

# Restructuring medical education financing: principles and priorities

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# Overview

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- Need for restructuring medical education financing
- Set of overarching principles for long-term restructuring
- Shorter-term, interim steps for Medicare

# Need for restructuring medical education financing

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- Medical education produces many superbly skilled clinicians and important advances in research
- But, delivery system reform cannot be accomplished without greater focus on value-based skills
- Medicare's financing arrangement has created many of the problems (as single largest GME payer):
  - Hospital admission-based payments
  - Little accountability for education
  - Lack of pipeline influence (by mix of clinicians, type of specialty, geography, race/ethnicity, income)
- Influence of FFS reimbursement system will persist

# *Principle 1:* Transition to general revenue financing

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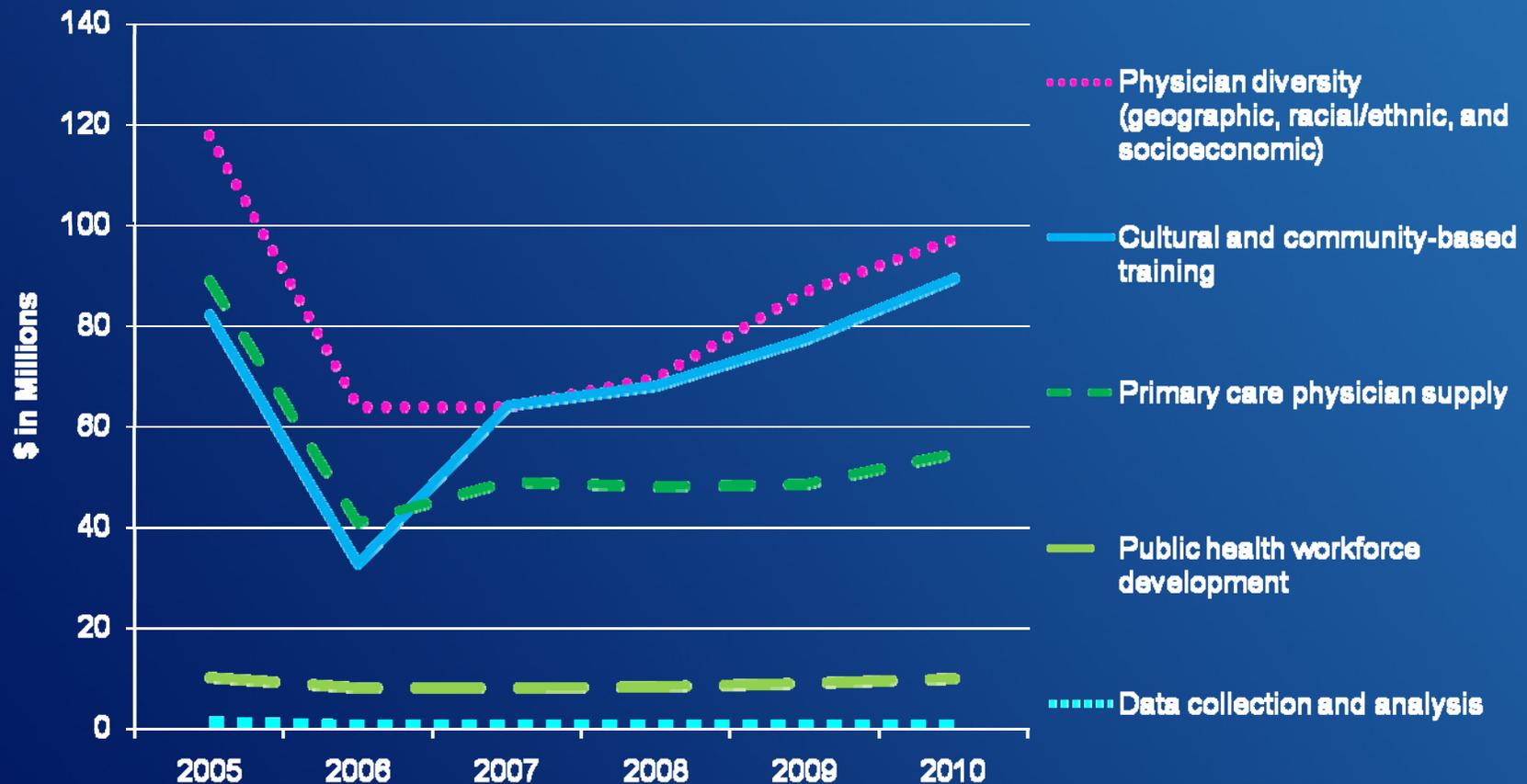
- Because medical education is a social good, it should be funded out of general revenues rather than from Medicare's payroll tax
- Pooling resources for medical education financing will help achieve workforce and educational objectives
- This transition should:
  - be deficit-neutral
  - be implemented in phases
  - assure multi-year funding stability

