# Medicare GME Payments – Background and Basics

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But any errors or misstatements are our own!

**Residency Program Solutions March 2018**

AMERICAN ACADEMY OF FAMILY PHYSICIANS

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# Part 1: Medicare GME Payments - Background and Basics

- understand the purposes and processes involved in Medicare GME payments to hospitals and thus to residency programs
- determine how much money any hospital in the US received in Medicare GME payments each year
- avoid common pitfalls in claiming Medicare GME payments and pursue strategies to maximize payments and avoid adverse Medicare audit judgments
- Medicaid and state support
- DSH



# Part 2: Medicare GME Hot Topics– Q & A with a CMS staffer and a call to reform!

## Many slides are for reference only…

- History
- Detail and clarification on technical rules



## Poll Question

How many times have you heard Lou and/or Kent give some version of this talk at RPS or PDW?

1. Never – I'm a newbee!
2. 1-3 times before
3. 4-8 times before
4. (Almost) every year since 2000!

# Poll Question

You are a…

1. Program director or Associate PD
2. Other faculty physician
3. A resident
4. A nurse
5. A residency coordinator/administrator
6. A hospital or health system administrator



# Poll Question

You come from

1. An established FM residency
2. A rural program in the planning stages
3. An urban program in the planning stages
4. A hospital
5. Other

# Hospital $$ Data

## You Can Find Out What Your Hospital(s) Got

- Graham Center Data Tables for Family Medicine
  - 2000-2015 hospital payment data including PRAs and resident FTE counts
  - http://www.graham-center.org/online/graham/home/tools-resources/data-tables.html
- CMS data from 2010 through now (constant updates)
  - link actually works as of Jan 2017!
  - http://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Hospital-2010-form.html
  - Scroll down to HOSPITAL-2010-REPORTS.zip and click on that to download
  - When unzipped there will be an IME-GME folder with a .csv file (open in excel) for each year starting 2010 through now



# Medicare Civics Lesson

- Congress passes laws
- CMS writes regulations with annual updates ("final rule"). Proposed final rules have comment period.
- Hospitals submit cost reports annually (often with consultant help)
- Medicare Administrative Contractors (MAC) (= "Intermediaries") process hospital cost reports, interpret regulations, and do audits. Regional variation in auditing.
- Audits final ~3 years after submission
  - then you find out what the rules really were!

# CMS Mission ?

- Mission IS:
  - Interpret laws
  - Write regulations
  - Enforce regulations
  - Detect and punish rule breakers
  - Provide quality cost effective health care services to Medicare and Medicaid beneficiaries.
- Mission ISN'T
  - To support the development and maintenance of a rational cost effective new physician workforce
  - To adjust rules to complement ACGME rules
  - To analyze GME outcomes or recommend legislative changes to congress
  - To make exceptions to rules for the purpose of the greater good



# CMS is the largest funder of Graduate Medical Education on the planet

- With no inherent overall control of costs (an entitlement system)
- No specific educational outcomes or workforce goals
- Attaching GME funding to Medicare was supposed to be temporary… until a more coherent responsible comprehensive funding mechanism took its place.

## Why the overall Medicare GME system is bad

- CMS likes to interpret legislation narrowly – to deny new teaching hospitals (especially rural) access to the system and to limit payments "in the spirit of the cap" while being required to run the program as an entitlement.
- Intermediaries are actually paid more if they can deny claims.
- Thus the proliferation of "gotcha" rules invented and then applied several years after cost reports are filed
- Tying GME payments to claims made by hospitals and providing all payments to hospitals creates multiple problems:
  - Much of GME does not happen in hospitals
  - Paying hospitals assumes (often wrongly) that the hospital will "pass through" the money to the residency program. The hospital has almost no obligation to do so.



## So what IS the current system (FY starting 7/1/2010 or later)?

# GME Payments Made Up Of

- DGME (Direct GME Payments)
- IME (Indirect Medical Education Payments)
  - Including capital IME
- Medicaid GME
- Other Insurance GME Support (VA System)
- State 'Line Item' Support or Grant Support
- Possibly DSH (Disproportionate Share)



# What Is DGME?

- Direct GME (DGME) is the amount Medicare pays the hospital for Medicare's share of the direct cost of the residency
  - Resident salaries, faculty teaching, administration, building maintenance, personnel, etc.

