



Graduate Medical Education Study Committee
REPORT TO THE OHIO GENERAL ASSEMBLY AND GOVERNOR
December 15, 2015

BACKGROUND

Section 327.320 of the 2016-2017 state operating budget (Am. Sub. H.B. 64) established a "Graduate Medical Education Study Committee" to study Medicaid payments to hospitals for the costs of graduate medical education (GME). The committee is required to compile recommendations into a report it submits to the Governor and Ohio General Assembly not later than December 31, 2015. Upon submission of this report, the committee ceases to exist.

MEMBERSHIP

Mike Anderson, Ohio Children's Hospital Association (appointed per statute)
John Carey, Ohio Board of Regents (appointed per statute)
Charles Cataline, Ohio Hospital Association (appointed per statute)
Dan Clinchot, Ohio State University (appointed by House)
Chris Cooper, University of Toledo (appointed by Senate)
Andrew Filak, University of Cincinnati (appointed by Senate)
Jay Gershen, Northeast Ohio Medical University (appointed by House)
David Hopkins, Wright State University (appointed by House)
Kenneth Johnson, Ohio University (appointed by Senate)
John McCarthy, Ohio Department of Medicaid (appointed per statute)
Roderick McDavis, Ohio University (appointed by House)
Greg Moody (Chair), Office of Health Transformation (appointed per statute)
Brent Mulgrew, Ohio State Medical Association (appointed per statute)
Andy Thomas, Ohio State University (appointed by Senate)
Jon Wills, Ohio Osteopathic Association (appointed per statute)

SCHEDULE

October 29, 2015
November 30, 2015

FINDINGS

- Currently, Ohio Medicaid subsidizes hospitals \$39,000 on average annually for each graduate medical intern or resident the hospital trains. However, some hospitals receive as much as \$385,000 per resident while others receive nothing at all (Appendix A).
- On October 29, 2015 the committee reviewed why the current GME formula generates dramatically different results for hospitals that provide similar medical training opportunities (Appendix B).
- On November 30, 2015, the committee received copies of written testimony (Appendix C) on recommendations to (1) update the GME formula (e.g., recognize changes since the program was created in 1987) and achieve fairness in training program support and (2) promote state health policy priorities (e.g., recruit and retain more physicians into primary care and specialties with shortages, and strengthen and improve minority training programs). No oral testimony was presented by these authors and the written testimony received little discussion or review during the committee meeting, although these recommendations appeared to be similar in principle to the draft discussion document described below.
- The focus on November 30 turned to a draft discussion document presented by several members of the committee (Appendix D). The discussion document proposes to transition direct Medicaid GME payments from the old formula to a new formula over time. The new formula would weight training priorities and apply those weights to actual training positions, then convert those results into a Medicaid payment per discharge for each teaching hospital.

RECOMMENDATIONS

- **The members of the committee agreed without dissent that the draft discussion document (Appendix D, pages 43-46) represents a promising starting point for future reforms.** They also agreed that explicit support would depend on being able to review the fiscal impact models of the proposed option and the implementation phase-in schedule.
- The Ohio Department of Medicaid agreed to use the draft discussion document as its starting point for future GME reforms. The department plans to initiate consideration of Medicaid GME reforms early in 2016.

APPENDIX A

Ohio Medicaid Graduate Medical Education Hospital Spending Report (2014)

Graduate Medical Education - Calendar Year 2014
Hospitals with a Teaching Program or Current GME Payments

Data Source: Historical Historical Historical Medicaid CR Medicaid CR Medicaid CR Paid Claims Calculation Medicaid CR Medicaid CR Historical Calculation Calculation Paid Claims Calculation

Provider Name	Historical Rate Setting Data SFY 86/87 Cost Reports			Current Cost Report Data (Cost Reports Ending in Calendar 2014)			Factors					Medical Education Component Reimbursement			
	Intern & Residents FTEs	Number of Beds	Discharges	Intern & Residents FTEs	Number of Beds	Discharges	Title XIX IP Factor	Title XIX IP Utilization	Total I & R Costs	Other Direct Medical Education	Percent of DME in Current GME Rate	DME (CY 2014)	IME (CY 2014)	GME (CY 2014)	Medicaid Medical Education Payment per I & R
Totals	4,281	32,466	134,178	6,361	21,906	262,132			\$878,964,920	\$78,511,159		\$100,109,774	\$147,616,683	\$247,726,458	\$38,945.95
Lutheran Hospital	28	221	275	4	202	2,986	0.10066	27.22%	\$0	\$0	52.21%	\$844,425	\$772,790	\$1,617,216	\$385,051.32
Toledo Children's Hospital	15	126	1,065	13	129	1,607	0.33349	39.06%	\$1,864,238	\$0	49.56%	\$2,277,149	\$2,317,432	\$4,594,581	\$353,429.33
Children's Hospital Med Ctr Akron	78	253	2,435	111	372	5,436	0.21137	53.61%	\$19,414,287	\$0	39.63%	\$4,844,698	\$7,379,346	\$12,224,044	\$110,126.52
Ohio State University Hospital	327	1,214	5,394	488	962	12,001	0.09633	14.37%	\$77,186,553	\$7,624,206	42.63%	\$15,225,890	\$20,489,972	\$35,715,863	\$73,188.24
Miami Valley Hospital	80	599	3,980	121	841	12,097	0.10059	20.21%	\$20,346,842	\$257,118	50.43%	\$4,185,914	\$4,114,246	\$8,300,160	\$68,596.36
Toledo Hospital	85	814	2,802	59	569	6,970	0.05322	15.79%	\$7,640,645	\$1,427,541	58.21%	\$2,251,121	\$1,616,314	\$3,867,435	\$65,683.33
Nationwide Children's Hospital	85	313	3,213	238	517	9,633	0.22018	31.17%	\$41,058,215	\$0	31.72%	\$4,963,690	\$10,684,105	\$15,647,794	\$65,678.04
Good Samaritan Hospital	66	659	1,740	73	483	6,425	0.08867	13.20%	\$19,290,370	\$7,409,316	61.97%	\$2,698,852	\$1,656,162	\$4,355,014	\$59,657.73
UHHS/Rainbow Babies & Children's Ho	377	818	2,849	153	227	6,473	0.37065	41.95%	\$16,926,906	\$45,862	26.84%	\$2,436,793	\$6,642,662	\$9,079,455	\$59,342.85
Kettering Memorial Hospital	57	482	374	71	380	3,333	0.04366	10.78%	\$10,303,117	\$9,044,884	60.76%	\$2,414,897	\$1,559,491	\$3,974,388	\$56,270.54
St. Vincent Charity Medical Center	113	809	3,634	65	159	2,962	0.10094	29.55%	\$8,237,708	\$275,152	61.08%	\$2,205,362	\$1,405,425	\$3,610,787	\$55,670.47
St. Elizabeth Health Center	87	819	2,592	60	353	3,822	0.06021	15.92%	\$8,324,059	\$1,078,105	46.62%	\$1,493,227	\$1,709,723	\$3,202,951	\$53,605.87
Flower Hospital	18	287	242	9	263	2,503	0.04038	15.24%	\$2,064,038	\$104,724	53.62%	\$244,489	\$211,519	\$456,008	\$50,667.55
Summa Health System Hospitals	150	775	3,364	200	531	7,873	0.05538	24.07%	\$28,864,136	\$1,662,296	46.33%	\$4,606,781	\$5,336,988	\$9,943,769	\$49,749.84
MetroHealth Medical Center	252	715	9,375	383	605	13,042	0.11089	34.59%	\$55,288,860	\$356,843	41.79%	\$7,867,468	\$10,958,185	\$18,825,653	\$49,110.83
Riverside Methodist Hospital	108	823	1,388	126	710	6,919	0.06592	8.66%	\$18,751,938	\$1,422,612	34.45%	\$2,020,786	\$3,844,761	\$5,865,547	\$46,426.68
St. Vincent Mercy Medical Center	67	442	2,909	172	394	6,748	0.10102	29.15%	\$22,798,914	\$15,862,590	53.01%	\$3,999,102	\$3,544,788	\$7,543,889	\$43,793.62
University Hospital	312	694	8,571	478	542	7,419	0.11550	16.62%	\$72,204,437	\$840,175	37.80%	\$7,605,534	\$12,515,674	\$20,121,208	\$42,094.58
Children's Hospital Med Ctr Cinci	136	330	3,846	331	514	6,072	0.13766	20.97%	\$45,546,331	\$0	18.85%	\$2,553,575	\$10,991,456	\$13,545,031	\$40,895.60
St. Charles Mercy Hospital	-	362	1,247	13	246	3,101	0.08233	25.24%	\$64,092	\$1,289	100.00%	\$543,084	\$0	\$543,084	\$40,864.10
Grant Medical Center	51	602	2,306	90	375	5,883	0.10665	17.17%	\$13,124,332	\$769,372	54.02%	\$1,961,509	\$1,669,474	\$3,630,983	\$40,371.17
UHHS/University Hosp. of Cleveland	377	862	5,100	532	608	12,423	0.07765	24.11%	\$71,054,922	\$1,362,436	25.09%	\$4,747,747	\$14,171,896	\$18,919,644	\$35,563.24
St. Joseph Health Center	22	499	3,352	24	143	2,462	0.04411	20.70%	\$2,414,682	\$0	43.80%	\$368,294	\$472,476	\$840,770	\$35,415.77
Mount Carmel Hospital	83	870	2,203	74	739	6,932	0.05723	12.26%	\$18,219,094	\$459,909	50.39%	\$1,302,629	\$1,282,702	\$2,585,331	\$35,122.00
Aultman Hospital	73	755	2,736	67	473	4,563	0.05031	13.54%	\$7,659,648	\$3,259,771	62.43%	\$1,409,742	\$848,330	\$2,258,072	\$33,647.32
Mercy Medical Center	30	594	2,217	28	279	3,310	0.03368	14.88%	\$5,046,053	\$198,032	57.69%	\$482,476	\$353,880	\$836,357	\$29,700.16
Akron General Medical Center	97	402	1,754	132	385	5,321	0.04549	17.02%	\$23,250,516	\$999,998	40.34%	\$1,557,777	\$2,303,635	\$3,861,411	\$29,281.95
Children's Medical Center - Dayton	17	155	1,731	57	155	3,345	0.24215	29.47%	\$3,678,125	\$0	35.65%	\$567,290	\$1,024,139	\$1,591,430	\$28,141.99
Summa Barberton Citizens Hospital	16	407	1,213	16	190	2,204	0.03937	24.05%	\$3,528,939	\$0	63.98%	\$240,082	\$135,162	\$375,243	\$23,900.85
Grandview Hospital	74	452	2,186	94	271	3,800	0.05370	20.39%	\$10,682,177	\$240,997	32.51%	\$696,099	\$1,444,861	\$2,140,961	\$22,810.15
Firelands Regional Medical Center	-	209	441	14	203	1,920	0.03183	16.85%	\$1,145,278	\$2,471,052	100.00%	\$307,605	\$0	\$307,605	\$21,971.79
O'Bleness Memorial Hospital	-	132	926	18	64	983	0.06129	17.85%	\$3,360,705	\$0	100.00%	\$378,227	\$0	\$378,227	\$20,873.47
Christ Hospital	50	726	1,134	73	427	2,819	0.03475	7.17%	\$14,174,748	\$6,755,625	59.53%	\$901,059	\$612,624	\$1,513,683	\$20,735.39
South Pointe Hospital	41	601	1,255	50	159	1,289	0.04332	14.07%	\$4,727,250	\$220,898	47.84%	\$493,563	\$538,132	\$1,031,695	\$20,453.90
Sycamore Hospital	3	126	79	13	172	1,664	0.04121	13.76%	\$1,477,628	\$1,749,699	53.95%	\$140,156	\$119,620	\$259,776	\$19,982.77

