicians

- Affordable Healthcare Act:
  - Coverage for 32 Million Persons
- Aging Population
  - Census Bureau projects a 35% increase in 65+ generation over the next ten years
  - 15 Million Additional Medicare Beneficiaries
- Retiring Physicians
  - Approximately 1/3 will retire over next ten years
Increased Demand For / Diminished Supply of Physicians

<table>
<thead>
<tr>
<th>Year</th>
<th>Physician Supply (All Specialties)</th>
<th>Physician Demand (All Specialties)</th>
<th>Physician Shortage (All Specialties*)</th>
<th>Physician Shortage (Non-Primary Care Specialties)</th>
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<tr>
<td>2008</td>
<td>699,100</td>
<td>706,500</td>
<td>7,400</td>
<td>None</td>
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<tr>
<td>2010</td>
<td>709,700</td>
<td>723,400</td>
<td>13,700</td>
<td>4,700</td>
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<td>2015</td>
<td>735,600</td>
<td>798,500</td>
<td>62,900</td>
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<td>2020</td>
<td>759,800</td>
<td>851,300</td>
<td>91,500</td>
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<td>2025</td>
<td>785,400</td>
<td>916,000</td>
<td>130,600</td>
<td>64,800</td>
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Source: AAMC Center for Workforce Studies, June 2010 Analysis

Increased Number of Medical Schools and Medical Students

- An increased number of medical schools will result in approximately 7,000 additional graduates/year over the next ten years.
- 3.1% increase in medical school applicants from 2011 to 2012, to a record 45,266
- 1.5% increase in enrollment to record of 19,517

Source: AAMC Reporter November 2012
**But, The Number of Medicare Residency Slots Is Frozen**

- As will be discussed, Medicare law was amended in 1997 to place a hospital specific cap on the number of residents for which Medicare payment is made.
- And, Medicare prescribes narrow requirements for establishing new residency programs.

**The National Residency Match Program (NRMP)**

- Private nonprofit corporation established in 1952
- An impartial venue for matching applicants’ and programs’ preferences
The National Residency Match Program (NRMP)

- **1952:**
  - 10,400 positions / 6,000 graduating seniors
- **1973:**
  - 19,000 positions / 10,000 graduating seniors
- **2012:**
  - All time high 38,377 applicants

*Source: NRMP 2012 Main Residency Match*

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The Pinch Hastened by 30% Incr. in 1st Yr Medical Students (Courtesy AAMC)

*Source: AAMC 2011 Medical School Enrollment Survey, at 12.*
Financing of Resident Education and the Special Missions of Teaching Hospitals Comes from Multiple Sources

Medicare (largest explicit payer)

Medicaid

Children’s GME program

Private patient care revenues

VA/DoD

Other Federal and state programs
Medicare Makes 2 Specific Payments With an “Education” Label

Direct GME Payments (DGME)
• Partially compensates for residency education costs

Indirect Medical Education (IME) Payments
• Partially compensates for higher patient care costs due to presence of teaching programs

DGME and IME Payments are Not Inconsequential

Estimated Federal Fiscal Year 2011:
DGME Payments = $3.18 billion
IME Payments = $6.96 billion
Total = $10.14 billion

Source: analysis of FY 2011 Medicare Cost Reports with backfilling of data from FY 2010 or FY 2009 if FY 2011 (or FY 2010) had not yet been completed
Medicare

DGME Payments

What Are DGME Payments Intended to Cover?

Compensate teaching institutions for Medicare’s share of the costs directly related to educating residents:

- Residents’ stipends/fringe benefits
- Salaries/fringe benefits of supervising faculty
- Other direct costs
- Allocated overhead costs
What is the Basic Methodology Underlying DGME Payments?

**Step 1:** Determine hospital-specific per resident base year cost amount (generally 1984)

**Step 2:** Update (to current year) base-year per resident amount (PRA) for inflation

**Step 3:** Multiply the updated PRA by the number of resident FTEs in the current year (this amount capped by BBA resident limits)

**Step 4:** Multiply by the hospital’s ratio of Medicare inpatient days/total days

Note: Teaching hospitals receive DGME payments associated with both FFS and managed care patients

What is the IRP and How Does It Affect DGME Payments?

• Residents in their “initial residency period” (IRP) are counted as 1.0 FTE

• Residents training beyond the IRP counted as 0.5 FTE (includes fellows, residents who repeat a year, etc.)

