Graduate Medical Education Funding

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Chair, AACPM Institutional Residency Development Committee
Chair, AACPM Balance Committee
Objectives

• Review Centers for Medicare and Medicaid Services (CMS) funding for a residency program
• Maximize CMS funding for a residency program
• Alternative funding resources for a residency program
• How to access the CMS funding report for your hospital
• Sample budget for a residency program
• Resources for GME funding
Reimbursement for Graduate Medical Education comes from 3 main funding sources:

- Medicare (CMS)
- Medicaid
- Other
  - Private payers, VA/DoD, Teaching Hospitals, Grants, Foundations
Centers for Medicare and Medicaid Services (CMS)

- Reporting for CMS funding is an accounting function
- CMS funding reported on hospital’s annual cost reports
- Complex formulas and statutory rules/regulations
- CMS GME funding requests are subject to audits
Medicare Funding- Broadly speaking two types of payments

**Direct Graduate Medical Education Payments (DGME)**
- Designed to cover Medicare’s share of the direct costs of operating a medical education program
- Includes general service costs related to the program

**Indirect Medical Education Payments (IME)**
- Designed to cover patient care costs that help teaching hospitals maintain an environment where doctors can be trained
- Partially pays for higher patient care costs due to presence of residents, for example longer admission stays
DGME

• The amount of DGME payment varies for each hospital, based on an amount known as the “hospital specific per resident amount” which, according to law, was determined by CMS for each teaching hospital in the 1980’s, and is updated each year by an inflation factor.

• DGME is based on the number of residents it is allowed to count, the hospital specific per resident amount, and the percentage of its inpatient population that is comprised of Medicare beneficiaries.
Direct Medical Education Payments

- Resident Salaries, Benefits, Malpractice
- Program Coordinator, GME office costs
- Teaching Physician compensation
- Licenses and Dues
- Recruiting Expenses
- Lab coats, scrubs
- Accreditation fees, intraining exams
- Certain overhead costs
IME

- Medicare provides the IME adjustment to teaching hospitals to recognize their higher costs of inpatient care when compared to nonteaching hospitals.
- The IME adjustment is an additional payment for each Medicare inpatient stay.
- The IME adjustment is based on a hospital’s ratio of interns and residents-to-beds.
Indirect Medical Education Payments

- Indirect patient costs: learner insufficiencies such as increased length of stay
- Technology and equipment enhancements
- Uncompensated care
How are DGME payments calculated

**Per resident amount** is adjusted annually for inflation. It may have been established in the base year—generally 1984.

Multiply PRA by number of resident **full time equivalents (FTE)** training in the hospital in the current year.

Then multiply this number by the hospital's ratio of **Medicare inpatient days/total days** (also called the hospital's Medicare share).
Calculating IME Payments

• Compensates teaching hospitals for a higher operating costs due to **unmeasured patient complexity** and other costs associated with being a **teaching hospital**- things take longer, because you have learners as part of the process

• IME is an additional amount of money on top of the Medicare in patient payment, this Medicare payment is called **Medicare severity diagnosis related group payment MS- DRG**

• IME adjustment is based on a formula using the **intern to bed ratio** **IRB**- The IRB measures the “**teaching intensity**”
IME = Multiplier X ((1 + IRB)^0.405 - 1

Current multiplier X is 1.35

Intern to bed ratio

Hospital A has 170 residents and 666 beds so the IRB is .255

170/666 = 0.255 = IRB

IME = 1.35 ((1 + .255)^0.405 - 1 = 13%

Payment for MS-DRG x IME % =

29,748 x 13% = $3867.24

So this teaching hospital gets an additional $3867.24 for this case.
What if a resident is rotating at another hospital?

• A sponsoring hospital may not count any time that a resident spends at another hospital, even if the other hospital does not seek DGME payments from Medicare.
  • Receiving hospital returns GME money
  • Receiving hospital does not return GME money
  • Receiving hospital demands money

• Be sure the affiliation agreements outlines the financial arrangement
Offsite rotations

A sponsoring hospital also may include residents working in a nonhospital site (clinic, surgery center) in its FTE “if the hospital incurs the cost of resident salaries and benefits in order to bill for resident time at offsite rotations”

• **Written affiliation agreement** with the offsite entity must be in place

• Documentation is critical

  ✓ Time spent at more than one location the same day
  ✓ Rotations to other hospitals that include time at the “home” hospital for didactic training or clinic time or research
Special consideration for offsite rotations

- **Psychiatric** and **rehabilitation** hospitals are paid differently under Medicare than acute care hospitals.
- These hospitals also receive IME payments, but the adjustment formula is based on the ratio of residents to the hospital’s average daily patient census rather than beds.
Research

• For DGME, a hospital may count the time a resident spends performing research, including bench research, as long as the research is part of an approved training program.

