2023 Grantee Annual Meeting

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Deep Dive Into Medicare Financing for IPPS and Non-IPPS Hospitals

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9/12/23

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Objectives

At the end of this session participants will know how to:

1. Better understand how GME reimbursement may vary by type of facility and funding source;

2. Understand how the deployment of residents triggers allowable reimbursement by facility type;

3. Evaluate the financial impacts of supporting new GME programs and the importance of sustainability.

Today's Agenda

- Baseline overview of GME reimbursement
- Types of hospitals and what qualifies for Medicare reimbursement
- How allowable reimbursement varies by hospital type
- The impact to funding based on curriculum design
- What can be counted and considered for GME reimbursement?
- Importance of sustainability, collaboration, and planning
- Q&A

Baseline Medicare GME Payment Methodologies.

Direct GME (DGME)

- Resident and teaching physician salary and benefits, and other direct costs.
- Per resident amount (PRA) established as proxy for costs.
- Medicare utilization %.

Indirect Medical Education (IME)

- Payment for patient costs associated with being a teaching hospital.
- Tied to both Medicare Fee for Service and Medicare HMO.

Resident Cap

- Limits to number of FTEs that can receive DGME and IME reimbursement.
- Rural hospitals, and rural reclassed hospitals have more flexibility.

Based on the type of hospital or facility training residents, there may be different applications of these methodologies or payment streams.

Provider type will determine the amount and qualifying type of Medicare funding.

Provider Type	Number of Providers	Definition	Percent Rural	DGME	IME	Hospital Specific Rate
Inpatient Prospective Payment Hospital	1911	Acute care hospital predominantly located in an urban area	7%	Yes	Yes	No
Rural referral center	619	Acute care hospital meeting several qualifying criteria based on location, bed size and/or referral patterns	12%	Yes	Yes	No
Indian Health Services	25	Hospitals administered through the Indian Health Care System	72%	No	No	No
Medicare Dependent Hospital	145	Hospital meeting certain criteria including operation of 100 or fewer beds, is not a SCH, and percentage of Medicare patients	78%	Yes	Yes*	Yes
MDH/RRC	32	MDH with RRC status	41%	Yes	Yes*	Yes
Sole Community Hospital	302	Hospital meeting certain criteria including geographic proximity to other hospitals and travel time	85%	Yes	Yes*	Yes
SCH/RRC	162	SCH with RRC status	71%	Yes	Yes*	Yes

* Receipt of full IME is dependent on whether the hospital is paid at a higher, hospital specific rate.

Source: FY2024 IPPS Impact File- Proposed Rule

There are other types of participants in GME training that may have different rules or funding streams.

Critical Access Hospitals	▪ Cost-based or can be treated as non-hospital location
Inpatient Psychiatric and Rehab Hospitals	▪ DGME and a teaching add-on factor payment in lieu of IME
VA Hospitals	▪ Separate GME payment program
Rural Emergency Hospitals	▪ New hospital category, can be treated as non-hospital location

There are other types of participants in GME training that may have different rules or funding streams (continued).

Children's Hospital GME Payment Program	▪ HRSA payments to separately licensed children's hospitals
Teaching Health Centers	▪ HRSA payments to community-based GME programs
FQHCs and RHCs	▪ Can receive direct GME funding, but tied to Medicare utilization

Acute care hospitals play a significant role in both rural and teaching health center programs.

Rural Training 50% rural, 1-2 tracks for FM

- For rural training programs, can serve as urban site, or if rural have more flexibility to design the curriculum and deploy residents.
- Can create urban RTP caps.

THC IP Site Participant

- For THC programs, hospital can collaborate with community-based site and and provide required inpatient rotations.
- Hospital must claim > 1.0 FTE.

Key financial questions:

- **Does the acute care hospital have caps?**
- **Does it have a PRA?**
  - ***If GME naive then a PRA and cap can be triggered*.**
- **Is the hospital in a rural area, or urban with a rural reclassification?**
  - ***Can grow new GME for DGME and IME, or IME only.***

Two categories of hospitals that have unique payment methodologies are MDH and SCH.

- Each has a hospital specific rate (HSR) that is compared to the federal rate and are reimbursed at the higher amount.

Medicare Dependent	Sole Community
▪ Operating payments are paid based on the higher of federal rate payment, or the federal rate payment plus 75% of difference between the federal rate and HSR.	▪ Payments are based on the higher of their HSR or the federal rate and the capital base rate.

Key financial considerations:

- **If the HSR is higher than the federal rate, *then IME for FFS is not realized*.**
- **Whether or not the HSR is higher, IME is received based on Medicare HMO business.**

The inability to qualify for full IME can be a significant barrier to MDH and SCH participation in GME.