# How Is DGME Calculated ??

- Base year (or regional average) **per resident amount** (PRA) established specific to each hospital
  - Example
    - $41,484 per FTE resident 1984
- Updated for inflation (CPI-U) with different inflationary adjustments for primary care residents vs. others
  - Example
    - $102,875 primary care; $100,956 other res. 2017



# More DGME Calculations…

Total FTE residents (up to CAP) sorted by primary care (PC) and other (NPC), discounted if some are beyond initial eligibility period

- Example
  - $102,875 *55 PC FTE = $5,658,125
  - $100,956 *165 NPC FTE = $16,657,740
  - Aggregate total DGME “cost” = $22,315,865

# More DGME Calculations…

Determining **Medicare's share** of total DGME based on proportion of inpatient days

- Medicare inpatient days = 52,560
- Total Inpatient Days = 175,200
  - Now includes OB inpatient days but NOT "Observation" days
- Medicare's share = 52,560/175,200 = 30%
- $22,315,865 *30% = **$6,694,760**



# DGME - The Base Year Is (Was) Vital!

- Medicare determines a "new" hospitals PRA by using the lower of
  - claimed expenses in base year (1st full year with GME claim on cost report) vs.
  - FTE weighted average PRA (separate primary care and non-primary care) of all current teaching hospitals in CBSA
    - or "updated average census region PRA" if <3 teaching hospitals in metropolitan CBSA.
    - Special issue with rural hospitals if >=3 rural hospitals in STATE already have PRA (see advanced talk)
  - Details in appendix and likely discussed in "advanced" talk with CMS staffer. Also advanced talk describes avoiding "zero PRA" when taking outside residents in a "virgin" teaching hospital.
- ALL subsequent years DGME reimbursement is tied to the base year PRA
  - make sure your base year costs equal or exceed the comparison PRA

# A PRA is set "when the first resident walks into the hospital"

- A hospital HAS TO claim any resident who is providing care as part of planned rotation even if the hospital has no costs or doesn't want to claim the resident.
- If the hospital doesn't claim the resident and it is determined later that they should have… CMS sets their PRA to zero (= no DGME $ forever) and a cap clock might also have been started for that hosp. Still would get IME… but the cap might also be low (if resident from new program).
- See part 2 talk for more on this…



# Who counts as a "Primary Care Resident" for DGME claims?

- family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, and obstetrics/gynecology
- No… this is not always the same as other definitions of "primary care" used by the federal government.

# What the "Per Resident Amount" (PRA) is and isn't

- It IS
  - A CMS defined term. Caution because it is used with very different meaning in other contexts (e.g. the THC program, the IOM report)
  - A set figure for a given hospital. Can vary widely depending on local/regional comparisons and windfalls or errors made in base year cost reports (or "zero PRA" errors).
  - The figure that sort-of approximates the direct costs of a residency if Medicare paid for ALL care in a hospital.
  - On average underestimates the direct cost of a residency
  - Is always DISCOUNTED to Medicare's share of care in calculating the DGME payment
- It is NOT what hospitals get paid per resident FTE!



# Average Census Region PRAs in 1998 are updated by CPI-U, NOT recalculated each year

| | states | FY 1998 | Dec 2013 |
|---|---|---|---|
| New England | CT, ME, MA, NH, RI, VT | $ 69,696 | $ 99,874 |
| Mid Atlantic | NJ NY PA PR | $ 92,567 | $ 132,649 |
| S Atlantic | DE, DC, FL, GA, MD, NC, SC, VA, WV | $ 62,513 | $ 89,581 |
| EN Central | IL, IN, MI, OH, WI | $ 67,120 | $ 96,183 |
| ES Central | AL, KY, MS, TN | $ 59,619 | $ 85,434 |
| WN Central | IA, KS, MN, MO, NE, ND, SD | $ 70,212 | $ 100,614 |
| WS Central | AR, LA, OK, TX | $ 55,240 | $ 79,159 |
| Mountain | AZ, CO, ID, MT, NV, NM, UT, WY | $ 60,697 | $ 86,979 |
| Pacific | AK, CA, HI, OR, WA | $ 68,652 | $ 98,378 |

# Why DGME is a bad system

- What does “Medicare’s share” have to do with the cost of resident education? Many rural hospitals have more Medicaid (e.g. maternity care) than Medicare.
- Why is the PRA so variable and set in such a variable manner? Why are hospitals rewarded for high pre-1996 claims (e.g. NY state) while some hospitals are chronically punished for conservative claims on cost reports >20 years ago or get a low (even zero) PRA through no fault of their own?
- Using 1998 data freezes in any regional disparities – then inflates this.
- Why is the national average PRA (assuming Medicare paid 100% of actual residency costs) so much lower than actual average residency costs?
- Why does the PRA calculation not take into consideration the specialty specific cost of a residency? A residency/fellowship cash cow (e.g. a procedure heavy program) gets counted as needing the same funding as a less “productive” program (e.g. primary care, psychiatry, geriatrics, etc.)



# What Is IME ??

- Indirect Medical Education (IME) payments are a calculated percent added to each DRG payment from Medicare. Hospitals with more residents per bed get a higher percent added to their DRGs (0 to over 40%)
- As of fiscal year 2002, hospitals were able to recover full credit for IME associated with Medicare capitation (Medicare Advantage plans) = Medicare “Part C”.
  - Basically a “dummy” DRG $ amount is added in for each service provided under capitated Medicare.
- Total IME usually about doubles DGME (wide variation)

# Theory of IME

•Theoretically IME payments cover hospital's "excess costs" of care due to residents' inefficiency (more tests, longer LOS) and sicker patients and "more advanced technology" at teaching hospitals.