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Jewish Hospital LLC	54	741	878	60	209	1,372	0.03952	10.65%	\$8,486,608	\$111,192	62.21%	\$731,065	\$444,015	\$1,175,080	\$19,729.35
University of Toledo Medical Center	113	275	1,258	200	267	1,671	0.07453	11.79%	\$17,683,983	\$1,749,246	23.06%	\$894,181	\$2,984,097	\$3,878,278	\$19,364.28
St. Ann's Hospital	3	227	576	13	253	4,385	0.06475	16.51%	\$992,847	\$0	56.25%	\$136,012	\$105,766	\$241,778	\$18,800.76
Good Samaritan Hospital - Dayton	50	510	2,066	74	374	3,363	0.04870	15.93%	\$11,404,276	\$0	44.52%	\$587,777	\$732,388	\$1,320,165	\$17,840.07
Bethesda Hospital	14	707	3,346	36	336	3,469	0.03666	7.96%	\$5,491,336	\$0	70.54%	\$435,512	\$181,910	\$617,422	\$17,150.62
Robinson Memorial Hospital	6	325	1,365	2	117	1,424	0.02953	16.23%	\$278,543	\$380,857	52.55%	\$11,816	\$10,667	\$22,483	\$14,988.69
Clinton Memorial Hospital	-	135	452	3	89	1,049	0.02885	19.28%	\$661,466	\$0	100.00%	\$47,236	\$0	\$47,236	\$14,270.81
Fairview Hospital	32	541	1,187	76	411	5,332	0.05634	16.54%	\$7,408,741	\$287,781	50.70%	\$533,221	\$518,427	\$1,051,648	\$13,772.24
Affinity Medical Center (Doctor's-Stark)	22	500	1,632	17	138	381	0.04778	5.71%	\$2,839,707	\$0	45.41%	\$101,272	\$121,739	\$223,010	\$13,095.13
Cleveland Clinic Hospital	354	1,008	684	918	1,274	7,853	0.03588	11.30%	\$88,920,917	\$5,233,704	31.88%	\$3,747,541	\$8,006,939	\$11,754,481	\$12,804.45
Northside Medical Center	119	768	2,835	84	188	2,046	0.07026	25.06%	\$6,572,763	\$0	36.53%	\$382,051	\$663,743	\$1,045,794	\$12,395.33
Doctor's Hospital - Columbus	86	569	5,015	109	178	2,541	0.08870	17.66%	\$22,878,204	\$0	40.02%	\$463,282	\$694,206	\$1,157,487	\$10,616.23
Summa Western Reserve Hospital	20	219	302	40	83	556	0.02475	11.51%	\$5,305,865	\$0	48.72%	\$173,077	\$182,151	\$355,228	\$8,945.57
Community Health Partners of Ohio	-	725	2,041	8	247	3,571	0.04792	21.56%	\$947,428	\$0	100.00%	\$66,525	\$0	\$66,525	\$8,284.50
UHHS/Richmond Heights Gen Hosp.	23	342	475	88	107	750	0.03142	11.82%	\$14,027,319	\$0	47.28%	\$170,724	\$190,375	\$361,098	\$4,102.46
Hillcrest Hospital	2	296	151	21	388	3,305	0.03152	8.82%	\$1,972,621	\$532,460	37.55%	\$19,210	\$31,951	\$51,161	\$2,453.75
Marietta Memorial Hospital	-	209	535	13	171	965	0.02348	8.67%	\$1,828,571	\$200,401	100.00%	\$15,657	\$0	\$15,657	\$1,204.39
St. John Medical Center	-	229	421	39	170	1,748	0.03472	13.04%	\$4,898,414	\$491,775	0.00%	\$0	\$0	\$0	\$0.00
Southern Ohio Medical Center	-	434	3,020	25	209	2,682	0.06561	17.77%	\$4,116,583	\$0	0.00%	\$0	\$0	\$0	\$0.00
East Liverpool City Hospital	-	275	1,118	14	126	1,089	0.05386	20.62%	\$1,876,342	\$0	0.00%	\$0	\$0	\$0	\$0.00
Fairfield Medical Center	-	250	743	21	212	2,242	0.03526	15.80%	\$3,407,160	\$0	0.00%	\$0	\$0	\$0	\$0.00
St. Luke's Hospital	-	295	205	17	202	1,504	0.03318	9.95%	\$2,847,026	\$0	0.00%	\$0	\$0	\$0	\$0.00
UHHS/Memorial Hospital of Geneva	-	63	326	2	25	98	0.00992	7.08%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0.00
Adena Regional Medical Center	-	275	889	16	196	2,908	0.06118	21.05%	\$2,770,093	\$0	0.00%	\$0	\$0	\$0	\$0.00
Alliance Community Hospital	-	184	1,119	9	118	693	0.02042	13.63%	\$898,399	\$0	0.00%	\$0	\$0	\$0	\$0.00
UHHS/Geauga Regional Hospital	-	172	241	2	126	1,953	0.04007	16.72%	\$216,639	\$395,049	0.00%	\$0	\$0	\$0	\$0.00
St. Anne Mercy Hospital	3	294	3,495	1	96	694	0.03798	12.43%	\$107,244	\$0	42.36%	\$0	\$0	\$0	\$0.00
St. Rita's Medical Center	-	477	1,165	3	380	4,216	0.05251	17.80%	\$328,794	\$294,191	0.00%	\$0	\$0	\$0	\$0.00
Atrium Medical Center (Middletown)	-	372	1,561	1	279	2,813	0.06168	18.15%	\$77,248	\$0	100.00%	\$0	\$0	\$0	\$0.00
Trinity Hospital Twin City	-	70	478	-	25	50	0.01023	10.46%	\$0	\$329,809	0.00%	\$0	\$0	\$0	#DIV/0!
Trinity Hospital Holding Company	-	242	1,080	-	262	1,713	0.03076	15.92%	\$0	\$2,093,805	100.00%	\$432,043	\$0	\$432,043	#DIV/0!
Parma Community General Hospital	-	358	175	-	246	1,061	0.01705	7.41%	\$0	\$339,110	0.00%	\$0	\$0	\$0	#DIV/0!
Euclid Hospital	-	377	273	-	191	1,002	0.03923	11.79%	\$0	\$171,277	100.00%	\$4,890	\$0	\$4,890	#DIV/0!
MedCentral Health System	-	521	1,741	-	224	3,101	0.05082	20.17%	\$0	\$0	100.00%	\$252,744	\$0	\$252,744	#DIV/0!
Greene Memorial Hospital, Inc.	5	237	996	-	49	357	0.02518	12.04%	\$0	\$0	46.89%	\$17,954	\$20,337	\$38,291	#DIV/0!
Marymount Hospital	-	297	406	-	298	1,835	0.04664	14.54%	\$0	\$0	100.00%	\$48,894	\$0	\$48,894	#DIV/0!

