Understanding the Costs and Financing of GME

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New GME Program Development

• Growth of GME is the limiting factor in increasing physician supply
• Positions capped by BBA 1997
• Growth of Medicare funded positions still possible in “virgin” hospitals
  – Five year window to establish funding cap
Starting New GME Programs

• Value to hospitals
• Retention of residents
• Providing assistance to hospitals
  – OGME Development Initiative
  – Consultants
• OPTI structure
  – Alignment with UME
  – Efficiencies
Costs

• Direct costs for primary care residency start-up
  – Trainee salaries and benefits
  – Faculty and staff salaries and benefits
  – Purchased services
  – Program administrative costs (fees, inspections, memberships, etc.)
  – Misc. (recruitment, travel, etc.)

• Target of $8-10K per resident/month for primary care program
Payment

- Medicare GME payment calculations are extremely hospital specific
  - Number of beds
  - Resident to bed ratio
  - “Medicare share”
- Per resident amount (PRA) set for existing programs in 1984
- New program PRA set on hospital by hospital basis
Barriers

- If a new teaching hospital rotates residents to a hospital without a teaching program, even for a month or two, CMS attributes a full-time equivalent resident cap and per resident amount (PRA) to the hospital, whether or not it seeks Medicare GME payment.

- If an existing teaching hospital rotates residents to a non-teaching hospital, CMS attributes a PRA to the other hospital.
Recommendations

• Increase stability and reduce uncertainty in GME financial support
• Eliminate penalties for consortium training model
  – Triggering of FTE cap and PRA
• The PRA for new hospitals should be set at the lower of costs or the regionally adjusted national average
  – The floor for all existing teaching hospitals should be raised to the regionally adjusted national average.
• Allow expansion of existing GME funding for primary care and other high-need specialties in underserved areas