# Reality Of IME

- IME makes up for the absence of medical education payments by other payers
- IME supports the whole out-of-control and expensive indigent care system in many localities
  - (e.g. New York City, Boston)
  - 1/5 of teaching hospitals receive 2/3 of IME payments

# Reality of IME?

The Medicare Payment Advisory Commission (MedPAC), a group that advises Congress, estimates that indirect payment levels may be $3.5 billion (~50%) higher than actual “indirect costs” (higher cost of care with teaching program)



# Reality of IME

FP resident care of patients is probably NOT more expensive than care by non-teaching FPs. Internal Medicine resident care probably is.

- Tallia AF. Swee DE. Winter RO. Lichtig LK. Knabe FM. Knauf RA. Family practice graduate medical education and hospitals' patient care costs in New Jersey. Academic Medicine. 69(9):747-53, 1994 Sep.
- **This can be shown locally at your hospital** by comparing FM teaching service DRG specific length of stay (LOS) and costs vs IM teaching service or community FM or hospitalist LOS and costs.

# So...

- **We (FP residencies) should get the IME money**
- However… recognition that care costs themselves might not be (or should not be) higher in teaching hospitals jeopardizes the continuance of IME - especially at the current rates.



# How is IME calculated?

- 1. Counting "IME" Residents (up to cap)
  - Ex: 200 FTE res countable for IME (vs. 240 for DGME)
- 2. Counting Beds: staffed beds.
  - Exclude: well baby beds, psych/rehab beds, custodial care beds, ambulatory surgery beds
    - NEW in 2004 rule: more detailed rules about counting beds sometimes used for observation or swing beds.
  - Include: Med/Surg beds, Newborn ICU
    - New in 2012 rule: count labor/delivery/postpartum beds
  - Ex: 600 beds

# more IME Calculation:

- 3. Calculate Intern Resident Bed ratio (IRB).
  - Ex: 200 res / 600 beds = 0.30 IRB
    - Note that IRB increases lag for one year:
      - IRB used in formula is the smaller of current year's IRB vs prior year's IRB
      - Somewhat delays "advantage" of decreasing number of beds (thus higher IRB) in terms of boosting IME payments
      - hospitals that add a new residency use a different IRB comparison method for IRBs (see appendix)



# more IME Calculation:

- 4. Find the "formula multiplier" for the year
  - pre 1997 was 1.89 corresponding (roughly) to 7.7% add on per 0.1 IRB
  - Starting 1999: multiplier 1.6 corresponding to 6.5% add on per 0.1 IRB
  - Starting 2003: see next slide…

# More IME Calculation

| Fiscal Year | Multiplier | % add on |
|---|---|---|
| 1999-2002 | 1.6 | 6.5% |
| 2003 | 1.35 | 5.5% |
| 4/04-9/04 | 1.47 | 6.0% |
| 2005 | 1.42 | 5.8% |
| 2006 | 1.37 | 5.55% |
| 2007 | 1.32 | 5.35% |
| 10/07on | 1.35 | 5.5% |



# more IME Calculation:

- 5. The magic formula for IME:

$$\%addon = multiplier * [((1 + IRB) \uparrow 0.405) - 1]$$

  - Excel:=mult*(POWER((1+IRB),0.405)-1)
  - For our sample hosp in 2017 = 1.35*(POWER((1+0.3),0.405)-1) = 15.1%
  - In 2002 that same hospital got 17.9% added onto each DRG payment.

# more IME Calculation:

- The %addon is then added on to EVERY DRG the hospital claims from Medicare for that year.
- It does NOT matter if residents were involved in any of this DRG billed care.
  - Example: A hospital bills a lot of DRGs for Medicare hip replacements none of which involve residents caring for these patients. The IME add-on applies…



# Sample hospital in 2017 gets…

- Total DRG (including capitated Medicare) claims for 2002 were $94,000,000. Times 15.1% =
- $14,194,000 in IME payments
- $ 6,694,760 in DGME payments
- $20,888,760 total Medicare GME payments

- = ~$87,000 per resident (for ~30% Medicare share)

# Why IME is a bad system

- There is VERY high variability in IME payments per region and per hospital. Some based on historical factors (caps) and most based on variable Medicare DRG volume. This has nothing to do with residency costs.
- The fundamental basis (residents increase care costs) is – or should be – nonsense. ALL specialties need to teach residents cost-effective care strategies. Having residents providing care 24-7 should actually decrease length of stay. "Non-teaching hospitals" often have the same advanced (costly) technology.
- Admit that a national strategy for funding resident education should be based on actual program costs and either involve ALL payers (not just Medicare) or be funded with no reference to "Medicare's share" or DRG volume which often has nothing to do with resident training.



