Graduate Medical Education Funding
Issues Relative to Statutes and Regulations
2012

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Medicare GME Funding
What do you need to Know?

- Medicare Statutes
- CMS Regulations
- Developing New Teaching Hospitals
  - CMS Rules
- How to count residents
- Impact of rotations
  - In-rotations to parent hospital
  - Out-rotations to host hospital
  - Agreements with parent and host hospitals
  - Records to be kept
Medicare GME Funding
What do you need to Know?

- Medicare GME payments
  - Direct Graduate Medical Education expense – DGME
  - Indirect Medical Education adjustment – IME

- Board eligibility limitation
  - relative to DGME resident count

- Ambulatory rotation regulations
  - Private practice
    - Office rotation mixed with hospital service
  - In-hospital/physician employee

- Affiliation/Aggregation agreements
  - Urban Hospitals
  - Rural Hospitals
  - New Teaching Hospitals
Medicare Statutes

- Balanced Budget Act (1997)
- Balanced Budget Refinement Act (1999)
- Benefit Improvement and Protection Act (2000)
- The Patient Protection and Affordable Care Act (ACA) 2010
AOCOO- HNS
GME
Funding

CMS Rules & Regulations

- CMS Rule August 05, 2002
- CMS Rule August 01, 2003
- CMS Rule August 11, 2004
- CMS Rule August 12, 2005
- CMS Rule August 18, 2006
- CMS Rule May 1, 2007
- CMS Rule August 13, 2009
- CMS Rules for the ACA November 2010
How to Count Residents

- Resident count
  - “CAP”
    - Employed residents
    - Accreditation – approved positions
    - CMS - Resident count
      - In-hospital rotations at parent hospital – 1.0 FTE count
      - Ambulatory rotations with agreement – 1.0FTE count
        » Private practice
        » Employed physicians at hospital clinics or off site
      - Out- rotations to another hospital - 0.0 FTE count
“CAP” Information

- **Resident Count** *
  - Not the employee count
  - Not the accreditation approved count

- **Resident Count relative to the "CAP" determined by:**
  - Resident time at the parent hospital
    - Resident time assigned to another hospital — no Medicare GME payments
    - New Programs — resident count creates “CAP”
  - Resident time at approved ambulatory faculty assignments with physician and hospital signed agreement prior to the rotation
Impact of Rotations – in & Out

- In-rotations to parent hospital
  - Agreement must be in place as to resident count for parent and host hospital
  - New Teaching Hospitals should not affiliate/aggregate with a teaching hospital until “CAP” is established

- Out-Rotations to Another Hospital
  - Parent hospital cannot collect DGME or IME
  - Agreement must be in place as to resident count for another hospital as well as the parent hospital

- Hospitals that are eligible to be new teaching hospitals should not allow resident rotations from teaching hospitals
  - At risk for the “CAP” to be set
  - At risk for the PRA to be set
How to Count Residents for Exempt Hospitals

- **Rural Hospitals**
  - Exempt from the “CAP” by hospital
  - “CAP” applied by program
  - Can develop a joint residency with an Urban Teaching Hospital

- **New Teaching Hospitals**
  - Can develop a “CAP”
    - Three year window
      - Highest number of residents in any of the three years
The Direct Medical Education Expense Payment (DGME) Per Resident Amount (PRA)

DGME calculation

- Based on 1984-85 GME costs at teaching hospital
- Or if a new teaching hospital the locally adjusted average X the Medicare in-patient utilization
- DGME Example:
  - Medicare allowable costs (DGME) $450,000
  - 10 Residents
  - 50% hospital Medicare utilization
    » $450,000 divided by 10 Residents – resident count for DGME = $45,000
  - 45,000 x 50% utilization = 22,500 + update
  - The DGME times the resident count (10) = $220,500 (PRA)
  - Resident count cannot exceed the DGME “CAP”
Indirect Medical Education adjustment -IME Formula

IME Adjustment Formula:

\[ 1.35 \times [(1 + \frac{\text{# of Res.}}{\text{# of Beds}})^{0.405} - 1] = \text{Old Formula} \]

