Acronyms & Definitions

Cap – Total number of residents/fellows CMS will pay for in your system
CBSA – Core Based Statistical Areas – socioeconomically tied regions around a city used by federal government to identify medical service areas
CMS – Center for Medicare & Medicaid Services – federal agency that pays for GME funding
DME or DGME – Direct Graduate Medical Education – reimbursement to hospitals for costs such as resident salary, benefits, and faculty and hospital overhead expenses
DSH – Disproportionate Share Hospital funding – additional funds for hospitals with more than 30% of patients whose payments come from indigent care funds
IME – Indirect Medical Education adjustment – higher operating cost to the hospitals from teaching activities including increased lengths of stay & higher acuity patients.
IRB – Intern & resident per bed ratio at each hospital used to calculate IME
IRP – Initial Residency Period – first GME program a resident enrolls in which sets the number of years for their full-time payment from CMS
IRIS – Intern Resident Information – reporting system of resident to CMS also known as the "Cost report"
PRA – Per Resident Amount – used to calculate DME

History of Graduate Medical Education (GME) Funding

- Pre 1965 – House Officers were given room & board for work/training
- 1965 – The Department of Health, Education & Welfare created the Social Security Act that included Medicare & Medicaid (and GME funding)
- 1980's – Hospitals found this was a way to pay for hospital-based indigent care & teaching hospitals/residents became the soul source of care for poor populations.
  Disproportionate Share Hospital funding (DSH) was developed to account for this phenomenon.
- 1983 – Prospective Payment System – broke GME into DME & IME
- 1997 – Residency spots or Intern & resident per bed ratio (IRB) at each hospital were capped retroactively to December 1996 (Exempted - dentists & podiatrists)
  1996 levels. First allowed payment for time spent in clinic (non-hospital setting)
- 2005 – GME redistribution of 3,000 residency positions

Center for Medicare & Medicaid Services (CMS) Financing

Direct Graduate Medical Education (**DGME**) – reimbursement to hospitals for costs such as resident salary, benefits, and faculty and hospital overhead expenses directly related to graduate medical education. (2012– $2.6 billion)

- Things that are paid for:
  - "…pay for time spent in hospital and "non-provider setting" that are 'primarily engaged in furnishing patient care' & for didactics."
    - Must pay for "substantially all (90%) of the cost of the residents salary & benefits while they are at a non-hospital site, and the portion of the teaching physicians salary & benefits that are attributable to GME"
    - Must have a written agreement with the teaching physicians
  - Leave and vacation time that do not prolong the resident's training

Indirect Medical Education adjustment (**IME**) – higher operating cost to the hospitals from teaching activities including increased lengths of stay & higher acuity patients. (2012 - $6.8 billion)

- Things that are not paid for
  - Time spent in medical school setting without a hospital
  - Research activities that "are not associated with the treatment or diagnosis of a particular patient"
  - Time spent on international rotations

- Reporting
  - IRIS (Intern Resident Information System)
  - Many hospitals that 'share' residents between sites have had to account for their residents' time by the hourly logs.
- To most successfully play "the game" to get maximum GME funding, a program needs residents "above the cap" for times that don't count for each resident.

Calculating the GME finances

Direct Graduate Medical Education

- DME remains tied to 1984 cost-based reimbursement for salaries, benefits, faculty and hospital overhead directly related to GME (office space) – this led to differences in payments across the country – per resident amount (PRA). Still, CMS only pays for Medicare proportion of hospital cost, presuming the other insurance, Medicaid & local indigent care funds pay for the rest.
    - Increases are based upon consumer price index & primary care was allowed more some years so the PRA is different for specialties.
    - Full payment is only for the initial residency training period (based on the 2nd year of training) & those training further are limited to 0.5 FTE for DGME funding.
- E.g. Each resident DGME cost is $100,000, you have 30 EM residents & 35% inpatient beds utilized by Medicare = $1,050,000

Indirect Medical Education

- IME is not different between primary care or adjusted for length of training.
    - IME adjustment payment over the past 10 years this has significantly decreased (1997 =7.7% to now = 5.5%). IME adjustment is calculated using:
        - IME multiplier for FYE 2009 = 1.35
        - Formula to calculate IME
            - Adjusted ratio = IME multiplier{[1 + (#residents/#beds)] $^{0.405}$ -1}
            - IME adjustment = Adjusted ratio x (%Medicare pts.)(DRG payment) (Case mix ratio)
        - E.g. Current IME Adjustment = 5.5% increase in DRG payment for every 10 resident increase per 100 beds

Medicaid GME Funding

- Most states (not IL) provide some monies for GME training; CMS provides ~50% of their GME cost obligation so they can match these funds – (2012 - $3.9 billion)

VA GME funding

- Generally only pays for DGME – (2012 - $1.4 billion)

Fellowship funding

- ACGME approved – Treated as a resident in all federal registry language
    - Can't bill for Medicare/Medicaid patients if in the same specialty
    - Only count as 0.5 FTE for direct GME funding in IRIS report
    - Can work & bill as attending if not in same specialty if working an outpatient setting including the ED
- Non-approved –work shifts in ED (80 hours/month average) - EMS, Education

GME Resident "Caps"

1997 law – the number of residency positions that CMS will pay each institution is "capped" – this number was determined to be the Intern & Resident per Bed ratio (IRB) at each hospital based on the number of trainees in the facility on Dec 31, 1996.

"Over the cap" means

- The hospital has more employed residents than we have slots.
- No one program is "over cap", adding residents just reduces the per resident subsidy

Why be over cap?

- Some subsidy is better than no subsidy (no other workforce element is subsidized)
- Residents are attractive (attract faculty, provide marketing value, facilitate service lines)
- They work more than the "usual FTE", some time twice as much (up to 80 hours)

References:

AAMC Medicare Payments for Graduate Medical Education series
Videos

- https://vimeo.com/130906135 - GME Primers - Part 1
- https://vimeo.com/130906133 - GME Primers - Part 2
- https://vimeo.com/130906134 - GME Primers - Part 3
- https://vimeo.com/130906132 - GME Primers - Part 4

Articles

- https://www.aamc.org/advocacy/gme/71152/gme_gme0001.html - Medicare DGME Payments
- https://www.aamc.org/advocacy/gme/71150/gme_gme0002.html - Medicare IME Payments
- https://www.aamc.org/advocacy/medicare/155102/dsh.html - Medicare DSH Payments
- https://www.aamc.org/advocacy/gme/275136/chgme.html - Medicare Children's Hospital (CHGME) Payment Program

CMS web site for GME funding:

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME.html
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Indirect-Medical-Education-IME.html
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

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