



Advanced Graduate Medical Education Financing  
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# Advanced Graduate Medical Education Financing

Topics to be covered today:

- Medicare reimbursement refresher-covered in brief
- Will touch on key components of the cost report that affect Medicare GME reimbursement
  - DRG Payments
  - Patient Days
  - Bed Days Available
  - FTEs
  - Per Resident Amount
  - Prior year IME resident to bed ratio
  - Medicare Managed Care volumes
  - Resident Caps
- GME Strategic reimbursement issues
  - Counting/Managing Bed Days Available
  - Impacts of Rotations to other hospitals/non hospitals
  - Ways to increase the number of residents you are paid for
  - Optimizing Medicare Managed Care
- Calculating reimbursement per resident and GME contribution margin
- How GME program and operational decisions can affect GME reimbursement



## Counting FTEs for Medicare IME and DGME

- ❑ Generally, must be an accredited program:
  - ❑ Accreditation Council on Graduate Medical Education (ACGME)
  - ❑ American Osteopathic Association (AOA)
  - ❑ American Dental Association (ADA)
  - ❑ American Podiatric Medical Association (APMA)
  - ❑ Programs that lead to board certification by the American Board of Medical Specialties (ABMS)
  - ❑ Note ACGME and AOA to develop single accreditation system
- ❑ An FTE equals the amount of time needed to fill one residency slot (not necessarily 40 hours/week)
- ❑ Count no individual as more than one FTE (across all providers)
- ❑ Count vacation, sick, and leave time that does not add to the time spent in training
- ❑ One misconception-Medicare audit contractors do not compare actual FTEs by specialty to accredited FTE slots



## Counting FTEs for Medicare IME and DGME

- ❑ Exclude time spent at another hospital or provider that would be able to claim the resident themselves-this does not mean you can count them if the other hospital or other provider has no approved program or chooses not to count them
- ❑ Time spent moonlighting at your hospital or another hospital is not counted for IME or DGME purposes
  - ❑ This can typically be billed as inpatient services for outpatient services, but not inpatient services
  - ❑ These are also not “residents in non approved programs” subject to Part B cost reimbursement
- ❑ Note you are counting time based on where the resident is:
  - ❑ Do not assume the resident is on site in preceptorship arrangements
  - ❑ The count should be based on actual, not scheduled rotations
  - ❑ These are important concepts for the reimbursement personnel at your hospital-failure to understand this can lead to unexpected cost report audit disallowances of FTEs
- ❑ Providers are required to report FTEs that correspond to CAP FTEs received in the latest redistribution



## Counting FTEs for Medicare IME and DGME

- ❑ Generally include time spent in non hospital sites as long as the hospital is compensating the residents for their time
  - ❑ This has not always been the case; at one time this could not be counted for IME, at other times there have been complicated formulas required to show that the hospital was incurring a significant % of the cost including teaching physician cost
  - ❑ The site should be one that is primarily engaged in patient care. Residents rotating to University locations are generally not included for Medicare reimbursement purposes
- ❑ Do not count time Residents are rotating to other hospitals, regardless of who is paying for the resident
  - ❑ I have in the past seen some Medicare audit contractors allow this as long as the other hospital was not counting the time, but this is not appropriate and is increasingly rare
  - ❑ Ideally, the other hospital is compensating your hospital for the salary and fringe benefits, but this does not always happen
- ❑ There are new requirements that hospitals segregate time counted that was spent at non provider sites
- ❑ Time is reported to Medicare via the IRIS electronic record submitted with the Medicare cost report