Graduate Medical Education - Calendar Year 2014
Hospitals with a Teaching Program or Current GME Payments

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Arthur G. James Cancer Hospital	-	-	-	58	251	1,343	0.05335	7.54%	\$10,112,493	\$0	0.00%	\$0	\$0	\$0	\$0.00
Drake Center, Inc.	-	-	-	4	137	162	0.09171	13.65%	\$420,909	\$0	0.00%	\$0	\$0	\$0	\$0.00

Direct Med Ed Cost per I&R FTE
Direct Med Ed Cost per Discharge

\$138,185
\$567

NOTES

- Data Source: Medicaid CR = Data is from the hospital's cost report ending during calendar year 2014.
- Paid Claims = MMIS paid claims data for claims with services dates during calendar 2014.
- Data Source: Medicare CR = Data is from the hospital's Medicare cost report for the reporting year ending during SFY 2014
- Other Direct Medical Education = Total costs of educating Non-Physician Anesthetists, Nursing School & Paramedic Education.

CALCULATIONS

- Title XIX IP Factor = Title XIX IP Charges / Total Facility IP Charges
- Title XIX Utilization = Title XIX Discharges / Total Facility Discharges
- DME = GME * Percent of DME in Current GME Rate
- IME = GME - DME
- Medicaid Medical Education Payment Per I & R = GME / Interns & Residents FTEs. If #DIV/0! is displayed, hospital had no I & R FTEs. Hospitals with no I & R FTEs may still have Other Direct Medical Education Costs, thus resulting in a Direct Medical Education Payment.

APPENDIX B

History of Payment for Graduate Medical Education

History of Payment for Graduate Medical Education (GME)

John McCarthy, Director
October 29, 2015

Making Ohio Better



OHIO DEPARTMENT OF MEDICAID

Making Ohio Better

All Sources of Funding for Graduate Medical Educations

- Funding Streams for GME
 - » Medical schools
 - » Medical school loan forgiveness
 - » Veterans Affairs
 - » Medicare GME payments to hospitals
 - » Medicaid GME payments to hospitals

Am. Sub. H.B. 64 – Section 327.320

-The Committee shall study the issue of Medicaid payments to hospitals for the costs of graduate medical education. The Committee shall include in its study the feasibility of targeting the payments in a manner that rewards graduates of medical schools of colleges and universities located in this state who practice medicine and surgery or osteopathic medicine and surgery in this state for at least five years after graduation.
- The Committee shall complete a report about its study not later than December 31, 2015. The Committee shall submit copies of the report to the Governor, the General Assembly (in accordance with section 101.68 of the Revised Code), and the Joint Medicaid Oversight Committee. The Graduate Medical Education Study Committee shall cease to exist on submission of the report.

Background

- Pre-Medicare
 - » Hospital-based training programs instead of medical schools
 - » Costs are modest prior to WW II and GI bill
 - » Post WW II saw increase in specialization by 6 fold
 - » GI bill provides federal funds to support GME and leads to increase in stipends for house staff
 - » Results in increased charges to insurance for faculty, technology and education program

OHIO DEPARTMENT OF MEDICAID *Making Ohio Better*

Background

- Medicare created
 - » Congress recognizes need to support medical education and patient care
 - » GME is an allowable cost for hospitals
 - » Encourage physician training to care for new Medicare beneficiaries
- Post Medicare
 - » Recognition that teaching hospitals incur higher cost
 - » Development of prospective payment for Medicare creates indirect and direct medical education components of graduate medical education.
 - » Medicare makes periodic adjustments to reduce the indirect portion and modify the direct portion of medical education paid to hospitals
 - » Many states include GME in their Medicaid programs

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OHIO DEPARTMENT OF MEDICAID *Making Ohio Better*

GME Sources of Funding

- Medicare – Approx. \$9.7 Billion in 2012
 - » Ohio \$611 million (SFY 2014 CR)
- Medicaid – nationally \$3.9 Billion in 2012
 - » Ohio \$247 Million in CY 2014
- Veterans Affairs – Approx. \$1.4 Billion in 2012
- HRSA – 4 programs in addition to Children’s Hospitals GME (\$270 Million)
- Third Party – minimal – Maryland is only all payer system

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Ohio Medicaid GME

- GME created as part of inpatient hospital payment formula in 1984
- GME = Indirect Medical Education (IME) + Direct Medical Education (DME)
- IME and DME components originally calculated in 1987 for teaching hospitals
- Since 1987, GME (sum of IME and DME) has been inflated most years
- Formula for GME adjusted in 1995 to add an adjustment for case-mix

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OHIO DEPARTMENT OF MEDICAID *Making Ohio Better*

Ohio Medicaid GME

- Prior to 1995 – a teaching hospital got paid a flat add-on per inpatient discharge equal to:
 - » Hospital DME per discharge amount + Hospital IME per discharge amount
- From 1995 and forward – a teaching hospital gets paid a case mix adjusted medical education add-on per inpatient discharge equal to:
 - » $((\text{Hospital DME per discharge amount} + \text{Hospital IME per discharge amount}) / \text{Hospital Case Mix Score}) * \text{DRG Relative Weight}$

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OHIO DEPARTMENT OF MEDICAID *Making Ohio Better*

Ohio Medicaid DME: How is it calculated?

 Ohio Department of Medicaid
John R. Kasich, Governor
John R. McCallister, Director

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Direct Medical Education (DME)

- Costs (e.g., supervision, salaries, benefits) reported on hospital cost report
- Formula uses base period costs and number of interns and residents
- Medicare modifications
 - » Allow inclusion of interns and residents in non-hospital settings in count
 - » Capped the number of FTE interns and residents
- Ohio has not adjusted its DME formula since 1987

 Ohio Department of Medicaid
John R. Kasich, Governor
John R. McCallister, Director

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OHIO DEPARTMENT OF MEDICAID *Making Ohio Better*

Ohio Medicaid DME: How is it calculated?

- Calculate a per intern and resident (I&R) cost by teaching hospital using the I&R costs on the hospital's Medicare cost report/number of I&R
- Compare the per I&R cost to the statewide average I&R plus one standard deviation
- Use the lower of the hospital's per I&R costs or the statewide average plus one standard deviation and multiply by the hospital's number of I&R from the Medicare cost report
- This is the total allowable I&R cost

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Ohio Medicaid DME: How is it calculated?

- Add to the hospital's total allowable I&R costs any costs they may have for nursing and paramedical education to arrive at the total allowable DME cost for the hospital
- Calculate Ohio Medicaid's portion of the total allowable DME costs by multiplying by the percent Medicaid inpatient charges is of the hospital's total inpatient charges across all payers
- Calculate the Medicaid per discharge DME amount by dividing Ohio Medicaid's portion of total allowable DME costs by the number of Medicaid discharges

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Ohio Medicaid DME: Who gets paid and for how many interns and residents?

- See Handout
- Current DME rates were developed from 1986/1987 Hospital Cost reports
- Rebasing DME rates with SFY 2014 cost reports using the current formula, would require approx. \$195 M (\$295 M - \$100 M)
- Total statewide DME costs = \$890 M
- Medicare paid \$ 133 M, for I/P DME (SFY 2014 CR)

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Ohio Medicaid IME: How is it calculated?

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Indirect Medical Education (IME)

- Designed to recognize increased costs of patient care in teaching hospitals over non-teaching hospitals
- Additional payment based on IME adjustment factor which is a percentage increase in payment for every 10 percent increase in intern and resident to bed ratio
- Has been reduced over time by Congress
- Ohio has not adjusted its IME formula since 1987

Ohio Medicaid IME: How is it calculated?

- Use the logarithmic formula to calculate the hospital's indirect medical education percentage:

$$2 \times \left[\left(\frac{1 + \text{Residents}}{\text{Beds}} \right)^{0.405} - 1 \right]$$

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Ohio Medicaid IME: How is it calculated?

- Divide hospital operating costs, net of direct medical education and capital, by (1+ hospital's indirect medical education percentage) to calculate the hospital's indirect medical education cost
- Determine the hospital specific mean unit cost of indirect medical education by dividing the hospital's indirect medical education cost by inpatient discharges
- Calculate the statewide mean unit cost for indirect medical education by summing across all hospitals indirect medical education unit costs and removing the highest and lowest value, and then dividing by the number of hospitals with indirect medical education unit costs

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Ohio Medicaid IME: How is it calculated?