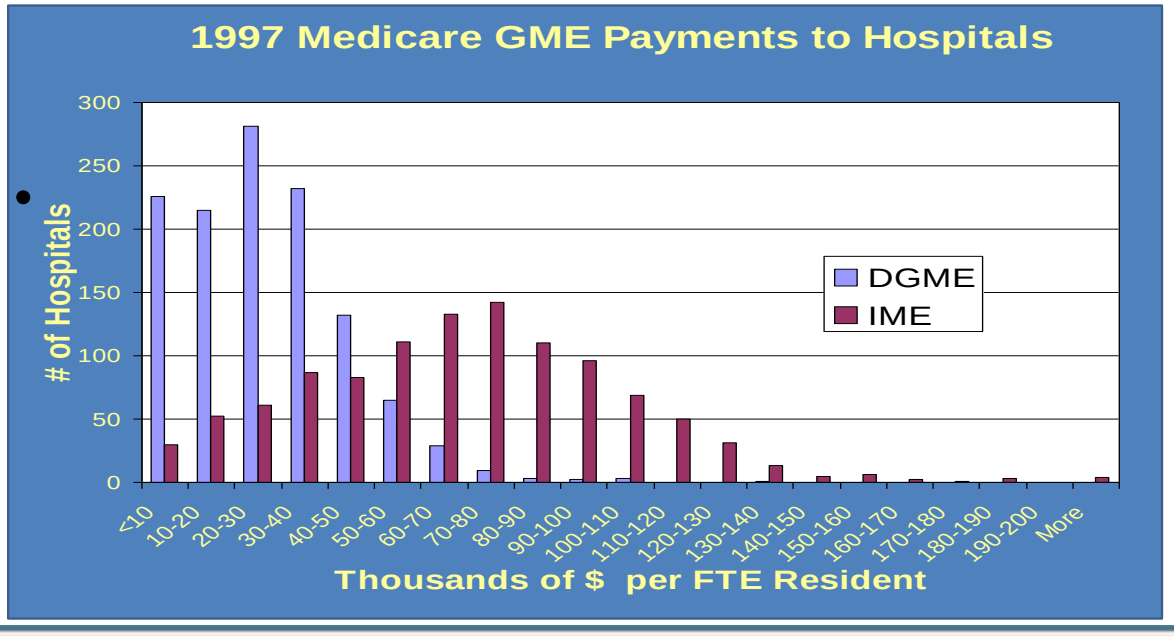
# How much money is this?

1997 per FTE resident:

| | Low * | High * | Average |
|---|---|---|---|
| DGME | $13 | $101,000 | $25,135 |
| IME | $700 | $190,000 | $63,717 |

* hospitals with at least 8 FTE residents

Total ~$6.8 billion for whole US in 1997,
$9-11 billion per yr since 2002.






# The AAFP Policy Center Analysis

- Graphic Proof of a Sadly Broken System
  - Average Total GME Per Resident $33,445 in LA
  - to $143,644 in RI
  - Within California Family Medicine Programs Approximately $50,000 to >$170,000/Res
  - One NY Program over $215,000/Res
- It takes a courageous sponsor to carry the red ink associated with $33,445/Res, and a foolish administrator to shut a NY State 'cash cow'

# CAPS

- Resident FTE Caps
  - IME and DGME FTE counts capped separately
    - "old" (pre 1998) hospitals have IME caps lower than DGME caps because old counting rules
    - "new" hospitals FTE counts DGME=IME in general
  - Redistribution – 2006 and 2010 so far



# Terms: Old, new, rural, urban

- "Old hospitals" have base year, PRA and caps in place.
- "New hospitals" are hospitals that have never had a resident do a formal "preplanned" rotation in the hospital or the hospital's clinics. Thus they shouldn't have claimed Medicare GME on a prior cost report. First FULL year that GME is claimed is the "base year".
- "New programs" are residencies with a new ACGME number that have not yet been claimed on ANY hospitals cost report. "Newness" now lasts 5 years.
- "Rural hospital" is an official designation by CMS – not always obvious from the apparent location of the hospital.

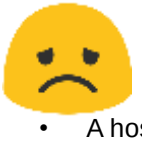
# Can this cap be increased?

| | new rural hospital | new urban hospital | old rural hospital | old urban hospital |
|---|---|---|---|---|
| **new program** | YES - 5th year rule | YES - 5th year rule | YES - 5th year rule (if new program) | NO - unless new program is an RTT. |
| **old program** | No cap but does trigger PRA | No cap but does trigger PRA. | NO but special rules if old hospital closing | NO but special rules if old hospital closing |

**5th year rule:** cap set using 5th year cost report based on max # res in one class during that year (e.g. 5 PGY-2s x 3 = 15 cap)

**New hospitals before Oct 2012 had just 3 years**





# Why the current CAP system is a bad idea

- A hospital can decide it is more lucrative to close (or never start) some residencies (e.g. primary care) in favor of more lucrative residencies and fellowships (e.g. procedural programs). How does that serve the national interests?
- A hospital system can finagle a way to move cap slots between "sister" hospitals far across the country in search of more profits – and close programs to accomplish this. How does this serve local/regional interests?
- As an "entitlement" system an urban community with no GME can build a very large multi-hospital GME system with a high cap fully funded by Medicare. The specialty mix of that system may have nothing to do with state/local needs for physicians. This is happening particularly in urban communities with new medical schools.
- Small community and rural hospitals are particularly vulnerable to getting small caps (and often zero PRAs) assigned due to participating in rural rotations for new urban residencies. Many have this problem stemming from rotations in the late 1990s.
- Why are we capping the things we want to grow (rural, primary care, etc.)? CAPs were from the "doctor surplus" era. Currently we have increased medical school graduations by >10%

