IME/GME Payments Overview, Common Issues, & Current Updates

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General Overview

- Medicare has participated in the costs of medical education since the program's inception in 1965.
- The IME add-on payment and DGME payment methodology were introduced in the 1980s and have been evolving through legislation ever since.
- BBA of 1997 had a major impact on the IME/DGME rules by setting "historic caps" based on residents training at the hospital in 1996, among other changes.
  - This has led to the delineation between "old" teaching hospitals and "new" teaching hospitals.

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DGME

- The purpose of DGME payments are to help compensate hospitals for their direct costs related to the teaching program, such as salaries and benefits for residents and teaching physicians as well as administrative and overhead costs.
- Basic formula: PRA x FTE count x Medicare patient load.
- DGME is cost reimbursed for the first cost report when residents are not on duty the first month of the cost reporting period. The first full year is the base year for the PRA.
- Paid on a pass-through (similar to Medicare bad debts)

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Per Resident Amounts

- Per Resident Amount (PRA) – this is hospital specific and for new teaching hospitals it is set by the lower of their actual DGME costs per resident or the weighted average of PRAs for surrounding teaching hospitals. Once set in base year, it is updated annually for inflation.
- There can be separate PRAs for Primary care & Non-Primary care residents.
- Example: The weighted average PRA for teaching hospitals in MS for FY 21 is roughly $94,808. Depending on your CBSA, it could be higher or lower.

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DGME Example

- Assumptions
  - Hospital A is a 6/30 FYE provider with a new Family Medicine program. They have 6 residents rotating at their hospital in the first year of the program, and all rotations were at their hospital.
  - Cost per resident is $150,000, but average PRA for CBSA 25 is $102,000
  - Total Medicare Days = 18,500; Total MA Days = 5,000
  - Total Days = 30,000

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DGME Example

Residents in Initial Years of Program			6.00	
PRA			$ 102,000	
Approved Amount of Resident Costs			**$ 612,000**	
Computation of Medicare Patient Load				
	Inpatient Part A	*Managed Care*		
Program Days	18,500	5,000		
Total Days	30,000	30,000		
Ratio	0.616667	0.166667		
Program GME amount	$ 377,400	$ 102,000		
Percent MA reduction		7%		
GME reduction for MA		$ (7,140)		
Net Direct GME Payments			**$ 486,540**	

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IME

- IME payments are made to help with any indirect costs associated with having a teaching program, since teaching hospitals typically have higher patient care costs. This is because teaching hospitals generally treat patients with more severe illnesses and incur additional unquantifiable costs (residents ordering extra tests, standby requirements for certain units, etc.).
- Basic formula: IME Multiplier x $[(1+\text{IRB ratio})^{0.405} - 1]$
- IME Multiplier – this is set by Congress. Currently it is 1.35.
- Multiply the product of the above formula times total DRG Payments and Managed Care Simulated Payments

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Counting FTEs

- 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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FTE Caps

- Originally, there was no limit to the number of residents a teaching hospital could receive Medicare reimbursement on.
- BBA of 1997 changed that, and existing programs were capped at the number of allopathic & osteopathic residents on the hospital's most recent cost report ending on or before 12/31/1996
  - IME & DGME have separate caps, due to different rules surrounding FTE counts
- New Programs
  - Hospitals that trained no FTE residents in 1996 and later start "new" programs may establish a cap.
  - Programs started after 10/1/12 now have 5 years to "cap build"
- Number of Accredited slots – cap cannot exceed the total slots the program is accredited for

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Cap Setting

- Phases of GME Program Development
  - Years 1-3 – Start-up period for planning and infrastructure; can be significant investment with no offsetting GME reimbursement. Grant funding can be crucial
  - Years 4-8 – Cap Building Period – Programs will have 5 years to build their FTE cap for Medicare purposes; PRA also set during first full year of program.
  - Years 9 and after – Once caps are set the goal is optimize your caps and reimbursement, manage costs, and mitigate risks
- Cap Setting – Caps are set based on highest number of residents rotating in any PGY year during the 5th year of your program times the number of years to complete the program.
  - Example: You have 6 residents rotating in PGY 1 in the 5th year of your Family Medicine program. PGY 2 and 3 only have 5 residents. Cap will be 6 x 3 = 18 (less any non claimable rotations). Program must be accredited for 18 residents to get the full cap.

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Consolidated Appropriations Act 2021

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Consolidated Appropriations Act 2021

- Section 126 – 1000 new Medicare-funded GME slots
- Section 127 – Rural Training Tracks
- Section 131 – PRA & FTE Cap resets

- The FY 2022 IPPS Final Rule has addressed implementation of these 3 major provisions

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Section 126

- 1000 new slots to be distributed over 5 years (200 per year), beginning July 1, 2023
- Application deadline is March 31st of the prior FY (i.e. the deadline for 7/1/23 slots will be 3/31/22)
- Hospitals will have to demonstrate likelihood of filling the positions within 5 years of the date the increase takes effect
- Hospitals must use the new slots to either add a new program or expand an existing program
  - Cannot be used for cap relief