- Determine one standard deviation from the statewide mean
- Compare the hospital's unit cost for indirect medical education against the statewide mean plus one standard deviation as a test of reasonableness
- Use the lower of the hospital's indirect medical education unit cost or the statewide mean plus one standard deviation - This is the allowable unit cost for indirect medical education

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<h2>Ohio Medicaid Inpatient Hospital Payment Components</h2>					
Total DRG Hospital Inpatient Spending By Payment Category					
	2014	2015 (est.)	2016 (est.)	2017 (est.)	
Base Payment	\$ 1,968,219,527	\$ 2,363,697,100	\$ 2,447,070,972	\$ 2,592,180,462	
Outlier	\$ 233,597,173	\$ 280,534,235	\$ 290,429,422	\$ 307,651,671	
Capital Payments	\$ 185,444,907	\$ 222,706,655	\$ 230,562,110	\$ 244,234,272	
Direct Med Ed	\$ 100,398,426	\$ 120,571,646	\$ 124,824,528	\$ 132,226,530	
Indirect Med Ed	\$ 147,566,139	\$ 177,216,845	\$ 183,467,753	\$ 194,347,255	
Total DRG Hospital	\$ 2,635,226,171	\$ 3,164,726,481	\$ 3,276,354,786	\$ 3,470,640,190	

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<h2>Opportunity to Improve GME Impact</h2>			
<ul style="list-style-type: none"> • SFY 2014/2015 Executive Budget proposed targeting these funds to support health sector workforce priorities related to primary care • OHT/ODM met with stakeholders during CY 2014 to develop a program • What we heard - a more direct strategy for attracting future doctors into primary care is to increase primary care rates 			

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Opportunity to Improve GME Impact

- **SFY 2016/2017 Executive Budget** proposed to re-direct \$25 million in DME spending to support Physician 'Primary Care' rate increases
- **Legislative Process:**
 - » Department Budget restores \$25 million to DME, with reform expectations
 - » Budget Act creates the GME Study Committee

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Opportunity to Improve GME Impact

- **OHT/ODM Objectives:**
 - » Fairness in Training Program Support
 - » Strengthen/Improve Minority Training programs
 - » Update GME formula and basis (re-basing)
 - How to recognize changing GME programs since 1986/1987
 - How to recognize 'new' programs since base year
 - How to handle 'shared' residency programs between hospitals

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Next Steps

- Receive recommendations through: November 13, 2015
- Committee Meets to Review Recommendations: November 30, 2015
- Committee Meets to Review Draft Report: December 17, 2015
- Submit Report not later than December 31, 2015 (Target 12/29/15)

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GME Reform

Questions/Discussion

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APPENDIX C

Stakeholder testimony for improving Medicaid Graduate Medical Education

- *Kristen Morris, Cleveland Clinic*
- *Ann Spicer, Ohio Academy of Family Physicians*
- *Mike Anderson, Ohio Children's Hospital Association*
- *Ryan Biles, Ohio Hospital Association*
- *Jon Wills, Ohio Osteopathic Association*
- *Randall Longenecker, MD*
- *Cindy Kelly, Summa Health*



Members of the Graduate Medical Education (GME) Study Committee, thank you for the opportunity to testify on our recommendations to update the GME formula, promote state health policy priorities and create a comprehensive approach to medical education.

My name is Kristen Morris and I am the Chief Government and Community Relations Officer at Cleveland Clinic. Cleveland Clinic is a nonprofit multispecialty academic medical center that integrates clinical and hospital care with research and education. Founded in 1921, we have 5.1 million visits per year and employ more than 42,000 caregivers, including 3,000 physicians. Cleveland Clinic is proud to be Ohio's #1 hospital, and Northeast Ohio's largest employer.

Cleveland Clinic's Graduate Medical Education program is one of the largest in the country. In 2014, approximately 1,400 residents and fellows trained in 70 training programs approved by the Accreditation Council for Graduate Medical Education (ACGME). In addition, roughly 140 fellows trained in 80 non-accredited programs.

Cleveland Clinic echoes Ohio's desire to provide comprehensive care to the state's medically underserved populations. However, we hold that a strong and comprehensive GME program is integral to providing this care. The Association of American Medical Colleges (AAMC) estimates a national physician shortfall of between 46,000 – 90,000 by the year 2025, with shortages in specialty physicians being particularly large. Unfortunately, the basis for the shortage in primary care is due, not to a shortage in training "slots", but instead to the very low level of reimbursement for primary care services. Student loan debt can unfortunately force young trainees to choose specialties that are compensated at higher levels, to allow them to repay these loans. Simply creating a larger number of primary care training slots will not alleviate this shortage.

Comprehensive care of the medically underserved requires a team consisting of both primary and specialty providers, working together in an integrated manner with nurses, social workers, and behavioral health specialists. Unfortunately, there are very few programs that train physicians to work in these multi-functional teams. Cleveland Clinic, like many other academic medical centers, already subsidizes a substantial portion of its GME program, about 35%. Reduced reimbursements have forced us to cut costs across the board, and we have eliminated several dozen trainee slots as a result. Other Ohio institutions have been forced to take, or anticipate taking, similar measures to ensure direct patient care can be maintained in the current healthcare market. Cleveland Clinic applauds the administration's efforts to address the physician workforce problem, but sees the issue as multi-faceted and requiring a holistic approach to its solution.

We propose a three-pronged approach to reforming State Medicaid GME: First, we call upon the administration to re-index the per trainee payment model to better reflect most current Medicaid service levels and per-trainee costs for each teaching hospital and to alleviate the gross disparities in per-trainee reimbursement.

Second, we call upon the Administration to institute a merit-based approach to incentivizing better care of Medicaid beneficiaries. The State of Ohio has already undertaken to reform delivery of Medicaid health services through the State Innovation Model programs. The specialty episodes associated with this program already have quality measures associated with them, with financial incentives/penalties associated with meeting or failing to meet these measures. Similar measures will assuredly be associated with the soon-to-be-implemented Patient Centered Medical Homes. We believe that adjusting the per-trainee reimbursement to teaching hospitals up or down depending on



their performance on these measures (for example top quartile performers could see a 20% increase in per-trainee reimbursement, where bottom quartile might see a 20% decrease) will best incent these centers to dedicate training and performance to best meet the needs of their local Medicaid populations.

Third, we believe that 10-15% of the State's Medicaid GME budget should be set aside to fund innovative education programs that train providers to function in the multi-functional teams that can best serve the needs of the Medicaid population. This reform is at the heart of the 2013 Institute of Medicine report on GME and IME funding reform, and enjoys increasing support at the Federal level. We also hold that the State Innovation Model (SIM) grant from CMS is intended to facilitate these sorts of programs, and so we believe that a matching amount from the SIM award should be allocated to this purpose.

Finally, we do need to address the issue of physician student loan debt and its effect on the shortage of primary care providers. We urge the Administration to consider loan forgiveness for physicians who choose community or family medicine and who practice in the State of Ohio for at least five years after finishing their training. This strategy could have the most immediate positive effect on the choice both to practice in primary care and to practice in Ohio.

Cleveland Clinic welcomes the opportunity for further dialogue on the role of Graduate Medical Education in ensuring the health of our Medicaid beneficiaries.

Thank you again for the opportunity to testify.



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December 7, 2015

Monica Juenger
Director of Stakeholder Relations
Governor's Office of Health Transformation
77 South High Street, 30th Floor
Columbus, Ohio 43215

Dear Monica:

On behalf of the 4,800 family physician, family medicine resident and medical student members of the Ohio Academy of Family Physicians, I am writing to comment on testimony provided to the Graduate Medical Education Study Committee during its meeting on Monday, November 30, 2015. We applaud the much needed review of the way the Ohio Department of Medicaid funds graduate medical education. Revising the decades-old funding distribution formula, correcting the uneven distribution of funding for resident training and distributing funding to incentivize the production of physicians that Ohio needs are all long overdue and essential to providing Ohioans with high quality, cost effective primary care.

The consensus proposal is a good starting point but we wish to make two important suggestions as the GME Study Committee moves forward with its recommendations to Governor Kasich and the members of the Ohio General Assembly.

1) Any recommendations must address what is commonly referred to as the "Deans' lie". Deans have historically inflated their production of primary care physicians by claiming 100% of those completing a family medicine, pediatrics or internal medicine residency. Everyone knows that 80 to 90 percent of those completing internal medicine residencies go on to subspecialize and do not practice as primary care physicians. Research also shows that approximately 50% of those completing a pediatric residency go on to subspecialize and do not practice primary care. Only those completing a family medicine residency are likely to actually stay and practice primary care in substantial percentages.

Dr. Pat Ecklar has done extensive research on this and has provided his research to Director Moody. If we truly want to reward medical schools and residencies for producing primary care physicians we need to look at what that physician is doing 5 years post-residency. This practice of inflating (in effect doubling) the numbers of primary care physicians by the deans needs to be corrected. Dr. Ecklar, in his research, calculates general internal medicine at 20% of total numbers completing an internal medicine residency and he states that he feels that 20 percent is generous. He calculates general pediatrics at 50% of total numbers completing a pediatrics residency and he calculates family medicine at 100%. Any payment made for the production of primary care physicians ought to be for physicians who are actually practicing primary care. This perpetual inflation of these numbers by the deans must be addressed.

2) While this appears to be a good first step, more than 25% is needed to stabilize primary care specialty funding. The funding formula needs to move much more quickly to the 50% mark.

We ask that the GME Study Committee consider our comments as they move forward with making formal recommendations. Both comments are vital if a new GME distribution formula is to be successful in achieving desired outcomes.

Please don't hesitate to contact us if you have questions. Thank you for your consideration of our suggestions.

Sincerely,

Ann M. Spicer
Executive Vice President



Ohio Children's Hospital Association
Saving, protecting and enhancing children's lives

FOR DISCUSSION PURPOSES ONLY
OCHA Proposed Ohio Medicaid Graduate Medical Education (GME) Formula Changes
November 2015

General Principles:

The Ohio Children's Hospital Association (OCHA) appreciates the opportunity to provide feedback and recommendations to the Graduate Medical Education Study Committee regarding GME funding and considerations in its entirety, including the reallocation specifically of Direct Graduate Medical Education (DGME) formula payments to Ohio hospitals. Adequate graduate medical education funding is critically important to OCHA members' ability to train physicians and serve patients and is one component of what makes Ohio's children's hospitals arguably the strongest network of children's hospitals in the nation.

