Overview of Graduate Medical Education Reimbursement

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GME Finance Information & Workshop

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General Overview

- Medicare has participated in the costs of medical education since the program's inception in 1965.
- The IME add-on payment and DGME payment methodology were introduced in the 1980s and have been evolving through legislation ever since.
- BBA of 1997 had a major impact on the IME/DGME rules by setting "historic caps" based on residents training at the hospital in 1996, among other changes.
  - This has led to the delineation between "old" teaching hospitals and "new" teaching hospitals

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What is a New Program?

- CMS's regulation defines a "new medical residency training program" as one that "receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." 42 C.F.R. § 413.79(1).
- Just receiving initial accreditation by ACGME is not enough for the program to be considered "new" though; instead, a program must be "new new"

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What is a New Program?

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DGME

- The purpose of DGME payments are to help compensate hospitals for their direct costs related to the teaching program, such as salaries and benefits for residents and teaching physicians as well as administrative and overhead costs.
- **Basic formula:** *PRA* x *FTE count* x *Medicare patient load*
- DGME is cost reimbursed for the first cost report when residents are not on duty the first month of the cost reporting period. The first full year is the base year for the PRA.
- Paid on a pass-through (similar to Medicare bad debts)

Per Resident Amounts

- Per Resident Amount (PRA) – this is hospital specific, and for new teaching hospitals it is set by the lower of their actual DGME costs per resident or the weighted average of PRAs for surrounding teaching hospitals. Once set in base year, it is updated annually for inflation.
- There can be separate PRAs for Primary care & Non-Primary care residents
- *Example*: The weighted average PRA for teaching hospitals in Rural MS (CBSA 25) for FY 20 is roughly $96,200
- Hospitals in CBSAs with less than 3 teaching hospitals may be compared to the average census region PRA (MS is in East South Central)

Do My Expenses Impact Reimbursement?

- *It Depends…*
- If you have a FYE other than 6/30, the first cost report with residents will be cost-reimbursed, so properly capturing expenses is crucial.
- The first cost report that residents are there for the full year will be used as the base for your PRA, so capturing expenses on Lines 21 and 22 of worksheet A is also very important.
- After the PRA is set, it is still important to capture your expenses, but it will not impact reimbursement going forward. GME costs should be excluded from operating costs, thus it is still important to record them on the proper lines of the cost report.

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FTEs

- Weighted FTE count – Residents in their initial residency period (IRP) are counted as 1.0 FTE and residents beyond their IRP are counted as 0.5 FTE.

- *Examples of residents paid at 0.5 FTEs for GME:*
  - Fellows
  - Residents who switch specialties mid-training
  - Residents who train longer in the program than set time frame
- 3-year rolling average applies

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Medicare Patient Load

- Medicare Patient Load – Medicare inpatient days/total inpatient days
  - Includes Routine, ICU(s), Rehab, Psych
  - Excludes Nursery
- There is also a separate calculation for Medicare Managed Care
  - Shadow billing HMO claims (both acute and subprovider) is important for your reimbursement

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E-4 Worksheet

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			303.93	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			2.73	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-4.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			302.66	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			448.24	6.00
7.00	Enter the lesser of line 5 or line 6			302.66	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	141.02	265.21	406.23	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	95.22	179.07	274.29	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		47.09		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	95.22	226.16		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	100.09	229.55		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	96.18	234.04		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	97.16	229.92		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	97.16	229.92		17.00
18.00	Per resident amount	89,786.38	89,786.38		18.00
19.00	Approved amount for resident costs	8,723,645	20,643,684	29,367,329	19.00

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E-4 Worksheet

					1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)				25.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)				145.58	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)				22.66	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)				105,630.87	23.00
24.00	Multiply line 22 time line 23				2,393,596	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)				31,760,925	25.00
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	24,339	7,985	7,193		26.00
27.00	Total Inpatient Days (see instructions)	122,906	122,906	122,906		27.00
28.00	Ratio of inpatient days to total inpatient days	0.198029	0.064968	0.058524		28.00
29.00	Program direct GME amount	6,289,584	2,063,444	1,858,776	10,211,804	29.00
29.01	Percent reduction for MA DGME		7.00	7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		144,441	130,114	274,555	30.00
31.00	Net Program direct GME amount				9,937,249	31.00

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Change Request 11642

- Just as Medicare pays for the Medicare Advantage portion of IME/DGME, it also pays for an MA add-on for Nursing and Allied Health. It funds this through a reduction in GME payments.
- Until recently, the reduction to pay for the add-on was 14.13%.
- CR 11642 was released in August 2020 with updates to the MA pool, factors and percent reduction to GME for 2002-2018.
- MA GME reduction factor will be 7% until a future change request is released.
- This ultimately benefits providers with GME programs, but has negative impacts on NAH add-on payments, so both must be weighed to determine final impact on providers.

