Paying to make a doctor

The future of Graduate Medical Education

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December 18, 2014

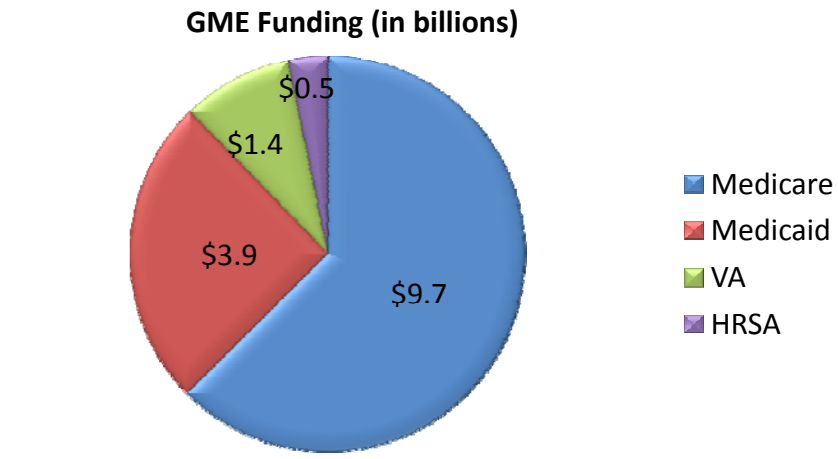
Disclosures

Dr. Racine reports that he has no disclosures or conflicts of interest to resolve.

Outline

- Financing Graduate Medical Education: where are we and how did we get here?
- Reform proposals and the IOM report
- Theoretical considerations: the microeconomics of GME financing
- Summary observations
- Political prospects

Paying to train a physician



Source: IOM Report, 2014

What makes up GME payments?

Direct Graduate Medical Education payments

- Pays for resident salaries and benefits, the salaries for teaching physicians and certain administrative costs of educating residents.

Indirect Graduate Medical Education payments

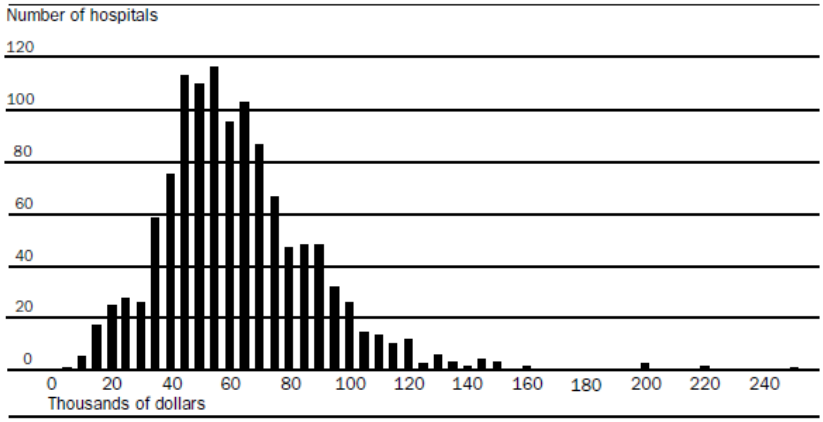
- Adjustment to Medicare PPS inpatient rates to defray additional costs of caring for patients assumed to be associated with residency training

How are DGME payments calculated?

- Weighted resident count
  - 3 year rolling average of resident FTEs with trainees in the initial period counted as 1.0 FTE while those in in later years and fellows counted as 0.5 FTE
- Per resident amount (PRA)
  - Hospital's 1984 costs (adjusted for inflation) divided by weighted resident count
- Medicare day ratio
  - Hospital's Medicare inpatient days to total inpatient days

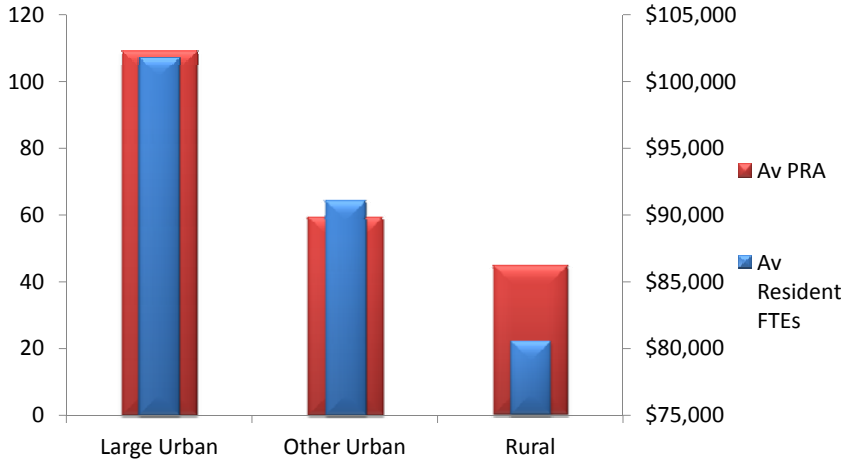
Distribution of DGME payments

EXHIBIT 2
Distribution Of Per Resident Payment Amounts To Teaching Hospitals, 1995



