# Counting FTEs: What is Required & Why It's Important

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1

## General Overview

- FTEs are the main driver in all IME and DGME calculations, so naturally there are regulations on how they should be counted.
- Things like where a resident rotates, how long they have trained, their specialty, and sometimes even the type of rotation can impact the FTEs a hospital can claim.
- The FTEs a hospital claims during it's cap-building period will impact reimbursement for your GME programs for the foreseeable future.

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2

# Initial Residency Period

- Initial Residency Period – the minimum number of years necessary for specialty Board eligibility
  - Ex. Surgery has an IRP of 5 years; Internal Medicine has an IRP of 3 years
- IRP is permanently set at the time the resident initially enters a residency program.
- Any resident still within their IRP is counted as 1.0 FTE for DGME and any resident beyond their IRP is counted as 0.5 FTE.


- Fellowships typically occur after IRP and are counted at 0.5 FTE.

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3

# Initial Residency Period

- IRP does not affect the FTE count for IME purposes, only DGME.
- Add-ons to IRP
  - Residents specializing in geriatrics or preventative medicine can get an additional 2 years added to their IRP.
  - IRP for child neurology is 5 years.
- For specialties with a separately accredited Transitional Year program, the IRP is determined in the resident's second year when the resident actually enters the specialty program. But the transitional year does count as part of the IRP.
- Radiology and anesthesiology require an initial year of general training (clinical base year).

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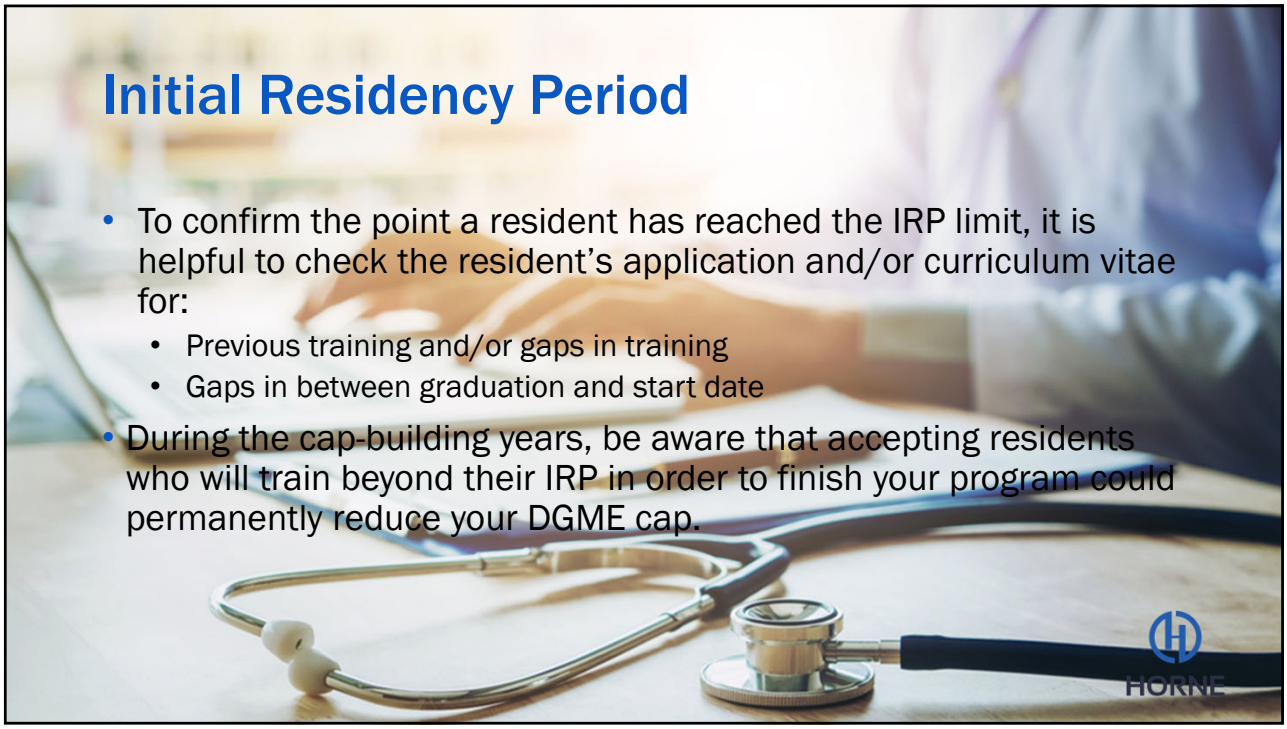
4




5

## Fellowships

- Fellows - trainees in specialty or subspecialty programs who have already completed their IRP
- Must be an approved program to receive IME/DGME
- With few exceptions, these residents are usually 0.5 FTEs for DGME, but can still be claimed as 1.0 FTEs for IME purposes
- Loss in DGME often offset by benefits of fellow being board certified or eligible to be board certified
- They can often assist with teaching interns and residents.
- Be careful with research fellowships – can dimmish IME
- Moonlighting needs to be separate from approved program activity

