



Tomorrow's Doctors, Tomorrow's Cures

Federal Funding of GME

Michigan Association of
Medical Education (MAME)

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Karen S. Fisher, J.D.
Health Care Affairs
AAMC

kfisher@aamc.org
202-862-6140

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Medicare Makes 2 Specific Payments With an "Education" Label

Direct GME Payments (DGME)

- Partially compensates for residency education costs

Indirect Medical Education (IME) Payments

- Partially compensates for higher patient care costs due to presence of teaching programs

DGME and IME Payments are Not Inconsequential

Estimated Federal Fiscal Year 2008:

DGME Payments	=	\$2.70 billion
IME Payments	=	<u>\$5.74 billion</u>
Total	=	\$8.44 billion

Source: CMS Office of the Actuary, July 2008

Medicare DGME Payments

What Are DGME Payments Intended to Cover?

Compensate teaching institutions for Medicare's share of the costs directly related to educating residents:

- Residents' stipends/fringe benefits
- Salaries/fringe benefits of supervising faculty
- Other direct costs
- Allocated overhead costs

Residents must be in approved programs

What is the Basic Methodology Underlying DGME Payments ?

- Step 1:* Determine hospital-specific per resident base year cost amount (generally 1984)
- Step 2:* Update (to current year) base-year per resident amount (PRA) for inflation
- Step 3:* Multiply the updated PRA by the number of residents in the current year (this amount capped by BBA resident limits)
- Step 4:* Multiple by the hospital's ratio of Medicare inpatient days/total days

Note: Teaching hospitals receive DGME payments associated with both FFS and managed care patients

Not Every Resident Counts the Same

Residents in their “initial residency period” (IRP) are counted as 1.0 FTE

Residents training beyond the IRP counted as 0.5 FTE

IRP determined at the beginning of the residency and DOES NOT CHANGE

--Must pay attention to specialties requiring a “preliminary year”

Physicians who decide to retrain in another specialty are counted as 0.5 FTE

More on Counting Resident Time

Can count all time in hospital complex (but not time spent in the medical school)

If meet the requirements, can count patient care time in nonhospital settings

Per Resident Amounts (PRAs)

In FFYs 94 and 95, PRAs updated only for primary care; frozen for other specialties.

- Consequently, PRAs for primary care residents are slightly higher than nonprimary care residents.

In 2002, PRAs for hospitals with low PRAs were raised to 85% of a “locality-adjusted” national average PRA.

Hospitals with PRAs greater than 140% of the national average receive no increases until 2014.

Medicare Only Pays Its “Share” of Resident “Costs”

Medicare Share * Per Resident Amount = Medicare Payment
Per Resident

40% x \$90,000 = \$36,000 payment per primary care
resident

40% x \$85,000 = \$34,000 payment per all other residents

(40% x \$85,000) ÷ 2 = \$17,000 payment for fellow

Medicare IME Payments

Medicare Payments with an Education Label: IME

Compensates teaching hospitals for higher inpatient operating costs due to:

- unmeasured patient complexity not captured by the DRG system
- other operating costs associated with being a teaching hospital (lower productivity, standby capacity, etc)

Percentage add-on payment to basic Medicare per case (DRG) payment

IME payments for managed care patients use “shadow” DRG claims

There also is a capital IME adjustment

Calculating the IME Adjustment Factor

The IME adjustment is based on statistical analysis using intern and resident-to-bed ratios (IRB)

% per case add-on =

$$\text{Multiplier X } ((1 + \text{IRB})^{0.405} - 1)$$

For FFY 2008, multiplier is 1.35

Short hand for IME: Hospitals get about a 5.5% increase in DRG payments for every 10- resident increase per 100 beds

Calculating the IME Payment

Step 1: Determine the IRB ratio:

Chicago Hope = 170 residents/ 666 beds = 0.255 = IRB
(Note: IME resident counts do NOT reflect weighted amounts)

Step 2: Use statistical formula and IRB to calculate IME%

$$1.35 \times ((1 + 0.255)^{0.405} - 1) \times 100 = \underline{13.00\%}$$

Step 3: Calculate the IME payment for each case

$$\begin{aligned} &(\text{Payment for DRG 547} \times \text{IME \%}) = \text{IME Payment} \\ &(\$31,321.91 \times 13.00\%) = \underline{\$4,071.85} \end{aligned}$$

Counting Residents for IME Payments

Cannot count time spent in PPS-excluded units (rehab, psych, SNF)

As of FY 1998, can count time in nonhospital settings if meet the requirements

Cannot count research or didactic time in hospital or in nonhospital settings

Keeping Track of IME and DGME Payments

Medicare hospital cost report:

IME payments: Worksheet E, Part A

DGME payments: Worksheets E-III parts IV and VI

Medicare Resident “Caps”

Medicare Resident Limits: 1997 BBA (P.L. 105-33, Sections 4621 and 4623)

Generally speaking, the number of FTE allopathic and osteopathic residents that a hospital may count for DGME and IME payments is limited to 1996 Medicare cost report count.

