Brief outline of process of establishing & maintaining a new FM residency or rural track – people, places, time and money

Lou Sanner, MD, MSPH
Chris Viney
Chris...

• The ACGME
• People
• Places
Lou...

• CMS (Medicare GME etc.)
• Timelines
• Money
Medicare & Medicaid GME Payments to Hospitals
Brief Overview

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University of Wisconsin
Madison Family Medicine Residency
We’ll Talk About

• Medicare GME:
  – DGME (Direct GME payments)
  – IME (Indirect Medical Education payments)
  – Counting residents, Caps

• DSH (Disproportionate Share payments)
  • Not strictly “GME” but one can argue that DSH might “go away” if residency low income clientele not served by hospital.

• Medicaid GME
Medicare GME Funding - “Hospital Passthroughs”

• Second largest income source for residencies.
Useful Web Sites

- Federal Register
- Section 1886 Social Security Act (early 1980s)
- Code of Federal Regulations, Title 42
  - IME regs
    - [http://www.access.gpo.gov/nara/cfr/waisidx_07/42cfr412_07.html](http://www.access.gpo.gov/nara/cfr/waisidx_07/42cfr412_07.html)
  - DGME regs
    - [http://www.access.gpo.gov/nara/cfr/waisidx_07/42cfr413_07.html](http://www.access.gpo.gov/nara/cfr/waisidx_07/42cfr413_07.html)
- CMS web pages (many links here, see IME, DGME, DSH on left)
  - [http://www.cms.hhs.gov/AcuteInpatientPPS/](http://www.cms.hhs.gov/AcuteInpatientPPS/)
More Useful Web Sites

• Medicare Claims Processing Manual (Pub. 100-4)
  – E&M code rules, teaching supervision requirements
• CMS Regional Offices and Intermediaries
  – http://www.cms.hhs.gov/RegionalOffices/
• AAMC:
  • http://www.aamc.org/advocacy/gme/
Hospital $$ Data

- Graham Center Data Tables for Family Medicine
  - 2000-2007 hospital payment data including resident FTE counts

- CMS data (the horse’s mouth...):
  - 1996-2010 currently, updated quarterly
  - Look under “downloads” area at bottom of page for “frequent reports”, you need reports #1(the $ data) and #2 (hospital ID codes). Currently these reports are:
What Is Medicare DGME?

• Direct GME (DGME) is the amount Medicare pays the hospital for Medicare’s share of the direct cost of the residency:
  – resident salaries, faculty teaching, administration, building maintenance, personnel, etc.
DGME - the base year is vital!!

- Medicare uses the lower of claimed expenses vs. geographic average in determining the base year (first claimed year) hospital specific Per Resident Amount (PRA) for a new teaching hospital.
- National PRA 2010 is $93,739 (WI GAF 0.968)
- ALL subsequent years DGME reimbursement is tied to the base year PRA at your hospital.
- 1984 original base
- New hospitals... don’t claim less than the regional average!
DGME Medicare’s share:

4. Determining *Medicare’s share* of total DGME based on proportion of inpatient days:
   - Medicare inpatient days = 52,560
   - Total Inpatient Days = 175,200
   - Medicare’s share = 52,560/175,200 = 30%
   - So hospital would get 30% of PRA for each resident (approx $30K per resident)
What is IME?

- Indirect Medical Education (IME) payments are a calculated percent added to each DRG payment from Medicare. Hospitals with more residents per bed get a higher percent added to their DRGs (0 to over 40%).
Theory of IME

• Theoretically IME payment cover hospitals “excess costs” of care due to residents’ inefficiency (more tests, longer LOS), sicker patients and costly new technology at teaching hospitals
Reality of IME

• FP resident care of patients is probably NOT more expensive than care by non-teaching FPs. Internal Medicine resident care probably is.
  – This can be shown locally at your hospital by comparing FM teaching service DRG specific length of stay (LOS) and costs vs IM teaching service or community FM or hospitalist LOS and costs.
So...

• For established FM residencies - We (FP residencies) should get the IME money
• For planned FM residencies – IME is income without associated increase in hospital costs
How is IME calculated?

1. Counting “IME” Residents (up to cap)
2. Counting Beds: staffed beds.
3. Use the magic formula
   
   \[ \text{multiplier} \times (\text{POWER}((1+\text{IRB}),0.405)-1) \]
4. The %addon is then added on to EVERY DRG the hospital claims from Medicare for that year
5. Generally 1.5-3 times the DGME
How many residents can each hospital count?

