DENTONS

Medicare GME "101"

Society of Academic Anesthesiology Associations

Lori Mihalich-Levin, J.D.
Health Care Partner
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Disclosure of Financial Relationships

I, Lori Mihalich-Levin, J.D., have no relevant financial relationships to disclose.

Objectives

At the conclusion of the presentation, participants will be able to:

- Identify principle sources of public GME funding.
- Contrast Medicare direct graduate medical education (DGME) funding from indirect medical education (IME) funding.
- Discuss limits ("caps") on Medicare funded training positions.
- Identify limited exceptions to Medicare caps.

Who finances resident education and teaching hospitals' special missions?

- **Medicare** (largest explicit payer – today's focus)
- Medicaid (last tally, 41 states)
- Children's GME (CHGME) program
- Private patient care revenues
- VA/DoD
- Other Federal and state programs

Medicare Funding

Medicare makes two different "education" payments

- Direct GME Payments (DGME)
  - Partially compensates for **residency education costs**
  - Paid based on "per resident amount"
- Indirect Medical Education (IME) Payments
  - Partially compensates for **higher patient care costs** because of presence of teaching programs
  - Add-on to inpatient DRG payment, based on formula that uses intern- and resident-to-bed (IRB) ratio

Medicare funding is significant

Estimated Federal Fiscal Year 2012 (payments made to approximately 1,000 teaching hospitals):

DGME Payments = $2.7 billion
IME Payments = $6.7 billion
Total = $9.4 billion

Source: GAO-13-709R Health Care Workforce Training Programs

Medicare DGME Payments

What are DGME payments intended to cover?

- Medicare's share of the costs directly related to educating residents, including:
  - Residents' stipends/fringe benefits
  - Salaries/fringe benefits of supervising faculty
  - Other direct costs (accreditation fees, etc.)
  - Allocated overhead costs

Note: To be counted for Medicare payment, residents must be in **approved programs**

How are DGME payments calculated?

- Step 1: Determine the hospital's per resident base year cost amount - i.e. how much the hospital spent per resident back in 1984
- Step 2: Update (to current year) for inflation the base-year per resident amount (PRA)
- Step 3: Multiply the updated PRA by the number of resident FTEs 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 (often called the "Medicare share")

Initial residency period ("IRP") affects payment

- IRP = minimum accredited length for each specialty
- Residents training during their IRP are counted as 1.0 FTE
- Residents training beyond the IRP counted as 0.5 FTE.
  - Examples?
    - Fellowships
    - Retraining in a different specialty (depending on which specialty)
    - Repeating a year of training
- IRP is determined at beginning of residency and does not change

Medicare pays its "share" of resident "costs":

EXAMPLE

Medicare Share * Per Resident Amount = Medicare Payment Per Resident

35% x $100,000 = $35,000 payment per primary care resident

35% x $90,000 = $31,500 payment per all other residents

(35% x $90,000) ÷ 2 = $15,750 payment for fellow

Medicare IME Payments

What are IME payments intended to cover?

- "Indirect" *patient care costs* associated with having a teaching program
- Higher inpatient operating costs because of the clinical environment where teaching occurs:
  - Unmeasured patient complexity not captured by the MS-DRG system
  - Other operating costs associated with being a teaching hospital (standby capacity, lower productivity, etc.)

How are IME payments calculated?

- Payment is a % add-on to basic Medicare per case (MS-DRG) payment
- IME adjustment is based on statistical analysis - critical factor is intern and resident-to-bed ratios (IRB), meant to be proxy for teaching intensity
- Formula in the statute:

$$\% \text{ per case add-on} = \text{Multiplier X } ((1 + \text{IRB})^{0.405} - 1)$$

(For FFY 2016, multiplier X is 1.35)

- Short hand for IME: Hospitals get about a 5.5% increase in MS-DRG payments for every 10-resident increase per 100 beds

Calculating the IME Payment

- Step 1: Determine the IRB ratio:
  IRB of Baltimore Hope Hospital = 340 residents/1332 beds = 0.255
  (Note: IME resident counts do NOT reflect weighted amounts like DGME counts do)
- Step 2: Use statistical formula and IRB to calculate IME%
  $1.35 \times ((1 + 0.255)^{0.405} - 1) \times 100 =$ 13.00%
- Step 3: Calculate the IME payment for each case
  EXAMPLE: IME add-on payment for MS-DRG 470 (major joint replacement) =
  ($11,378 x 13.00%) = $1,479.14

Medicare Resident "Caps"

Medicare resident limits or "caps"

- Result of 1997 Balanced Budget Act (BBA)
- Generally speaking, a hospital's FTE caps = # of DGME and IME FTEs reported 1996 Medicare cost report.
- Limits may be different for DGME and IME
- No cap for dental or podiatry residents
- Different rules for inpatient rehab and psych facilities

Very few exceptions to the caps

- **New Teaching Hospitals**
  - Get 5 years to start all programs; cap attaches in 6th year
  - Watch out for resident rotator issues
- **Rural Teaching Hospitals**
  - Cap = 130% of 1996 count (BBRA)
  - Cap can be adjusted for new programs
- **Rural Training Track Programs**
  - Urban hospitals can get cap adjustment to accommodate first year of these programs
- **Temporary and Permanent Adjustments Associated with Closed Hospitals and Programs**
  - Temporary slot – through end of displaced resident's training
  - Permanent slot – awarded through application process (Section 5506 of ACA)
- **GME Resident Limit Affiliation Agreements**
  - A way to share cap slots under certain conditions

Counting Resident Time

Counting resident time matters for payment

- How many resident FTEs the hospital is able to count determines its DGME and IME payments
- It is NOT intuitive which time counts and which time does not
- Time-counting regulations are voluminous and complicated
- WHERE the resident is at a given moment is key factor

Resident time counted and not counted for Medicare DGME and IME payments (ACA § 5505)

DGME

Hospital	Non-Hospital
Patient Care	Patient Care
Vacation/Sick	Vacation/Sick
Didactic	*Didactic (July 1, 2009+)*
Research	NOT Research

IME

Hospital	Non-Hospital
Patient Care	Patient Care
Vacation/Sick	Vacation/Sick
Didactic (Jan. 1, 1983+)	NOT Didactic
*NOT Research (Oct. 1, 2001+)**	NOT Research

Note: Text in italics indicates language in the Affordable Care Act.

Thank you

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Dentons US LLP
1301 K Street, NW
Suite 600, East Tower
Washington, DC 20005-3364
United States