• For the IME, a hospital may only count the time a resident spends performing clinical research that is associated with the treatment or diagnosis of a particular patient.
Maximize CMS collections

• Document resident time/rotations well
• Move research into hospital
• Move didactics into hospital
• Have affiliated hospitals pay, put in affiliation agreement
• Clinics do not get DME/IME but hospital can get DME if there is an affiliation agreement
• Surgery Centers do not get DME/IME but hospital can get DME if there is an affiliation agreement
Maximize CMS reimbursement

• Resident FTE count at each site is a major factor in determining both IME and DME payments and CMS has a lot of regulations governing this.
• Your hospital will need to prove this to CMS in audits to track research, outpatient time and didactics.
• The better you count, the more money your resident gets for DME/IME
• Have an organized rotations schedule, sign in sheets for didactics
Alternative Funding Sources
Medicaid GME funding

- Differs by state
- Reimbursement usually tied to budget allocations
- Some states have a separate indigent care fund
Additional State funding

- Funding at the individual state level may provide funds for GME support.
- Identify workforce studies that show the states have a need to train future podiatrists to fulfill their workforce needs.
- State GME funding is tied to legislation and this can vary annually with budget discussions.
- Texas, Michigan, Wisconsin, Florida
Foundations

• National foundations and local foundations at individual hospitals may be an available source for GME funding.
• Grant application to access funds
• Examples:

[Logos of foundations]
Questions to consider?

• Do you know what happens to the CMS GME money paid to your hospital?
• Are your residents meeting the rules for CMS GME funding?
• Will you hospital pay more for program faculty?
Discussing GME funding data with administration

• Present the GME Funding information
• Present a budget
• Provide a rotation schedule that assures hospital administration you are increasing efforts to maximize FTE counts at the sponsoring hospital.

• Additional considerations:
  • Resident cap – Podiatry and Dental residents are currently exempt from the cap
  • rolling average are applicable
Medicare Reimbursement Information

The COTH is pleased to provide you with the applicable GME reimbursement information for your institution for federal fiscal year 2015.

<table>
<thead>
<tr>
<th>Medicare ID:</th>
<th>150004</th>
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<tbody>
<tr>
<td>Facility Name:</td>
<td>FRANCISCAN ST</td>
</tr>
<tr>
<td>City:</td>
<td>HAMMOND</td>
</tr>
<tr>
<td>State:</td>
<td>IN</td>
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<tr>
<td>MSA:</td>
<td>23044</td>
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<tr>
<td>Number of Beds:</td>
<td>237</td>
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<tr>
<td>Ratio Medicare Days to Total Days:</td>
<td>41.63 %</td>
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<tr>
<td>Total FTE Residents:</td>
<td>6.00</td>
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<tr>
<td>Additional Allowed FTE Residents*:</td>
<td>0.00</td>
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<tr>
<td>Approved DGME Per Resident:</td>
<td>$90,875.33</td>
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<tr>
<td>Medicare DGME Per Resident:</td>
<td>$39,230.50</td>
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<td>IME Per Resident:</td>
<td>$72,450.17</td>
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<td>Part A DGME Payments:</td>
<td>$147,497.00</td>
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<td>$87,086.00</td>
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<td>Total IME Payments:</td>
<td>$434,701.00</td>
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<td>Total DGME and IME Payments:</td>
<td>$670,084.00</td>
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<td>Total DSH Payments:</td>
<td>$924,933.00</td>
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<tr>
<td>Uncompensated Care Payments:**</td>
<td>$2,130,771.00</td>
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<tr>
<td>Total Operating Expenses:</td>
<td>$173,716,336.00</td>
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The percentage of Medicare days at the hospital has a major impact on actual overall GME per resident amounts.

Total amount of reimbursement PRR resident is calculated by dividing “Total DGME and IME Payments for the facility” by “Total FTE residents at the facility.” Remember pediatrics is NOT capped so this is $111,680.67 per resident in non-GME money for the hospital.