# ACA rule changes

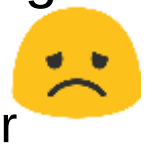
- Kinder and gentler:
  - Counting patient care time in nonhospital sites - **just have affiliation agreement and pay resident salary and benefits**
  - Counting didactic time – must occur in a patient care setting (hospital or clinic – more "audit proof" if in hospital)
  - Counting vacation/leave: any absence (vacation, sick time, jury duty, voting…) that doesn't extend residency training can be counted on cost reports.
  - Apportioning time between hospitals – reasonable method (no double counting)
  - Hospitals with "not settled" old cost reports can apply to use new rule definitions.



# ACA rule changes

- Slot (Cap) redistribution program (2010)
  - unused slots and closed hospitals.
  - very complicated rules and priorities used
  - "section 5503 of ACA"… in Pennsylvania section 5503 is criminal charge disorderly conduct!
  - Winners and losers in 2011:
    - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html
    - Under "downloads" see section 5503

# Cap Redistribution effective in achieving congressional goals?



- 2005-6 redistribution was supposed to favor rural hospitals.
  - <3% of redistributed positions went to 13 rural hospitals (out of 304 hospitals)
  - 68% added slots went to non-primary care increases
  - 32% to “primary care” (including OB Gyn and all internal medicine)
  - Chen C, Xierali I et al. The Redistribution of GME Positions in 2005 Failed to Boost Primary Care or Rural training. Health Affairs 32, No 1 (2013), 102-110



# Cap Redistribution effective in achieving congressional goals?

- 2010 redistribution more stringent criteria - ? Different effect. Nope.
- Cap redistribution (unused slots) will only happen in future if congress mandates it. ?? if that will happen and ?? the effect.
- The coming crisis in “unused cap slots” from hospitals with DO-only programs if those programs lose accreditation.
  - Most of these programs are in primary care

# Affiliation Agreements

- The regs: "§413.78(g) for direct GME and at §412.105(f)(1)(ii)(E) for IME require that the hospital must **either have a written agreement** with the nonprovider setting, **or the hospital must pay** for the costs of the stipends and fringe benefits of the residents **concurrently** during the time the residents spends in that setting."
- Concurrently?
- So… best to have affiliation agreements



# Hospital cost-report claims for residents' patient care time

- **A hospital MUST claim:**
  - Any time a resident spends on a formal residency rotation caring for patients in that hospital or its provider based clinics.
  - Regardless of whether the hospital incurs ANY costs associated with that rotation time.
  - Having residents rotating at your "virgin" hospital will likely trigger a PRA (and possibly a cap clock if resident from new program) even if your hospital does not claim the resident on it's cost report. PRA then likely will be set at zero – no DGME ever.
- **A hospital CAN claim:**
  - Any time a resident spends on a formal residency rotation caring for patients in a non-hospital ambulatory care setting
  - As long as it has an affiliation agreement and pays the salary and benefits of the resident for this time. Payment can be direct to the residents (as employees) or payments to the residents' employer.
- **A hospital CAN'T claim:**
  - Patient care time spent at another hospital or its provider-based clinics
    - That includes time spent at a Critical Access Hospital
  - Patient care time spent at a non-hospital ambulatory care site where the hospital did NOT pay resident salary and benefits.
  - Patient care time spent out of the USA
  - Strictly "research" rotations not involving patients being cared for by the health system
  - Non-educational weeks that extend a residents training program duration (e.g. most parental leave)

# Affiliation Agreements

- Many need better (simpler!) affiliation agreements, and letters of agreement (LOA) need to be redone with the elimination of the 'Volunteer Faculty' rule – hopefully already done since ACA is now "ancient history"
- This has been the recurrent area of great vulnerability during Medicare audits
- No 'standardized models' or clear 'safe harbor'–
- Main assertion is that residents time is spent as official part of residency, caring for patients (or educational conferences) and hospital that claims GME is paying cost of residency salary and benefits.