## Counting FTEs for Medicare IME Specifically

- ❑ For IME, count the time the resident spends in inpatient and outpatient areas of the hospital that are subject to PPS(exclude time spent in PPS exempt subproviders)
- ❑ Important to remember to count time based on where the resident is training, not the specialty. A common mistake I have seen is that Psychiatric residents are counted as being in the Inpatient Psychiatric unit, regardless of where the training takes place. This is important because PPS exempt inpatient psychiatric units and Rehab units have their own separate reimbursement for IME
- ❑ Count Didactic time spent as long as it is spent in the hospital
- ❑ Do not count time spent on research, unless it relates to a specific patient's care
- ❑ Both Inpatient Psychiatric Hospitals and Units and Inpatient Rehabilitation Hospitals and Units have IME provisions unique to those payment methodologies, and caps that are specific to those programs as well



## Counting FTEs for Medicare DGME Specifically

- ❑ For DGME, count the time the resident spends in inpatient and outpatient areas of the hospital that are subject to PPS and include time spent in PPS exempt subproviders
- ❑ Count Didactic time spent as long as it is spent in the hospital and include time spent in non hospital sites
- ❑ Count Research time that is incurred at the hospital site. Otherwise, do not count time spent on research, unless it relates to a specific patient's care
- ❑ PGY (post graduate year) refers to the year of training the resident is currently enrolled in and is important for FTE weighting purposes
  - ❑ It is critical that the IRIS submission to Medicare reports both the residency specialty and the PGY correctly so the resident FTE is appropriately weighted at 100% or 50%
- ❑ For DGME, residents must be counted by specialty as different PRAs apply to Residents in Primary Care and OB
- ❑ Weighted Residents-certain residents FTEs are weighted by a factor of 0.5 for purposes of Medicare reimbursement-note that the residents FTEs are compared based on unweighted FTEs, and the percentage disallowance, if any, is then applied to the weighted count of FTEs



## Counting FTEs for Medicare DGME Specifically

### Weighted GME Residents FTEs

- ❑ Used to apply to foreign medical graduates that did not pass their equivalency exam
- ❑ Now applies to residents that continue training past the minimum number of years required for Board Certification in each specialty, not to exceed 5 years, referred to as Initial Residency Period (IRP) limitation
- ❑ IRP limits are based on the first specialty chosen by the resident, except for certain “combined programs” such as internal medicine/pediatrics
- ❑ Exceptions of up to two years for preventative medicine and geriatrics completed after other specialties





# Counting FTEs for Medicare DGME Specifically

## Weighted GME Residents FTEs

- ❑ In general, programs affected are:
  - ❑ Programs with prerequisites (Sometimes applies when an Osteopathic residents transfers to an ACGME program and the ACGME program does not give credit for the first year of Osteopathic training)
  - ❑ Combined programs where one or more of the specialties does not relate to primary care
  - ❑ Subspecialty programs requiring the completion in a specific specialty prior to starting the subspecialty program
  - ❑ Establishing a Transitional Year specialty accredited program is one way to help reduce IRP limitations-the IRP count does not start until the resident's second year, when a specialty is selected
  - ❑ In Osteopathic programs, a Traditional Year specialty accredited program is treated the same way an ACGME transitional year program is treated
  - ❑ In CMS final rules for 2005 and 2006, CMS indicated that residents that simultaneously(or before first year training starts) match for both a preliminary year program and a second year specialty program begin their IRP in the second year



## Medicare Medical Education Reimbursement Refresher

- ❑ Both DGME and IME reimbursement calculations include limitations such as the following:
  - ❑ A cap on residents FTEs based on the 1986 Medicare cost report allowable FTEs or a subsequent year if there was no teaching program in 1986-the cap for IME is not necessarily the same as the cap for DGME. Cap is applied before the weighting for residents for DGME reimbursement purposes. The cap does not apply to dental or podiatric residents. Rural Hospital caps were increased by 30% subsequent to 1986.
  - ❑ Current cost report year allowable FTEs are not based solely on the current year, but a three year rolling average including the two previous cost reporting periods
  - ❑ DGME residents FTEs are weighted by a factor of 0.5 if the resident has exceeded their “initial residency period limitation”, which is determined based on the minimum numbers of years it would take to complete training in the applicable residency specialty. This has the effect of reducing reimbursement for many fellows and chiefs, as well as residents that switch specialties and/or take longer than the minimum amount of time to complete training
  - ❑ The IME resident FTEs to bed ratio used to calculate the IME add-on to DRG rates is limited to the prior year resident FTEs to beds(**Prior year FTEs not prior year rolling average FTEs**). This has the effect of forcing hospitals to wait one year to see the financial benefit of an increase in FTEs or a decrease in beds, **all other things being equal**.



