

GME Finance :

The Basics

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Financing of Resident Education and the Special Missions of Teaching Hospitals Comes from Multiple Sources

- Medicare (largest explicit payer)
- Medicaid
- Private patient care revenues
- Veterans Administration
- Dept. of Defense
- Other Federal and state programs

Medicare Makes Specific Payments With an “Education” Label

- **Direct GME Payments (DGME)**
 - Partially compensate for residency education costs
- **Indirect Medical Education (IME) Payments**
 - Partially compensate for higher patient care costs due to presence of teaching programs

DGME and IME Payments are Significant

Estimated Federal Fiscal Year 2003:

DGME Payments = \$2.54 billion

IME Payments = \$5.07 billion

Total = \$7.61 billion

Source: CMS Office of the Actuary, 2003

Medicare Direct Graduate Medical Education Payments

What Are DGME Payments Intended to Cover?

- Compensate teaching institutions for 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
- Originally, only paid to hospitals; BBA 97 made available to certain nonhospital sites

Why Does Medicare Recognize Direct GME Costs?

The initial Medicare legislation states:

“Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program.”

House Report, Number 213, 89th Congress. 1st Sess. (1965) and
Senate Report, Number 404. Pt 1. 89th Congress. 1st Sess. 36 (1965))

What is the Basic Methodology Underlying DGME Payments ?

- Step 1:* Determine hospital-specific per resident base year cost amount (generally 1984)
- Step 2:* Update 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:* Multiply by the hospital's ratio of Medicare inpatient days/total days

Primary and Non-Primary Care Per Resident Amounts (PRAs) Differ

- PRAs were updated ONLY for primary care residents in FFYs 94-96; specialty PRAs were frozen over this period
- Primary care comprises
 - family medicine
 - general internal medicine
 - general pediatrics
 - preventive medicine
 - geriatric medicine
 - osteopathic general practice
 - OB-GYN

How are DGME Payments Determined at the Resident Level?

	<u>PRA * Medicare Share</u>	<u>Payment Amt.</u>
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Primary Care Resident:	$(\$75,000) \times 30\%$	\$22,500
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Nonprimary Resident:	$(\$70,000) \times 30\%$	\$21,000
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Not Every Resident Counts the Same!

- Residents in their “initial residency period” (IRP) are counted as 1.0 FTE
- Residents training beyond the IRP are counted as 0.5 FTE
- IRP determined at the beginning of the residency and DOES NOT CHANGE
- Physicians who decide to retrain in another specialty are counted as 0.5 FTE
- Special rules for combined programs

How are DGME Payments Determined at the Resident Level?

	<u>PRA * Medicare Share</u>	<u>Payment Amt.</u>
Resident in IRP:	$(1.0) \times (\$75,000) \times 30\%$	\$22,500
Resident Beyond IRP:	$(0.5) \times (\$75,000) \times 30\%$	\$11,250

How to Compute a Hospital's DGME Payment: An Example

- Residents in primary care specialties 50 FTEs
- Residents in non-primary care specialties (in the initial residency period) 110 FTEs
- Residents beyond period of initial board eligibility 40 FTEs
- Total number of residents 200 FTEs

Step 1: Determine Base-Year PRA

- Hospital's Reimbursement Office can provide
- Based on audit of 1984 (or 1985) actual costs divided by number of residents
- Example: $\$10,000,000/200 \text{ FTEs} = \$50,000$
PRA for base year

Step 2: Update PRA for Inflation

- Again, Hospital's Reimbursement Office can provide
- For example, assume current year PRA of \$75,000 for primary care and \$70,000 for nonprimary care

