Revising IME Payments: Potential Impact on Teaching Hospitals

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• Teaching hospital environment
• Perspectives on GME finance
• Priorities for a new system
• Prerequisites
• Wish list
Teaching Hospital Context

- ↓ payments and ↑ expenses continue after successive rounds of cost-cutting → unprecedented budgetary pressure
- ↑ demand for services
- ↑ demands associated with implementation of HIT, population health, new payment models, new delivery models/team-based care
- GME seen as an expensive investment; for some it’s a core mission, for others it is not
What does GME do to – or for – the bottom line?

Hospitals see GME as costly; many would cut slots in response to funding cuts

**Yet**

# GME slots ↑17.5%
2003-12 despite cap on Medicare-funded slots

WHY???

Expedient response to duty hours limits
Disproportionate growth in subspecialties

*Net* change overshadows variable dependence on federal funding
Mission trumps ROI; tied to other initiatives

Tipping point?
Does GME Represent a Net Profit or Loss for Teaching Hospitals?

answer: YES
Cannot simply “do the math”

resident salaries, program administration, etc.

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<th>Direct costs</th>
<th>Direct revenue</th>
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<tr>
<td><em>Indirect costs</em></td>
<td><em>Indirect revenue/cost savings</em></td>
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DME, \([IME]\), +/-Medicaid

↑utilization, LOS

↑faculty productivity, ↓personnel expense
Directional changes in GME financial impact: less favorable

- Duty hours limits
- ↑ Training time needed in ambulatory and other non-hospital settings
- ↑ Supervision
- New curricular topics and other education requirements (ex: multi-source evaluation)
- Increasing technology needs
- ↑ Need for documentation (ex: milestones and clinical competency committees)
Reactions to H.R. 3292

POSITIVE

- Funding is stable, predictable
- Increases for new programs (? growth of existing pgms)
- Removes disincentive for non-hospital training
- Removes incentive for high density of trainees

NEGATIVE

- Not performance-based
- Does not address problems with DME
- Risks sudden financial hit to vulnerable institutions
- No targeted funding for R&D – critical questions will remain unanswered

Unclear:
- are children’s hospitals included
- are non-hospital GME sponsors included
What’s needed as the foundation of a new system for GME funding?

- Better, continually updated, workforce data
- Better understanding of financial impact of GME
- Proposals for pilot studies, e.g.
  - Incentives to align specialty mix w/ need
  - Best approach for achieving access to care
  - Alternate funding for fellowships (subspecialties)
  - New approaches to training
What’s Needed?

• Agreement on outcomes linked to funding, e.g.
  » Quality/cost/value of care delivered by program graduates
  » Type, location, and volume of care delivered
  » Extent to which graduates advance the field
  » Other societal contributions
Wish list

• Avoid substituting one arbitrary, inflexible distribution scheme for another
• Don’t squander the momentum for reform
• Allocate funds for GME R&D

How we spend $16 billion impacts what we get for the $3 trillion