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6

## Research Time

- For IME, the only research time that may be included in the FTE count is clinical research associated with the treatment or diagnosis of a patient.
- For DGME, research is allowable as long as it takes place in the hospital and is part of an approved training program.
- Helpful to use research questionnaires to carve out the non-research, approved program activity that is performed during a research block
  - Call coverage, continuity clinic, surgical duties, didactic time, etc., may still occur during research rotation and can be included for IME purposes

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7

## Didactic Time

- Didactic time is time spent in seminars, classroom lectures, other scholarly pursuits
- Only allowable for DGME as long as didactic time spent is in a setting primarily engaged in furnishing patient care (hospital and non-hospital).
- For IME purposes, didactic time is only allowable if it is within the hospital (didactic time in non-hospital and med schools not allowable)

8

## Displaced Residents

- A receiving hospital who temporarily trains displaced resident from a closed hospital gets full reimbursement for the resident.
- Recent changes in rules surrounding displaced residents


  - As of 10/1/20, a resident no longer has to be present on the last day of training at closed hospital to receive full funding for temporary training at next hospital.
  - Instead, a resident can be considered "displaced" if they leave a closed program after the closure if publicly announced but before the actual closure.
  - This can now also include residents accepted into a GME program at the closing hospital/program but has not yet started training there.
  - FTE slots can now transfer before the program closes.

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9

## Foreign Graduates

- Because medical schools outside the U.S. can vary in educational standards, curricula and evaluation methods, foreign medical graduates must receive a certificate from ECFMG in order to enter GME programs in the U.S.
- The examination requirements for ECFMG Certification include passing Step 1 and Step 2 of the USMLE.
- These certificates are important documentation to keep on hand for all foreign medical graduates that rotate in your program. This information is recorded as part of IRIS.
- This step can lead to gaps between graduation date and beginning a residency program.

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10

## Off Campus Rotations

- Where the resident trains also affects the FTE count.
- Training at another hospital *does not count for IME or DGME*
  - It does not matter if the other hospital does not claim it on their cost report
  - If time is *split* between two hospitals for a rotation, best practice is to establish an agreement on how time will be claimed to avoid overlap.
    - For example, hospitals may be close enough that resident still has didactic time or continuity clinic at main hospital while having clinical rotations at neighboring hospital
- Beware if you are the hospital accepting residents from another program, this could trigger FTE caps and PRA if you are not already a teaching hospital.

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11

## Off Campus Rotations

- Training at other non-hospital sites does count, as long as the provider is paying for substantially all the resident's salary and benefits.
  - Must be providing patient care at this site, otherwise may only be allowable for DGME if approved program activity
  - If non-hospital site does not exist to care for patients, then no reimbursement (e.g. resident presents at a conference at a hotel)
- FQHCs/RHCs – technically they can receive GME if incurring costs of the residents, but no IME; usually treated as non-hospital site and claimed by the hospital because of this

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12

# Worksheet S-2

- Non-provider rotations are reported on S-2, Lines 64-67
- Stems from ACA Section 5504
- Compares current year FTE residents in non-provider settings to that of base year (7/1/09 – 6/30/10)
- Broken out for primary programs, all non-primary programs lumped together
- Currently, only used for informational purposes

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13

# Worksheet S-2

| | | | | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 1/ (col. 1 + col. 2)) | |
|---|---|---|---|---|---|---|---|
| | | | | 1.00 | 2.00 | 3.00 | |
| | **Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.** | | | | | | |
| 64.00 | Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) | | | 0.00 | 3.59 | 0.000000 | 64.00 |
| | | Program Name | Program Code | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 3/ (col. 3 + col. 4)) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 65.00 | Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) | FAMILY MEDICINE | 1350 | 1.51 | 16.99 | 0.081622 | 65.00 |

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14

# Worksheet S-2

| | | | | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 1/ (col. 1 + col. 2)) | |
|---|---|---|---|---|---|---|---|
| | | | | 1.00 | 2.00 | 3.00 | |
| | Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 | | | | | | |
| 66.00 | Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) | | | 0.00 | 2.86 | 0.000000 | 66.00 |
| | | Program Name | Program Code | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 3/ (col. 3 + col. 4)) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 67.00 | Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) | FAMILY MEDICINE | 1350 | 1.00 | 21.74 | 0.043975 | 67.00 |

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15

# Moonlighting

- Definition - services that licensed residents perform that are outside the scope of an approved GME program.
- "Furnished by the individual in his or her capacity as a physician, rather than in the capacity of a resident"
- Prior to COVID-19, residents could only moonlight in the outpatient or ER of hospitals where their training program exists, as long as it was outside the scope of the program.
  - Moonlighting in the inpatient setting could only be at different hospitals not part of teaching program

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16

# Moonlighting

- COVID waiver (*now made permanent*) – residents may now moonlight in inpatient setting of hospital where they train as long as:
  01. Services are identifiable physician services and meet conditions for payment
  02. Resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which services are performed
  03. Services can be separately identified from those required by GME program
- Documentation is key to avoid double dipping
- Will be asked about during desk reviews/cost report audits

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17

# FTE Count Example #1

Facts:

- Resident A graduated from med school on 5/31/21
- Begins internal medicine residency at Hospital A on 7/1/21.
- All rotations were at Hospital A.
- Hospital A has a 9/30/21 FYE.