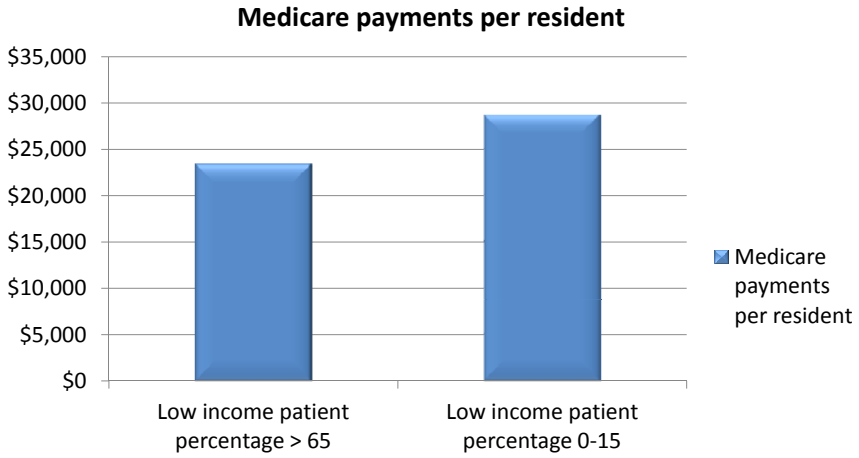
SOURCE: Unpublished data from the Medicare Payment Advisory Commission (MedPAC) staff.

Distribution of DGME payments



Source: IOM Report, 2014

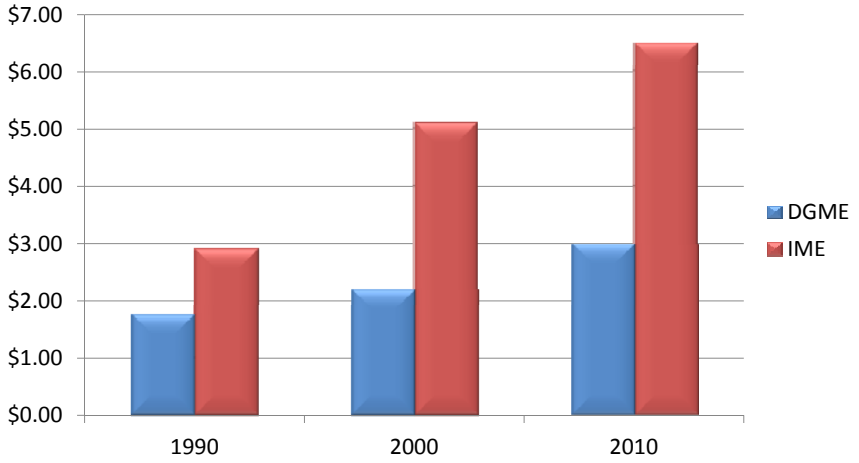
Distribution of DGME payments



Source: IOM Report, 2014

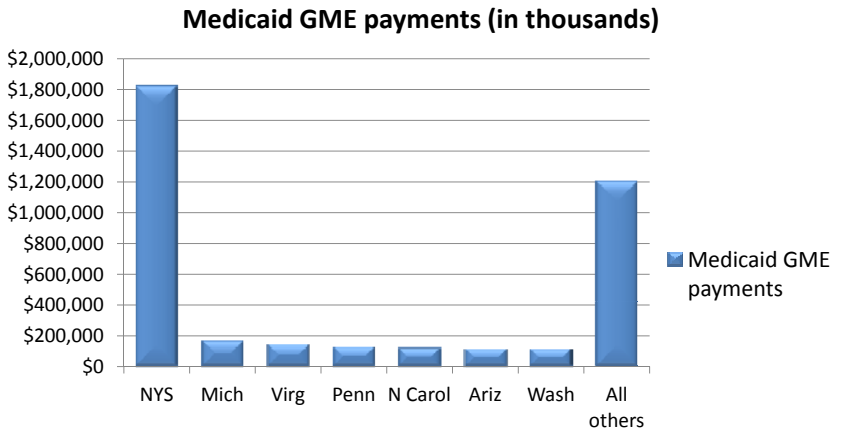
Growth of Medicare GME Funding

(in Billions of dollars)



Source: COGME 15th Report, Dec. 2000; and IOM Report 2014

Medicaid GME payment distributions



A Short History of GME Funding

Before 1940

Hospitals pay for trainees

1945-1965

GI bill offers federal support to residents and hospitals; hospitals begin to build training costs into insurance rates

1965

Medicare with retrospective cost based reimbursement for hospital inpatient stays including DME

Medicare's GME payments rationale

"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 borne to an appropriate extent by the hospital insurance program."

1965 Social Security Act (Senate Report No. 404, 89th Congress, 1st Sess. 36 [1965]; H.R. No. 213, 89th Cong., 1st Sess. 32 [1965]).

A short History of GME Funding

1983

PPS replaces cost-based reimbursement in Medicare and introduction of IME

1985

COBRA establishes prospective payments for DME per resident based on hospital's cost in 1984; IME reduced

1987

OBRA reduces IME adjustment factor

A short History of GME Funding

1993

OBRA increases the per resident stipend for primary care and obstetrics by 6 percent and withholds the inflation adjustment factor for non primary care for 2 years

1997

DME payments made available to certain ambulatory sites including FQHCs; IME payments reduced; total number of residency program positions capped.