OCHA recommends that any proposal to revise the current Graduate Medical Education funding formula(s) should follow the following principles:

1. The Ohio Department of Medicaid (ODM) should continue to make additional explicit payments to teaching hospitals (including children's hospitals) in order to adequately reflect their unique role—and the significant costs associated with that role beyond patient care—in training physicians to care for all Ohioans now and in the future.
2. A GME methodology should incorporate state workforce policy priorities including increasing primary care and other identified areas of clinical pediatric shortages in Ohio.
3. GME methodology should incorporate state workforce policy priorities including increasing primary care and other identified areas of clinical pediatric shortages in Ohio.
4. Overall fairness in GME payments should be a priority-GME methodology should reflect new programs and discontinue funding to programs that have ceased to operate.
5. Implementation of a new GME formula should include a transition period in which a new GME funding methodology is phased in and establishes maximum reimbursement loss and gain compared to current payments during the transition period.

As a first step, OCHA proposes that the current DGME formula be re-run utilizing 2014 cost report data, reduced by the needed percentage to maintain state-level budget neutrality and this fiscal impact shared as a point for discussion.

OCHA also supports the OHA recommendation that ODM adopt a Major Teaching Peer Group with a threshold of at least 100 interns and residents or a 0.35 ratio of interns and residents to inpatient beds such that any institution qualifying under either measure would be included in the peer group.

DGME Formula Potential Changes:

OCHA proposes four related ideas/potential scenarios for discussion with regard to any DGME formula changes.

OCHA respectfully requests additional modeling be done for these as well as any other proposed scenarios, in order for the Committee and stakeholders to understand their fiscal impact to the hospital industry before a final determination regarding DGME formula changes is complete.

In 2014, OCHA members identified clinical shortages of highest priority in the following areas of pediatric medicine:

- Child Psychiatry
 - Genetics
 - Developmental Pediatrics
 - Pulmonology
 - Neurology
 - Neurosurgery
 - Cardiothoracic
 - Adolescent medicine
1. A DGME formula could be crafted to create enhanced DGME add-on payments for the DRGs associated with the list above.
 2. With hospitals providing additional reporting on the number of clinicians in training (or “slots” filled), a formula could be crafted at a per-resident (defined as including fellows) level, weighted higher for primary care residencies and fellowships associated with the pediatric shortage list above.
 3. A DGME formula could be crafted by allocating a total portion of DGME funding based on the amount of training an academic medical center or children’s hospital conducts in the ambulatory setting. The National Academy of Medicine (formerly the Institute of Medicine) encourages training physicians in the ambulatory space, where most medical care is delivered. Quality ambulatory care increases population health and reduces hospital admissions. Similarly, much of the care provided by specialists in shortage areas (e.g. child psychiatry) is delivered in the ambulatory setting. Sites can be easily determined by billing codes, and resident involvement can be ascertained by use of the GE and GC modifiers.
 4. A DGME formula could be crafted that brings focus to regional rural shortages, including in primary care pediatrics.

We recommend that any approach that targets specialty/subspecialty areas as outlined above should be periodically reviewed and updated to prevent future shortages or surpluses. The state and stakeholders should identify an appropriate amount of time to reassess, recognizing that the list identified above, as an example, may change in 2, 5, or 10 years.

Additional Considerations:

- OCHA recommends a DGME add-on to outpatient services via EAPGs.
- With regard to a definition for primary care: While a Medicare definition of primary care specialties, including family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, and obstetrics/gynecology is a start, OCHA believes primary care for Ohio’s children includes specifically and at a minimum:
 - Well child visits
 - Developmental pediatrics
 - Behavioral health/psychiatry
 - Dental care
- For some children with severe illnesses, primary care is delivered in a sub-specialty clinic.

- In the long term, OCHA supports reporting all clinical residents in the care team, including NPs and PAs, for DGME formula calculation/weights, especially with regard to primary care services.
- OCHA would also give long-term consideration related to creating a GME incentive pool for portion of the GME available, i.e. a pool that would be based on prospective costs and/or new programming to increase access/training.



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MEMO

TO: John McCarthy, Director, Ohio Department of Medicaid
Greg Moody, Director, Ohio Governor's Office of Health Transformation

FROM: Ryan Biles, Senior Vice President, Health Economics & Policy

DATE: November 27, 2015

SUBJECT: Recommendations to Ohio General Assembly GME Study Committee

The Ohio Hospital Association appreciates this opportunity to comment on a methodology to update the Ohio Medicaid Graduate Medical Education (GME) payment formula and to promote future state medical education policy priorities.

Because Ohio's hospitals will support both the budget-neutral funding of any Medicaid GME program initiatives and the physician residency programs that carry them out, OHA strongly encourages the Study Committee to recognize the vital role hospitals play in the success of any program reforms. The association itself is committed to that success and intends to continue its work with member hospitals and health systems to reach consensus on long term goals.

As a necessary step to that consensus, OHA recommends the Study Committee endorse a two-phase process by which ODM can transition its existing Direct GME payment methodology to one that is more equitable and still reflects the significant and unique costs associated with a residency training program, while the Study Committee continues to investigate long term recommendations on ways to incent future programs in line with the goals of the Ohio General Assembly.

OHA also recognizes that any effort to reform Medicaid GME payments must be done in tandem with an updated recognition of all hospital-based teaching programs and the reorganization of the Medicaid prospective payment systems major teaching hospital peer group, PPS base rates and outlier payment methods. The major teaching hospital peer group should include hospitals with a significant number of interns and residents, both relative to the size of the institution and to the size of the training programs. Specifically, and as reflected in its discussions with ODM, OHA recommends the department adopt a major teaching hospital threshold that includes programs with at least 100 interns and residents, or a 0.35 ratio of interns and residents to inpatient beds.

As such, and with appreciation of the objectives set forth to the Graduate Medical Education Study Committee, OHA proposes the following two-phase strategy to reform Medicaid GME payments:

Phase I

- 1. OHA recommends ODM rebase hospital-specific GME add-on payments using data from the most recently available Medicaid and Medicare cost reports.**
 - a. Rebasing should be repeated on a routine basis, as defined in rule by ODM, to ensure the payment methodology recognizes changes in the size and scope of hospital teaching programs in a reasonable time after they occur.

2. **OHA recommends ODM develop a new Direct GME add-on payment methodology that utilizes a “per resident amount” approach, whereby a primary care per resident amount would be set higher than non-primary care per resident amounts for eligible teaching hospitals.**
 - a. The methodology should be budget neutral to ODM and include a transitional period built around reasonable limits of hospital-specific losses and gains.
 - b. Primary care should be defined in accordance with Medicare definitions of primary care specialties, including family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, and obstetrics/gynecology. OHA requests additional modeling be performed before recommending specific percentages of total direct GME payments assigned to non-primary care vs. primary care per resident amounts.
 - c. Primary care fellows should also be included, in accordance with Medicare’s formula for counting eligible residents.
3. **OHA recommends these reforms be implemented in time to affect payment for discharges occurring on or after July 1, 2016.**

Phase II:

1. **OHA recommends further study to determine the feasibility of creating supplemental direct GME payments for eligible hospitals based on:**
 - a. The number or percentage of high performing residents who end up practicing in Ohio for at least one year post-residency;
 - b. generally accepted measures of cost-effectiveness and program quality; and
 - c. the frequency of specific outpatient codes that clearly indicate a resident, intern or fellow treated Medicaid patients in a clinical setting.
2. **OHA recommends the establishment of new payment policies based on this study, provided such approaches are feasible.**
 - a. Such supplemental payments could be “carved-out” from the direct GME payment system and paid to hospitals via ODM and managed care plans in a lump sum, supplemental upper payment limit-type year-end payment.
3. **OHA recommends these reforms be implemented in time to affect payment for discharges occurring on or after July 1, 2017.**

OHA appreciates the opportunity to provide these recommendations for a transformative graduate medical education reimbursement system. While OHA acknowledges that its recommendations require additional effort on metrics and timelines, we remain committed to the creation of a mutually acceptable system and hope they are viewed by the Study Committee, ODM and OHT as

DRAFT MEMO CONTINUED P. 3
November 27, 2015

a workable road map towards a new program in which Ohio hospitals can continue to train the next generation of Ohio physicians with incentives that are properly aligned with the needs of a future healthcare delivery system.