Step 3: Multiply the Updated PRAs by the Number of Residents

- Primary Care (PC) PRA * PC FTEs
$$\$75,000 * 50 = \$3,750,000$$
- Nonprimary Care (NPC) PRA * NPC FTEs
$$\$70,000 * 110 = \$7,700,000$$
- NPC PRA * Residents Beyond IRP * 50%
$$\$70,000 * 40 * 50\% = \$1,400,000$$
- Aggregate DGME Amount:
$$\$3,750,000 + \$7,700,000 + \$1,400,000 =$$

$$\$12,850,000$$

Step 4: Multiply by the Hospital's Inpatient Medicare Ratio

- Medicare Inpatient Days 30,000
- Total Inpatient Days 100,000
- Medicare Share = 30%
 $30,000/100,000$

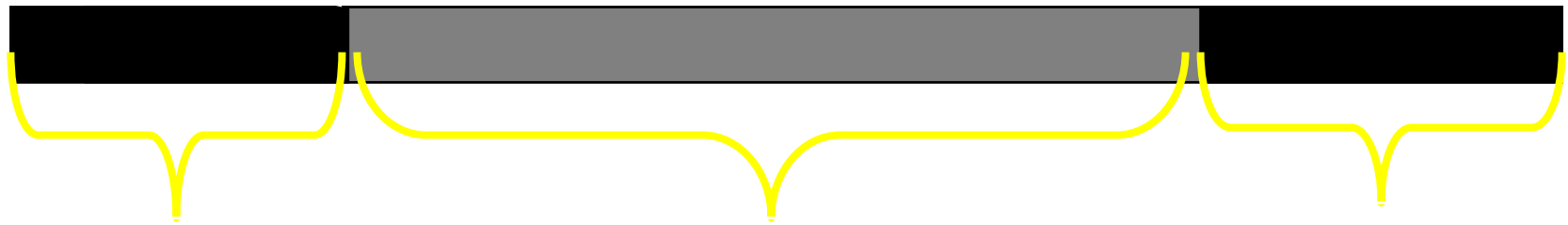
- Aggregate DGME Amount * Medicare Share
 $\$12,850,000 * 30\% = \$3,855,000$

BBRA, BIPA and DGME “Corridors”

- Historically, PRAs varied significantly across hospitals
- The BBRA and BIPA reduced this variation by increasing low PRAs and freezing high PRAs
- BIPA further increased the low PRAs

DGME Corridors

Per Resident Amounts (PRAs)



DGME Corridor Methodology

Step 1) 1997 PRA National Average = \$68,464

Step 2) Update to 2001 based on hospital's fiscal year

- 2001 DGME national average varies from \$76,132 to \$77,647

DGME Corridor Methodology

- Step 3)* Adjust step 2 amount to reflect wage differences in the area where hospital is located (“locality adjustment”)
- “locality adjusted national average” will be higher in NYC than in South Dakota
- *Step 4)* Compare the hospital’s own PRA with its locality adjusted national average

Counting Resident Research Time for DGME Payments

- A hospital may count the time a resident spends performing research, including bench research, so long as the research is part of an approved training program
- Note—This policy differs from the IME research counting policy!

Medicare Indirect Medical Education Payments

Medicare Payments with an Education Label: IME

- Compensates teaching hospitals for higher inpatient operating costs due to:
 - unmeasured patient complexity not captured by DRG system
 - other operating costs associated with the presence of GME programs (more tests, lower productivity, etc)
- Percentage add-on payment to basic Medicare per case (DRG) payment
- IME payments made only to hospitals

The Purpose of the IME Adjustment

“ This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.” (House Ways and Means and Senate Finance Committee Reports, March 1983.)

IME Adjustment, Cont.