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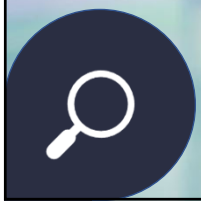
DGME Example

- Assumptions
  - Hospital A is a 6/30 FYE provider with a new Family Medicine program. They have 6 residents rotating at their hospital in the first year of the program, and all rotations were at their hospital.
  - Cost per resident is $150,000, but average PRA for CBSA 25 is $96,200
  - Total Medicare Days = 18,500; Total MA Days = 5,000
  - Total Days = 30,000



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DGME Example

Residents in Initial Years of Program			6.00
PRA			$ 96,200
Approved Amount of Resident Costs			**$ 577,200**
Computation of Medicare Patient Load			
	Inpatient Part A	*Managed Care*	
Program Days	18,500	5,000	
Total Days	30,000	30,000	
Ratio	0.616667	0.166667	
Program GME amount	$ 355,940	$ 96,200	
Percent MA reduction		7%	
GME reduction for MA		$ (6,734)	
Net Direct GME Payments			**$ 458,874**

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IME

- IME payments are made to help with any indirect costs associated with having a teaching program, since teaching hospitals typically have higher patient care costs. This is because teaching hospitals generally treat patients with more severe illnesses and incur additional unquantifiable costs (residents ordering extra tests, standby requirements for certain units, etc.).
- **Basic formula:** *IME Multiplier x [(1+IRB ratio)$^{0.405}$ -1]*
- IME Multiplier – this is set by Congress. Currently it is 1.35.
- Multiply the product of the above formula times total DRG Payments and Managed Care Simulated Payments.

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Intern-and-Resident-to-Bed Ratio

- Intern & Resident-to-Bed (IRB) ratio – 3-year rolling average of unweighted FTE count divided by number of beds.
  - Take available bed days and subtract observation equivalent days. Then divide by # of days in cost reporting period.
- Compare current year IRB to prior year IRB and use the lower of the two.
- Residents in Initial Years of Program are not subject to 3-year rolling average.

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Counting Beds

- 42 CFR 412.105(b) "For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period."
- Excludes:
  - Beds in unit or ward that is not occupied to provide acute care level of care at any time during the 3 preceding months
  - Beds in a unit or ward that is otherwise occupied that could not be made available for inpatient occupancy within 24 hours for 30 consecutive days
  - Beds in excluded distinct part hospital units
  - Beds otherwise countable used for outpatient observation services, skilled nursing swing-bed services, or inpatient hospice services
  - Beds or bassinets in the healthy newborn nursery
  - Custodial care beds

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Counting Beds

- How to go about counting beds:
  - Floor plans
    - Do a walk through of the hospital
  - Average Daily Census
    - May can provide a guide on areas to look at closely
  - State Bed licenses
  - Renovation, capital and strategic plans
- Bed counts can have a big impact on IME payments not only in current year, but in future years
  - Prior Year RTB ratio limitation

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E, Part A

4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	445.75	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	294.65	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	2.73	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	-4.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	293.38	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	452.74	10.00
11.00	FTE count for residents in dental and podiatric programs.	56.52	11.00
12.00	Current year allowable FTE (see instructions)	349.90	12.00
13.00	Total allowable FTE count for the prior year.	353.15	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	355.43	14.00
15.00	Sum of lines 12 through 14 divided by 3.	352.83	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	352.83	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.791542	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.787578	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.787578	21.00
22.00	IME payment adjustment (see instructions)	16,120,073	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	8,927,310	22.01

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Operating IME Example – Initial Years

- Assumptions:
  - Hospital A is a 6/30 FYE provider with a new Family Medicine program. They have 6 residents rotating at their hospital in the first year of the program, and all rotations were at their hospital.
  - DRG payments for the FY were $25m and Managed Care simulated payments were $12m
  - The hospital has 175 routine and ICU beds and had 6,000 observation equivalent days during the FY

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Operating IME Example – Initial Years

Bed Days Available:	
Routine	54,750
ICU	9,125
Less: Observation Equiv Days	(6,000)
	57,875
# of Days in CR Period	365
	158.56
CY Resident-to-Bed Ratio	
FTEs	6.00
Beds (from above)	158.56
RTB Ratio	**0.037840**
PY Resident-to-Bed Ratio	
FTEs	6.00
Beds (From PY Calc)	157.50
PY RTB Ratio	**0.038095**
Lesser of CY or PY	0.037840

