

# **The Basics of GME Finance for Program Directors February 26, 2015**

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# What PDs need to know

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1. What happens to your CMS GME money paid to your hospital?
2. Is your hospital over its cap?
3. Are your residents meeting the rules for getting CMS money?
4. How do you get more for PD, PC, faculty?
5. What about the future?

\*CMS: Centers for Medicare and Medicaid Services



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# 1. What happens to your hospital's CMS GME money?

(CMS money goes to hospitals, not  
medical schools)



# Sources of Funding in 2012

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☼ Medicare DME	2.6 Billion
☼ Medicare IME	6.8 Billion
☼ Medicare total	9.7 Billion
☼ Medicaid (declining)	3.9 Billion
☼ VA (10% of residents)	1.4 Billion
☼ Children's Hospitals	251 Million
☼ HRSA Teaching HC centers	46 Million



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# Direct (DME) and Indirect (IME) Funds

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- ✿ Direct GME Payments (DGME or DME)
  - ✿ Pays Medicare's share of residency education costs
  - ✿ Based on each hospital's 1984 cost estimate
  - ✿ Reported on annual "hospital cost report"
- ✿ Indirect Medical Education (IME) Payments
  - ✿ Partially pays for higher patient care costs due to presence of residents and "inefficiencies"
  - ✿ Paid through a higher inpatient DRG rate



# How Much does your Hospital Get from CMS?

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Varies for each hospital

Example	Resident	Fellow/2 <sup>nd</sup> Resident
1/3 DME	\$30,000	\$15,000*
2/3 IME	\$60,000	\$60,000
Total	\$90,000	

\*Fellows/2<sup>nd</sup> Resident get ½ of the DME

\*Most hospitals only pay for resident salary/benefits and not faculty salary (mostly generated by practice plans routed through the medical school)



# What Are DME Payments Intended to Cover?

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- ✿ For costs directly related to educating residents:
  - ✿ Residents' stipends/fringe benefits
  - ✿ Faculty Salaries/fringe benefits
  - ✿ Other direct costs
  - ✿ Allocated overhead costs
- ✿ Residents must be in ACGME approved program or pre-req for ABMS certification
- ✿ Residents/Fellows cannot bill



# Indirect Medical Education (IME)

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- ❖ Compensates teaching hospitals for higher inpatient operating costs due to:
  - ❖ unmeasured patient complexity not captured by the Diagnosis Related Group (DRG) system
  - ❖ other operating costs associated with being a teaching hospital (lower productivity, standby capacity, etc)
- ❖ Percentage add-on payment to basic Medicare per case (DRG) payment





# What Happens to the CMS money?

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- ✿ Hospitals get about \$25,000 DME and \$50,000 IME per resident
- ✿ Hospitals often pay resident salary and stipend, make sure they cover vacation
- ✿ Hospitals *resist* paying faculty/PD costs
- ✿ Hospitals may or may not pay Program Coordinator
- ✿ Hospitals can hire on-site Program Coordinator for you



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# Medicare Resident Cap

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- ✿ The number of FTE allopathic and osteopathic residents that a hospital may count for DME and IME payments is limited to hospital 1996 Medicare cost report count,
  - ✿ 1997 Balanced Budget Act  
(P.L. 105-33 Sections 4621 and 4623)
- ✿ Limits may be different for DME and IME
- ✿ 78,000 nationally out of 117,000 total positions



# Is your Hospital over its Cap?

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- ✿ Almost certainly YES
  
- ✿ Hospital CFOs are trying to limit and cut GME expenses and resident slots
  1. Shrink and eliminate programs
  2. Not pay you and faculty for teaching
  
- ✿ CFOs want residents that maximize DME/IME
  1. Residents that spend time in hospital
  2. Well documented FTE counts



# PDs Have to Count Their Residents

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- ✿ Resident FTE count at each site is a major factor in determining both IME and DME payments and CMS has lots of regulations governing this
- ✿ Your hospital will need to prove this to CMS in audits to track research, outpatient time, didactics
- ✿ The better you count, the more money your resident gets for DME/IME (hospitals prefer to cut unpaid residents)



# ACA: Resident Time Counted for DME and IME Payments

## DGME/DME

Hospital	Non-Hospital
Patient Care	Patient Care
Vacation/Sick	Vacation/Sick
Didactic	<i>Didactic (since 2009+)</i>
Research	<b>NOT Research</b>

## IME

Hospital	Non-Hospital
Patient Care	Patient Care
Vacation/Sick	Vacation/Sick
<i>Didactic (since 1983+)</i>	<b>NOT Didactic</b>
<b>NOT Research (after 2001+)*</b>	<b>NOT Research</b>

ACA: Affordable Care Act

Note: Text in italics indicates language in the ACA.

\* The ACA clarifies that IME research time does not count after October 1, 2001



# How Does this Affect You?

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1. Maximize your CMS collections
  1. Document residents well
  2. Move research into hospital, QA projects count
  3. Move didactics into hospital
2. If you change sites, make sure new hospital will pay
3. Clinics do not get DME/IME but hospital can get DME if they have an agreement
4. Some sites not eligible for DME/IME: find out what those are



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# How Does this Affect You?

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**5.** If you want to increase the number of residents and you are over your cap, you have to:

make a business argument, more patients, faculty retention, high value service (side agreement outside the usual DIO/GMEC)

**6.** If your hospital CFO wants to cut slots, you have to:

have your residents fit the CMS definition better than other programs



# How Does this Affect You?

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7. If you want more faculty/PD/PC time:
  1. No hospital wants to pay if others are not; get all hospitals to pitch in based on your resident FTEs
  2. Change the site where the PD works
  3. Get hospital to hire Program Coordinator instead of paying for the position from your department/ medical school





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What about the future of  
Medicare GME funding?



# IOM 2014 Recommendations

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1. Keep current levels for 10 years but phase out current CMS methodology
2. Build new policy and finance infrastructure
3. Develop Operational fund and Transformation fund
4. Pay per resident amount based on available funds
5. Medicaid by state decision



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# What is the Future?

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- ✿ Congress can do (or not do) whatever it wants
- ✿ Clear trends
  - ✿ Less money to GME, less per resident
  - ✿ More accountability
  - ✿ Redistribution for geography, primary care
  - ✿ Cap on GME slots
- ✿ More reliance on hospital clinical dollars

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