In this example, Resident A will be counted as 1.00 FTE x the # of months in the cost report year rotated at Hospital A.

**1.00 FTE x 92/365 days = 0.2521 FTEs**

Resident A will be a PGY 0 in IRIS because he is in his first year of residency. His FTE count for both IME and DGME will be 0.2521

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18

# FTE Count Example #2

Facts:

- Resident B graduated from med school on 5/31/19
- Completed 2 years in Family Medicine
- Decides she wants to be an OBGYN instead and transfers to Hospital B's program on 7/1/21
- She receives 12 months credit for prior training and will complete OBGYN program on 6/30/24
- All rotations were at Hospital B.
- Hospital B has a 6/30 FYE
- Family Medicine has a 3-year IRP

In this example, Resident B will exceed her IRP after 6/30/22, so 7/1/22 and after will be 0.5 FTEs for GME purposes. She will still remain 1.00 FTE for IME purposes.

FY 22 – PGY 2 – 1.00 FTE IME & DGME
FY 23 – PGY 3 – 1.00 FTE IME & .50 FTE DGME
FY 24 – PGY 4 – 1.00 FTE IME & .50 FTE DGME

19

# FTE Count Example #3

Facts:

- Resident C graduated from med school on 5/31/21
- Begins Family Med residency on 7/1/21 at Hospital C
- 2 rotations (Oct & July) occur at Hospital D
- September rotation is 70% bench research
- Hospital C has a 9/30/22 FYE

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20

## FTE Count Example #3

- In this example, the two rotations at another hospital cannot be counted for Hospital C. In addition, only 30% of the Sept. rotation is allowable for IME.
- PGY 0 (Oct '21 – June '22) 1.00 FTE x 242/365 = .6630 IME & DGME
- PGY 1 (July '22 – Aug '22) 1.00 FTE x 31/365 = 0.0849 IME & DGME
- PGY 1 (Sept '22) 1.00 FTE x 30/365 x 30% = 0.0247 for IME (0.0822 for DGME)
- IME Total for FYE 9/30/22 = 0.7726
- DGME Total for FYE 9/30/22 = 0.8301

21

## Common Questions

- How do I account for residents transferring into my program?
- How do I handle residents who are off-cycle or need remediation?
- What if off-campus rotation requires living arrangements at away site?
- What about rotations to CAHs, IPF subproviders, or IRF subproviders?

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22

# IRIS

- Stands for Intern/Resident Information System
- Resident data & rotations entered into software program, and software will generate various reports for confirm FTE counts used on the cost report
- Similar to creating an ECR file for the cost report, IRIS records (called M&A files) must be exported from the software and submitted along with the cost report.
- IRIS FTE counts must match cost report, or risk rejection of cost report
- MACs import IRIS data to master CMS database to check for overlaps

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23

# IRIS

- Certain information is required for all residents in IRIS files:

1. SSN
2. Name
3. Medical School
4. Graduation Date
5. ECFMG Certificate Date & # (if foreign graduate)
6. Initial Residency Specialty (and any simultaneous matched, if applicable)
7. Rotation schedule
8. Paying Institution

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24

## Residency Software

- There are several programs on the market for tracking residents and FTE counts. Many produce the necessary M&A files for IRIS submission.
- Examples include (in no particular order):
  - HFS IRIS
  - New Innovations
  - MedHub
  - I-Rotations
- Note that software helping track duty hours for ACGME may not always reflect the final FTE count for cost report purposes.

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25

## Current COVID Waivers Impacting FTE Counts

- Counting Resident time
  - During the PHE, teaching hospitals may count FTEs of their residents at other hospitals if:
    - Resident sent, on an emergency basis, in response to pandemic (either hospital treating COVID-19 patients; however, resident does not have to be involved in COVID-19 patient care activities)
    - Time spent by the resident at the other hospital would be considered to be time spent in approved training at the sending hospital
    - Time spent by the resident immediately prior to and subsequent to the PHE was included in the sending hospital's FTE count
  - If residents are sent to a non-teaching hospital due to PHE, their presence will not trigger the establishment of a per resident amount or FTE resident cap at that hospital.

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26

## Current COVID Waivers Impacting FTE Counts

- Counting Resident time
  - Hospitals paying the resident's salary and benefits can count the time a resident is working from home or a patient's home but performing duties within scope of the approved residency program
    - Must still meet appropriate physician supervision requirements
- In both scenarios, it will be important to document "COVID" or some other notation on the rotation schedule to indicate resident is claimable under the waiver and was properly supervised.

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27

# Questions?

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28

# THANK YOU!

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29