- IME adjustment based on statistical analysis using intern and resident-to-bed ratios (IRB)
- % per case add-on =
$$\text{Multiplier} \times ((1 + \text{IRB})^{0.405} - 1)$$
- Current multiplier is 1.47
- Short hand for IME: Hospitals get about a 6.0% increase in DRG payments for every 10- resident increase per 100 beds

Calculating the Indirect Medical Education (IME) Payment

Step 1: Determine the IRB ratio:

$$200 \text{ residents}/1000 \text{ beds} = 0.20$$

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

$$(1.47 \times ((1 + .20)^{0.405} - 1)) \times 100 = 11.3\%$$

Step 3: Calculate the IME payment for each case

$$(\text{Payment for DRG 306} * \text{IME \%}) = \text{IME Payment}$$

$$(\$5,031 * 11.3\%) = \$569$$



BBA '97 and IME

- The BBA reduces IME payments for each hospital by **29.6 percent over 4 years** (BBRA and BIPA slowed down the onset of the full reduction)

IME REDUCTIONS UNDER BBA, BBRA AND BIPA

IME “ADD-ON” PAYMENTS

	BBA 97	BBRA 99	BIPA 00
1997	7.7%	--	--
1998	7.0%	--	--
1999	6.5%	--	--
2000	6.0%	6.5%	--
2001	5.5%	6.25%	6.5%
2002	5.5%	5.5%	6.5%
2003 and beyond	5.5%	5.5%	5.5%

Medicare Prescription Drug, Improvement, and Modernization Act of 2003: IME

	Adjustment	Multiplier
FY 2002	6.5%	1.5
FY 2003	5.5%	1.35
10/01/03 to 3/31/04	5.5%	1.35
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4/1/04 to 9/30/04	6.0%	1.47
FY 2005	5.8%	1.42
FY 2006	5.55%	1.37
FY 2007	5.35%	1.32
FY 2008 and Beyond	5.5%	1.35

Resident FTE Counts for Determining IME Payments

- The IRP weighting policy does not apply under IME payment policy (ie, all residents are counted as 1.0 so long as in an approved program)
- Cannot count resident time spent in PPS-exempt units (rehab; psych)
- Research: may only count research time associated with the “treatment or diagnosis of a particular patient”

Aside: Counting Beds for IME Payments

- IME payments are premised on the intern/resident to BED (IRB) ratio
- Beds determined by: No. of available bed days in a year (excluding newborn, custodial etc bed days) divided by 365
- Fewer beds increases the IRB ratio, which increases IME payments
- More beds decreases the IRB ratio

Aggregating Resident Limits

The BBA Permits Hospitals To Aggregate Their Resident Limits

- Members of “affiliated groups” may combine their limits to create an “aggregate” limit
- “Affiliated group” defined in several ways:
 - Hospitals in same or contiguous areas if residents work at each hospital
 - Not in same area but jointly listed as sponsor or primary clinical site
 - Hospitals under common ownership
- Members of the affiliated group must have shared resident rotation arrangements

Benefits of Aggregating Resident Limits

- Allows resident rotations without loss of GME payments
- Parent hospital maintains its cap if it withdraws from the agreement

Resident Limit Aggregations: An Example

Resident Limit Affiliation Agreements

Must be submitted to Federal Intermediary and CMS by July 1 of each year and include:

- Statement indicating the hospitals meet the regulatory criteria for affiliating
- The respective resident limits and corresponding resident count increases or decreases
 - Sum of counts should not exceed aggregate limit
 - Resident counts may be adjusted through June 30 of the residency year if the actual resident counts for the program year are different than projected in the original agreement
 - Resident limits revert when the agreement ends

Regulations Permit Temporary Resident Limit Adjustments

- **Hospital Closures**

- Hospitals that take on, and complete the training of, affected residents may have their resident limits temporarily adjusted upward
- Does not apply to VA closures
- Once the residents complete their training, the limit reverts to the base year

- **Program Closures**

- Resident limit for receiving hospital is temporarily adjusted upward if the hospital closing the resident program agrees to temporary downward adjustment

Rolling Average Resident Counts

DGME and IME 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 included in rolling average calculations
- 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>
1996	400	400
1997	400	400
1998	380	$(400+380)/2 = 390$
1999	370	$(400+380+370)/3 = 380$
2000	410	$(380+370+400)/3 = 383$

Medicare Payments for Residents Training at Nonhospital Sites

Payments for Residents in Non-Hospital Settings

- 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
- Hospital and nonhospital must have a written agreement

Payments for Residents in Non-Hospital Settings, Cont.