In addition, “Total DSH Payments” are the “Disproportionate Share Hospital” payment made to institutions that have large volumes of uncompensated care. Theoretically, a pediatric residency program would be involved in clinics serving that population and an appropriate reason to receive some share of those funds as well.

The row “Additional Allowed FTE Residents” is included on this report to capture the Affordable Care Act’s changes to the Medicare DGME reporting, which provides for reallocation of GME slots from teaching programs that have recently closed. The “Total FTE Residents” for the facility already accounts for these additional residents. The “Approved DGME Per Resident” has also been calculated with the additional residents. No further calculations with this figure are necessary.

The row “Uncompensated Care Payment” is included on this report to reflect additional payments made to hospitals reporting after October 1, 2013. This is for reference only and no further calculations with this figure are necessary.

Please let us know if we can be of any further assistance.
Example of Podiatry Residency Program
Expenses for 2 incoming residents year 1

<table>
<thead>
<tr>
<th>Personnel</th>
<th>FY 17</th>
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<tr>
<td>Program Director</td>
<td>$60,000</td>
<td></td>
</tr>
<tr>
<td>Resident Salaries</td>
<td>$120,000</td>
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</tr>
<tr>
<td>Resident benefits 22%</td>
<td>$26,400</td>
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</tr>
<tr>
<td>Program Coordinator .5 FTE</td>
<td>$27,500</td>
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<tr>
<td>Coordinator benefits 22%</td>
<td>$6,050</td>
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Subtotal                    | $239,950 |         |

<table>
<thead>
<tr>
<th>Operations</th>
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<tbody>
<tr>
<td>Annual Educational Stipend (1000/each)</td>
<td>$2,000</td>
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</tr>
<tr>
<td>Podiatry Residency Resource logs, intraining</td>
<td>$2,000</td>
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<tr>
<td>Dues ACFAS</td>
<td>$236</td>
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<tr>
<td>Administrative Costs (CPME, COTH, CASPR)</td>
<td>$4,350</td>
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</tbody>
</table>

Subtotal                    | $8,586  |         |

TOTAL                      | $248,536 |         |

CPME: Council on Podiatric Medical
Education- annual fee $3000, application fee $1500
COTH: Council of Teaching Hospitals annual fee $750
CASP: Match process, required, annual fee $600
Annual Education Stipend, negotiable
Podiatry Residency Resource intraining exams, $1000/resident
ACFAS resident membership $118 annually

Estimated Per Resident Amount from                         $111,680.67
COTH Medicare Reimbursement Information                   2.0 FTE    $223,361.34
Future of CMS GME funding
Introduction of new legislation

• Resident Physician Shortage Reduction Act of 2017 (H.R. 2267; S. 1301)
• There is projected shortage of up to nearly 105,000 physicians by 2030, This legislation will provide critical additional federal support to help address this shortfall adding 15,000 residency slots over 5 years.
• This bipartisan legislation contains an increase in federal support for GME that is part of a multi-pronged approach to relieving the shortage.
• Introduced in May 2017, currently referred to the Subcommittee on Health
Future of CMS GME funding

• Advocates for GME funding at the national level: Association of American Medical Colleges (AAMC) is convening an Academic Caucus that focuses on political key supporters of GME
• It is unlikely CMS will cut GME funding completely
• There is increasing auditing and accountability reporting and looming budget cuts to GME funding.
Resources

Association of American Medical Colleges (AAMC)

Graduate Medical Education Primers - Parts 1-4:

https://www.aamc.org/advocacy/gme/71152/gme_gme0001.html
Resources

• Accounting services available for GME cost reporting and audits
PriceWaterHouseCoopers:
Dale Deatsch
One North Wacker Drive
Chicago, IL 60606
312-298-5187 (p)
630-347-7862 (c)
813-207-3240 (f)
dale.g.deatsch@us.pwc.com
Resources

Council of Teaching Hospitals GME funding

http://www.cothweb.org/coth/members/members_gmefunding.aspx
Acknowledgments

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References


• PriceWaterhouseCoopers. “Graduate Medical Education Funding.” AACPM IRDC presentation, November 2015.


• AAMC. “Medicare Payments for Graduate Medical Education.” accessed November 2017.

• Mihalich-Levin L. Federal Medicare Funding for GME. August 2013. AAMC.
Thank You