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Medicare's Role in Financing GME

"Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. 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 considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program" (emphasis added, S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965); H.R. No. 213, 89th Cong., 1st Sess. 32 (1965)).

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CMS's Role in GME

- Congress enacts the law (Social Security Act)
- CMS is the regulatory agency implementing the law
  - CMS is limited by what the law says
  - CMS does not make recommendations to Congress
- Oversight and quality – law delegates to accrediting agencies
- Workforce issues – not CMS's purview.
  - Council on Graduate Medical Education at HRSA

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2 Types of Medicare GME Payments

- Direct GME Payments (DGME)
  - Partially compensates for residency education costs
    - Salaries of staff, residents, and other direct costs
- Indirect Medical Education (IME) Payments
  - Partially compensates for higher patient care costs due to presence of teaching programs
- It's a percentage add-on payment to basic Medicare per case (DRG) payment

Direct GME Payment Formula

For each hospital:

- DGME payment = $PRA x FTE residents x Medicare utilization
  - Per Resident Amount (PRA) is a hospital-specific cost per resident in a 1984 base year updated for inflation.

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IME Payment Formula

- The IME payment is based on a statistical adjustment dependent upon each hospital's ratio of FTE residents to inpatient beds

- IME payment =
  - DRG Payment X 1.35 X ((1 + FTE Res/Beds)$^{0.405}$ - 1)

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Definition of a Teaching Hospital

- 42 CFR §415.152. "Teaching hospital" means a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

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Definition of a Teaching Hospital

- CMS staff has said that if the training occurs according to a planned and regular schedule (i.e., not spontaneous or random), then it's a teaching hospital, *even if*
  - It is not incurring the costs of the residents' salaries and fringe benefits
  - It is not the sponsor of the program
  - It is only training a very small amount of FTEs

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FTEs on the Cost Report

- A "teaching hospital" is required to report FTEs on the Medicare cost report.
- One hospital is not allowed to claim residents for IME or DGME payment that are training at another hospital (1886(h)(4)(B), 42 CFR 412.105(f)(1)(iii), 413.78(b))

What triggers a DGME PRA?

- PRA (Per Resident Amount) is triggered by the presence of medical, osteopathic, dental, or podiatry FTE resident(s) in an approved (new OR existing) program rotating in the hospital according to a planned and regular schedule.
  - if PRA was established at any point in the past, retrieve that PRA– do not calculate a new PRA.

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What if no PRA was calculated?

- MAC would use the *earliest, still reopenable* cost report in which the hospital was training residents, as the PRA base period

4. Determine if Hospital has Permanent IME and DGME FTE caps

- How? Hospital and MAC must check records
  - "1996 Base Year Caps" – check most recent cost reporting period ending on or before 12/31/96
  - IME: Check cost report that includes 10/1/97
  - DGME: Check cost report beginning on or after 10/1/97
- If FTEs and/or payment reported, then hospital already has FTE caps. Retrieve those FTE caps and the hospital must use them.

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If no 1996 Base Year Caps…

- If no1996 Base Year Caps, permanent FTE caps are triggered when a hospital participates in training residents in a brand new program started or accredited *on or after January 1, 1995.*

- NOTE: *Triggering a PRA does not always mean a cap is triggered*. Training residents from an existing program will trigger the PRA, but not permanent caps. Only training residents in a new program will trigger permanent caps.

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5. Determine if Training was/is in a New Program

- Consider (August 27, 2009 FR, page 43908):
  - Is the program director new (separate)?
  - Is the teaching staff new (separate)?
  - Are the residents PGY1s, not residents from existing programs (designated to go to RTT)?
  - More generally, is this program part of any existing hospital's FTE caps? If yes, then this is a spinoff of an existing program, and is not new.

Implications for Rural Training

- Refer to "new" criteria
  - Rural hospitals can get additional cap slots for participating in new programs, but not for program expansions

- Some rural hospitals served as an additional training site for urban hospitals' existing programs
  - PRA could have been triggered
  - No additional cap slots provided, so rural hospital may not be able to receive IME and DGME $

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Implications for Rural Training

- Urban hospitals: If already has a RTT in family medicine, additional residents added or rural sites added may be an expansion
  - E.g., Hub and Spoke model
- No new cap slots provided if "new" criteria are not met
- New RTTs may be established in specialties other than family medicine, but must be "separately accredited"

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RTTs in the Law- Section 1886(h)(4)(H)(iv) of the SSA

"*Nonrural hospitals operating training programs in rural areas.*—In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas."

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RTT law continued

- In the case of a hospital that is not located in a rural area [i.e, urban hospital] . . ., the Secretary shall adjust the limitation under subparagraph (F)
  - What about adjusting the limitation for both the urban AND the rural hospital?
  - What about adjusting the limitation of both urban and rural hospitals for the first RTT, and when additional tracks are established at additional rural sites?

Misc. Issues

- HRSA THC grant – these are approved residency programs, FTEs rotating at hospitals must be reported on Medicare cost report, would trigger PRA, and if new, would trigger caps
- CAHs – paid based on 101% of reasonable costs, PRAs and caps do not apply, no limit on FTEs for reimbursement
- SCHs – If paid on HSR, IME is inherent in HSR payment. IME for Medicare Advantage enrollees is paid to SCH regardless if paid on Federal rate or HSR. (see 79 FR 50001, August 22, 2014)

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Changes from Rural to Urban Status

- Due to new OMB census delineations effective 10/1/14, regulations provide for transition period for previously rural hospitals to "reclassify" back to rural status, but only for IME purposes, not DGME
- RTTs – urban hospitals must find geographically rural partners, or if previously rural hospital reclassifies back to rural status, only affects the urban hospital's IME payments, not DGME
- Previously rural CAHs must also reclassify back to rural to maintain CAH status
- See FY 2015 IPPS rule, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page-Items/FY2016-IPPS-Proposed-Rule-Regulations.html

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