“All or substantially all of resident training costs” means as:

“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” 42 C.F.R. §413.86(b)

Payments for Residents in Non-Hospital Settings, Cont.

Written agreement must state that the hospital:

- will incur the resident's salary and fringe benefits
- provide reasonable compensation to the non-hospital site for supervisory teaching activities; and
- indicate the supervisory teaching compensation amount.

42 C.F.R. §413.86(f)(4)(ii)

“Community Support” and “Redistribution of Costs” Principles

Community Support and Redistribution of Costs

Important quote from the FY 2004 Medicare inpatient final rule preamble:

“It is longstanding Medicare policy that if the community has undertaken to bear the costs of medical education, these costs are not to be assumed by the Medicare program. In addition, medical education costs that have been incurred by an educational institution may not be redistributed to the Medicare program.”

(68 Fed. Reg. at 45436)

Community Support and Redistribution of Costs

NEW 42 CFR §413.86(i):

(1)(i): *Community support*. If the community has undertaken to bear the costs of medical education through community support, the costs are not considered [GME] costs to the hospital for purposes of Medicare payment

(1)(ii): *Redistribution of costs*. The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered [GME] costs to the hospital for purposes of Medicare payment

2004 Inpatient Final Rule: Community Support and Redistribution of Costs, Cont.

(2) *Application.* A hospital must continuously incur costs of direct [GME] of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents. . .

2004 Inpatient Final Rule: Community Support and Redistribution of Costs, Cont.

- Issue particularly impacts dental residents
- Regs affect DGME for *both* hospital and nonhospital sites
- Regs do not affect IME payments for residents in HOSPITAL settings
- To comply with CS and ROC principles, hospitals need only incur SOME of the direct GME costs since program inception)

2004 Inpatient Final Rule: Community Support and Redistribution of Costs, Cont.

- It gets even more complicated!
 - Don't forget distinction between training at nonhospital vs hospital sites
 - Nonhospital sites: hospital must incur “all or substantially all costs” in addition to being in compliance with CS and ROC principles
 - Hospital sites: do NOT need to incur “all or substantially all” costs to claim residents

2004 Inpatient Final Rule: Community Support and Redistribution of Costs, Cont.

- What about hospitals that are in violation of CS and ROC principles?
 - No retroactivity; provision effective Oct 1, 2003
 - Grandfather provision: hospitals will continue to get paid for residents that began training prior to Oct 1, 2003 until resident(s) finishes training, or 3 years, whichever comes first

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

- IME relief (sec. 502)
- DGME freeze (sec. 711)
- Redistribution of unused residency limit slots (sec. 422)
- Treatment of volunteer supervision at nonhospital sites (sec. 713)
- Provisions affecting initial residency periods
 - Preliminary year programs (conf. rept. of section 712)
 - Geriatrics (sec. 712)

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (H.R. 1)

- **DGME Freeze**
 - 10 year freeze (through 2013) for hospitals with per resident amounts above 140 percent of their locality adjusted national average

Prescription Drug Bill

Sec. 422: Redistribution of Unused Resident Positions

- Resident limits reduced for hospitals with a resident counts below the limit for a year ending on or before September 30, 2002 for which a cost report has been settled or submitted
 - Limit reduced by difference of limit and 75% of resident count
 - Hospitals could seek resident count adjustment based on 2 situations
 - Expansions of programs not yet reflected on hospital cost report
 - New programs
 - Special provision for members of resident limit affiliation groups
- Applies to both IME and DGME limits

Prescription Drug Bill

Sec. 422: Redistribution of Unused Resident Positions, Cont.