1.35*(1+(.037840)^.405)-1		
IME Percentage		0.020461
Operating FSP	$	25,000,000
Managed Care Simulated Payments	$	12,000,000
Operating IME	$	511,520
Managed Care IME	$	245,529
Total IME	$	757,049

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Capital IME

- Similar to Operating IME payments, Capital DRG payments also have an add-on for IME payments
- **Formula:** $2.71828^{(.2822 \times (FTEs/ADC))} - 1$
- FTEs are same as used in Operating IME equation
- ADC = Total Patient Days (Excluding Nursery, SWB, & Subproviders) divided by Number of Days in the Year

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Worksheet L

	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	3,558,414	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	234,068	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	335.81	3.00
4.00	Number of interns & residents (see instructions)	377.83	4.00
5.00	Indirect medical education percentage (see instructions)	37.37	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	1,329,779	6.00

Capital IME Example

- Assumptions:
  - Same Program as IME above (6 FTEs)
  - Total Patient Days = 30,000
  - Capital FSP = $2.5m

Total Patient Days	30,000	
# of Days in Year	365	
ADC	82.19	
# of FTEs	6.00	
Number of residents	6.00	a
Average daily census	82.19	b
	0.073	a/b
	0.0206006	Times .2822
	1.020814243	2.71828 to the cell above power
	0.020814243	Minus 1
Capital IME Percentage	**2.08%**	
Capital FSP	$ 2,500,000	
Capital IME Payments	**$ 52,036**	

FTE Caps

- Originally, there was no limit to the number of residents a teaching hospital could receive Medicare reimbursement on.
- BBA of 1997 changed that, and existing programs were capped at the number of allopathic & osteopathic residents on the hospital's most recent cost report ending on or before 12/31/1996.
  - IME & DGME have separate caps due to different rules surrounding FTE counts.
- No caps for dental or podiatry residents

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FTE Caps

- New Programs
  - Hospitals that trained no FTE residents in 1996 and later start "new" programs may establish a cap.
  - Programs started after 10/1/12 now have 5 years to "cap build"
- Number of Accredited slots – cap cannot exceed the total slots the program is accredited for

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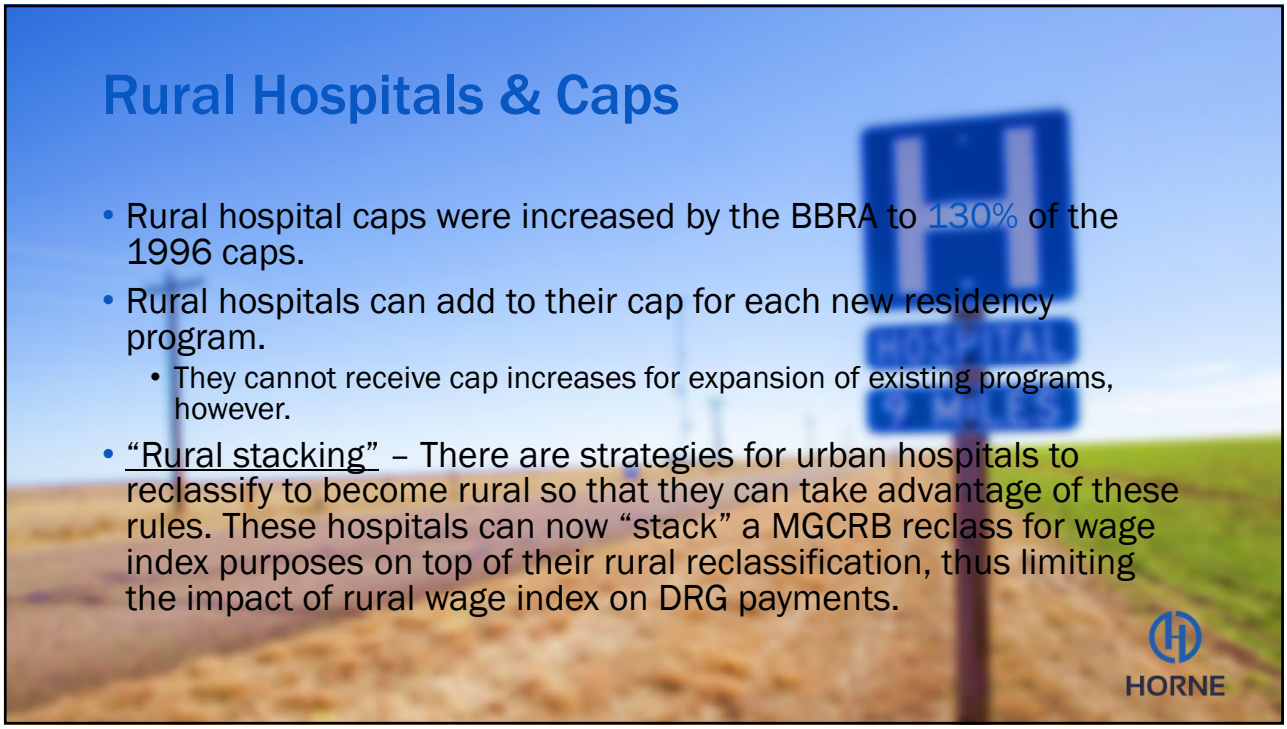