• IRP is determined at beginning of residency and does not change

• Physicians who decide to retrain in another specialty are counted as 0.5 FTE
**Medicare Pays Its “Share” of Resident “Costs”: EXAMPLE**

Medicare Share * Per Resident Amount = Medicare Payment Per Resident

\[
40\% \times \$100,000 = \$40,000 \text{ payment per primary care resident}
\]

\[
40\% \times \$90,000 = \$36,000 \text{ payment per all other residents}
\]

\[
\frac{(40\% \times \$90,000)}{2} = \$18,000 \text{ payment for fellow}
\]
Medicare Payments with an Education Label: IME

Compensates teaching hospitals for higher inpatient operating costs due to:

- unmeasured patient complexity not captured by the MS-DRG system
- other operating costs associated with being a teaching hospital (lower productivity, standby capacity, etc.)

Percentage add-on payment to basic Medicare per case (MS-DRG) payment

Calculating the IME Adjustment Factor

The IME adjustment is based on statistical analysis using intern and resident-to-bed ratios (IRB)

\[
\text{\% per case add-on} = \text{Multiplier} \times ((1 + \text{IRB})^{0.405} - 1)
\]

For FFY 2013, multiplier is 1.35

Short hand for IME: Hospitals get about a 5.5% increase in MS-DRG payments for every 10-resident increase per 100 beds
Calculating the IME Payment

**Step 1:** Determine the IRB ratio:

Chicago Hope = 170 residents / 666 beds = 0.255 = IRB
(Note: IME resident counts do NOT reflect weighted amounts)

**Step 2:** Use statistical formula and IRB to calculate IME%

\[
1.35 \times ((1 + 0.255)^{0.405} - 1) \times 100 = 13.00\%
\]

**Step 3:** Calculate the IME payment for each case

(Payment for MS-DRG 227 x IME %) = IME Payment

($29,975 \times 13.00\%) = $3,896.75

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Medicare Resident "Caps"
Medicare Resident Limits:
1997 BBA (P.L. 105-33, Sections 4621 and 4623)

Generally speaking, the number of FTE allopathic and osteopathic residents that a hospital may count for DGME and IME payments is limited to 1996 Medicare cost report count.

- Limits may be different for DGME and IME

The Medicare statute provides very few exceptions to the caps

Rural Teaching Hospitals
  - Cap = 130% of 1996 count (BBRA)
  - Cap can be adjusted for new programs

Rural Training Track Programs
  - Urban hospitals can get cap adjustment to accommodate first year of these programs

New Teaching Hospitals (see next slide)

GME Resident Limit Affiliation Agreements (sort of)

Temporary and Permanent Adjustments Associated with Closed Hospitals and Programs
Hospital that wasn’t training residents in 1996?

“New” Teaching Hospital =

- Had no allopathic or osteopathic residents reported on most recent Medicare cost report ending on or before 12/31/96 (42 CFR 413.79(e)(1))
- Get 5 years to start all residency programs; cap attaches in 6th year

Keys to receiving payments:
  Establishing per resident amount (PRA) for DGME payments
  - Establishing resident caps (for DGME & IME)

Resident Limit Aggregations: An Example

Base Limit: Hospital A 100 Hospital B 100

Limit Per Agreement: 90 110

Association of American Medical Colleges
Changes re: Cap Slots in the Affordable Care Act (ACA)

- Unused slot redistribution program
- Closed hospital slot redistribution program

Note: Final regulations on these programs were published in the Outpatient PPS Final Rule in the Federal Register on November 24, 2010 (75 Fed. Reg. 71800, 72133)

Resident Caps and Teaching Hospital Closures

- If a teaching hospital closes, regulations provide for “temporary” cap increases for those hospitals that take on and complete the training of the displaced residents

- After displaced residents complete training, the temporary cap increases end and hospitals revert to original caps

- But now, under ACA, the cap slots are ultimately redistributed on a permanent basis (with geographic preference, and preference for hospitals that took displaced residents)
Sec. 5506 Slots by Teaching Status – 1st & 2nd Rounds

- Total Slots Redistributed to Date:
  - IME: 957.92 FTEs
  - DGME: 1,016.38 FTEs
- A total of 118 hospitals applied for DGME/IME Slots:
  - 62% received IME slots
  - 65% received DGME slots
  - 90% of hospitals awarded slots received both IME and DGME slots
- 3rd round slots still pending

Threats to Funding and Proposed Legislation
GME is on every list as a potential cut...

- But no cuts yet…

- Plenty of ideas on the table:
  - President’s FY 2013 Budget:
    - 10% cut to IME
  - Simpson-Bowles Deficit Reduction Plan:
    - Limit DGME to 120% nat’l avg resident salary in 2010
    - Reduce IME from 5.5% to 2.2%
  - And there’s always sequestration…

Anticipate Accountability in GME

- MedPAC recommendation is to tie 50% of IME funding to accountability metrics
- Modify the current system of funding for GME to “support medical education that supports skills needed in a delivery system that reduces cost growth while maintaining or improving quality”
- Members of Congress very interested in accountability concept
AAMC Accountability Considerations

- Shortage of >90,000 physicians in next decade w/ physician retirement exceeding new entrants
- Should address half of shortages through delivery innovation, ↑ other HPs, teams, etc.
- Lift 15 yr-old cap to train additional physicians to meet other half in shortage specialties including, but not limited to, primary care
- Combine legislation to foster future workforce’s ability to work in new system; encourage transparency and accountability within Medicare’s support for GME

Bills to Keep an Eye On...