# Operating IME Example

Operating Indirect Medical Education:		Typical Source	
FTE cap	150.50	Per MAC or audited cost report	<ul style="list-style-type: none"> <li>▪Formula = (1+ (residents FTEs to average bed days available) raised to the power of .405) -1 multiplied by 1.35</li> <li>▪1.35 factor had been subject to change in past years but has not changed since 2008</li> <li>▪For FTEs allowed as a result of redistribution the factor changes from 1.35 to 0.66</li> <li>▪Settlement is on cost report Worksheet E Part A and regulations are at 42 CFR 412.105</li> </ul>
Redistribution/Affiliation Adjustments to cap	(25.00)	Per MAC correspondence	
Adjusted cap	125.50	Calculation	
Current year FTEs	130.00	Current year log of FTEs	
Current year Dental and Podiatry Residents	5.00	Current year log of FTEs	
Current year allowable FTEs	130.50	Calculation	
Prior year allowable FTEs	129.00	PY cost report and known adjustments	
Penultimate year FTEs	100.50	PY cost report and known adjustments	
Three year average FTEs	120.00	Calculation	
1 time adjs (FTEs closed hospitals, new residents)	3.00	Per CMS correspondence	
Three year average FTEs plus adjustments	123.00	Calculation	
Bed days available	265.00	Current year Census by nursing unit	
Residents to beds ratio	0.4642	Calculation	
Prior year residents to beds ratio	0.4562	PY cost report and known adjustments	
Lessor of current or prior year	0.4562	Calculation	
Operating IME Factor	0.2219	Calculation	
Inlier DRG payments	75,000,000	Per rate letters, PS & R, or PPS pricer	
Projected Operating IME payments	16,646,130	Calculation	
Interim Payment Factor	0.2100	Per rate letters or PS & R	
Interim Payments	15,750,000	Calculation	
Interim Lump Sum Adjustments	1,250,000	Per rate letters	
Net settlement	(353,870)	Calculation	



# Medicare IME Reimbursement

## Operating IME

- ❑ IME reimbursement is usually why teaching program P & Ls are in the black-difficult to identify indirect costs, so the revenue is added but costs are not
- ❑ MEDPAC recommends reducing the IME payment factor as they believe it is currently still too high (exponent was once 1.86, now 1.35)
- ❑ Note that inlier DRG payments in this example would include DRG payments associated with Medicare Managed Care patients-hospitals must bill these claims directly to Medicare to receive credit for these
- ❑ Note the cost report allows for some adjustments to FTEs after the three year average has been calculated-this is primarily for hospitals taking on residents from closed hospitals and new teaching programs
- ❑ The same is true for adjusting the prior year residents to beds ratio
- ❑ On an interim basis, payments are made as a per inpatient case percentage add-on, but reconciled to actual on the cost report



# Medicare IME Reimbursement

## Capital IME:

- ❑ There is also a separate payment for capital IME
- ❑ Payment is based on Operating IME FTEs divided by average daily census (PPS units only and excluding normal newborn)
- ❑ This is converted to a factor, which is applied to capital inlier DRG payments
- ❑ Interim payments are based on this factor applied to inlier capital DRG payments for each inpatient, but reconciled to actual on the cost report
- ❑ Capital IME payments are generally small, because they are added to the capital rate, which is approximately \$425 before being adjusted for area wages and the DRG weight for each patient
- ❑ Factor =  $\{e^{-.2822 \times \text{FTEs/Average daily census}}\}^{-1}$  where  $e = 2.71828$