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Affiliation Agreements

- CMS does allow hospitals to enter into Medicare GME affiliation agreements.
- Teaching hospitals in the affiliated group can share the FTEs in a zero-sum arrangement (i.e. the positive FTE adjustment to one hospital is offset by a negative FTE adjustment at another).
- The agreements must be for at least one year and be received (signed & dated) by CMS by July 1 of the program year.

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Affiliation Agreements

- Affiliated groups do have some restrictions
  - The hospitals must have a shared rotational arrangement, and one of the following:
    - Located in the same or contiguous CBSA
    - Under common ownership, or
    - Jointly listed as the sponsor, primary clinical site or major participating institution for one or more programs
- Special rules for urban new teaching hospitals as of July 1, 2019
  - May now loan slots to other urban new teaching hospitals
  - May now loan slots to other existing teaching hospitals at least 5 years after FTE cap is established

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Other Ways to Add to Your Cap

- ACA Section 5506 – Preservation of Resident Cap Positions From Closed Hospitals
  - Higher rankings given to hospitals who took over closed program, who were in GME affiliation agreements with closed hospital and hospitals who took in the displaced residents
  - Priority also given to hospitals in same or contiguous CBSA, followed by those in same state, and those in same region
- Section 126 of Consolidated Appropriations Act 2021
  - 1,000 new Medicare-funded GME positions (200 per year) beginning in FY 2023
- Future legislation
  - Chatter of more FTE slots being added through Infrastructure bill

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Rural Training Tracks

- RTT programs are an opportunity for urban hospitals, rural hospitals, and nonhospital clinical settings to partner together and train residents to practice in rural areas.
- RTTs are one of the few ways an urban hospital can add to their cap.
- More than one-half of a resident's training must occur in a rural area in order for the urban hospital to be eligible to receive payments for residents in the RTT (up to their RTT cap).
- Previously, rural hospitals could not join an existing RTT program and add to their cap; must participate in establishing a new one instead. Section 127 of CAA 2021 changes that.
- Regulations surrounding RTTs can be found at 42 CFR §413.79(k)

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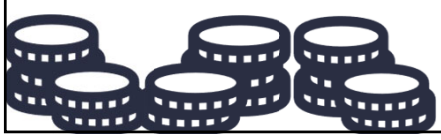
Teaching Health Centers

- The THCGME program, administered by the Health Resources and Services Administration (HRSA), provides funding to increase the number of primary care medical and dental residents training in community-based settings across the country.
- They can be located in FQHCs, RHCs, CMHCs, IHS health centers or other outpatient clinics.
- Since funded by HRSA, cannot double dip and also receive CMS funding; however, there are still cost report implications to consider



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Nursing & Allied Health

- Approved nursing and allied health education programs operated by the provider. (Separate from graduate medical education)
- Common N&AH education programs include training for dietetic interns, nurse anesthetists, occupational therapists, pharmacy residents, X-ray technologists and hospital chaplains.
- These costs are separately identified and "passed through" (that is, paid separately on a reasonable basis). Reimbursement is based on the Medicare share of those costs.
- Existing regulations on nursing and allied health education program costs are located at 42 CFR 413.85.

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Current COVID Waivers Impacting GME

- Increases in beds = less IME
  - Bed counts frozen as of Jan 26, 2020
  - 42 C.F.R. § 412.105(d)(1) – "excluding beds temporarily added during the time frame that the Public Health Emergency as defined in §400.200 of this chapter is in effect"
- Flexibility with Affiliation Agreement deadlines
- Counting Resident time

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Current COVID Waivers Impacting GME

- Teaching Physician Supervision
  - Requirement for the presence of a teaching physician can be met through direct supervision by interactive telecommunications technology, thereby giving teaching physicians the option to be physically present or present through interactive telecommunications technology during the key portion of the service.
- Moonlighting
  - Rule changed to allow moonlighting in the inpatient setting of hospital where they train (this has been made permanent).

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Current COVID Waivers Impacting GME

- Physician Time Studies
  - One Week time study every 6 months (2 weeks/year)
  - Use time studies from CY 2019
  - Use time studies in cost report period prior to Jan 27, 2020

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Questions?

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