## *Principle 2: Enhance workforce analysis, pipeline strategies, program evaluation*

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- **Increase capacity for workforce analysis**
  - Understand supply/demand across all health professions
  - Inform a strategic plan for pipeline dollars
  - Conduct longitudinal program evaluation
- **Enhance effective pipeline programs**
  - Including from Title VII, VIII, NHSC
  - Increase health professional career choices for people with low-income, rural, and minority backgrounds
  - Assure funding stability for initiatives proven successful

# Title VII funding by type of program



## *Principle 3: Support accountability for high educational standards*

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- **Restructure payment formulas**

- Link payments to achievement of educational goals
- Use standards developed by educational and accrediting bodies, insurers, patient organizations
- Support faculty teaching time and development

- **Reward environments and settings that provide high-value care**

- Establish incentives for teaching sites to support delivery system reforms (e.g., team-based care, cost-awareness activities, coordinated discharge planning)

# Invest in high-priority areas

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- \$3.5 billion in Medicare overpayments for IME in 2008
- Reduce IME outlays and use savings to offset spending in 5 high-priority areas:
  - Pipeline goals
  - DGME's increased costs
  - Supervision in offices and outpatient clinics
  - Hospital quality incentive payment program
  - Medicare solvency

## *With IME savings:* Enhance workforce analysis and pipeline strategies

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- Consistent with Principle #2
- Medicare's GME/IME financing does not address healthcare workforce objectives
  - Influencing career choices occurs much earlier than residency time
  - It overlooks other health professionals

## *With IME savings:* Increase DGME to support educational activities and faculty development

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- Although DGME and IME payments are essentially fungible to the institution, boosting DGME highlights educational purpose of subsidies
- Recognizes that direct costs of graduate medical education and training have risen
  - Increased accreditation requirements, competencies
  - Supervision costs
  - Faculty development needs
  - Resident compensation
- Provide support for clinical portion of graduate nursing and PA programs

## *With IME savings:* Make payments to offices and clinics to help offset supervision costs

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- Need to encourage training in community settings (offices, clinics) where most health professionals will ultimately practice
- Teaching and supervision reduces productivity in these community settings
- When actively supervising graduates, Medicare payment adjustments could help offset these efficiency losses
  - Replaces current regulation for teaching hospital to pay supervision costs

## *With IME savings:* Fund a quality incentive program for hospitals

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- The Commission has stated that Medicare should develop payment incentives for high quality care
- A quality incentive payment program would provide a strong incentive for hospitals to improve quality
- Commission has previously recommended that Medicare fund a quality incentive payment program for hospitals through:
  - Reduction in base rates
  - Savings from lower IME adjustment

# *With IME savings:* Increase Medicare solvency

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- Medicare is facing Part A bankruptcy
- Teaching hospitals benefited from IME overpayments for more than a quarter century
- Reduction in IME spending could be a small, but reasonable means for increasing the solvency of Medicare

# Increasing transparency: background

Medicare provides financial support to teaching hospitals

Direct GME payment

Indirect medical education payments



Hospitals provide financial support to residency programs

Pay residents' stipends and benefits

Pay for supervising faculty and program administrative expenses



Programs knowledge on how they are supported

Programs may feel they are not getting fair share of support from Medicare

# How could Medicare increase transparency on funding?

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- CMS provide annual report on direct and indirect payments
  - Could be easily calculated from cost reports
  - CMS already creates a files that includes this information (may not be user friendly)
- New York COGME proposal on transparency

# Reducing barriers to residents educational experience in community settings

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- Current rules and regulations create disincentives for training in nonhospital settings
  - Time spent in didactic activities outside the hospital may not always be counted
  - Rules governing requirement that hospitals pay “all or substantially all” of training costs in nonhospital settings
  - Paperwork burden of tracking resident hours from different sites
- Other financial disincentives for nonhospital experience will persist
  - Residents provide valuable hospital services (e.g., on-call)
  - Paying non-resident (higher-wage) staff to perform these duties is more expensive

# Summary

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## **1) Restructure overall medical education financing**

- Transition to general revenue financing model
- Enhance workforce analysis and pipeline strategies
- Support accountability for educational standards

### *In interim...*

## **2) Redirect Medicare's IME overpayments**

- Enhance workforce analysis and pipeline strategies
- Increase DGME payments
- Make payments for office and clinic supervision
- Fund hospital quality incentive payment program
- Extend Medicare solvency

## **3) Increase IME / DGME payment transparency**

## **4) Modify statutory / regulatory nonhospital provisions**