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MEMORANDUM
July 1, 2015

TO: COTH Member Programs

FROM: Thomas Tanner
Director, Office of Graduate Services

RE: **GME Payment Data Information**

As part of our services to COTH members, AACPM/COTH provides an annual update of the graduate medical education (GME) payment data information for participating hospitals. This information is collected and reported based on the financial data reported by hospital administrations in their CMS 2552 reports to Medicare.

Attached is a more detailed explanation of both the data points and the process used in collecting and reporting of this important funding data for graduate medical education programs.

Please note that GME payment information does not differentiate among medical specialties. All residency programs are paid at the same level by CMS. Additionally, it is important to note that podiatric medicine continues to enjoy an exemption from the cap on the number of residents allowed at an individual institution.

Purpose and Data Content

The purpose of this report is to describe various capacity measures, medical education payments, and financial statistics for hospitals in the United States. *Table 1* in the attached Excel file contains information on teaching hospitals, which are defined as those hospitals that received at least some Direct Graduate Medical Education (DGME) payments and/or Indirect Medical Education (IME) payments. *Table 2* displays information for non-teaching hospitals (i.e., those hospitals that received no DGME or IME payments).

This information was extracted from the March 31, 2015 release of the Hospital Cost Report Information System (HCRIS) data from the Centers for Medicare & Medicaid Services (CMS). HCRIS contains annual reports submitted by institutional providers to Medicare. It provides information to CMS that assists with the annual settlement summary between CMS and the institutional provider.

The cost report data contains facility-level information on:

- Utilization,
- Costs,
- Charges,
- Medicare payments; and
- Financial information.

The CMS has made a reasonable effort to ensure that the provided data/records/reports are up-to-date, accurate, complete, and comprehensive at the time of disclosure. This information reflects data as reported to HCRIS by Medicare Administrative Contractors. These reports are a true and accurate representation of the data on file at CMS.

Data Extract Rules

We extracted information for federal fiscal year (FFY) 2013 (hospital fiscal years beginning on or after October 1, 2012) if the database had hospital information for that year. The "Federal Fiscal Year" column indicates which year's data was used for each hospital.

The following information is provided for each of the teaching hospitals[1]:

- Medicare ID Number

[1] Teaching hospitals were defined as facilities reporting number of FTE residents greater than zero. We extracted the data exactly as they appeared in the cost reports, which means that any incorrect data that the hospitals submitted are carried over into our tables. For example, some hospitals have the street address in the "city" field and other hospitals have improbable numbers such as tens of thousands of full time equivalents (FTEs).

- FFY cost report from which the data were extracted
- Hospital cost report begin date, end date, and number of days in cost report period
- Hospital name
- The city and state in which the hospital is located
- The Core Based Statistical Area (CBSA) for the hospital, as defined by the Office of Management and Budget (OMB)[2]
- The number of beds at the hospital, which is defined as the total beds available for use by patients in the hospital at the end of the cost reporting period (including adult and pediatric beds, intensive care unit beds, coronary care unit beds, burn intensive care unit [ICU] beds, surgical ICU beds, other special care unit beds, and sub-provider beds)[3]
- The ratio of Medicare days to total days in the hospital, which is calculated as Medicare inpatient days (including Medicare health maintenance organization [HMO] days) divided by total inpatient days for all patients
    - Medicare inpatient hospital days, which include routine care days, intensive care days, coronary care days, burn ICU days, surgical ICU days, other special care unit days, and sub-provider days[4]
    - Total inpatient hospital days, which include routine care days, intensive care unit days, coronary care unit days, burn ICU days, surgical ICU days, other special care unit days, nursery days, and sub-provider days for all patients[5]
- The total full-time equivalent (FTE) residents, which is defined as the number of FTE interns and residents allowed by Medicare for the GME computation (i.e., subject to cap on residents in new programs and based on 3-year rolling average) and is computed as the sum of primary care (including OB/GYNs), non-primary care residents, and additional allowable residents under Section 413.79(c)(4) of the Social Security Act.