Discussion Concepts Submitted by the Ohio Osteopathic Association for Ohio Medicaid Direct GME Payment Redesign November 2015

Current Conditions-create an imbalanced response with the least impact potential and greatest harm to stakeholders						
Decision-making	Allocation	Recipient	Reporting	Utilization	Outcome	
Ohio Medicaid direct GME funds re-allocated to: 1) Reward desired medical education choices and 2) Fund health transformation efforts aligned to state policy and 3) Respect existing conditions and the impact of change	\$100 million	Teaching hospital with GME (primarily academic health centers and larger community-based facilities)	IRIS	\$ Invested primarily in hospital-based GME programs	Produce physicians across a broad range of specialties who provide needed care to Ohioans	
Target Conditions-create a balanced response with the greatest impact potential and least harm to stakeholders						
	Allocation	Recipient	Reporting	Utilization	Outcome	Comments/Impact
	\$60 million	Teaching hospitals with GME programs	IRIS report	\$ Invested in hospital-based GME programs	Continue to produce physicians across a broad range of specialties who provide needed care to Ohioans (particularly those recognized as vulnerable populations)	Utilize a five year phase-in period intended to minimize impact upon hospital budgets

Notes	<p>Will require the creation of a floor and ceiling payment structure</p> <p>Must allow for an updated cost report and ongoing reviews and adjustments</p> <p>Will continue to favor higher payment to the larger academic health centers</p>	Teaching facilities will have the ability to access funds regardless of the type of GME programs offered, although the absence of programs in high need fields should have an impact upon payment	<p>The existing reporting structure should be utilized, but the inclusion of simple outcome criteria could be recommended in order to reward for performance</p> <p>The outcome criteria could follow existing Medicare performance metrics</p>	Maintain current configuration of training programs		<p>Some hospitals will see a decrease in Ohio Medicaid direct GME payment</p> <p>Some hospitals will see an increase in Ohio Medicaid direct GME payment</p> <p>Some hospitals will see no change in Ohio Medicaid direct GME payment</p>
	<p>Allocation</p> <p>\$30 million</p>	<p>Recipient</p> <p>Medical Schools</p>	<p>Reporting</p> <p># Of graduates entering high need fields in Ohio submitted annually</p>	<p>Utilization</p> <p>\$ Invested in clinical learning environment, innovative programming, and role modeling by desirable faculty</p>	<p>Outcome</p> <p>Investment by the medical schools into clinical learning environment (inclusive of GME) results in an increased number of graduates entering high need fields</p>	<p>Comments/Impact</p> <p>Five year phase-in period intended to allow for meaningful changes in medical school-hospital and medical school-physician relationships</p>
Notes		While this payment may initially favor certain schools, it must be assumed all of Ohio's medical	<p>Simple reporting structure aligned to policy</p> <p>Per graduate</p>	<p>1. Strengthen medical school-hospital relationships</p> <p>2. Strengthen</p>		Medical schools have the ability to invest directly in the clinical learning environment,

		<p>schools can achieve the desired outcome and a balanced payment will result</p> <p>The possibility of an equal number of graduates from each Ohio medical school entering a high need field must be considered</p>	<p>payment based upon entry into high need fields</p> <p>High need fields must be published and updated by Ohio Medicaid with advance notice and input from community of interest</p>	<p>clinical learning environment associated with high need fields</p> <p>3. Support role model in high needs fields</p>		<p>creating an opportunity to promote high need fields to students</p> <p>Some funds lost by hospitals in the re-allocations process are potentially regained through these relationships</p>
	Allocation	Recipient	Reporting	Utilization	Outcome	Comments/Impact
	\$10 million	Newly graduated physicians entering high need fields and practicing in Ohio (DO and MD)	<p># Of students precepted</p> <p># Of Medicaid patients treated</p> <p>Location of practice (high need preferred)</p>	\$ Invested in new graduates for teaching and quality care of Medicaid patients	Investment by the State into new graduates results in an increased number of graduates entering high need fields	
Notes		The enhanced payment must align to the five year phase-in period and be calculated to account for an increasing number of new physicians receiving the enhanced payment over time	<p>Simple reporting structure aligned to policy</p> <p>Formula:</p> <p># of teaching weeks x # of Medicaid patients treated x enhanced payment = annual payment</p>	<p>1. Increase teaching in high need fields through role models</p> <p>2. Increase payment to new graduates for five years in high need fields</p> <p>3. Promote quality care using of</p>		<p>New graduates entering high need fields are supported during a vulnerable period in practice (funds can be directed toward loan repayment)</p> <p>New graduates are encouraged to</p>

			<p>or</p> <p># of teaching weeks x enhanced payment = annual payment</p> <p>High need fields must be published and updated by Ohio Medicaid with advance notice and input from community of interest</p>	<p>Medicaid patients using established metrics</p>		<p>become active with teaching</p> <p>A teaching pool with needed and desirable competencies is created</p> <p>Needed services are provided to Ohio Medicaid patients</p>
Summary						
	<p>\$100 million program expense maintains budget neutrality</p>	<p>No single solution is applied to a complex problem</p> <p>Funds are now allocated to multiple recipients</p> <p>Funds are linked to teaching and patient care</p>	<p>Simple new formulas and use of existing data is intended to minimize burden upon end users</p>	<p>Available funds are spread across involved stakeholders and conditions are created for low risk, high reward investments toward stated goals</p>	<p>The likelihood of achieving State health transformation goals is increased</p> <p>Can be studied to promote best practices and treated as an experiment rather than a solution</p>	<p>New system is adaptable as change occurs and is designed for the intended outcome</p>

GRADUATE MEDICAL EDUCATION STUDY COMMITTEE PUBLIC HEARING

Testimony to be presented by Randall Longenecker MD, November 30, 2015

Given the marked disparity in GME funding for residency training in Ohio, as well outlined in the public notice for this meeting and in the press, and given that the current system inordinately disadvantages rural and small community programs, I feel compelled to testify on the behalf of rural communities who face significant physician workforce shortages across our state.

I was a family physician in small town Ohio for 30 years, 15 of those as program director for a rural residency in Family Medicine. I practiced and taught comprehensive FM, including obstetrics, and served a large Amish community as a part of my practice. I designed and implemented a rural training track residency – the Ohio State University Rural Program – and taught students and residents to be small town doctors. Over 12 years we graduated 17 family physicians, 75% of them to rural practice. 60% of those individuals had not even grown up in a rural community and prior to residency had had no intention of practicing in a rural place, let alone family medicine. Some of them, in the scramble for limited GME slots nationwide, simply wanted a residency. But after 3 years of practice under supervision in a rural community they were sold on the benefits of rural living and practice.

The OSU Rural Program closed in 2011, because of a lack of funding. Because the program was initiated in 1998, well after the last rebasing for Medicaid GME in the 1980's, our hospital received no Medicaid GME from the State of Ohio for the time the residents spent there. To add insult to injury the program was capped by the Balanced Budget Act of 1997, under Medicare GME, at 1.39 FTE residents for a 6 resident program. Over the years of the program, the Mary Rutan Hospital community Board, believing in the importance of the program to our community, had subsidized the residency program and residency practice as the community benefit and safety net primary care practice that it was, to the tune of \$100,000 per resident per year, but in the economic downturn of 2010 could no longer sustain that level of support.

Since 2011, two (2) more of Ohio's five (5) rural family medicine residencies active at the turn of the century have closed – the program in Wilmington closed in 2014, and now the program in Portsmouth, OH, has announced it's closing. The only 2 remaining rurally located programs, both of them osteopathic programs, in Athens and Lancaster are facing the expensive challenges of transition to the new ACGME accreditation system, and both are stuck with very low per resident amounts for state Medicaid GME.

I recommended in July of last year that Medicaid GME in Ohio be rebased in a way that addresses the workforce needs of rural communities. For those who may not know, Ohio has more people living in rural places than all but 4 states in the US. That surprises many people, because only 18% of Ohioans live in a rural zip code. But 18% of a big number is a big number, and Wyoming and Montana don't even come close!

I recommended to the committee a process and a formula that I believe would create a more equitable and nimble system of Medicaid GME, and that can change as needed from time to time to address our workforce priorities. At least in the case of ambulatory primary care resident training, it directs the money to the entity that is closest to the incurred cost of training and that can be held most accountable for its outcomes – to the residency program and teaching practice itself, rather than as a percentage adjustment to hospital revenue. This is consistent with State initiatives in other parts of this nation, follows the pattern set by the very successful federal Teaching Health Center GME program nationwide, and creates a more rational basis for the State's investment in graduate physician education.

I am aware of at least three efforts to increase rural training in Ohio for both medical students and residents – in rural communities in southeast Ohio, northeast Ohio, and west-central Ohio, through Ohio University, NEOMED, and Wright State. It makes sense. A rural residency provides an excellent backbone for medical student and other health professions education in rural communities. But the physician education components of these efforts are very unlikely to come to fruition without a predictable, equitable and accountable formula for State Medicaid GME.

Thank you for this opportunity to testify and for listening to my testimony.

Medicaid GME Advisory Group – Formula Proposal

Randall Longenecker MD

July 7, 2014; revised July 14, 2014; revised February 23, 2015; revised November 24, 2015

Premise/Assumptions

The proposal must be:

1. Revenue neutral
2. Community responsive – should be workforce need driven (as opposed to unqualified measures of demand which favor specialties over primary care), equitable, and strategic, in addressing "primary care and other generalist specialties of primary importance to rural and underserved communities."
3. Evidence-based, and not bound by historical cost report data, which is highly variable in amount, in quality, and in comprehensiveness; it should be aligned with plausible costs
4. Geographically equitable – fairness and justice demand a negotiated combination of the following approaches: “according to need,” “according to an equal share,” and/or “according to geography.”
5. Rational, easy to justify and promoting of accountability, e.g. follow the resident with money going directly to the residency program, not the hospital

Proposal (Generated by Dr. Longenecker, representing “rural” on the committee)

I recommend that GME be disassociated from hospital finance in order for it to be more nimble, more rational, and more accountable. I recommend instead that Ohio establish a funding consortium for GME (e.g. modeled after the Utah GME Consortium) that strategically distributes funds in a way that addresses workforce disparities in the manner described above.