1999

DME payments adjusted by geography; CHGME program created for children's hospitals

A short History of GME Funding

2003

Decreases in IME payment adjustment factor and number of Medicare-funded training slots for DME is reduced while the maximum DME payment rate is frozen

2006

CHGME extended and a reporting requirement introduced

2010

ACA creates teaching hospital GME program to expand primary care training; training slots reduced in hospitals with excess capacity and redirected to those with low resident to population ratios

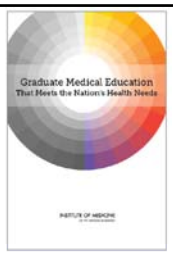
GME funding history: summary

- Switch from cost-based reimbursement to prospective payment
- Gradual redistribution of teaching slots based on capacity
- Continual downward pressure on IME payments over time
- New rules introduced for children's hospitals
- Current GME payments average $100,000 per resident per year

Reform Recommendations

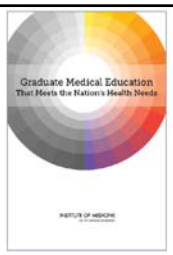
- 2010 – COGME recommends increasing training for primary care and using governmental and non-governmental sources
- 2010 – MedPAC recommends cutting $3.5 billion in IME payments by reducing the DRG adjustment from 5.5% to 2.2%; increasing accountability and pay for performance; public disclosure of Medicare payments; analysis of workforce data

Graduate Medical Education That Meets the Nation's Health Needs



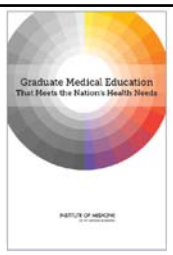
- DGME funding does not offset the cost of training physicians. Residents pay the full cost. DGME simply transfers money to hospitals.
- GME funding aids hospitals caring for indigent patients but the ACA provides greater coverage for the poor and obviates this need.
- Large geographic variations in GME payments are hard to justify.

Graduate Medical Education That Meets the Nation's Health Needs



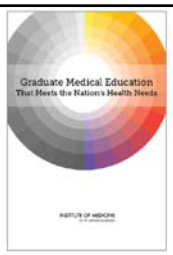
- Hospital training inadequately prepares physicians for the roles they will play in practice (team training, communication, systems analysis).
- There is little accountability or transparency in how the GME funds are spent by hospitals.
- The distribution of primary care and specialty trainees is unplanned and provides too few primary care practitioners.

Graduate Medical Education That Meets the Nation's Health Needs



- Create two Medicare GME funds
  - *Operational* fund to distribute ongoing support
  - *Transformational* Fund to finance initiatives, evaluations, performance measures, and award new training positions in priority areas
- Modernize Medicare GME payment methods
  - Replace DGME and IME with one payment based on national PRA
  - PRA set as total value of GME Operational Fund divided by total number of FTE slots
  - Implement performance based payments

Graduate Medical Education That Meets the Nation's Health Needs



- Maintain current aggregate GME payments; institute reform measures to insure oversight and accountability; phase out the current system
- Develop a GME Policy Council to create strategic plan for Medicare GME financing (specialty distribution, geographic distribution, etc.).
- Create a GME Center to manage transformation fund, collect data, issue reports, monitor demonstration projects, etc.

Critique of IOM report

- AMCs have multiple missions conjoined with training including research, wide spectrum of care, community health.
- Some training service lines such as inpatient psychiatry, geriatrics, or obstetrics are essential but poorly reimbursed.
- Teaching hospitals represent 5% of all hospitals but provide 37% of all charity care and 26% of all Medicaid hospitalizations.

Critique of IOM report

- Teaching hospitals operate nearly all regional standby services (trauma and burn centers) with substantial fixed costs.
- More than half of all NIH grants went to faculty at AMCs but due to insufficient indirect costs AMCs must subsidize this effort.
- The direct cost of training residents amounts to $16 billion per year but Medicare DGME payments account for only $3.0 billion.

What is the theoretical justification for the expenditure of taxpayer funds on financing GME?

Are doctors a public good?

- A good, service or resource is "***excludable***" if it is possible to prevent someone from enjoying its benefits.
- A good, service or resource is "***rival***" if its use by one person decreases the quantity available for someone else.

A fourfold classification

	Excludable	Non-excludable
Rival	Private Goods	Common Resources
Non-rival	Natural Monopoly Goods	Public Goods

The Origins of Utility

Neo-classical economic theory:

Utility or happiness is a function of decisions made with respect to the acquisition of goods and services to satisfy personal needs.