- Number “capped” in 1996 for each hospital based on total FTE residents (all programs) claimed by that hospital for FY 1996.
- DGME and IME resident counts capped separately for each hospital.
New caps and cap changes

• “Old hospitals” Redistribution – done for 2006 and also again 2010
• “New hospitals” are hospitals that have never claimed Medicare GME before 1997.
• “New programs” are residencies accredited after 1996.
Can this cap be changed?

<table>
<thead>
<tr>
<th></th>
<th>new rural hospital</th>
<th>new urban hospital</th>
<th>old rural hospital</th>
<th>old urban hospital</th>
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</thead>
<tbody>
<tr>
<td><strong>new program</strong></td>
<td>YES - 3rd year rule</td>
<td>YES - 3rd year rule</td>
<td>YES - 3rd year rule</td>
<td>NO - unless new program is a 1-2 RTT.</td>
</tr>
<tr>
<td><strong>old program</strong></td>
<td>YES - 3rd year rule</td>
<td>? - best to start a new program</td>
<td>YES - 30% increase over 1996 cap starting 2001</td>
<td>NO</td>
</tr>
</tbody>
</table>

**3rd year rule**: set at third year based on max # res in any one year times the length of training
Can this cap be changed?

Rural goodness:

- Rural hospitals that are new teaching hospitals have three years to establish a cap
- 30% increase in 1996 cap OK for old rural hospitals (applies starting 2001)
- Some urban hospitals can be reclassified as rural (but usually net effect is less Medicare $)
- An adjustment to the resident limits of urban hospitals that establish separately accredited training programs in rural areas, including integrated rural training tracks (2/3 of resident time must be rural).
Counting residents

• Used to be (pre 2010 reform) a big issue of paying volunteer faculty in order to count resident time spent in outpatient setting (e.g. Dermatology rotation)

• Now fairly straight-forward: can count time in patient care and educational activities inpatient and outpatient (just not “research” unrelated to pt care)
Disproportionate Share Payments (DSH)

- DSH funds preserve access to care for Medicare and low-income populations by financially assisting the hospitals they use.
- DSH payments are concentrated in relatively few hospitals. More than 95 percent of all DSH payments go to urban hospitals, and about 250 hospitals receive one-half of all DSH payments. Teaching hospitals received $3 billion in DSH payments in 1997, or about two-thirds of all DSH payments.
Why should DSH be on the Residency’s plate?

- Often Residencies provide a significant amount of care for the hospital’s impoverished clientele.
- Residencies that provide lots of poverty care can be criticized by their hospital(s) for their adverse payer mix (low collections) and financially penalized.
- Sometimes the amount of poverty care brought to a hospital by the residency puts them over threshold to obtain *substantial* DSH $ (often more than IME and DGME combined)
- Thus the impact of the residency on DSH needs to be considered in the whole fiscal performance/impact of the FMR on the hospital.
Medicaid GME

- Varies by state from a little to a lot and methods of calculating vary
  - Many are parallel to Medicare methods
- Tim Henderson’s report on all states Medicaid GME system from 2006, commissioned by the AAMC
- Lou.sanner@fammened.wisc.edu
Rural training options and CMS

• New FM Residency
• RTT
• Expansion of established residency
  – Additional rural FMC (new continuity clinic)
  – Adding residents
  – More rural rotations for established residency
Income flow when Residency NOT part of Hospital

- Medicare GME
- GME kept by hospital
- Clinical Income
- GME "passthrough"
- State Support
- Grants
- Residency
Income flow when Residency IS a part of Hospital and IS a clear cost center

Clinical Income
Medicare GME
State Support
Grants
Income flow when Residency IS a part of Hospital but NOT well defined cost center

Clinical Income

Medicare GME

State Support

Grants

Hospital

Residency

? Revenue and expense allocation
<table>
<thead>
<tr>
<th>Year</th>
<th>Period</th>
<th>Timeline Details</th>
</tr>
</thead>
</table>
| 0    | now- 6/2012 | - generate draft budget/business plan for mature 2-2-2 program  
|      |             | - generate draft "start-up" budget  
|      |             | - get commitments from core institutional partners for RTT  
|      |             | - write draft PIF including curriculum structure and identify FMC  
|      |             |   - final PIF may end up following new rules version later in 2012-13  
|      |             | - Plans for build/modification of space to function as RTT FMC  
|      |             | - identify RTT physician site director and budget for preparation work in years 0, 1, and 2. |
| 1    | 7/2012- 6/2013 | - identify specific faculty (needed for PIF) at rural site including subspecialty teachers  
|      |             | - write and submit PIF by December  
|      |             | - RRC site visit (curriculum, FMC, FM faculty, other faculty) in spring 2013  
|      |             | - RRC approval by June 2013  
|      |             | - list new program in ERAS summer 2013  
| 2    | 7/2013- 6/2014 | - resident recruitment  
| 3    | 7/2014- 6/2015 | - 1st year with residents (total 2 PGY-1s) mainly at urban site this year  
|      |             | - resident recruitment for 2nd class  
|      |             | - 2nd PIF  
|      |             | - 2nd RRC site visit  
| 4    | 7/2015- 6/2016 | - 2nd year with residents (total 2 PGY-1s, 2 PGY-2s), PGY-2s now mainly at rural site  
|      |             | - resident recruitment for 3rd class  
| 5    | 7/2016- 6/2017 | - 3rd year with residents (total 2 PGY-1s, 2 PGY-2s, 2 PGY-3s)  
|      |             |   - could be increase this year to 4 PGY-1s to capture "3rd year cap set"  
|      |             | - resident recruitment for 4th class  
|      |             | - 3rd PIF  
|      |             | - 3rd RRC site visit  