1.35 2008 October

IME payment driven by:
1. Medicare inpatient utilization
2. Resident count for IME
3. Case Mix Index -CMI
Medicare Utilization and the Case Mix Index impact on Medicare revenue

- The Medicare utilization and the Case Mix Index (CMI) drives the Medicare revenue payment and the IME payment.
  - The higher the inpatient Medicare utilization to the total inpatient volume and the higher the CMI, the higher the Medicare DRG revenue and the IME payment.
Proposed residents: 12
# beds: 346
Ratio Res/Beds: 0.0347
1+ratio: 1.0347
To .405 Power: 1.014
less 1: 0.0139
times 1.35 (2008): 1.877% IME Adjustment Factor

This Adjustment factor would be multiplied by the Medicare payments to Hospital for AYE 06/30/10.
If Hospital receives from Medicare approx. $84,900,000.00
the approximate IME payment to Hospital would be:

0.01877  $84,900,000.00 = $1,593,573.00

$1,593,573.00 / 12=$132,797.75 per resident
Medicare Statutes
Balanced Budget Act 1997

**BBA’97**
- Set the hospital “CAP” based on the 1996 cost report – Hospital specific
- Two “CAP” numbers
  - DGME
  - IME
    - Prior to BBA’97 Medicare only paid DGME payment for ambulatory rotations
    - After BBA’97 Medicare paid DGME and IME for ambulatory rotations if Physician agreement in order
- Based on **resident count** for – DGME and IME
- New teaching hospitals- resident count sets the “CAP”
Medicare Statutes
The Medicare Prescription Drug Improvement and Modernization Act

• MMA - 2003
  - Maintains DGME & IME Payments associated with “Medicare Advantage Plans”
    - Formerly “Medicare +Choice”
MMA - 2003

Non-Hospital Setting- CMS Rule 8/11/04

- Hospital incurs cost of:
  - Resident salary and fringe benefits Note: ACA’10 This requirement is all that is necessary for hospitals to count residents in non provider settings.
  - Physician agrees to supervise residents
  - PD provides curriculum (goals & objectives) to physician supervisor and he-she agrees to teach
  - Reasonable compensation for supervisory teaching time
  - Travel and lodging costs for rotating residents
  - Professional liability insurance provided the interns-residents
MMA -2003

- Non-Hospital Setting- CMS Rule 8/11/04
  - Exclusivity:
    - One hospital must incur all the costs
    - Two hospitals rotate to same office neither hospital may count FTE's – a reduction of the resident count to both hospitals.
  - Note: ACA’10 allows hospitals to proportionally share the costs of the resident training as long as the hospitals divide the resident time proportionally as agreed in a written agreement.
Medicare Statutes
Balanced Budget Refinement Act

BBRA - 1999

- Per resident amount (PRA)
  - Floor - 70% of the locally-adjusted national average PRA
    - BIPA – 85%
  - Ceiling - 140% of the locally-adjusted national average PRA

- New Teaching Hospital utilizes the locally adjusted average

- Affiliation Aggregation Agreement
  - New Teaching Hospitals cannot affiliate/aggregate with urban teaching hospitals
Medicare Statutes
The Medicare Prescription Drug Improvement and Modernization Act

MMA - 2003

- Affiliation Aggregation Agreement
  - Hospitals must be in the same MSA/CBSA area or under common ownership
  - Allows resident rotations without loss of GME payments
  - Parent hospital maintains cap if it withdraws from the agreement
  - Does not allow for transfer of the position if parent hospital closes program
  - New teaching hospital cannot affiliate/aggregate with an Urban teaching hospital
MMA - 2003
Affiliation Aggregation Agreement

- Hospital Closure
  - Residents can complete training
  - Host hospital cap + to complete training
  - Positions lost after training complete **Note: ACA ’10 allows for redistribution of resident positions in closed hospital**

- Hospital rotates resident without A/A
  - If host hospital over cap **no** GME payments
  - If host hospital under cap GME payments
Major Provisions of the ACA relative to GME:

- Hospitals can count resident time in Non Provider settings if they incur cost of residents’ salaries and Fringe benefits.
- Hospitals can count resident time in certain non-patient care activities (including didactic conferences and seminars).
- Hospitals can count residents, vacation, sick leave, and other approved leave time.
Redistribution of Residency Slots