- Hospitals Could Apply to Increase Their Resident Limits
- Aggregate increase could not exceed aggregate decrease
- Applied to both IME and DGME resident limits
- Could not exceed 25 FTEs and had to demonstrate slots would be filled

Prescription Drug Bill

Sec. 422: Redistribution of Unused Resident Positions, Cont.

- Priority to teaching hospitals in the following order:
 - 1) rival teaching hospitals with only residency program in the state;
 - 2) rival teaching hospitals;
 - 3) teaching hospitals in small urban areas with only residency program in the state
 - 4) teaching hospitals in small urban areas
 - 5) teaching hospitals in large urban areas with only residency program in the state
 - 6) teaching hospitals in large urban area

Prescription Drug Bill

Sec. 422: Redistribution of Unused Resident Positions, Cont.

- DGME payment for additional residents = locality-adjusted national average per resident amount
- IME adjustment for additional residents = 2.7%
- Both resident limit reductions and expansions take effect July 1, 2005
- This is a “one time” program

Prescription Drug Bill

Sec. 422: Redistribution of Unused Resident Positions, Cont.

- Additional information:
 - CMS “One Time Notification” published on April 30, 2004 (http://www.cms.hhs.gov/manuals/pm_trans/R77OTN.pdf)
 - FY 2005 Medicare inpatient PPS Proposed Rule
 - CMS to notify hospitals that applied by June 2005

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (H.R. 1)

- Volunteer Faculty GME Issue
 - Allowed, for 1 year, hospitals to count residents in osteopathic and allopathic family medicine programs in existence as of Jan. 1, 2002, who were training in non-hospital sites without regard to the financial arrangement between the hospital and the teaching physician in the non-hospital setting.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (H.R. 1)

- Volunteer Faculty GME Issue, Cont.
 - Required the HHS Inspector General to study the training of allopathic and osteopathic residents in non-hospital settings and the use of volunteer faculty in those settings.
 - Had numbers of physicians in rural and underserved areas increased?
 - Evidence of misuse of federal \$ with respect to volunteer supervisory physicians?
 - Supervisory physicians freely volunteering their time?
 - What incentives available to physicians who volunteer?
 - Report submitted December 8, 2005

Medicare DGME Payments: Preliminary Year Issue

- Issue: Weighting residents in specialties that require a “broad-based” clinical training year as the first year of training
- Applies in specialties, such as radiology, anesthesiology, and pathology
- “Broad-based” initial year programs include:
 - Transitional Year Programs
 - Preliminary Year in Internal Medicine
 - Preliminary Year in Surgery, Pediatrics, etc.