[2] CBSAs are new geographic definitions of areas developed by OMB. They replace and expand the old Metropolitan Statistical Area (MSA) geographic definitions.

[3] From CMS form 2552-10, Worksheet S-3, Part I, Column 2, and Lines 14, 16, 17 and 18.

[4] From CMS form 2552-10, Worksheet S-3, Part I, Column 6, Lines 14, 16, 17, and 18, plus total Medicare inpatient HMO days from CMS form 2552-10, Worksheet S-3, Part I, Column 6, Line 3.

[5] From CMS form 2552-10, Worksheet S-3, Part I, Column 8, Lines 14, 16, 17, and 18.

    - 3-year rolling average of weighted FTE count of primary care and OB/GYN residents subject to Medicare FTE limits[6]
    - 3-year rolling average of weighted FTE count of non-primary care residents and specialists subject to Medicare FTE limits (includes dental and podiatry residents, which are not subject to Medicare limits) [7]
    - Additional allowable weighted FTE residents (under 42 Sec. 413.79(c)(4))[8]
- The weighted dental and podiatric resident FTE count for the cost reporting period[9]
- The approved DGME amount per resident, which is computed as the weighted average of the updated per resident amounts for primary care, non-primary care and additional allowed residents that have been approved by the hospital's fiscal intermediary.
    - The aggregate approved amount is computed as the approved amount per primary care resident times the number of Medicare allowed FTE primary care residents plus the approved amount per specialty resident times the number of FTE specialty residents plus the locality adjusted national average approved amount per resident times the number of additional allowed FTE residents [10]; this aggregate amount is then divided by the total number of Medicare allowed FTE residents as defined above
- Medicare DGME payment, which is Medicare's share of the hospital's DGME and is estimated as the proportion of Medicare inpatient fee-for-service and managed care days to total days for all patients, multiplied by the aggregate approved amount and apportioned to Part A (inpatient) and Part B (outpatient) based on each parts share of the hospital's Medicare reasonable costs
    - The total Medicare Part A DGME payment amount[11]
    - The total Medicare Part B DGME payment amount[12]
- Medicare IME payments, which are payments that Medicare adds to the base Diagnosis-Related Group (DRG) payment amount for teaching hospitals[13]; these

[6] From CMS form 2552-10 Worksheet E-4, Column 1, Line 17.

[7] From CMS form 2552-10 Worksheet E-4, Column 2, Line 17.

[8] From CMS form 2552-10 Worksheet E-4, Column 1, Line 22

[9] From CMS form 2552-10 Worksheet E-4, Column 2, Line 10.

[10] From CMS form 2552-10, Worksheet E-4, Column 3, Line 25.

[11] From CMS form 2552-10, Worksheet E-4, Column 1, Line 49.

[12] From CMS form 2552-10, Worksheet E-4, Column 1, Line 50.

[13] From CMS form 2552-10, Worksheet E, Part A, Column 1, Line 29.

payments are intended to help defray the higher costs incurred by teaching hospitals that are not directly related to the salaries and benefits that the hospital pays its residents

    - The total amount of Medicare IME payments is divided by the number of Medicare allowed FTE interns and residents (described above) to compute the Medicare IME per resident amount[14]

- Total Medicare disproportionate share hospital (DSH) payments, which are payments that Medicare adds to the base DRG payment for hospitals that provide care to a large number (disproportionate share) of low-income patients[15]

- Total facility operating expenses[16]

[14] For illustrative purposes, IME is presented in the tables as a per-resident amount. However, in contrast to DGME, IME is paid by Medicare on a per discharge basis.

[15] From CMS form 2552-10, Worksheet E, Part A, Columns 1 and 1.01, Line 34.

[16] From CMS form 2552-10, Worksheet G-3, Column 1, Line 4.