- Limits may be different for DGME and IME

The Medicare statute provides very few exceptions to the caps

Rural Teaching Hospitals

cap = 130% of 1996 count (BBRA)

cap can be adjusted for new programs

Rural Training Track Programs

Urban hospitals can get cap adjustment to accommodate first year of these programs

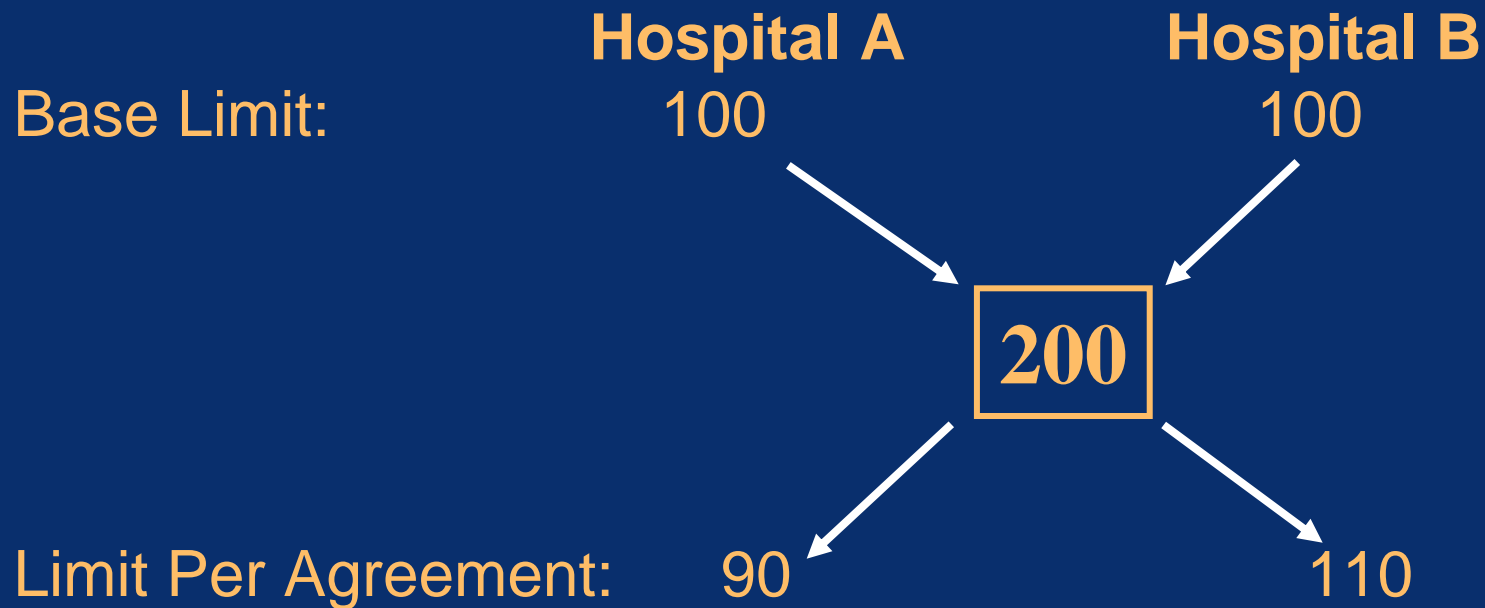
New Teaching Hospitals

Get 3 years to start any and all residency programs; cap attaches in 4th year

Medicare GME Affiliation Agreements

Temporary Adjustments Associated with Closed Hospitals and Programs

Resident Limit Aggregations: An Example



GME Payments Are Now Based on a Rolling Average

DGME and IME payments are based on a 3-year rolling average of resident counts

Dental and podiatry residents are included in rolling average calculations; residents from closed hospitals/programs are excluded

Rolling average is subject to resident limits

BBA intent was to lessen resident downsizing effects

How Does the Rolling Average Work?

