Medicare Payment: Graduate Medical Education Disproportionate Share

Institute of Medicine
Panel on Governance and Financial of Graduate Medical Education

Marc Hartstein
Acting Director
Hospital and Ambulatory Policy Group
Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. 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 a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program (S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965); H.R. No. 213, 89th Cong., 1st Sess. 32 (1965)).
Historical Hospital Payments

• 1965 to 1983 – All hospital payments based on reasonable cost.
• Beginning in 1984 – Inpatient operating costs is prospective payment (IPPS).
• Beginning in 1985 – Direct graduate medical education based on per resident costs.
• Nursing and Allied Health – “Hospital operated” programs continue to be paid based on reasonable costs.
Types of Graduate Medical Education

Subsidies

• Direct Graduate Medical Education (DGME): Salaries of residents, portion of teaching physician compensation allocated to teaching, and other direct costs.

• Indirect Medical Education (IME): Compensates hospitals for higher patient care costs due to presence of teaching programs.

• MDs, DOs, DPMs and DDSs accredited training that counts towards certification in a specialty or subspecialty.
Medicare Payment = Per Resident Amount (PRA) x full time equivalent (FTE) residents x Medicare utilization.

- PRA = 1984 costs per resident updated by inflation or later year for hospitals first participating in training.
- PRA varied in 1984 based on how hospitals incurred/reported costs. Statute provides lower limit equal to 85% of national average and limited or no update for 2001 to 2005 for PRAs exceeding 140% of national average.
- PRA slightly higher for primary care and OB-GYN residents. (No update for other residents for two years in the 1990’s).
DGME Counting Rules

- Count residents in all areas of the hospital complex and non-hospital sites if the hospital incurs the costs of residents’ compensation.
- Count as 1.0 FTE during “initial residency period” and 0.5 FTE afterwards.
- Initial residency period is length of the 1\textsuperscript{st} program in which the resident begins training.
• Percentage add-on to IPPS payment based on the number of FTE residents and hospital beds.
• Count residents in IPPS portion of the hospital, outpatient department and non-hospital sites where the hospital incurs the costs of residents’ compensation.
• Not counted in psychiatric and rehabilitation units for IPPS (althoughIME is paid under the psychiatric PPS).
• No initial residency period limitation.
  – Allows Secretary to develop rules so that hospitals that jointly train residents have a pooled cap.
  – Allows Secretary to develop rules to cap new teaching hospitals after they start training.
Major Legislation

• Medicare Modernization Act – Redistributed 75% of unused slots below cap with priority to:
  – Rural hospitals and small urban hospitals.
  – Hospitals starting specialty program that is unique in its state.
Major Legislation

• Affordable Care Act – Redistributed 65% of unused slots with priority to:
  – 70% to states in lowest quartile of medical residents to population.
  – 30% to top states with highest ratios of total population living in shortage areas and to hospitals located in rural areas of any state.

• Hospitals receiving residents must:
  – Maintain primary care # of residents.
  – 75% of new residents must be in primary care or general surgery.
Medicare payments to approximately 1030 teaching hospitals in 2010 were $6.8 billion for IME and $2.8 billion for direct GME.

Total IME and direct GME payments for several recent years:

- 2007: $8.4 billion
- 2008: $8.7 billion
- 2009: $9.2 billion
- 2010: $9.6 billion
“Medicare’s IME payments totaled an estimated $6.5 billion in 2009, but repeated Commission analysis finds that only 40 percent to 45 percent of these payments can be analytically justified to cover the higher patient care costs of Medicare inpatients.”

“The indirect medical education (IME) payments above the empirically justified amount should be removed from the IME adjustment and that sum would be used to fund the new performance-based GME program.”
President’s Budget

• Set standards for hospitals receiving graduate medical education payments to:
  – Encourage the training of primary care residents;
  – Promote skills that promote high-quality and high-value health care delivery.

• Goal: Pay the same amount for graduate medical education but transform hospital training programs to meet training and workforce goals.
Disproportionate Share (DSH)

- Percentage add-on to IPPS payment based on Medicare/SSI inpatient days and Medicaid (not Medicare) inpatient days.
- Approximately $10 billion to about 80% of all hospitals.
- 1,031 teaching hospitals. 964 are urban and 825 of those also receive DSH.
Disproportionate Share

• Affordable Care Act:
  – Beginning in FY 2013, reduces DSH to 25% of current amount—the “empirically justified amount as determine by MedPAC in its March 2007 Report to Congress.”
  – The remaining 75 percent will be adjusted based on reductions in the percent of uninsured and distributed to each hospital based on its share of total national uncompensated care costs.
Questions?
And...

Thank You

Marc Hartstein
Marc.Hartstein@cms.hhs.gov