# DGME Example

Direct Graduate Medical Education:			Typical Source
FTE Cap	160.00		Per FI or audited cost report
Redistribution/Affiliation Adjustments to cap	(35.00)		Per CMS correspondence
Adjusted cap	125.00		Calculation
Current year unweighted FTEs	134.00		Current year log of FTEs
Current year weighted primary care and OB/GYN FTEs	82.00		Current year log of FTEs
Current year weighted all other FTEs	48.00		Current year log of FTEs
Current year Dental and Podiatry Residents	5.00		Current year log of FTEs
	Primary	Other	
Current year allowable FTEs	76.49	49.78	Calculated based on ratio of cap to current year total
Prior year allowable FTEs	76.30	50.10	PY cost report and any known adjustments
Penultimate year FTEs	70.10	45.35	PY cost report and any known adjustments
Three year average FTEs	146.40	95.45	Calculation
One time adjustments (FTEs closed hospitals)	2.00	1.00	Per CMS correspondence
Three year average FTEs plus adjustments	148.40	96.45	Calculation
Per Resident Amount	123,100.00	119,250.00	Per FI correspondence
Total Approved amount	29,769,703		Calculation
Medicare Patient Days	43,000		Per YTD Census and/or PS & R
Total Patient days	90,000		Per YTD Census
Medicare reimbursement	14,223,303		Calculation
Medicare Managed Care Patient Days	7,500		Per YTD Census and/or PS & R
Medicare Managed Care Reimbursement (and reduction)	2,130,270		Calculation (14.13% reduction)
Total expected reimbursement	16,353,573		Calculation
Interim Payments	16,100,000		Per rate letters
Net settlement	253,573		Calculation



# Medicare Direct GME Reimbursement

- ❑ Inputs are: allowable Primary Care and OB/GYN FTEs, Allowable other FTEs, per resident amount, Medicare patient days, Medicare Managed Care patient days (again claims must be billed to Medicare), total patient days
- ❑ Patient days exclude normal newborn patient days
- ❑ Interim Payments are made as a biweekly lump sum adjustment
- ❑ Formula = Residents FTEs multiplied by Per Resident Amount and Medicare and Medicare HMO percentage of total patient days
- ❑ Per resident amount is hospital specific
- ❑ For FTEs allowed as a result of redistribution the per resident amount is a national average amount
- ❑ Settlement is on cost report Worksheet E-4 (formally E-3 Part IV) and regulations are at 42 CFR 413.75-413.83



## Medicare Medical Education Reimbursement-FTE Caps

The opportunities to adjust or receive exceptions to the FTE caps have been and are limited:

- ❑ There have been two national redistributions of caps where CMS engineered shifts of “excess cap FTEs” to hospitals that were over the caps and/or met other criteria-most rural hospitals were exempt from “excess cap adjustments”
  - ❑ Recipient Hospitals were determined through a criteria based application process-most recent redistribution steered most slots to states with the lowest resident-to-population ratios and to primary care through an elaborate point system
  - ❑ Recipient hospitals do not receive the same reimbursement levels for the additional slots
  - ❑ New cost reporting requirements for hospitals to identify the newly approved actual residents for the ACA section 5503 (most recent) redistribution
  - ❑ Post redistribution, primary care residents cannot be less than average for three most recent cost reports submitted by March 23, 2010. Must use 75% for primary care. Failure to meet these criteria will result in permanent loss of the cap increase





## Medicare Medical Education Reimbursement-FTE Caps

The opportunities to adjust or receive exceptions to the FTE caps have been and are limited:

- ❑ Hospitals that meet applicable criteria can affiliate for purposes of applying the residents cap to actual FTEs
  - ❑ Generally, hospitals must be in the same CBSA, officially listed as joint sponsors of teaching program, officially listed under “affiliations and outside rotations” (AOA), or commonly owned
  - ❑ Can be more than two hospitals
  - ❑ Each participant must rotate residents to another participant
  - ❑ File application prior to training year(July 1), but have opportunity to true up (prior to June 30)
  - ❑ Letter must include each hospital’s pre-affiliation cap and each hospital’s post affiliation cap
  - ❑ Total cap among all participants cannot change
  - ❑ Rules state that positions received through one of the redistributions cannot be shared with other hospitals
  - ❑ New teaching hospitals can only participate as a cap recipient-not as a donor to other affiliated hospitals



## Medicare Direct Medical Education Reimbursement-FTE Caps

Adjustments to Caps continued:

- ❑ Some Hospitals received adjustments to the cap for new specialty programs started prior to the end of the cost reporting period on which the cap was calculated but for which the program had not yet been through a full cycle of training-Interventional Cardiology was a common program for this
  - ❑ Hospitals submitted these adjustments in subsequent cost reporting periods
- ❑ Hospitals can receive temporary and/or permanent adjustments to the cap for taking on residents from closed hospitals (ACA 5506)
  - ❑ Permanent adjustments are for closed hospitals, not closed programs
  - ❑ CMS announces slots available and hospitals can apply for permanent cap adjustments
  - ❑ Applications assessed based on specific criteria; being the hospital that took on some or all of the residents when the hospital closed puts you first in line; being in the same CBSA, state, then region and primary care and surgery applications receive preferential treatment
- ❑ Urban hospitals can start a rural track program in which there must be minimum level of rotations to rural settings, and which allows for an exception to the cap for the urban hospital



## Medicare Direct Medical Education Reimbursement-FTE Caps

Adjustments to Caps continued:

- ❑ There is periodic discussion of adding more FTEs to the national totals, particularly as so many hospitals are above their caps-Current President's proposed budget includes 13,000 new resident cap slots
- ❑ Rural Hospitals can start a new specialty program at any time and receive a higher cap
- ❑ Hospitals that have not had a teaching program since 1996 can start their own teaching program and establish their own cap:
  - ❑ Cap is based on fifth year of program; within each specialty, highest FTE count by PGY level multiplied by number of years on program, capped at accredited slots. Note cap is calculated based on each specialty, but applied in later years in the aggregate.
  - ❑ Per-Resident-Amount is based on first full year of cost, divided by FTEs. Also capped based on other area teaching hospitals' per resident amounts
  - ❑ Payments during transition are based on actual FTEs for that year rather than the three year rolling average, until the hospital has trained residents through the minimum number of years for board certification-this is done on a specialty specific basis
  - ❑ New teaching hospitals must avoid all appearance of transferring residents, teaching physicians, coordinators from existing programs, which makes it more difficult to ramp up to full capacity



## Medicare IME Strategies (Other than FTEs)

- ❑ Anything that increases Inlier DRG payments increases IME proportionately
  - ❑ Wage Index optimization and geographic reclassification
  - ❑ A great target for teaching hospitals is Medicare casemix; clinical documentation improvement programs usually yield higher casemix values and therefore higher DRG rates
- ❑ Bed days available:
  - ❑ FTEs is only half of the IME factor equation-reducing bed days available helps too. And there is no “cap” on bed days available. This statistic is simply maintained beds divided by days in the cost reporting period
  - ❑ Nursing units that have been closed to inpatients for three months can be excluded from the count of bed days available-all you need to show is census data with no activity
  - ❑ Individual beds that are not able to be reopened within 24 hours for 30 days or more can be excluded as well. MAC auditors assume they can be reopened unless the provider can demonstrate otherwise.
  - ❑ Observation patients in inpatient beds are reported on cost report worksheet S-3 Part I and the bed days available calculation is automatically adjusted. Days are calculated by dividing observation hours by 24.