- Rural Hospitals (less than 250 beds) exempt
- Hospitals not filling will be at risk to lose 65% of unfilled slots
- Priority Categories
  - 70% of slots to hospitals located in States with resident to population ratios in the lowest quartile
  - 30% of slots to hospitals in states among top 10 in the ratio of population to health professional shortage
Preservation of Residency Slots for Closed Hospitals

- Slots closed no longer exist
- Deadline-April 1, 2011
  - Other closures CMS would inform
    - Four (4) months time to apply
  - Priority Categories
  - Ranking Criteria
CMS Rule August 18, 2006 Cont’

- CMS restated in this rule that in non-hospital settings residents must be engaged in “patient care activities” to include the time in the calculation of the resident count (FTE).

- **Note: ACA’10 states:**
  - Hospitals can count resident time in Non Provider settings if they incur cost of residents’ salaries and Fringe benefits.
  - Hospitals can count resident time in certain non-patient care activities (including didactic conferences and seminars).
New Teaching Hospital
August 13, 2009 CMS Rule

- Clarifies the definition of a new medical residency training program, specifically excluding from the definition a program that receives initial accreditation for a teaching program that existed previously at another hospital.
- Proposes permitting a new teaching hospital that begins training residents for the first time after July 1 to submit a Medicare GME affiliation agreement prior to the end of its cost reporting period in order to participate in a Medicare affiliated group for the remainder of the academic year.
- Consistent with the American Recovery and Reinvestment Act of 2009 (ARRA), the rule also updates current Medicare GME regulations to provide for payment of the full capital indirect medical education (IME) adjustment in the current fiscal year.
New Teaching Hospital

- New GME program residents prior to 1-1-1995 may set “CAP”
- Rotations from other teaching hospitals
  - Newly accredited or old accredited programs’ resident rotations from other teaching hospitals can set the “CAP and/or affect the PRA
- New Program on or after 1-1-1995
  - Internship 3 years CAP determined by highest number in one of the three years
  - Residency CAP determined by the highest number of residents in any program year subsequent to the internship
- GME programs must be approved or CMS will deny payment
- Rotations from other teaching hospitals will not count towards the “CAP” unless the rotations are from newly accredited programs
The Direct Medical Education Expense Payment (DGME) Per Resident Amount (PRA)

New Programs:
- Lower of cost or locally adjusted average
Teaching time for full time or part time paid faculty

- Medicare will not pay a part A payment if the faculty is also billing for a Part B payment.
CMS rules for physician teaching time

- Non-patient care teaching activity
- Teaching related administrative activities
- Department education committee meetings
- Advising and or counseling
- Faculty skills development
- Formal conferences and classroom rounds
- Preparation time
Government Medicare GME Funding

- Impact of proposed reductions to GME Medicare funding
  - Debt reduction may include reductions in either or both Medicare DGME and IME payments

- Impact of Medicaid reductions to GME funding
  - Many States looking at the payments made to GME
Changing Environment for GME?

- An increase in American medical student
- Competency tests for residents and attending physicians
  - Joint Commission requirements for privileging
- Hospitals reviewing their GME strategy
- New teaching hospitals
What will be Hospital’s Medical Education Strategic Initiative?

Program sponsors will renegotiate existing affiliations with medical schools, hospitals, FQHC’s, and community organizations.

Medical Education has shifted from an in-patient based model to an ambulatory care based teaching model, will the new modality of teaching residents influence medical care and/or teaching?

From a teaching hospital perspective, FQHC is more cost effective means to care for underserved and indigent patients.

FQHC/CHC/THC a means to add primary care “CAP” if GME payment flaw is fixed.

Competition for quality residents will be a challenge. What is the right strategy for recruitment and retention? Note 2017 more American graduates than CMS positions!

How competencies for practicing physicians may change board certification and recertification and influence hospital privileging?

Patient safety and cost effective medical care will drive new medical technology and changing modalities of care. How will government and insurance respond?
“To be Forewarned is to be Forearmed”

United We Stand