<u>Year</u>	<u>Resident Count</u>	<u>Count Used for IME/DGME Payments</u>
2002	400	400
2003	400	400
2004	380	$(400+380)/2 = 390$
2006	370	$(400+380+370)/3 = 380$
2007	410	$(380+370+400)/3 = 383$

New Teaching Hospitals: Receiving DGME and IME Payments

Defining “new” teaching hospitals:

- Had no allopathic or osteopathic residents reported on most recent Medicare cost report ending on or before 12-31-1996 (42 CFR §413.79(e)(1))

Keys to receiving payments:

- Establishing the per resident amount (PRA) for DGME payments
- Establish resident caps (for both DGME and IME)

Establishing PRAs for New Teaching Hospitals

The PRA equals the LOWER of:

The new hospital's actual GME costs

OR

The average of the teaching hospitals in the same geographic wage area (if less than 3, then census region)

Once the PRA is established, it is permanent

Source: 42 CFR § 413.77(e)

New Teaching Hospitals: Establishing a Resident Cap

3 year window to establish the cap:

- Window starts when the hospital begins to train residents in the first NEW program started
 - relocating an existing program, or adding the hospital as a new training site for an existing program DOES NOT COUNT!
- Window closes at the end of the 3rd program year of the first new program started
- Permanent caps are effective as of the first day of the 4th program year of the first new program started

Source: 42 CFR §413.79(e)(1)

Establishing a Resident Cap: 3 Year Window, Cont.

Cap equals the sum, for all programs, of:

The highest number of FTE resident counts in any program year multiplied by the initial residency period, subject to the number of accredited slots for that program

- If a resident does a rotation at an existing teaching hospital, the new hospital cannot claim that time as part of the FTE count and the existing hospital CANNOT claim the new rotation as part of its cap

Remember, this calculation occurs in the 3rd year of the first program's existence

Source: 42 CFR § 413.79(e)(1)(i)

Counting Resident Time in Research and Didactic Activities

FY 2007 IPPS Final Rule: Counting Resident Time in Didactic Activities

Fundamental CMS position—didactic and research activities are not “patient care” and therefore:

- If occur in a nonhospital setting—must exclude time for both DGME and IME payments
- If occur in a hospital setting—exclude time for IME but not DGME payments

Current Medicare Policy

	Medicare Direct GME	Medicare IME
Training in a hospital	All approved activities (patient care, education, and research) are reimbursable	Only direct “hands on” patient care time is reimbursable
Training in a nonhospital setting	Only direct “hands on” patient care time is reimbursable	Only direct “hands on” patient care time is reimbursable

Examples of Didactic Activities for which the time would be excluded

Journal clubs

Classroom lectures

Grand rounds

Conferences

Etc.

Counting Resident Time in Didactic Activities, Cont.

August 18, 2007 final rule modification due to concerns about administrative burden of identifying and documenting didactic time: the “one day documentation threshold”

“as long as an entire workday is not scheduled for didactic activities, then for documentation purposes, that day may be recorded as spent in patient care activities.” (August 18 Federal Register at 48091)

Problem—CMS defines this narrowly and inconsistently

What Does this “One Day Threshold” Really Mean??

CMS will be issuing “clarifying” information, but in the meantime, some thoughts:

- How to keep track of day-long didactic activities when you have block/monthly rotation schedules
- If a hospital has rotation schedules that are less than a day, must exclude the didactic time
- If the hospital has monthly schedules, but FI “comes across” didactic time, the time will be excluded
 - But note that the rotation schedule is the “primary documentation” for supporting resident counts (72 Fed. Reg. at 48077)

Current Exclusion of Resident Time in Research

Nonhospital Settings—According to CMS, research time is not countable for either DGME or IME because does not meet the definition of “patient care activities”

Hospital Settings—

DGME—research time is countable

IME—“time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable.” (42 CFR 412.105(f)(iii)(B))

Medicare Payments Resident Training At Nonhospital Sites

Payments for Residents in Nonhospital Settings: Background

Hospitals may include residents training in non-hospital settings in their resident counts as long as the hospital pays “all or substantially all” of the training costs at that site and the resident spends their time in patient care activities.

Applicable for both DGME and IME (since FY 1998) payments

The Medicare DGME/IME Nonhospital Site Final Rule

Published in the Federal Register (as part of the long term care hospital final rule) on May 11, 2007

Effective with cost reporting periods beginning on or after July 1, 2007

Regulatory Definition of “All or Substantially All”

Before 1999: resident's stipends and benefits

1999-2007: “residents’ salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians’ salaries and fringe benefits attributable to direct graduate medical education”

July 1, 2007: “at least 90 percent of the total of the costs of the residents’ salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians’ salaries attributable to direct graduate medical education”

Payments for Residents in Nonhospital Sites, Cont.

Big Issue:

- How does the hospital deal with Volunteer Physicians?