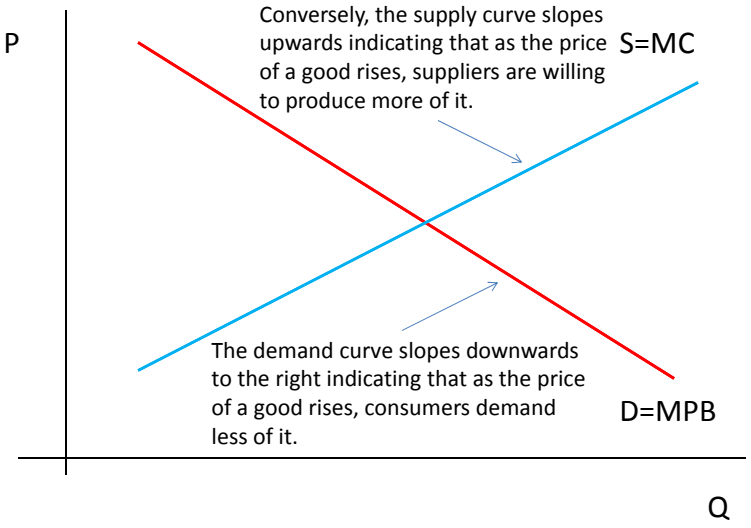
What happens, however, when these decisions affect not only my own utility but the utility of others?

We refer to these situations as “externalities”.

When my actions *benefit* others, the actions are considered to have *positive* externalities. Conversely, when my individual actions *harm* others, the actions have *negative* externalities.

Externalities exist whenever a transaction affects an *uncompensated* party.

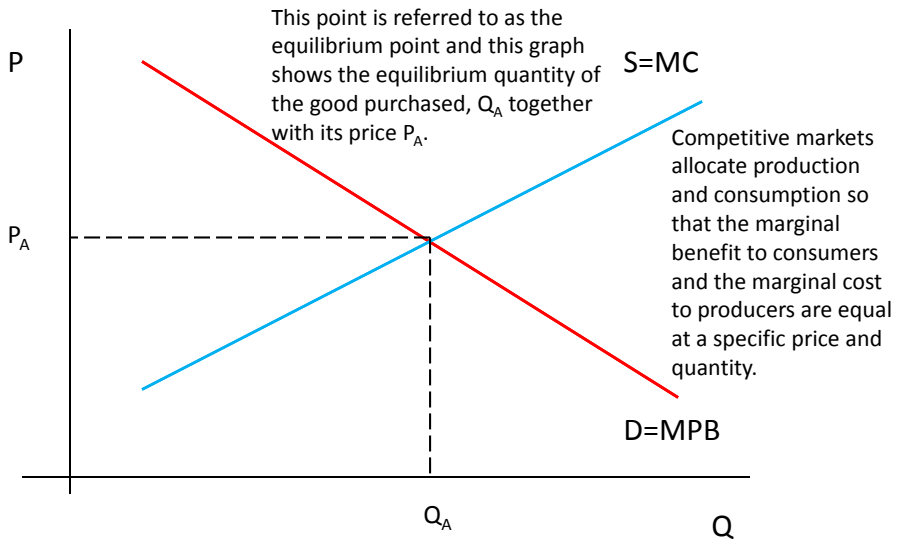
Supply and Demand



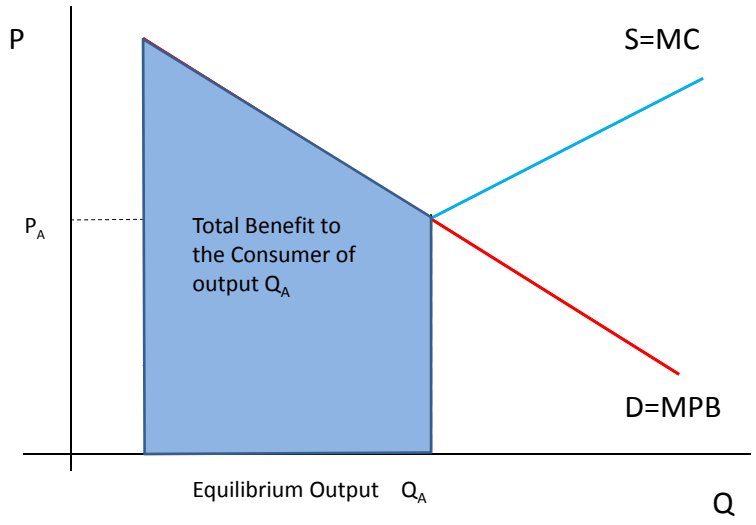
Benefits and Costs

- The lines are labeled MPB to indicate that the demand curve reflects the Marginal Private Benefit to the consumers of their purchases.
- The supply curve indicates the marginal cost of producing the good or service at any given quantity.