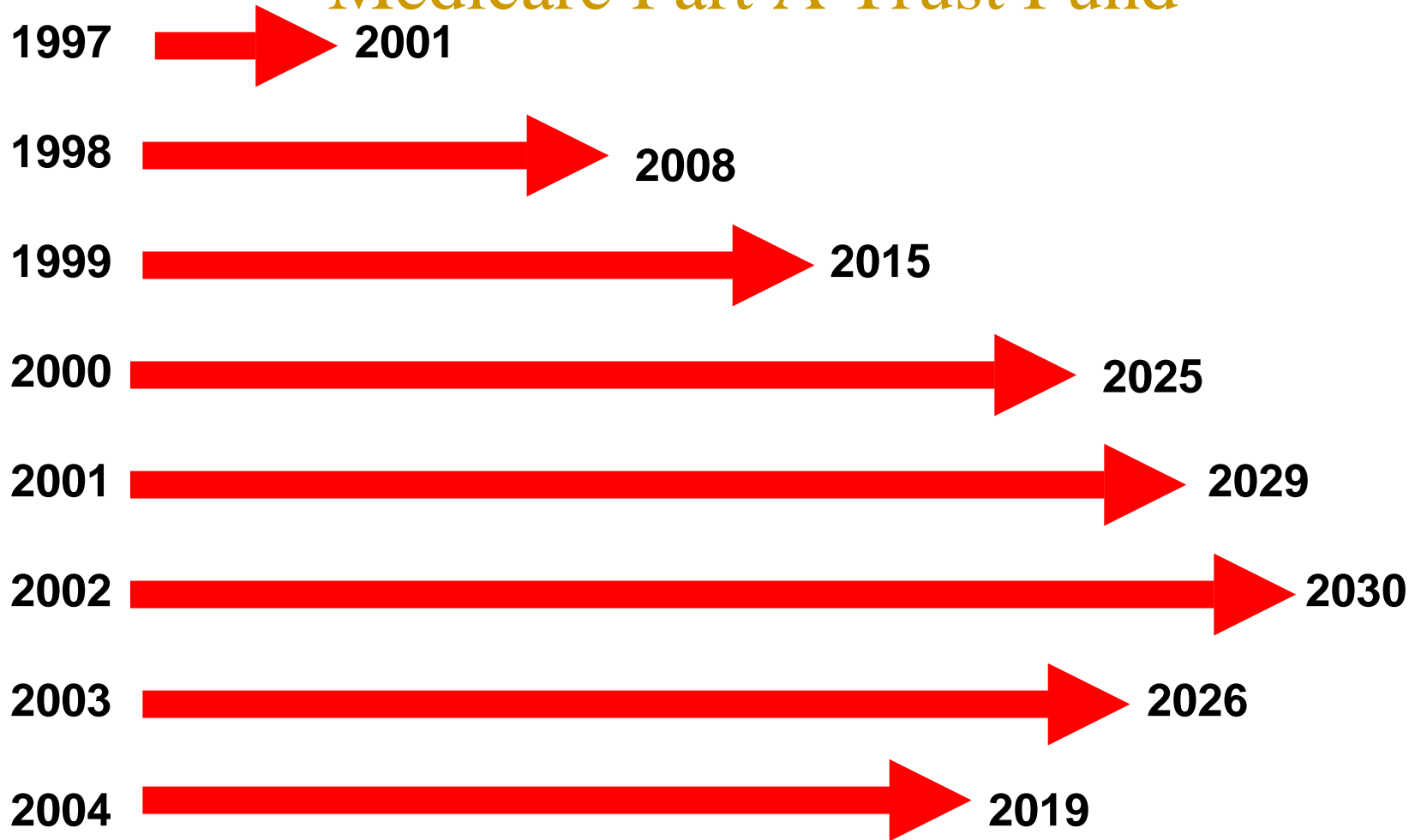
For details and recent updates on these and other GME financial issues, attend tomorrow's 10:00 a.m. session
by
Thomas C. Gentile, Jr., MSA on
“GME Finances : An Update”