June 2017 graduate first class of residents
New residency or RTT budgeting

• Start-up
  – Residency “$1,000,000 and 5 years”
  – RTT “$500,000 and 5 years”

• Ongoing mature budgets
### A Model Rural Training Track Projected Expenses (mature, NOT startup)

**per academic year when program mature with 2-2-2 residents employed**

presumes all possible RTT expenses charged to Rural Hospital

<table>
<thead>
<tr>
<th></th>
<th>Rural Hospital Claimable FTEs</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RTT residents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R1</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>R2</td>
<td>1.75</td>
<td></td>
</tr>
<tr>
<td>R3</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td><strong>Urban Residents (on rural rotation)</strong></td>
<td>0.6</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Personnel costs (salary + fringe)</th>
<th>R1 FTE</th>
<th>R2 FTE</th>
<th>R3 FTE</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT Physician Site Director</td>
<td></td>
<td></td>
<td></td>
<td>$55,000</td>
</tr>
<tr>
<td>RTT Education Coordinator</td>
<td></td>
<td></td>
<td></td>
<td>$28,000</td>
</tr>
<tr>
<td>RTT Continuity Nurse at FMC</td>
<td></td>
<td></td>
<td></td>
<td>$40,000</td>
</tr>
<tr>
<td>Urban site Residents education staff</td>
<td></td>
<td></td>
<td></td>
<td>$22,000</td>
</tr>
<tr>
<td>RTT Residents counted at Rural Hospital</td>
<td></td>
<td></td>
<td></td>
<td>$24,480</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Program Expenses</th>
<th>$261,180</th>
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<tbody>
<tr>
<td>Urban faculty/admin travel</td>
<td>$1,000</td>
</tr>
<tr>
<td>Rural faculty/admin travel &amp; CME</td>
<td>$5,000</td>
</tr>
<tr>
<td>Rural resident expenses</td>
<td>$4,000</td>
</tr>
<tr>
<td>Rural resident travel</td>
<td>$4,000</td>
</tr>
<tr>
<td>DEA license for R2</td>
<td>$1,000</td>
</tr>
<tr>
<td>AAFP dues</td>
<td>$100</td>
</tr>
<tr>
<td>ATLS (R3)</td>
<td>$2,000</td>
</tr>
<tr>
<td>PALS (R1)</td>
<td>$600</td>
</tr>
<tr>
<td>NRP (NALS) (R1)</td>
<td>$200</td>
</tr>
<tr>
<td>ACLS (R1)</td>
<td>$400</td>
</tr>
<tr>
<td>Resident retreat</td>
<td>$200</td>
</tr>
<tr>
<td>Rural RTT accreditation fee</td>
<td>$4,000</td>
</tr>
<tr>
<td>R1 February Dinner</td>
<td>$150</td>
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<tr>
<td>Telephone related expenses</td>
<td>$1,800</td>
</tr>
<tr>
<td>Capital equipment</td>
<td>$0</td>
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</table>

**TOTAL RTT EXPENSES** | $578,840 |

Salary assumptions for 1.0 FTE:

- residents $51,000 $53,000 $55,000
- fringe 20% $10,200 $10,600 $11,000
- resident salary plus fringe $61,200 $63,600 $66,000
Startup budget notes

- Site director for 1.5 years before 1\textsuperscript{st} residents arrive at urban program (2.5 years before PGY-2s at rural site)
- Staff support for RTT development and recruiting
- FMC development costs and practice building for faculty
- Delay in getting money from CMS for GME
Final advice: Build excellence because...

• Only excellence will recruit good residents
• Only good residents will keep motivating local stakeholders
• Good residents trained in an excellent program make great doctors
• Excellent training programs make excellent practice climates
• Great doctors want to stay and practice where the practice climate is excellent