## Medicare IME Strategies-Beds

### Assessing Bed Days Available:

- ❑ On one spreadsheet, identify beds, monthly inpatient census, peak inpatient census, and outpatient census (observation or bedded outpatients) by inpatient nursing unit
- ❑ Units showing the greatest disparity between beds and average census should be targeted, and the following strategies considered:
  - ❑ Close/combine nursing units that are severely underutilized by inpatients and for which the patients can realistically be treated elsewhere. You can then take advantage of the three month rule applicable to entire units
  - ❑ Consider reducing the license for severely underutilized specialty units (Do we really still need 25 pediatric beds when our average census is 4, and the peak census for the last two years is 8?)
  - ❑ Reducing the license is frequently met with resistance; if that is not feasible, consider covering the oxygen and other hookups, and removing the track for the privacy curtain. This investment will enable you to effectively argue to the MAC auditors that the beds in question could not be reopened within 24 hours and therefore can be excluded after 30 days
  - ❑ Some providers offer the continuum of Cardiac Care in one unit; CCU, step down, and med./surg. This would enable the provider to reduce bed capacity.



## Medicare IME Strategies-Beds

### Assessing Bed Days Available Continued:

- ❑ Units showing the greatest disparity between beds and average census should be targeted, and the following strategies considered:
  - ❑ Consider units where many observation and other types of outpatients are treated. If there are enough of these patients, consolidating the services to one nursing unit, and not allowing inpatients to that unit, would enable the hospital to take advantage of the three month rule here also. Because observation patients are carved out based on hours divided by 24, the impact of doing this is typically greater than the impact of carving out observation based on individual patient days. Because there is no mechanism in the cost report for carving out other types of outpatient utilized beds, this strategy is even more effective for these patients.
  - ❑ Examples of “bedded outpatients” include; infusion therapy patients, outpatient surgery recovery patients, dialysis patients, etc.
  - ❑ If your hospital has a traditional labor and delivery and separate maternity units, consider an LDRP or single room maternity set up (Labor and Delivery beds used to be excluded, but not any longer)
  - ❑ Units where peak census is often much higher than average census-burn units, trauma units, maternity units
- ❑ **Lastly, do a walk through-you never know what you will find**



# Medicare Managed Care Reimbursement for GME

Medicare managed care payors will not reimburse hospitals for teaching, because:

- ❑ Medicare includes managed care reimbursement on the cost report for both IME (Operating only, not capital) and DGME
- ❑ Hospitals must bill Medicare directly for all Medicare managed care claims in order to receive credit for Medicare managed care-have one year after the end of the cost reporting period to do so
- ❑ PS & R report type 118 reports the claims information related to these claims; specifically the inpatient inlier DRG payments to which the IME factor is applied, and the inpatient days used to calculate the Medicare portion of DGME reimbursement
- ❑ DGME reimbursement for Medicare managed care is reduced by 14.3% to pay for the Medicare allied health Medicare managed care reimbursement
- ❑ Medicare managed care days for the PPS exempt units such as Rehab and Psych are reflected in the DGME days **if they are billed to Medicare**



# Medicare Managed Care Reimbursement for GME

## Strategies:

- ❑ Make sure you are capturing all Medicare managed care patients for GME billing
  - ❑ To include Rehab and Psych subprovider patients for DGME days
- ❑ Consider a vendor or develop your own process to review the Medicare common working file to ensure that all Medicare eligible patients are captured
- ❑ Remember that the IME factor is applied to inlier DRG payments, which should be optimized as well
  - ❑ Many Hospitals have a clinical documentation excellence or clinical documentation improvement program, but the program may be restricted to Traditional Medicare patients
  - ❑ Open up the process to review Medicare managed care patients and ensure that any coding changes are reflected in the “shadow bill” to Medicare





