GME Finance: Updates

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Chief Academic Officer LECOMT
Objectives:

- Understand Medicare/CMS GME reimbursement (20 min)
- Understand nuances developing your CMS cap and HRSA grants which promote THC programs (15 min)
- Updates on GME funding: Where we are now (5 min)
Graduate Medical Education

2014

6.0B-IME and 3.5B DGME

COST BILLIONS

IME

DME
Take Home Point # 1
Make sure your hospital does not already have a CMS CAP

- A waste of your time if they have no cap or a minimal one
- Must be considered a “new program”
- Send letter to CMS intermediary to confirm
- Podiatry and Dental “outside of CAP”
CMS intermediary: Send letter to confirm your institution has never had residents rotating at hospital!
Take Home Point # 2
Thou shall get the CFO to see the “light” $$$$$$

- It is always about money
- If there is money they will come........
GME Makes money

- GME programs improve quality and add resources
- “grow your own” – save on recruitment costs
- If CFO not with you.......no go.
- Money drives the development of GME. But remember there are other factors that support GME (clinic consider FQHCs)
- Intangible benefits significant beyond the CMS money. Train and retain.
- ????? But what if they get cut (it will be ok....)
GME: FUNDING made simple

Direct Graduate Medical Education Expense (DGME) 3.5 B

- Medicare Utilization X the lower of base year cost or the regional adjusted average

Indirect Medical Education (IME) 6.0B

- It is an add on payment to the DRG
DME and IME Formula based on the following

% Inpatient Medicare utilization
Medicare days/total days

Medicare case mix index

Average daily census

Medicare in-patient collect DRG revenue for last fiscal year (Excludes: Psych and Rehab)
DGME CALCULATION

$44,000

Note: The rule is the lower of base year cost or the regional adjusted average
DGME made simple:

- Medicare allowable costs: $880,000
- 10 residents
- 50% Medicare utilization
- $3.5 billion annually on DGME

- $88,000 \times 0.50 = $44,000 DGME per resident
- Critical point: if resident outside of Initial Residency Period (IRP) (fellows, transfer in residents) you only get $\frac{1}{2}$ of the calculated DGME ($22,000.00)
Take home point # 3
Understand The IRP

- **Initial Residency Period (IRP):** the minimum accredited length of time for each specialty (AOA or ACGME)
  - For example: Internal Med: 3 years
    - FM 3 years.
    - Surgery 5 years.
  - Some transitional years or rotating internships count all depends on if the resident simultaneously matches into both the transitional year and a specialty program.
How will my hospital’s IME payments be calculated?

**IME**
- Compensates for “indirect” patient care costs
- Add on to your Medicare per case MS-DRG payments
- Uses the Residents-to-bed ratio
- $6.0 billion annually on IME

**IME not affected by IRP**
- Hospital will also receive a small adjustment to capital inpatient payment rates
IME CALCULATION

- $c \times [(1 + r) \times 0.405 - 1]$. The multiplier $c$ is set by Congress.
- This is based on the IRB (resident to bed count)
- IME = $106,000
- Multiplier is 1.35 as set by Congress
Total funding per resident at Hospital XYZ

DGME 44,000 + IME $106,000 = $150,000.
Show me the money:

4 residents per year

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue</th>
<th>Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>0</td>
<td>200,000</td>
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<tr>
<td>Year 2</td>
<td>400,000</td>
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<tr>
<td>Year 3</td>
<td>800,000</td>
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Work with the CFO to help develop at least a 5 year projected GME budget

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<td>Gross Revenue</td>
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<td>Direct (36,736/resident)</td>
<td>$360,710.00</td>
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<td>Indirect (110,065/resident)</td>
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<td>$28,781</td>
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<tr>
<td>Total</td>
<td>$360,710.00</td>
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<td>$28,781</td>
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<table>
<thead>
<tr>
<th>Expenses</th>
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<td>Supplies</td>
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<table>
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<th>Contract &amp; Medspec</th>
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Take Home Point # 4
Understand The “CAP”

- Since 1997 Congress has placed a “CAP” on the number of FTE resident each hospital may claim for DGME and IME payment purposes.
  - 5 years to establish your cap.
  - Don’t only think initial number of residents but what is your “ultimate number” of residents after 5 years.
  - NOT UNDERSTANDING THE CAP WILL HAVE LONG TERM AFFECTS TO YOUR HOSPITAL’S Medicare GME payments and may jeopardize the GME program.
The “Cap” Made Ridiculously Simple

- Largest number of FTE residents, for all programs, in any post-graduate year x the IRP
- Example: program XYZ with 18 accredited spots