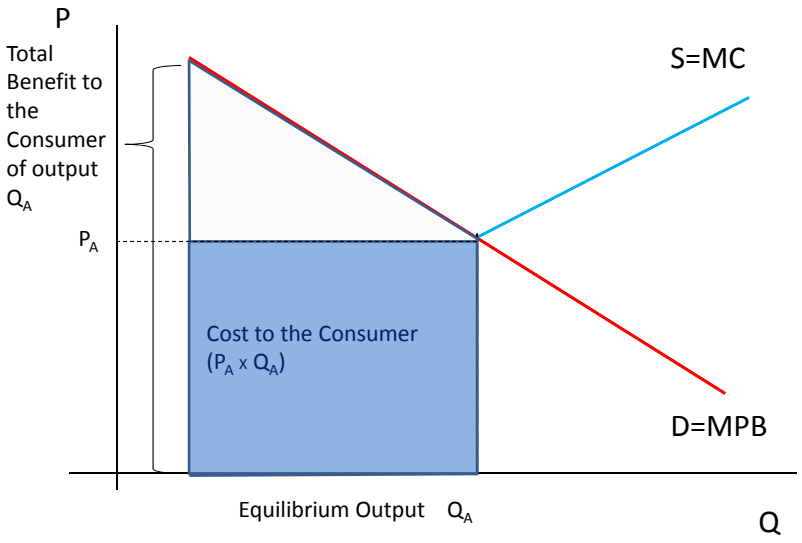
Supply and Demand



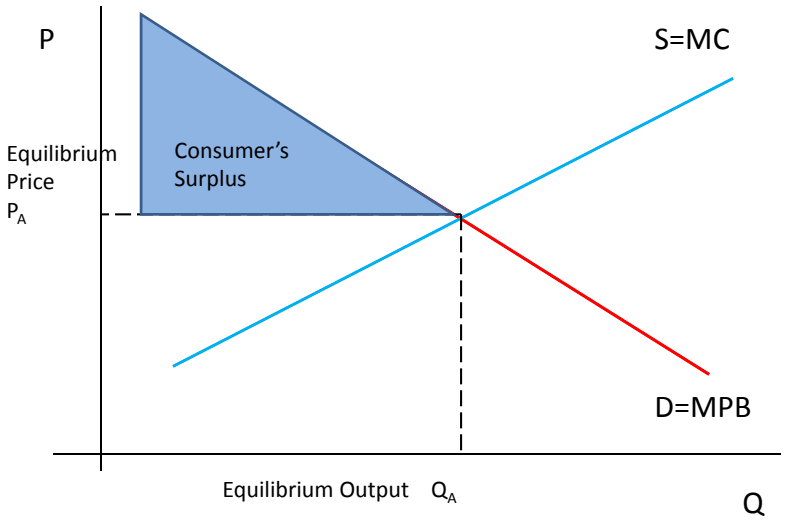
Total Consumer Benefit



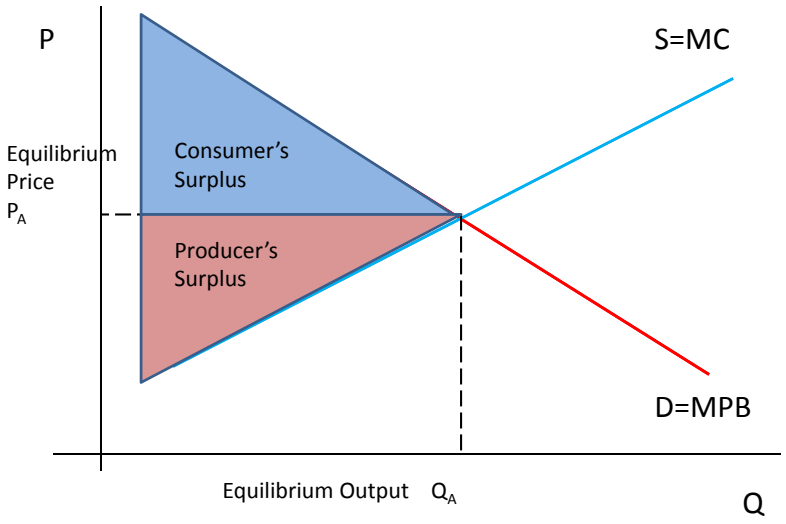
Total Consumer Cost



Consumer Surplus



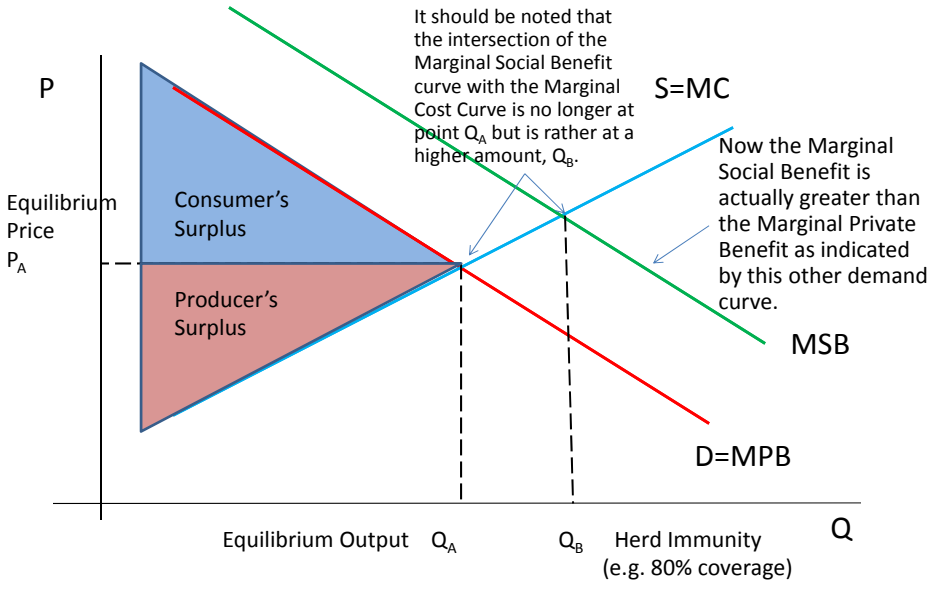
Positive Externalities



Positive Externalities

But what if others, not party to this exchange, also benefit from the transaction?