Some Brief Observations About the
Future of Medicare DGME and IME
Payments

Musings About the Future of Medicare DGME and IME Funding

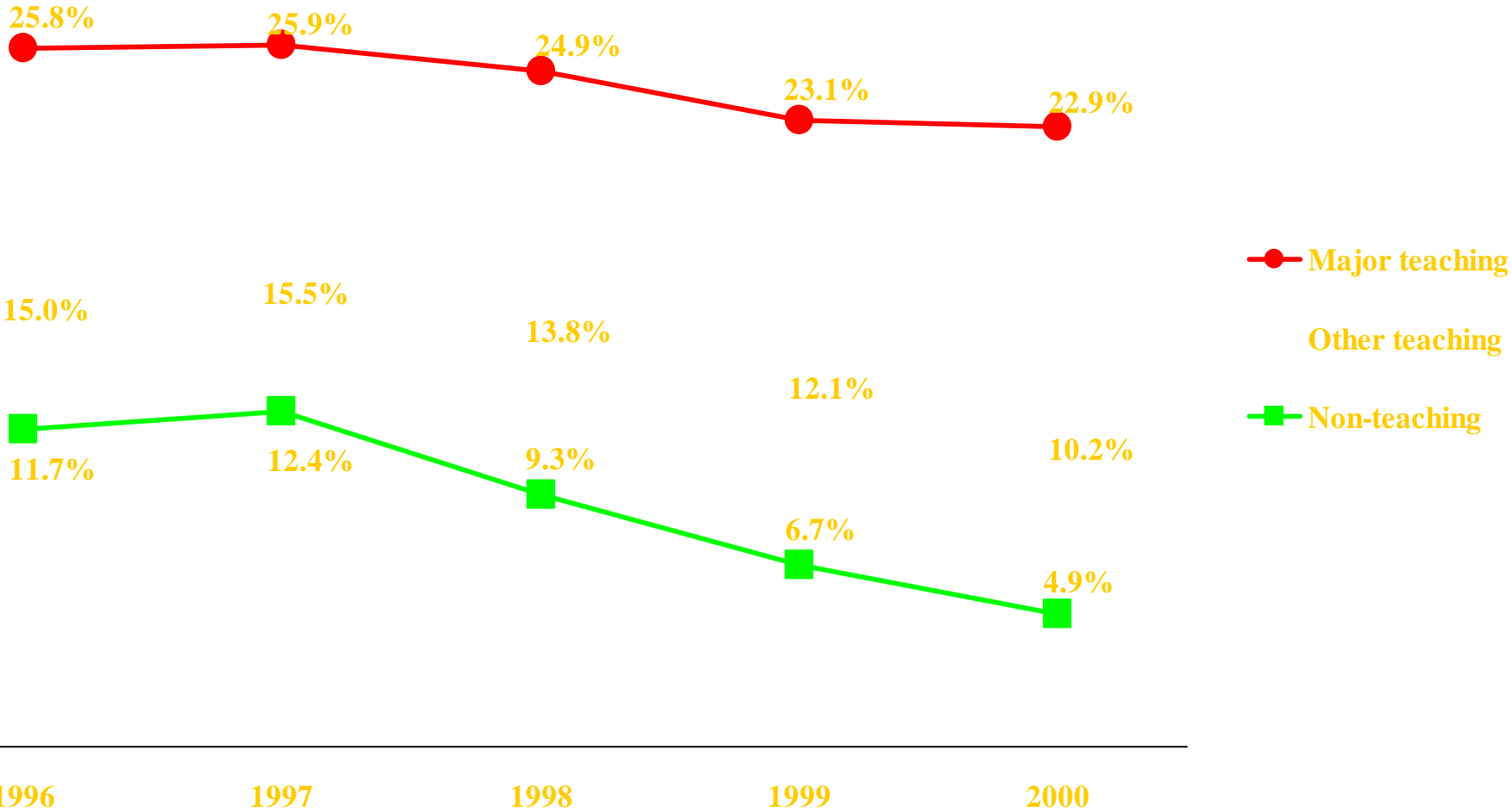
- Not everybody loves the fact that Medicare is making these payments
 - Medicare pays teaching hospitals more than other hospitals
 - Some people think IME payments are higher than they should be
 - Why shouldn't everyone pay for educating residents rather than just Medicare patients
- What impact will overall Medicare reform have on the DGME and IME payments?