# Affiliation Agreements– Key Medicare GME Issues

- Agreement is between hospital (which will claim resident) and non-hospital* site where resident will spend time caring for patients under supervision of physician as part of the resident's formal curriculum. Both parties assert that hospital is paying 100% of resident salaries and benefits for all residents' time in non-hospital site
- Payments must be made
  - * A "provider-based clinic" is considered part of the hospital. Next slide…

# "Provider based clinics"

- Many hospitals operate clinics either physically in the hospital building(s) or free standing many miles away.
- Hospitals are often a part of a larger health care organization which may operate clinics that are - or are not -"owned" by the hospital. So… not obvious from sign on the building if clinic is "provider based"
- For Medicare GME purposes it matters a lot if a clinic is - or isn't -"provider-based"



# More on "Provider based clinics"

- A "provider-based clinic" is run by a hospital, patients usually getting both a professional charge and a facility fee charge.
  - A resident on rotation at a provider-based clinic is counted as working in the hospital that runs that clinic. The resident CAN'T be claimed for that time by another hospital.
  - A resident doing an official rotation at a provider-based clinic owned by a "virgin" hospital can seriously affect the future of that hospital as a teaching hospital. See "zero PRA" risk slides in this talk and advanced talk.
- A "non-provider based" clinic can have a LOA with one or more hospitals that would allow resident time at the clinic to be claimed by whichever hospital pays the resident's salary and benefits for that time.

# Counting Residents: *IRIS*



## IRIS (Intern Resident Information System)

- Must work closely with the reimbursement analyst to provide accurate rotation information
- Must be sure to accurately account FPC time on rotations outside the sponsor's institution (for fractional IME payment)
- Must keep appropriate paper trail for 'office rotations'
- Try to make 'away' rotations 'outpatient'
  - » (maximizes IME recovery by sponsor)

# Medicaid GME

- Yes it does still exist! (was in decline… but many states are reviving giving matching funds advantages)
  - 3.2 billion in Medicaid GME funding vs 9.7 billion Medicare GME funding in 2009
- Ask your hospital reimbursement specialist about what your state does.
- AAMC Medicaid GME survey by Tim Henderson (most recent 2016)
  - Sometimes hard to find most recent publication. As of Jan 2018 this link worked: **https://nosorh.org/wp-content/uploads/2016/02/Data-and-Medicare-Expansion-Tim-Henderson-Medicaid_GME_2015_Data.pdf**
  - Or contact Merle Haberman, Association of American Medical Colleges, at mhaberman@aamc.org, or Tim Henderson, health workforce consultant, at TimMHend@aol.com



# Medicaid GME

- Attractive to states because federal matching funds come through Medicaid program so states can double or triple the money available for new Medicaid programs (including GME) beyond what the state appropriates.
- There is, however, an upper payment limit on federal matching funds so in some states there may be no room to leverage new state GME funding through this mechanism without diverting matching funds from other programs.

# Medicaid GME 2015 selected "data"

- the overall level of support for GME continued to grow, **reaching $4.26 billion**. This represents a significant increase since 1998, when Medicaid GME support totaled $2.3–$2.4 billion.
- Across states, GME payment amounts varied widely, ranging from about $1.64 billion in New York to $73,500 in Hawaii. 8 states report no Medicaid GME payments.
- Combined, the 20 states with the lowest levels of Medicaid GME funding represented just 5 percent of total support
- two states—California and Massachusetts—ranking in the top 10 for number of teaching hospitals and medical residents reported no payments under Medicaid for GME
- Across the US Medicaid accounts for 19 percent of state general fund expenditures. State and federal Medicaid spending has more than doubled in the past decade, estimated at over $512 billion in FY 2015. Although Medicaid enrollment growth is expected to slow in FY 2016, total enrollment is predicted to reach 79 million by 2023.



# Disproportionate Share Payments (DSH)

- DSH funds preserve access to care for Medicare and low-income populations by financially assisting the hospitals they use.
- DSH payments are concentrated in relatively few hospitals. More than 95 percent of all DSH payments go to urban hospitals, and about 250 hospitals receive one-half of all DSH payments. Teaching hospitals received $3 billion in DSH payments in 1997, or about two-thirds of all DSH payments.

# Disproportionate Share Payments (DSH)

- DSH often more than total IME and DGME
- DSH may be seen as part of the overall positive impact the residency has on the hospital:
  - –Offsets the "**adverse payer mix**" the residency may have by virtue of caring for more medicaid and uninsured patients
  - –Residency clinic patients may actually push the hospital over **threshold** to get *any* DSH (e.g. Medicaid maternity care).
  - –"**service to the poor**" may be part of the core mission of the hospital



# In summary…

- Close communication needed between residency program and hospitals' reimbursement specialists
- Know what your hospitals are getting
- Maximize your hospitals claims for GME and protect them from audit vulnerability
- Get the money… include DGME, IME, Capial IME, Medicaid GME, DSH in the conversation.

# Poll Question:

Enter your email address to be included in any follow-up communication from the presenter(s).



# Questions?

# Please…

Complete the session evaluation.


Thank you.