Positive Externalities



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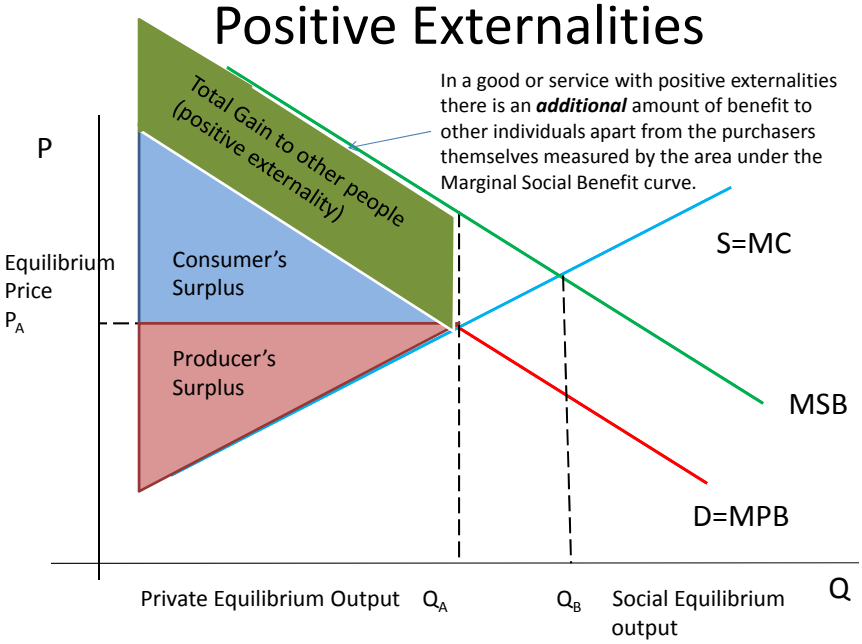

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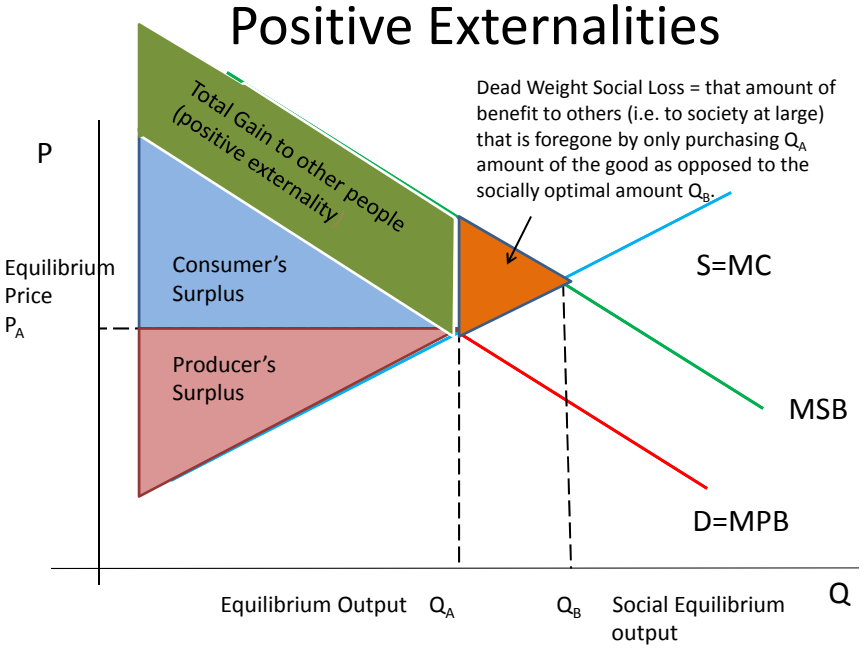


Positive Externalities

To summarize:

1. When there are *positive externalities*, people other than the individual consumer derive benefit from that consumer's purchase of a particular set of goods or services.
2. The individual, however, only seeks to match her own private benefit to her private cost of consumption (the price of the good).

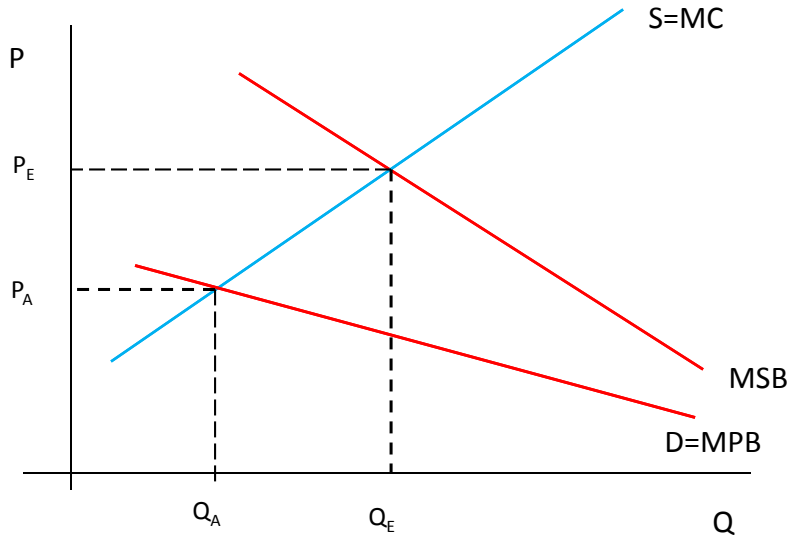
Positive Externalities

3. As a result, individuals purchase an amount of the good or service that is *less* than what would be socially desirable resulting in a net dead weight social loss.