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tbody>
<tr>
<td>Example</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>6</td>
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<tr>
<td>Total</td>
<td>5</td>
<td>16</td>
<td>22</td>
<td>50</td>
<td>68</td>
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</table>
Cap Calculation:

- Calculate hospitals total FTES over all 5 years (68)

- Take the highest FTE number from any year 5 and multiply this x IRP (minimum accredited length of program (6x3 = 18))

- Take 18 x total FTE over 5 years (68/Total FTE time in hospital (68) = 1 so 18 x 1 = 18)

- Your CAP is 18
How To Mess Up The Development Of A New Cap

- Rotate resident out to other hospitals (just don’t) – It will reduce the cap.
- Rotate residents out to other offices not part of your system and you do not have affiliation agreements (you will not be able to claim them!).
- Do Not have rotations called “research” you can not get paid! include the assignment in other rotations
- Try to develop a cap at two places at the same time (just plain dumb!- avoid).
- Take residents in to your new program from another program that is developing a “cap”, but only if in the same specialty.
The Rules For Lending Your Cap Spots

- Attractive way to offer another hospital an incentive to offer rotations to your residents.
- Must have a Medicare aggregation affiliation agreement.
- Accepting hospital will receive their DGME and IME not yours.
- Your resident count will be the FTE’s based at your hospital.
- Do not do this with non-teaching hospitals if they plan on pursuing a teaching program at some point.
Other Cap Caveats

O When developing a cap- you do not have one to trade. Resident goes out you do not get paid and accepting teaching hospital can not claim them either if they are at their cap or over their cap.

O You may not count any residents rotating from existing facilities in your cap.

O If you are a virgin hospital and residents rotate at your site: Your cap will be triggered (Don’t allow it)

O You can “loan cap spots” if you are an existing teaching hospital but MUST have a “GME Aggregation/Affiliation agreement”.

O If Slots are not “loaned” from existing teaching hospital with an aggregation/affiliation agreement in place, you will not be paid.
Cap “Exceptions”

- Rural Hospital
  - No time limitation if rural hospital starts new program and has no residents.
  - Rural hospitals are capped by program – Urban hospitals are capped by Hospital.
  - No FTE adjustment to its cap if rural hospital expands an existing program.
Medicare Aggregation Affiliation agreement

Existing regulations at § 413.75(b) permit hospitals that share residents to elect to form a Medicare GME affiliated group if they are in the same or contiguous urban or rural areas, if they are under common ownership, or if they are jointly listed as program sponsors or major participating institutions in the same program. The purpose of a Medicare GME affiliated group is to provide flexibility to hospitals in structuring rotations under an aggregate FTE resident cap when they share residents. The existing regulations at § 413.79(f)(1) specify that each hospital in a Medicare GME affiliated group must submit a Medicare GME affiliation agreement (as defined under § 413.75(b)) to the Medicare fiscal intermediary (FI) or MAC servicing the hospital and send a copy to CMS’ Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.
Teaching Health Centers vs. FQHCS
HRSA Grants
Teaching Health centers

NON CMS FUNDING
$150,000 per Resident

No Cap ↔ Ambulatory Focus
What is a Teaching Health Center

- Community based primary care clinic that operates a primary care residency.
- Includes:
  - FQHC
  - Rural clinic
  - Title X
  - IHS or tribal clinic
  - Community mental health clinic
Teaching Health centers

- HRSA funded
- For primary care:
  - FM
  - IM
  - PEDS
  - OB
  - Psych
  - Geriatrics
Take Home point # 5
Explore THC GME

- Many FQHCs out there.
- Much expertise in field (Many AOA programs).
- Great option for primary care.
- HRSA funding subject to the whimsical nature of Congress
But worth the risk.
GME Updates: Obama’s Budget For 2015

- Proposed 10% cut in Medicare add on payments (960 million this year: 14.6 billion next decade).
- 5.2 billion in a competitive GME program to incentivize primary care and other “high need specialties” Strong emphasis on development of consortia models and a focus on ambulatory training (money via HRSA).
OTHER Innovative GME Funding Streams

- Pvt Insurance (MD)
- Critical Access Hospitals
- State Grants TX
- State/Med School
- Expand Spots (Exceed Cap)
Bills Pending In Congress

H.R. 1201 and S. 577
$15,000 New GME Spots $9 Billion

2020 Shortage of Physicians
45,000 PCP Short
46,000 Specialists
Key Points

Understand basic finances of starting new GME
DGME  IME

Exploit THCGME – money being thrown here USE IT
Many FQHCS  Adequate reimbursement

Understand Cap development and cap lending
Consortia models work but beware of cap
Think: what do I want the cap to be in 5 years