# Appendices

- Useful web sites
- History of the Medicare GME system
- Initial eligibility rules (e.g. taking residents transferring from other specialties' residencies)
- Capital IME
- Children's Hospitals
- 4 year FM residencies
- Rolling average FTE count
- New residencies impact on IRB
- Expanding residencies – options given the cap rules

# Useful Web Sites

- Federal Register
  - https://www.archives.gov/federal-register/the-federal-register/indexes.html
- Section 1886 Social Security Act (early 1980s)
  - http://www.ssa.gov/OP_Home/ssact/title18/1886.htm
- CMS web pages (many links here, see IME, DGME, DSH on left)
  - http://www.cms.hhs.gov/AcuteInpatientPPS/



# More Useful Web Sites

- Medicare Claims Processing Manual (Pub. 100-4)
  - E&M code rules, teaching supervision requirements http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf
- CMS Regional Offices and Intermediaries (“Contractors”)
  - http://www.cms.hhs.gov/RegionalOffices/
  - http://www.cms.hhs.gov/ContractingGeneralInformation/Downloads/02_ICdirectory.pdf
- AAMC:
  - http://www.aamc.org/advocacy/gme/
  - Excellent booklet: “Becoming a New Teaching Hospital – AAMC – 2012 Guide to Medicare Requirements”

# Brief History - Federal GME Funding

- Pre-1983
  - Cost based reimbursement by Medicare: Hospitals submitted costs of residency training as part of costs of operating the hospital (the "cost report").
  - Medicare paid "it's share"
  - Wide variation and limited cost control
- 1983 DGME and IME invented (TEFRA 1982)
  - Developed at the time DRG/ PPS was implemented in 1983
  - Split into Two Payments
    - DGME (Cost based on residency training costs only)
      - PRA established for each hospital based on 1983 claims
    - IME (Premium Added to DRG Payment)



# Brief History (Cont.)

- 1986 base year (1984) PRA limit invented.
  - DGME modified by COBRA 1986 to include a PRA (per resident amount) formula with PRAs for new teaching hospitals set at lower of base year costs claimed or "locally adjusted national average PRA", rules different now…
  - Base year fiscal '84 plus "inflation" adjuster
  - "initial residency period " defined with 50% discount DGME thereafter
- 1993 divergence in how specialties handled:
  - Primary care good: CPI inflation adjuster limited to Primary Care plus Ob/Gyn
  - Primary Care bad: Limit placed on total years of training for full reimbursement (yrs. to first board eligibility)
    - FM is 3 years, General Surgery is 5 years…

# Brief History (Cont.)

- 1997 (BBA) THE MOTHER LODE
  - CAPS: resident FTE (DGME and IME separate Caps), IRB Caps (actually a lag process)
  - IME now claimable for time in non-hospital settings
    - But IME FTEs capped by prior rules - usually lower than DGME FTE #
  - rolling average FTE counts
  - managed care Medicare credit
  - FQHC sponsorship (little used)
  - new vs old and rural vs urban hospitals.
  - "all or substantially all"… with ongoing modifications/interpretations



# Brief History (Cont.)

- 1999 (BBRA) 70% PRA floor, some rural relief
- 2000 (BIPA) 85% PRA floor
- 2003 (MMA) teacher payment rules, 140% PRA ceiling (sort of), IME lowered to 5.5% as of FY 2008
  - Set off years of chaos over "volunteer" physician payment.
- 2010 (ACA) removes teacher payment rule, establishes THC program

# Laws (alphabet soup)

- Tax Equity and Fiscal Responsibility Act (TEFRA) 1982
- Consolidated Omnibus Budget Reconciliation Act (COBRA) 1986
- Balanced Budget Act (BBA) of 1997
- Balanced Budget Refinement Act (BBRA) of November 1999
- The Benefits Improvement and Protection Act (BIPA) Enacted 12/00
- Medicare and Medicaid Reform Act (MMA) of 2003
- Patient Protection and Affordable Care Act (ACA) 2010
  - "Obamacare"



# Goals(?) Of BBA, BBRA and BIPA and MMA and ACA

- Cut Costs
- Be Fairer
- Do Good Things (Rural, Primary Care)
- Minimize Large $ Shifts (Preserve the System)
- Clarify Rules and Soften the Fall of IME
- These "goals" conflict with each other…

# Counting Residents: Initial Eligibility

- Core programs:
  - 3 years:  FM, IM, Peds, ER, Nuc Med, Path
  - 4 years: Med-Peds, Anesth, Derm, Neurology, OB, Ophth, Rehab, Psych, Urology
  - 5 years: all other Surgical specialties, Rad Onc, Dx Rad, Child Neurology
- Special issues:
  - +2 years added if transferring into Geriatrics or Preventive Medicine fellowship or residency
  - Rotating Internship period of 100% eligibility set by specialty field of 2nd year of training



# Initial Eligibility continued

- For Medicare DGME purposes, a resident can be counted 100% during the initial eligibility period, then only 50% beyond that.
  - So if you start in Peds and after 1 year transfer to FM the FM program will get to count you 100% for 2 years but then only 50% for DGME after that.
- IME  for residents is NOT discounted – continues at 100%
- Fellows:
  - A fellow in ACGME accredited fellowship gets counted 50% for DGME and 100% for IME.
  - A “fellow” in non-accredited fellowship is not counted at all for DGME or IME purposes.