Are there positive externalities associated with producing a physician?

What to do?

The World according to AMCs



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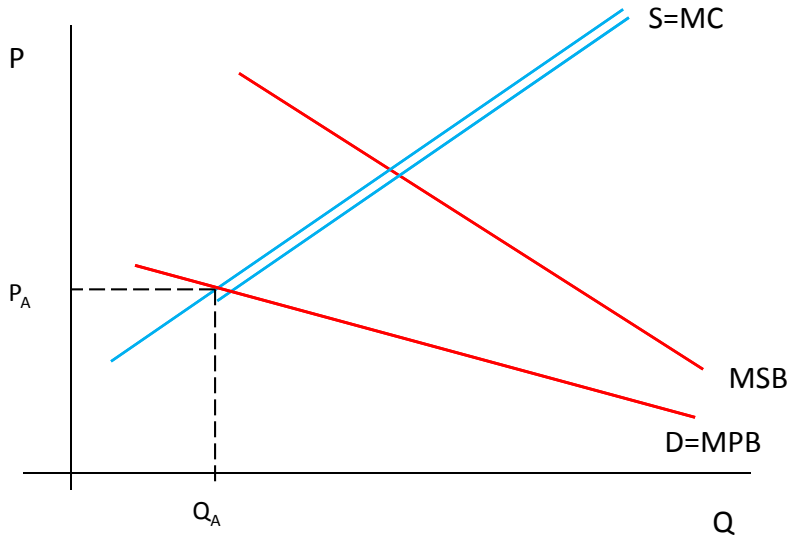

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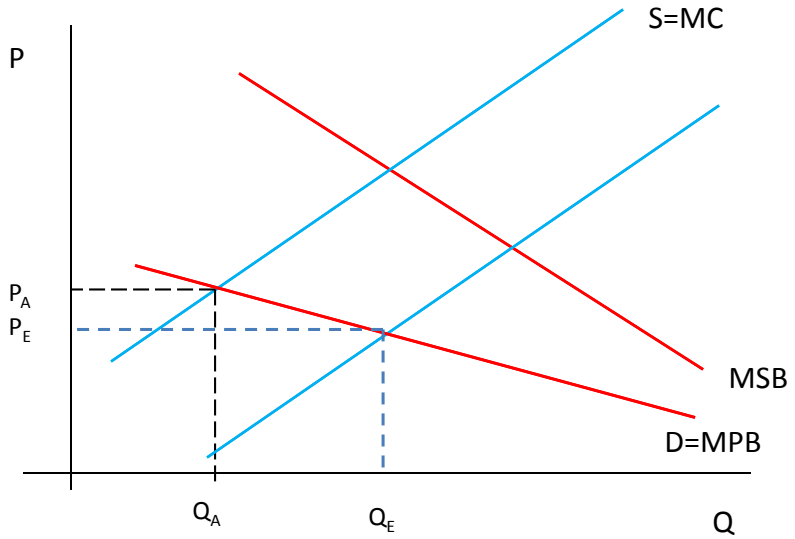

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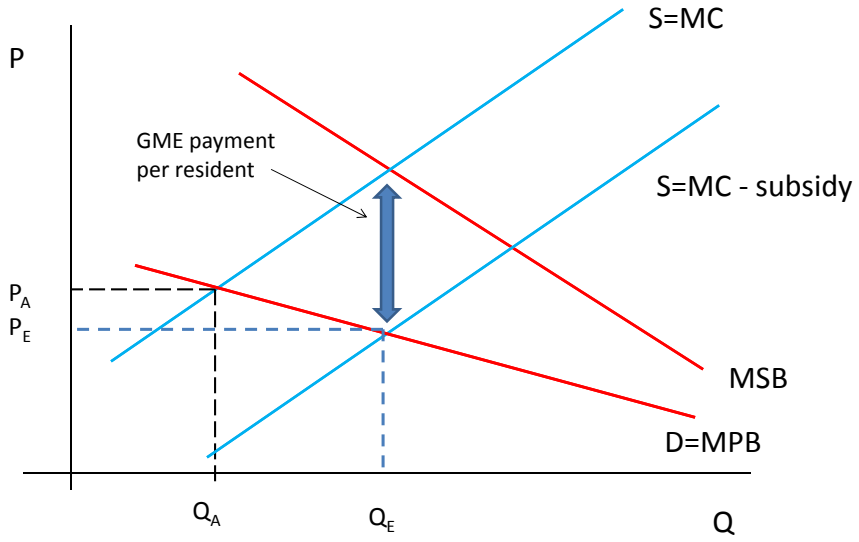