I further recommend that payment follow the trainee and that it be made to the residency program or sponsoring institution as a direct and rational payment. This could be a teaching hospital or a teaching health practice¹ or practice group (e.g. a non-hospital setting such as a CHC, a health system, or a consortium), but would be specifically marked for resident education.

Proposed formula: (Trainees X Per Trainee Amount X Weighted Adjustments)

- #Trainees (FTE count of resident physicians in training)
In addition to patient care activity, I recommend allowing educational time, and activities devoted to quality improvement and population health)
- Per trainee FTE amount
This can be an arbitrary amount that takes into consideration (1) a historic cost base (which could be phased out over time, as the formula becomes more rational and related to true costs defined across the state, not per institution), (2) reasonable costs based on resident salaries and specialty-specific requirements for teaching faculty and staff, (3) “actual costs,” as reported for each institution, and (4) state resources. The last may be the most important, in assuring that the resulting formula is revenue neutral.

¹ A teaching health practice can be:

- An entity that has received payments under section 340H of the Public Health Service Act for a community based, ambulatory patient care center and that operates a primary care residency program, or a related teaching consortium recognized by the federal Health Resources and Services Administration.
- A separately incorporated community-based, independent medical education entity collaborating with three or more hospitals and/or medical schools in operating one or more primary care residency programs.

Adjustments, weighted for individual residency programs:

- %Medicaid (could be inpatient discharges if primarily a hospital, or outpatient E&M visits if primarily a primary care ambulatory practice, or a combination in association with a resident count in each setting)
- % primary care specialty training
Here I like the phrase “primary care (e.g. FM, General IM, General Peds) and generalist specialties of primary importance to communities and to population health (e.g. general surgery, OB-GYN, psychiatry, geriatrics, general and pediatric dentistry, and emergency medicine)”
- Place of training/geography - enhanced payment for rural and underserved areas of the state (“rural,” since rural areas that are not underserved have been shown to still produce compelling numbers of physicians who go on to serve in safety net settings²) For Ohio, the federally accepted RUCA³ score is the best measure of rurality.
- Primary care production @ 5 years following medical school graduation
This represents a more accurate picture of educational outcome and retention in primary care, and is a better accountability measure than the residency training discipline as such. Measurement at 1 year following resident graduation (generally this is only 4 years after graduation from medical school) is unduly impacted by “specialty” training, even in family medicine (e.g. a chief resident year, a fellowship in teaching, or even a fellowship in general geriatrics or women’s health). Many of these family physicians actually go on to serve in primary care practices in rural and underserved settings where traditional specialties are under-represented or cannot survive (e.g. a community may not be able to support 2 OB-GYNs, but could support another family physician with additional training in maternity care).

² [Rural Residency Training for Family Medicine Physicians: Graduate Early-Career Outcomes, 2008-2012](#), January 2013. (Accessed July 14, 2014)

³ Rural Urban Commuting Area <http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx> (Accessed November 24, 2015)



**Graduate Medical Education Study Committee
Testimony by Cindy Kelley, DO
Vice President of Medical Education, Summa Health
November 30, 2015**

Introduction

Chairman Moody and members of the Graduate Medical Education Study Committee - thank you for the opportunity to provide testimony and recommendations on how to improve how our state invests in training our physician workforce. My name is Dr. Cindy Kelley and I am a practicing family medicine doctor as well as the vice president of Medical Education for Summa Health. I was born in the community that I now serve, educated almost entirely within this state from kindergarten to medical school and even through my postdoctoral training. And now, I am proud to be leading the important work of educating the next generation of physicians and members of the integrated care team. Moreover, I am excited to be doing this within a system focused on maximizing the health of the community in which we live and work. In other words, my story and that of Summa is not too dissimilar from what the administration has articulated as their goals for this process: focus on investments in primary care and moving towards population health management, while recruiting and retaining the students and physicians in whom the state has already invested so much.

Summa's Story

At Summa, our graduate medical education primarily takes place within our faculty practice clinics, community-based clinics and our two community hospitals: Akron City-St. Thomas and Barberton hospitals. We train 250 residents and fellows across fifteen residency programs and seven fellowship training programs.

As a system comprised of community hospitals Summa is somewhat different than our academic medical center brethren. We train primary care doctors and specialists that seek training in community settings so that they are best prepared to treat patients and practice in a rapidly-evolving population health focused, value-based health care setting.

We have a long history of medical education excellence and innovation, especially in primary care. We offer in our Family Medicine Center much-needed programs such as long term opiate therapy designed to improve care of our chronic pain patients. Our residents work with pain management, psychologists, social workers, nurses, and embedded behavioral health care professionals for this population. We have presented our model at the state level and have also used it to inform discussions within the Governor's Cabinet Opiate Action Team discussions.

We also offer fellowship programs that are connected to the community we serve - two of particular importance to the state. Our Addiction Medicine Fellowship is an important



service to the community especially in Ohio with increasing opiate dependence and rising heroin use. Our women's health clinic, in which our Fellows serve, has seen a 400% increase in the number of opiate-addicted pregnant women in the last 4 years.

And Summa has the only Medical Simulation Fellowship between New York City and Chicago. We provide a myriad of training services to our community partners such as basic disaster and advanced disaster life support and hospital emergency response team training, something very few hospitals in the country offer. But we also have a HRSA grant for the interprofessional training of healthcare providers from a variety of different specialties done in conjunction with the department of Geriatrics and Palliative care. We even have created a series of simulation modules for pastoral care and our residents.

Recommendations

As I turn to offering Summa's recommendations, I would like first to call attention to the proposal offered by the Ohio Hospital Association. While understanding that change is both coming and needed for the Medicaid GME program, we believe it provides for a solid foundation from which to build any long-term solution. There are two items that we would like to emphasize:

1. Any solution should not be based merely on the number of residents a teaching program teaches and trains but should be primarily based on the number of Medicaid patients residents take care of.
2. Additionally, a new Direct Medical Education add-on payment methodology that utilizes a "per resident amount" approach and invests in primary care at a higher per resident amount than non-primary care per resident amounts is laudable. In doing so, the methodology should include a transitional period built around reasonable limits of hospital-specific losses and gains.

Graduate Medical Education as a Tool for Recruitment and Retention

So, what does GME mean to Summa, the city of Akron, and its surrounding communities? Akron, like many of its mid-size metro peers across the state, never appears on the top 10 of most desirable places to live. So we work hard to find the people who want to come there and are excited to learn and train there. In doing so many residents come to realize what a gem Akron is and want to stay and serve patients here. Medical education is one of, if not, the best recruitment tools we have to ensure we have the physician talent we need.

However, we are finding that it is becoming increasingly difficult to attract physicians to health systems in mid-size cities like Akron, let alone critical access and rural hospitals. In a recent Merritt Hawkins survey, sixty-two percent of residents said that they had received 50 or more job solicitations during the course of their training, while 46 percent



said they had received 100 or more job solicitations. The physician shortage that has been discussed for so many years will quickly be upon us and only exacerbated as the residents we train in Ohio look to go to another state. And in order for smaller health systems like Summa to recruit talented, recently graduated residents to communities like Akron, we need to innovate. Therefore, we would like to explore creating a model designed to recruit physicians to practice in rural and underserved areas, southeast Ohio or Small Metros – Toledo, Akron, Canton, Youngstown, Dayton and the like. At the conclusion of their residency, participants would be required to practice for no less than five years in a NCQA Level 3, Patient-Centered Medical Home, accept Medicaid patients, and have 50% or more of their payments in Medicaid be value-based.

Predictability in Rebasing

We also recommend ODM rebase per hospital-specific GME add-on payments based on the most recent Medicaid and Medicare cost reports as of December 31, 2015. This would eliminate some of the discrepancies that may have been created when a large number of Medicaid members under expansion had their enrollment terminated in 2015. It would encompass any hospital who filed their 2014 cost report in 2015 and make sure all hospitals and health systems are in the same calendar year, thereby creating consistency. We recommend the formula be rebased on a regular basis, perhaps every three to five years, thereby creating predictability in budgeting.

Stability in Transition - Stop-Loss, Stop-Gain

As we transition to a different reimbursement model for Medicaid GME, there will be winners and losers. While we agree with incentivizing the outcomes we hope to achieve, this should be accomplished as part of incremental change and a transition period. During this time, we can better understand the true impact to each residency program. Without this stability, we're making a big gamble regarding our ability to keep the commitments we made to our residents. For example, we are currently recruiting for eighty residents and have another forty who have at least four more years at Summa who could be negatively impacted by cuts in reimbursement. To make significant changes in funding could be harmful. Therefore we recommend no less than a 3-year transitional, stop-loss, stop-gain program.

Investing in the Building Blocks of Population Health

At Summa, over the next five years we will invest tens of millions of dollars in facilities plan aimed at supporting population health initiatives such as integrating our physical and behavioral health services. While it's a significant investment, our biggest and most important investment is in training our residents and interns. As members of our physician workforce, they will help us in our efforts to achieve the Triple Aim.