- Basic Premise:
  - Increase # of funded residency positions by 15,000 over 5 years
  - Tie 2-3% (in line with other P4P programs) of IME $$ to quality metrics
- House & Senate Bills Introduced:
  - HR 6352, Physician Shortage Reduction and Graduate Medical Education Accountability and Transparency Act (Schock (R-IL) and Schwartz (D-PA))
  - S.1627, Resident Physician Shortage Reduction Act of 2011 (Nelson (D-FL), Schumer (D-NY), and Reid (D-NV))
  - S. 3201, Graduate Medical Education Reform Act of 2012 (Reed (D-RI) and Kyl (AZ))
Medicare Litigation

- Training in the “Nonprovider Setting”
- Establishment of New Residency Programs
- Residents Engaged In Research

Residents Training At The “Nonprovider” Setting

- For Inpatient Rotations Payment Is Based On **Site Of Service**
  - No payment for out-rotations to other hospitals
  - Payment for in-rotations from other hospitals
- Rotations outside the hospital clinics and physician practices referred to as the "nonprovider setting"
Residents Training At The “Nonprovider” Setting

- **Statutory Requirements**
  - Residents engaged in patient care
  - Hospital incurs all or substantially all of the costs
  
  42 USC § 1395ww(d)(5)(B)(iv)

- **Regulation**
  - Adds the requirement of a “written agreement” between the hospital and the nonprovider setting. 42 CFR § 413.86(f)(4).
  - Optional 10/1/04. 42 CFR § 413.86(e)(3).

Residents Training At The “Nonprovider” Setting

- **The Multiple Hospital Funding Prohibition**

  Although not issued as a codified regulation, in 2004 CMS published the policy that if two or more hospitals fund a separate training entity, referred to as a “third party medical education entity,” then neither hospital can claim the payment.

  **Rationale**: None are incurring all or substantially all of the cost.

Residents Training At The “Nonprovider” Setting: PPACA 5504

- If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.
- Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.

See 42 U.S.C. 1395ww(h)(4)(E)(ii); 42 C.F.R. § 413.78(g)(2)(ii)

Residents Training At The “Nonprovider” Setting


- Medcenter One Health Systems and St. Alexius Medical Center v. Sebelius, 635 F.3d 348 (8th Cir. 2011).
Establishment Of A New Medical Residency Program

- “[A] new medical residency training program means a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.”

42 C.F.R. § 413.79(l)

Establishment Of A New Medical Residency Program

- CMS Has Identified The Following “Supporting Factors”:
  - Is the program director new, and
  - Is the teaching staff new, and
  - Are there new residents?

See FY 2010 Inpatient PPS Final Rule
CMS Recognition Of A New Medical Residency Program

- ACGME recognition of a newly accredited program is not sufficient for CMS.
- CMS is reluctant to recognize a new residency program if CMS determines that the program has been “relocated” from an existing teaching hospital’s programs.

Establishment Of A New Medical Residency Program

- "If we were to find that a program at one hospital is a newly established program merely because it was relocated from another hospital, the result would be that an FTE resident cap adjustment would be granted based on the same program at two different hospitals. Furthermore, if both hospitals continue to operate, the FTE resident cap slots that were vacated from the program at the first hospital could potentially be filled with residents from that hospital’s other residency training programs. We do not believe such an increase in the aggregate number of FTE residents and the potential duplication of the FTE resident cap adjustment would be consistent with the statutory mandate to adhere to the principles of the base-year FTE resident caps when devising rules to account for newly established medical residency training programs." (Fiscal Year 2010 Final Rule For The Medicare Inpatient Prospective Payment System; CMS Display Copy Page 617.)
Establishment Of A New Medical Residency Program

CMS Has Identified Factors Applicable To Relationships With Other Hospitals and Medical Schools:

- More generally, is this program part of any existing hospital’s FTE cap determination?
  “We would not consider a transferred program to be new in the case where the program director, teaching staff, and residents are the same as another program that closed in another hospital and the first hospital remains open, or when an FTE cap that was associated with the first program is still available for use by an existing provider.”
  (FY 2010 IPPS Final Rule, Pages 630-631.)

Establishment Of New Residency Programs

Residents Engaged In Research Activity

- *Henry Ford Health System v. HHS*, 654 F.3d 660 (6th Cir. 2011)
- Compare To:
  - *University of Chicago Medical Center v Sebelius*, 618 F.3d. 739 (7th Cir. 2010)

Q and A

- Questions and Answers