# Decisions that Can Affect GME Reimbursement

- What drives Medicare reimbursement for GME programs
  - More Residents FTEs
  - Fewer residents with IRP limitations
  - Fewer beds
  - Higher Inlier DRG payments for Medicare and Medicare managed care patients
  - Lower total patient days and/or higher Medicare and Medicare managed care patients days resulting in Higher Medicare and Medicare managed care days as a percentage of total days
  - Higher DGME per-resident amounts



# Decisions that Can Affect GME Reimbursement

## ❑ Beds:

- ❑ “Our census is really high today. Let’s reopen that Med./Surg. Unit we closed three months ago, just for a day or two”. We just lost the right to exclude that unit from our bed count for another three months.
- ❑ Even if you have a dedicated observation unit, you can still put observation patients in the inpatient units and receive the benefit of the carve out based on hours divided by 24

## Shifting Residents between providers:

- ❑ If you have multiple providers it pays to know which one offers greater reimbursement per resident FTE. Otherwise, the decision to move residents to the provider that has more beds and less Medicare volume may cost you, literally.
- ❑ It also pays to understand why reimbursement is higher; for example:
  - ❑ Applying for PPS exemption for a psych unit or reversing that decision affects bed days available; however, you may be able to count residents in the exempt unit if you have a cap
  - ❑ Moving a service line to a Joint Venture such as pediatrics is a win for IME and DGME-decreases beds, increases Medicare percentage of total days



# Decisions that Can Affect GME Reimbursement

## ❑ Configurations of residents:

- ❑ Adding Fellows reduces GME reimbursement-on the other FTEs too because the cap comparison is done at gross and then applied to net
- ❑ Consider a Transitional or Traditional residency program as an effective means of reducing IRP reductions in the last year of some specialties
- ❑ Prioritize residents that can match for a preliminary year program and a second year specialty program for applicable specialties to ensure that the IRP starts in year two

## ❑ Rotations:

- ❑ Consider the provider type of the rotations to non hospital sites; rotations to physicians' offices can still be counted; rotations to an FQHC can potentially be counted by the FQHC, which means your hospital cannot count them
- ❑ Rotations to sites not primarily engaged in healthcare cannot be counted
- ❑ Rotations to and from other hospitals related to cap affiliation agreements or other reasons should ideally be consistent. Rotating first to another provider and then back causes the hospital to lose reimbursement via the IME lower of current or prior year resident to bed ratio
- ❑ Rotations to PPS exempt Psychiatric and Rehabilitation units removes them from PPS IME but may allow PPS exempt unit IME reimbursement



# Decisions that Can Affect GME Reimbursement

- ❑ Where certain types of time is spent:
  - ❑ Didactic time spent at hospital allowable for both DGME and IME-only for DGME at an otherwise allowable non provider site. Research time is allowed for GME time spent at the hospital only
- ❑ New Teaching Hospitals:
  - ❑ Understand the Per-Resident Limit calculation and the not to exceed limits versus your cost-if your cost is lower, year one is not the time to hold the line on costs-you will be forced to live with that forever
  - ❑ Understand how the cap will be calculated and manage accordingly-again this is something you will always live with. The cap is calculated by specialty but applied in the aggregate, so if it is easier to ramp up one program, it behooves the hospital to take advantage of that
  - ❑ Learn the methodology and timing of any Medicaid or other state programs reimbursement for GME
  - ❑ CMS defines new as new residents, new coordinator, new teaching physicians. If it's not new, you will not be able to establish a cap and be paid
- ❑ New programs; be aware of the “community redistribution principle”
- ❑ Overall, there should be a strategic plan, and education of management as to the key drivers of revenue and how they can impact the key drivers of revenue