Prioritizing Primary Care

As we look at how to best invest in primary care we encourage the state to explore the creation of modifiers for the following specialties:



- Family Medicine
- Ob-Gyn
- Geriatrics
- Pediatrics – Specifically, General and Psychiatric; and
- Dental – at Summa, over 75% of our Dental patients are Medicaid or self-pay

However, the question of how to invest in general internal medicine residents is one that is perplexing. Many general internal medicine residents pursue a subspecialty and never deliver primary care –what we define as a practice that is either ambulatory or both ambulatory and hospital-based in nature. On average, only 15% of internal medicine residents practice general internal medicine. If the state’s goal is to invest in primary care might we create a formula by which we reward those programs whose internal medicine residents both go into primary care but also stay here in Ohio?

The potential to include general surgery and psychiatry as primary care or, at the very least areas of need, is something that bears further exploration. I have heard from many of my colleagues in smaller programs that general surgeons in rural and smaller hospitals oftentimes function in a primary care role and are difficult to recruit. And over 95% of the patients seen by our psychiatry residents are in the Medicaid program.

Alignment with PCMH and Accountable Care Organizations

In an effort to align medical education with the state’s efforts to invest in patient centered medical homes and move to value-based payment arrangements, we believe there is an opportunity for the state to recognize and reward health systems in which residents train in care settings where they tackle population health challenges. The state could do this by adding a modifier for residents who training in a PCMH certified as NCQA Level 3. This can be done on a cost-neutral basis. While early adopters and those systems who invest more in primary care will initially benefit the most, as more programs make this investment, the benefit to individual teaching programs will be less noticeable. However, the goal of the state to have more patients getting care from a physician in a PCMH will be more readily attained.

The Role of Fellows

If the state is to invest in residents who train as fellows, we recommend priority be placed on those in child psychiatry, geriatrics, palliative medicine, and addiction medicine as these have been identified as areas of need within the state.

Conclusion

While we encourage the state to approach the inevitable changes to the Medicaid GME program with care, we would also be remiss if we didn’t use this as an inflection point to begin to look at what graduate medical education could be. Perhaps with matching funds from OBR and Medicaid we could create a Medical Education Innovation Fund where we further develop comprehensive programs, in essence a pipeline to train and



retain medical students and residents and perhaps most importantly, help them land a job opportunity here in Ohio. Early exposure to health system education and meaningful clinical experiences are concrete ways that the medical schools and residency programs can collaborate, perhaps, regionally to realize the shared goal of training Ohio's future physicians. This Medical Education Innovation Fund can be targeted to performance-based GME demonstration projects that support programmatic outcomes in such areas as meeting areas of need for the state's workforce, promoting positive changes in population health, and delivering community-based care, whereby we encourage community-clinical linkages.

On behalf of Summa Health, thank you again for the opportunity to speak with you today about our recommendations for the future of the state's investment in medical education. We look forward to continuing to work with members of this committee as well as the administration in developing a funding system that encourages stability and predictability while prioritizing the training of physicians that will tackle the population health challenges our state faces.

APPENDIX D

Medicaid Direct Graduate Medical Education Formula Proposal

*Presented for discussion at the November 30, 2015 meeting of the
Graduate Medical Education Study Committee.*

*The members of the Committee agreed without dissent that this
proposal represents a promising starting point for future reforms.*

*They also agreed that explicit support would depend on being able to
review the fiscal impact models of the proposed option and the
implementation phase-in schedule.*

Medicaid Direct GME Formula Proposal
Draft for Discussion at Medicaid GME Study Commission
November 30, 2015

This is a proposal to change the formula for a substantial portion of the Medicaid Direct GME (DGME) add-on payment under Ohio Medicaid. This proposal is presented as a discussion draft for the Medicaid GME Study Commission that was appointed in the Fall of 2015 to advise the legislature on this issue. The current formula was designed in 1987 and has not been updated since that time.

The principles discussed at the first meeting of the Medicaid GME Study Commission included the following:

- **Most importantly, the proposal should provide incentives to teaching hospitals to produce physicians for the State of Ohio in primary and other “underserved” specialties**
- The proposal must be budget neutral
- The proposal should continue to pay the DGME payments as an add-on to patient care payments in order to preserve Federal draw-down funds for this purpose under the Medicaid program
- The proposal should take into account the current number of trainees at any given institution
- The proposal should provide greater “fairness” in the DGME dollars paid to Ohio teaching hospitals on a per resident basis
- The proposal should be based on data that can easily be collected through the Medicaid Cost Report either through currently collected data or through a new addendum to the cost report that Medicaid can create

The amount of funding for DGME under the Ohio Medicaid program for CY2014 was \$100 million. With Medicaid expansion in Ohio, that number will most likely continue to grow over time since the DGME payment is an add-on to the DRG payment for each Medicaid discharge for a teaching hospital. **This proposal would initially move one fourth of the total Direct GME payments to the new payment methodology – for the purposes of this example, \$25 million is used to represent one quarter of the total current Direct GME payments.** This percentage could increase over a period of five years to a 50/50 split between the current CMI-adjusted Direct GME formula and the newly proposed formula.

Although additional work needs done on details and data collection, the newly proposed formula would be structured as follows:

- **Step 1: Weighting GME positions based on specialty of program**

In order to incentivize teaching institutions to create more training positions in primary care and “underserved” specialties, the proposal would provide increased weights for primary care

(e.g., family medicine, pediatrics, OB/GYN, internal medicine) and underserved specialties (e.g., psychiatry, child/adolescent psychiatry, geriatrics, general surgery). Other specialty residency and fellowship programs would receive lower weights. The relative weights would be determined by a standing GME advisory body created by the legislature.

- **Step 2: Determine the number of actual trainees in each specialty at each teaching hospital**

Each teaching hospital would submit an annual report to the Department of Medicaid as an appendix to the annual Medicaid Cost Report which would outline each training position that rotates at that institution or is financially covered by that institution in the case of outpatient rotations. Rules for which positions could be counted would follow Federal Medicare rules so that positions where an institution covers “all or substantially all” of the costs associated with the trainees training could be counted by that institution.

- **Step 3: Determine the total number of “Weighted Positions” at each teaching hospital**

Using the weight for each specialty from Step 1, a total number of weighted positions for each teaching hospital would be calculated.

- **Step 4: Determine the proportion of “Weighted Positions” at each teaching hospital as a percentage of all “Weighted Positons” in Ohio**

Once all Cost Reports are submitted, the Department of Medicaid would determine the total number of weight positions for the state of Ohio. A proportionate percentage of all weighted positions in the state would then be calculated for each teaching hospital.

- **Step 5: Determine the estimated annual “Weighted Position Funding” for each teaching hospital**

In Year 1 of the new formula, the “Estimated Weighted Position Funding” for each teaching hospital would be total funding for “weighted position” (in this example, we are using \$25 million) multiplied by the percentage of all weighted positions in the state for that teaching hospital from Step 4. For example, if a hospital had 5% of all of the weighted positions and the total funding pool is \$25 million, the estimated annual “Weighted Position Funding” for that teaching hospital would be \$1.25 million.

- **Step 6: Determine the “Weighted Position Add-on Payment per Discharge” for each teaching hospital**

The “Estimated Weighted Position Funding” from Step 5 would be divided by the total number of Medicaid discharges for the previous fiscal year to determine the “Weighted Position Add-on Payment per Discharge” for each teaching hospital. For example, if the total estimated funding for the year from Step 5 is \$1.25 million and the hospital had 5,000 Medicaid discharges in the

previous fiscal year, the “Weighted Position Add-on Payment per Discharge” would be \$250 per discharge for that teaching hospital. In order to reflect difference in the complexity of patients seen by a teaching hospital as well as the share of uninsured and Medicaid patients seen, the add-on payment should also be modified by the average case mix index (CMI) for Medicaid patients and whether the hospital is a high DSH/“deemed” DSH facility based on those definitions.

- **Step 7: Actual annual reimbursement for each teaching hospital**

The actual total reimbursement received by any teaching hospital for the “Weighted Position Add-on Payment” for a given year would then be determined by the total number of Medicaid discharges from the hospital in the following fiscal year. For example, if the hospital being used in this example had 5,500 Medicaid discharges in the following year, the hospital would receive a total of \$1.375 million; if the hospital had 4,500 Medicaid discharges the following year, the hospital would receive only \$1.125 million.

- **Step 8: Impact on current Medicaid Direct GME Funding add-on payments**

In year 1, Medicaid Direct GME Funding add-on payments would be calculated as they have been in the past, but they would simply be multiplied by 0.75 to compensate for the fact that 25% of the funding for Direct GME will be paid under this new formula. In future years, if the ratio of Direct GME payments between the old formula and the proposed new formula were to change, this percentage would change accordingly.

Other issues to be discussed:

- Estimates of current weighted positions at each teaching hospital (see attached) are difficult to determine because this information is not currently submitted to the Department of Medicaid.
 - The best estimates come from the NRMP, AOA and San Francisco match programs which can tell us how many positions are “offered” at each GME sponsor.
 - However, some sponsors are not teaching hospitals and it is unclear at which hospitals those trainees rotate.
 - Also, many teaching hospitals send some trainees to other inpatient facilities to train (i.e., Children’s hospitals or other hospitals in the local area), so the estimates for those teaching hospitals with a count of positions may be over or under-estimates.
- The newly proposed formula is not case mix index (CMI) adjusted like the current DME and IME formulas. As noted in Step 6, additional weighting based on average CMI should be applied to the add-on payment.
- As noted in Step 6, the newly proposed formula should include an additional weighting factor for teaching institutions that are high or “deemed” DSH hospitals who take on a larger than usual proportion of uninsured or Medicaid patients.