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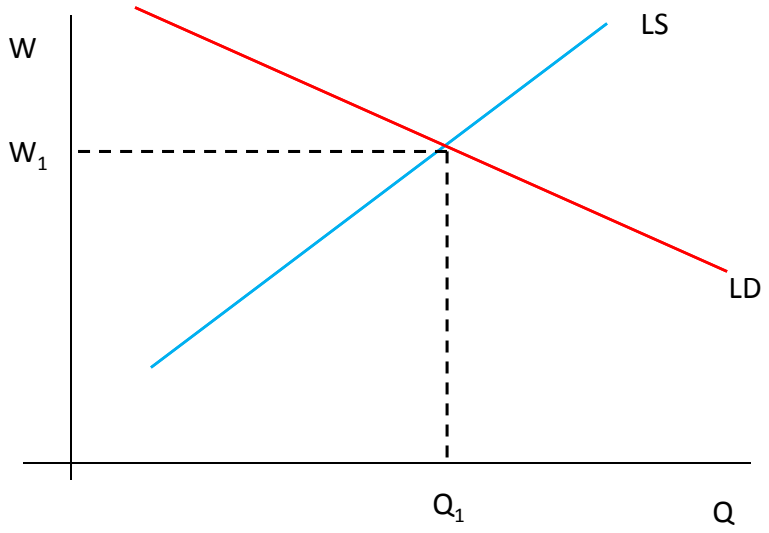

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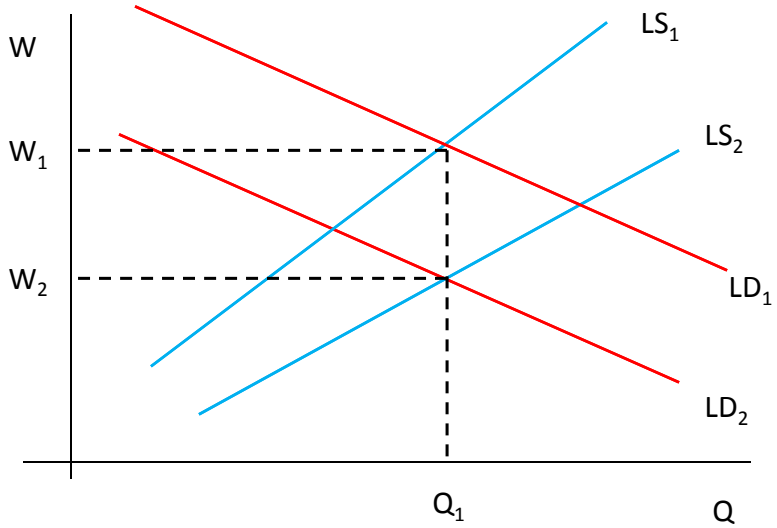

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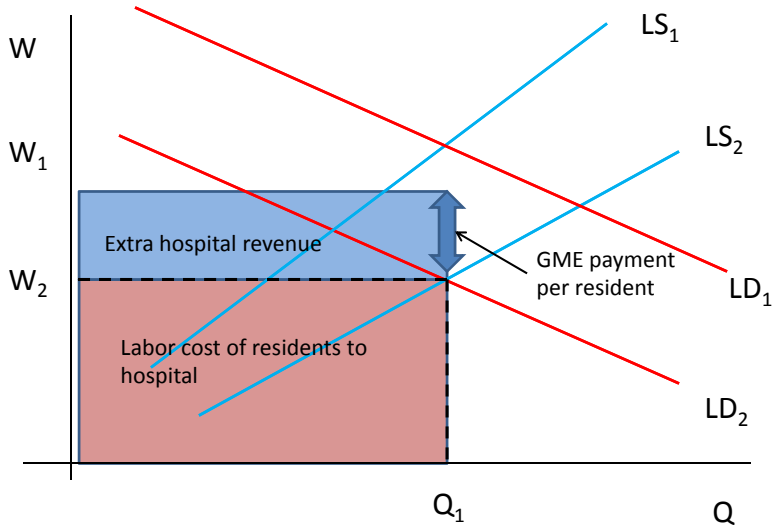

Summary of the arguments

- Everyone (AAMC, COGME, IOM, ACGME, MedPAC) agrees that training could be modernized, made more accountable, and transparent.
- Critics of current system maintain that GME funding pays for more than training, is geographically badly distributed, and promotes too many specialists.
- Defenders of AMCs maintain that the costs of training are underestimated and cross subsidies are necessary to sustain training programs.

Politics of GME

Senate Finance Committee

Orrin Hatch

Ron Wyden

Democrats on committee universally support GME. Republicans more mixed depending upon geography.

House Ways and Means Committee

Paul Ryan

Sander Levin

Democrats on committee universally support GME. Some significant Republican support as well but budget constraints are tempting for those interested in cutting.

Politics of GME

- Cut IME from $6 billion to $3 billion
- Reallocate IME funds for other teaching or health related activities (FQHCs)
- Tie funding to accountability