# Medicaid Reimbursement for GME

- ❑ Many (most?) states offer some reimbursement for the Medicaid share of GME costs
- ❑ Can be paid as an add-on to inpatient rates or lump sum periodic payments (the latter is probably more common)
- ❑ Often payments are determined in a base year and not adjusted for subsequent changes in the individual hospital teaching program (e.g. New York and Pennsylvania)
- ❑ Reimbursement is often through the Medicaid DSH program, which is scheduled for reduction beginning in Federal Fiscal Year 2016 (2017 now based on the legislation passed earlier this month)
- ❑ Some states reimburse hospitals for both IME and DGME (eg New Jersey, which also reimburses hospitals for the Charity Care portion of GME)
- ❑ State reimbursement for teaching programs is often a political football, with caps on total reimbursement changing frequently and dependent on optimizing federal funding that may be shrinking
- ❑ Individual hospitals may not receive more from Medicaid than the cost of treating Medicaid and indigent patients



# Reimbursement Per Resident Calculation

<b>Medicare Reimbursement per resident FTE:</b>	<b>Amount</b>	<b>Source</b>			
IME Reimbursement	1,574,645	Worksheet E Part A line 29			
Adjust for impact of prior year resident to bed ratio	121,127	Recalculate based on current year ratio			
<b>Total IME reimbursement</b>	<b>1,695,772</b>	Calculate			
IME FTEs allowed	16.45	Worksheet E Part A line 18			
FTEs allowed due to redistribution	0.36	Worksheet E Part A line 25			
<b>Total IME FTEs</b>	<b>16.81</b>	Calculate			
<b>IME reimbursement per FTE</b>	<b>100,879</b>	Calculate			
DGME Reimbursement	1,689,094	Worksheet E-4 Line 31			
DGME FTEs allowed	16.32	Worksheet E-4 Line 17			
FTEs allowed due to redistribution	0.46	Worksheet E-4 Line 31			
<b>Total DGME FTEs</b>	<b>16.78</b>	Calculate			
<b>DGME reimbursement per FTE</b>	<b>100,661</b>	Calculate			
<b>Total Reimbursement per FTE</b>	<b>201,540</b>	Calculate			
Using 2552-10 cost report lines					

- ❑ This particular hospital has a very high DGME per-resident-amount. Typically IME is significantly higher than DGME
- ❑ Calculation could be more detailed-could break out redistribution FTEs
- ❑ Adjusting for prior year resident to bed ratio allows you to calculate a generic baseline



# GME Income Statement

Graduate Medical Education Program Income Statement		Source			
IME Reimbursement	1,574,645	Worksheet E Part A line 29			
DGME Reimbursement	1,689,094	Worksheet E-4 Line 31			
Psych IME Reimbursement	165,000	Worksheet E-3 Part II Line 11			
Rehab IME Reimbursement	175,000	Worksheet E-3 Part III Line 12			
Medicare Reimbursement	3,603,739	Calculate			
Medicaid Reimbursement	168,909	Based on receipts from Medicaid			
Other State Reimbursement	23,647	Based on receipts from other state programs			
<b>Total Reimbursement</b>	<b>3,796,295</b>	Calculate			
Expenses:					
Total Direct Expenses	3,898,229	Worksheet A line 21 and 22 column 7			
Add back: RCE disallowance	291,957	Worksheet A-8-2 line 21 and 22 column 17			
Overhead Expense	3,502,692	Worksheet B Part I column 25 less Direct Expenses			
Total Expenses	7,692,878	Calculate			
<b>Net Income/(Loss)</b>	<b>(3,896,583)</b>	Calculate			
Direct Expenses	4,190,186	Above, plus RCE disallowance add-back			
Fringe Benefits	1,168,712	Worksheet B Part I lines 21 and 22 column 5			
Total Direct Expenses Incl. Fringes	5,358,898	Calculate			
<b>Contribution Margin</b>	<b>(1,562,603)</b>	Calculate			

- ❑ Most GME programs lose money based on fully allocated cost
- ❑ Ideally contribution margin is positive
- ❑ There can also be mitigating factors in contribution margin such as money saved on attending physician coverage otherwise needed



## Questions????

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