Projected Solvency of the Medicare Part A Trust Fund

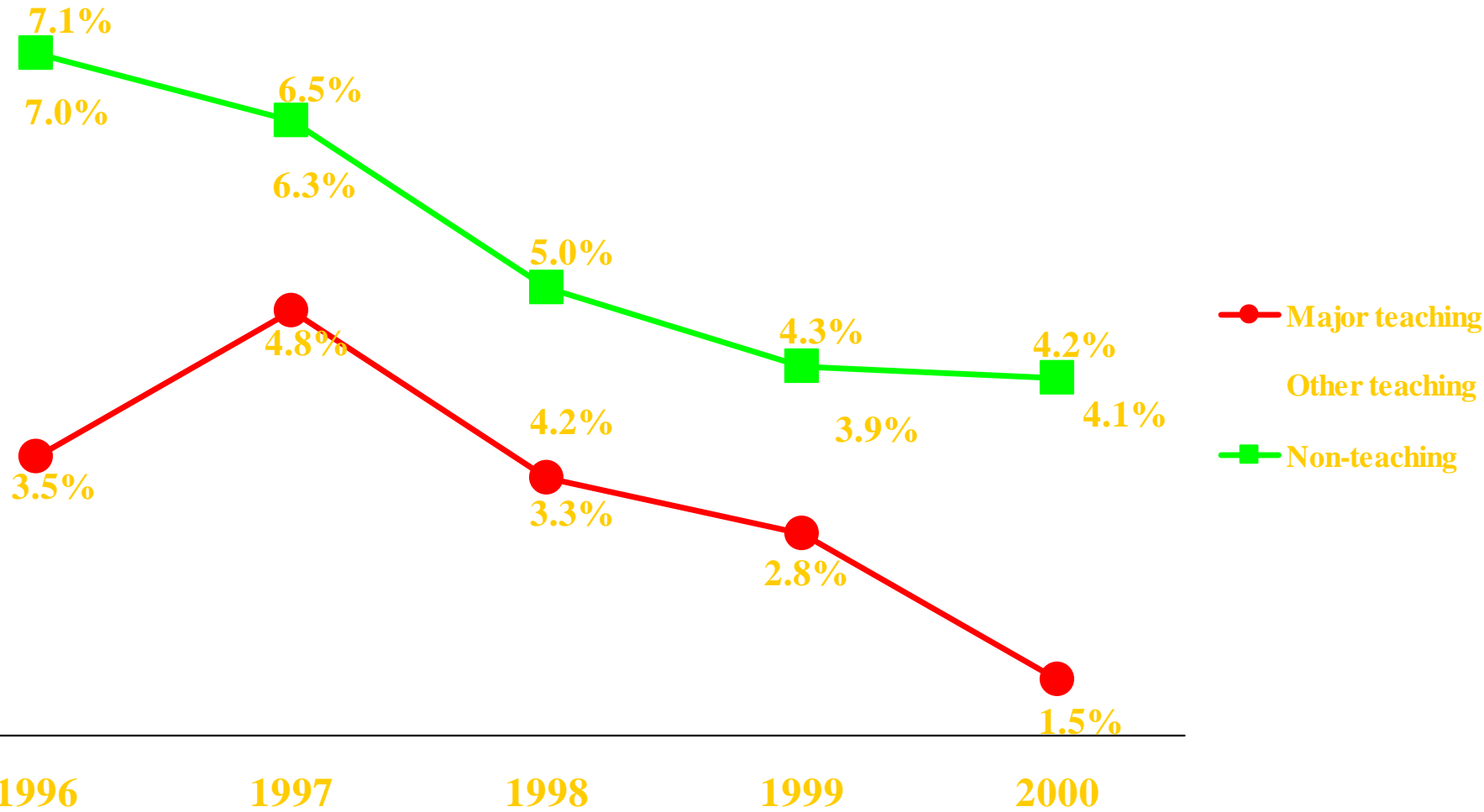


Source: Health and Human Services Press Releases Announcing Release of Annual Medicare Trustees Report 1991-1997. Medicare Trustees Reports, 1998-2004

Medicare Inpatient Margin by Teaching Status 1996 - 2000*



Hospital Total Margin by Teaching Status 1996 - 2000*



Some Final Thoughts

- **Short term concerns:**
 - IME payment levels
 - Resident limits
 - Impact of community support regulations
 - “nickel and dime” regulatory disallowances that are adding up to be real money
- **Longer term concerns:**
 - Dedicated, stable funding for the funding of physician training and the other valued contributions of teaching hospitals and their faculties
 - Potential privatization of Medicare

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