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Section 126

- First round applications were due this past March 31, 2022, for slots available July 1, 2023
  - Round 2 applications will be due 3/31/23, for slots available 7/1/2024
- Priority of distribution will be based on the HPSA score of the area in which the residents will do the majority of their training
- Hospitals may request up to 3 – 5 FTEs per year through the application, limited by the length of program that is being added or expanded
- Hospitals should be notified in January of the year following their application on FTE awards

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Rural Training Tracks History

- RTT programs are an opportunity for urban hospitals, rural hospitals, and nonhospital clinical settings to partner together and train residents to practice in rural areas.
- RTTs are one of the few ways an urban hospital can add to their cap.
- More than one-half of a resident's training must occur in a rural area in order for the urban hospital to be eligible to receive payments for residents in the RTT (up to their RTT cap).
- Previously, Rural hospitals could not join an existing RTT program and add to their cap; must participate in establishing a new one instead. Section 127 of CAA 2021 changes that.
- Regs surrounding RTTs can be found at 42 CFR §413.79(k)

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Section 127

- Urban hospitals with existing RTTs can now create additional RTTs with different rural hospitals and both can add to their cap
  - Example of a new "spoke" from the "hub"
- ACGME no longer has to "separately accredit" an RTT program for it to qualify. This opens RTTs up to specialties beyond family medicine.
- New RTTs treated like other new programs in initial years and not subject to 3-year rolling average during first 5 years of program

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Section 131

- Reset of Per Resident Amount for hospitals with extremely low or $0 PRAs
  - Must meet certain criteria:
    - Hospital has a PRA that was established based on less than 1.0 FTE in any cost reporting period beginning before Oct 1, 1997 (Category A Hospital)
    - Hospital has a PRA that was established based on training of no more than 3.0 FTEs in any cost reporting period beginning on or after Oct 1, 1997 and before Dec 27, 2020 (Category B Hospital)
- If a Category A Hospital trains at least 1.0 FTE in a cost reporting period beginning on/after Dec 27, 2020, and before Dec 26, 2025, then it can reset its PRA

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Section 131

- If a Category B Hospital trains more than 3.0 FTEs in a cost reporting period beginning on/after Dec 27, 2020 and before Dec 26, 2025, then it can reset its PRA
- Resetting of PRA will follow same methodology as a new teaching hospital (42 CFR 413.77(e))
- Hospital does not have to be training these residents in a new program in order to qualify
- Once reset, the PRAs are permanent

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Section 131

- For cost reporting periods beginning on/after Dec 27, 2020, CMS will only establish a PRA when a hospital trains at least 1.0 FTEs
  - Exception – hospital enters into Medicare GME affiliation agreement
- Similarly, for all hospitals that have not yet triggered a cap, permanent FTE caps will no longer be triggered until a hospital trains at least 1.0 FTE.
- Also proposing that all hospitals must enter the FTE counts on E, Part A and E-4 of the cost report for cost reporting periods during which the hospital trains at least 1.0.

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Section 131

- Resetting FTE resident caps
  - Category A Hospital – Hospital with an IME or DGME FTE cap of less than 1.0 that was established from their 1996 cost report
  - Category B Hospital – Hospital with an IME or DGME FTE cap established after 1997 (and before Dec 27, 2020) based on training of no more than 3.0 FTEs
- Thresholds for resetting FTE caps are similar to PRA, with the exception that FTE caps will only be reset if a Category A or B Hospital begins training FTE residents in a new residency program.
- FTE replacement caps will be calculated based on existing regulations (42 CFR 413.79(e)(1))

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FFY 2023 IPPS/LTCH PPS Final Rule

Released 8/1/22

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GME Updates

- Change to Direct GME calculation as a result of *Hershey v. Becerra*
  - Providers who had weighted FTE counts for GME and trained over their cap were previously "penalized" by the nature of the calculations on E-4
  - Calculation now updated to be the FTE cap if the total weighted allopathic & osteopathic FTE count exceeds the FTE cap
- This calculation change will also apply to PY and Penultimate Year FTE counts in the rolling average as well as the MMA 422 add-on
- CMS has stated this cannot be used as the basis for reopening final-settled NPRs

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FTE Calculation Change

1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			133.61	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			133.61	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			158.29	6.00
7.00	Enter the lesser of line 5 or line 6			133.61	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	68.87	77.20	146.07	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	58.13	65.16	123.29	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		2.71		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		2.83		10.01
11.00	Total weighted FTE count	58.13	67.87		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	54.13	68.95		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	54.84	66.53		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	55.70	67.78		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.23		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	55.70	68.01		17.00

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GME Updates

- GME Affiliation Agreements
  - CMS is finalizing its proposal to allow Rural Track Medicare GME affiliation agreements for hospital that have separately accredited 1 – 2 family medicine programs with established caps prior to 10/1/22. Hospitals must be within the same program to be eligible.
    - It must be separate from any other Medicare GME affiliation agreements
    - Proposed to be effective for the 7/1/2023 academic year

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Common Issues

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Common Issues

- Away Rotations & Cap Setting
- Medicaid Funding
- New Programs not working out
- Sharing residents with VA hospitals
- Rotation overlap in IRIS
- “New New” Programs
- Proving FTE counts for PRA and Cap resets (Sec. 131)

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THANK YOU!

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