Secondary Issue:

- How does the hospital determine physician “supervisory costs”?

Determining Physician Supervisory Costs

Before—Physician’s salary and the “percentage of time he/she devotes to activities related to non-billable GME activities at the nonhospital site.” (CMS April 2005 Q and A, No. 5)

Final Rule—Current method **OR** National average salary data (per specialty) and presumption of 3 hours of supervisory time per week

Note: Supervisory costs do not need to be calculated if resident(s) is/are training with a solo practitioner

Determining Physician Supervisory Costs— How Does the Alternative Methodology Work?

Example—resident training entire year at a family practice clinic and is being supervised by one teaching physician:

1. National median FP salary (AMGA) = 178,366
2. Nonbillable supervising time = 3/60 (time clinic open per week) = 5%
3. Supervisory cost = $\$178,366 * 5\% = \$8,918$

Note: If resident spends less than a year at the nonhospital site, prorate accordingly

How is the 90% Threshold Calculated?

1. 90% (residents stipends and fringe benefits (including travel and lodging where applicable) + nonbillable supervisory costs

2. Previous example, cont.

Residents salary and fringe benefits = \$60,000

Physician supervisory costs = \$8,918

$90\% * (\$60,000 + \$8,918) = \$62,026 = 90\% \text{ Threshold}$

3. $\$62,026 - \$60,000 = \$2,026$

Summary: If the hospital incurs the resident stipends and benefits, it would also have to pay the nonhospital site \$2,026 in physician supervisory costs to meet the 90% threshold

Resident Stipends and Benefits

Hospitals must take into account the actual stipend and fringe benefits for each FTE resident that trains in the nonhospital site, which may vary by resident.

Malpractice does NOT count as a fringe benefit

If you don't like the 3 hour supervision proxy . . .

The teaching physician may complete two separate 2-week time studies (or a 1 week time study if the teaching physician supervises residents for the equivalent of a month or less during the academic year).

Requirements for Written Agreements

Must be in place between the hospital and nonhospital site before the training begins.

State that the hospital will incur at least 90% of the total of the resident's salary and fringe benefits (and travel and lodging if applicable) and the portion of the cost of the teaching physician's salary attributable to nonpatient care direct GME activities.

Specify the total cost of the training program at the nonhospital site and the amount (90%) that the hospital will incur.

Indicate the portion of the 90% amount that reflects the resident's stipends and fringe benefits and the portion that reflects teaching physician compensation (if there are teaching costs).

Determining What Needs to be Paid

The hospital needs to determine up front the amount it must pay to meet the 90% threshold

- Whether a hospital opts to enter into written agreements or opts to pay concurrently (i.e., by the end of the 3rd month following the month in which the training in nonhospital site occurred).

If residents in more than one specialty program are rotating to the same nonhospital site, the 90% threshold must be determined separately for each program.

Global Agreements Between Teaching Hospitals and Schools of Medicine

Statement that includes a global payment is not sufficient

According to CMS, without a breakout of the residents' costs and the teaching physician's costs, the FI is unable to determine whether the hospital has properly paid the costs of each specialty training program at each nonhospital site.

Nonhospital Sites Owned by the Hospital

According to CMS:

If teaching physicians are paid a salary by the hospital and they teach residents in the hospital and in the nonhospital sites owned by the hospital, the hospital is already paying the teaching costs.

However, hospital still must demonstrate that it is paying 90% of the costs

Can use either written agreement or concurrent payments

- NEW: If use written agreement, it need not specify the total amount of costs the hospital will incur, and what costs are included in that total amount

The hospital would need to demonstrate that it is paying 90% of the costs of the training program by actually paying the nonhospital site through the hospital's accounts payable system. (If the hospital and nonhospital site share a single accounting system, the hospital could demonstrate payment of the nonhospital site training program costs using journal entries that expense these costs in the hospital's GME cost center and credit the nonhospital site.)

What if the hospital is over its resident cap?

“[A] hospital may choose not to pay for the costs relating to the training of residents in a nonhospital setting if it is training FTE residents in excess of its caps, and there, would also not include those FTE residents training in nonhospital sites in its FTE counts.”

“[A] hospital may only claim residents training at nonhospital sites on its cost report if the hospital would, in the absence of the FTE caps, be permitted to count those FTE residents for direct GME and IME payment purposes, even if those residents would be over its caps.”

Other Issues Associated with the Nonhospital Final Rule

The physician supervisory cost percentage is capped at 7.5%

Hospitals are allowed to modify their agreements with nonhospital sites up until the end of the academic year (June 30) to accurately reflect 90% threshold calculations

Group practices and salaried members—presumption of supervision costs