# Capital IME payment

- Teaching hospitals also receive an IME payment associated with Medicare's capital PPS.
- Make sure you ASK your hospital what they get!
- This payment is based on a slightly different formula and uses residents-to-average daily census (RADC) rather than the IRB to measure teaching intensity.
  - ***Adds 4-5% to total IME payment***.
  - Unsure how long this will last



# Children's hospitals don't have many Medicare patients, so…

- Children's Hospital Graduate Medical Education Payment Program (CHGME) established in 2000
- Provides funding for residency training in free-standing children's hospitals using similar DGME, IME, caps and counting methods used by "grown up hospitals".
- Subject to annual appropriation (like Title VII)
- If your residents rotate at a Children's Hospital… then only that hospital can claim their time there.
  - They should be paying resident salary and benefits ... But are under no obligation to do so
- Is a FIXED amount of $ nationally (if hospital X gets more, hospital Y gets less)

# Four year FM Residency claims reduce usable DGME cap

- There is a 50% discount for each resident after 36 months (FM initial training period set at 3 years).
- This 50% discount is applied to actually reduce the usable cap for DGME!
- The smoking gun: Form CMS-2552-10 worksheet E-4 PART A "Computation of Total Direct GME Amount" line 9.00.
  - Year 0 IRB recalculates as 22/80=0.275 but now Year 1 IRB calculates as 22/70= 0.314. The smaller is used from recalculated Year 0 (0.275) but note it is not as small as the original Year 0 IRB of 0.25.



# Example of four year residency usable DGME cap loss

- 8-8-8 program with DGME cap 22 (over cap by 2)
- Converts to 6-6-6-6 program, when mature:
  - Claims:
    - Unweighted FTE residents 6+6+6+6 = 24
    - Weighted FTE residents 6+6+6+3 = 21
  - 21/24 = 87.5% is applied to DGME Cap
  - 87.5% x 22 = 19.25 is max DGME FTE count that will be paid for this year. Loss of 1.75 FTE from 3 yr program.
  - Thus mature 4 yr programs all lose 12.5% of cap FTE's worth of DGME payments each year.

# Four year residencies can take solace from other positive financial effects:

- DGME is usually << IME
- IME is not discounted
- Clinic billings by PGY-4s may more than make up the difference
- Shifting some PGY-4 rotations to away hospitals would decrease the PGY4 DGME discount
- The rules may change granting >3 years for initial training in FM



# Rolling Average Resident FTE count

- Once the current year's resident FTE count for DGME and IME is determined for the hospital then CMS uses the rolling average of FTE counts from the current and past 2 years in calculating what it will actually pay for the current year.
- Example: IME FTE count is 200 for 2003, 190 in 2002 and 174 in 2001.
  - Rolling average IME count used in 2003 cost report is (200+190+174)/3= 188
- Same method used for DGME (splitting PC and NPC FTE count) and IME FTE counts

# Rolling Average Resident FTE count exception for NEW residencies

- Hospitals (established or new teaching hospitals) that add a new residency use a different rolling average calculation method for the first 3-5 years of a new residency
  - Use the length of new program, e.g. new FM program is 3 years and new Surgery program is 5 years.
  - The new resident FTEs are added to the current and the prior two years and then the three totals are averaged. Basically the hospital gets full credit for the new residents in the rolling average FTE counts for both IME and DGME. Each year then the FTE claims get larger since a new program keeps adding residents.
  - This doesn't change the cap for established teaching hospitals (unless "rural" as per advanced talk)



# New residencies impact IRB calculation (in good ways):

- Hospitals that add a new residency use a different IRB comparison method for the first 3-5 years
  - The new resident FTEs are added to both the current and prior year numerators in calculating the current vs prior year IRB and the smaller of these two recalculated IRBs is used.
- Simple example:
  - if hospital just adding FM residency and bed count doesn't change then the current year IRB is used for the first three full years. Then the comparison formula (smaller of current vs prior year IRB) kicks in.

# IRB examples for new residency

- Simple: Hospital decides to add a Family Med residency. It already has other residencies
  - Year 0: no new FM residents, current (established programs) resident FTE 20, bed count 80, IRB 20/80 = 0.25
  - Year 1: first new FM residents added (2 FTE) and resident count now FTE 22, bed count still 80, IRB 22/80 = 0.275 for current year and prior year IRB (to compare) recalculated also at 22/80 = 0.275. So 0.275 is the IRB figure used (smaller of identical numbers…).
- To complicate the example, in year 1 the bed count drops to 70.
  - Year 1: first new FM residents added (2 FTE) and resident count now FTE 22, bed count 70, IRB 22/70 = 0.31 for current year and prior year IRB (to compare) recalculated also at 22/70 = 0.31. But 0.275 is the IRB figure used (smaller current vs prior yr IRB…).



# Expanding your residency – where's the (Medicare) $ ?

- internal specialty shuffle (e.g. less Orthopedics and more FM)
- Start an RTT or expand via a THC
- maximize yearly hospital claims and if claims always > cap… cap may go up if a future cap reassignment
  - Past priorities (2006 and esp 2010) have favored states with lower residency FTEs/population or higher % HPSAs, Rural over Urban and Primary care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