	Per Resident Reimbursement Amounts		
	IPPS Hospital	MDH	SCH
DGME	$ 50,218	$ 50,218	$ 50,218
IME FFS	$ 118,440	$ 29,610	$ -
IME HMO	53,604	53,604	53,604
Total IME	$ 172,044	$ 83,214	$ 53,604
Total GME	**$ 222,262**	**$ 133,432**	**$ 103,822**
Variance to IPPS	**$ -**	**$ 88,830**	**$ 118,440**

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GME sustainability can and does vary based on options programs have for residency deployments.

PGY 1 Program curriculum

Block	Block 1	Block 2	Block 3	Block 4	Block 5	Block 6	Block 7	Block 8	Block 9	Block 10	Block 11	Block 12	Block 13
Sites	Site 1	Site 2	Site 2	Site 2	Site 3	Site 3	Site 4	Site 4	Site 1	Site 1	Site 1	Site 1	Site 1
Rotation	ICU	Inpatient	Inpatient	Inpatient	Inpatient	Inpatient	Night Float	Night Float	EM	OB	OB	OB	Nursery
Continuity Clinic Sessions/Week	2	1	1	1	1	1	1	1	4	1	1	1	1

	Location	Blocks	Total DGME/IME Per Block
Site 1	IPPS Hospital	6	$ 222,262
Site 2	SCH	3	103,822
Site 3	MDH	2	133,432
Site 4	CAH	2	222,262

CAH, continuity of care at clinic, and any other non-hospital sites claimed by site with highest allowable reimbursement rate.

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In addition to where residents go to train, what they do there matters too.

	Location of Training			
	Hospital		Non-hospital Clinical Site[1]	
Activity	DGME	IME	DGME	IME
Patient Care	Yes	Yes	Yes	Yes
Vacation/ Sick	Yes	Yes	Yes	Yes
Didactic	Yes	Yes	Yes	No
Research	Yes	No[2]	No	No
Orientation[1]	Yes	Yes	N/A	N/A

[1] Hospital must incur costs of residents to claim. Critical Access Hospitals and Rural Emergency Hospital can be considered as non-hospital for purposes of GME reimbursement.

[2] If research is with an individual patient or leads to the diagnosis of an individual patient, then IME can be claimed.

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HRSA administers both the Children's Hospital and Teaching Health Center programs.

- Payments are made to support residency training outside of traditional Medicare funding, and are discretionary.

CHGME	THC
▪ Average payment per resident was approximately $79,813 in FY22. ▪ Payments made to freestanding children's hospitals.	▪ Current payment set at $160,000 per resident. ▪ Limited number of programs supported.

Key financial considerations:

- **CHGME need to consider other revenue streams to offset funding shortfalls.**
- **THC payments are for community-based programs, but a significant amount of hospital time is required.**

For a THC, where residents are deployed and the reimbursement rules at participatory sites need to be fully understood.

PGY 2 Program curriculum

Block	Block 1	Block 2	Block 3	Block 4	Block 5	Block 6*	Block 7	Block 8	Block 9	Block 10	Block 11	Block 12	Block 13
Sites	Site 2	Site 1	Site 1	Site 1	Site 2	Site 2	Site 3	Site 2	Site 2	Site 3	Site 2	Site 2	Site 3
Rotation	Elective	IM	Ob/Gyn	Ortho	Elective	Elective	Pediatric Inpatient	Family Medicine	Family Medicine	Pediatric Outpatient	Community Primary Care	Community Primary Care	Pediatric Emergency Medicine
Continuity Clinic Sessions/Week	2	2	2	2	3	2	1	5	5	2	4	2	2

	Location	Blocks	Total DGME/IME Per Block
Site 1	IPPS Hospital	3	$ 222,262
Site 2	THC	7	160,000
Site 3	Children's	3	79,813

CAH, continuity of care at clinic, and any other non-hospital sites can be claimed by THC. Hospitals must report > 1.0 FTEs trained.

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Program sustainability is a critical aspect for THCs given funding uncertainty.

- A clear and documented funds flow arrangement should be considered to ensure each participatory site is compliant with its applicable regulations, and that any sharing of expenses is well documented.
- Residents that rotate into hospitals that qualify for DGME and IME reimbursement will need to be claimed by the hospital if the FTE amount is > 1.0.
  - Hospital rotations may result in funding coming in from CMS and not HRSA, and how those funds are distributed to cover GME costs should be negotiated.

How do I plan and pull all this together?

- Evaluate curriculum first, assess whether there are options to flex deployments to generate more allowable reimbursement.
- Any non-hospital rotations to be claimed by site that generates more allowable reimbursement.
- Choose your partners wisely to the extent that you can; cooperation and collaboration are key to success, and formal agreements (e.g., master services, consortium, funds flow) should be considered and executed between participants.
- Know the rules.
- Revisit the rationale for participating in GME and quantify the residual benefits of having residents besides the federal/state funding that may be generated.

Questions/Comments

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