

# 2023 Grantee Annual Meeting



Hyatt Regency Crystal City At Reagan National Airport  
Arlington, VA

A partnership between



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

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# Disclosures

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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 reclassified 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
<b>Inpatient Prospective Payment Hospital</b>	1911	Acute care hospital predominantly located in an urban area	7%	Yes	Yes	No
<b>Rural referral center</b>	619	Acute care hospital meeting several qualifying criteria based on location, bed size and/or referral patterns	12%	Yes	Yes	No
<b>Indian Health Services</b>	25	Hospitals administered through the Indian Health Care System	72%	No	No	No
<b>Medicare Dependent Hospital</b>	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
<b>MDH/RRC</b>	32	MDH with RRC status	41%	Yes	Yes*	Yes
<b>Sole Community Hospital</b>	302	Hospital meeting certain criteria including geographic proximity to other hospitals and travel time	85%	Yes	Yes*	Yes
<b>SCH/RRC</b>	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.

# 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 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

- 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.

## Sole Community

- 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.



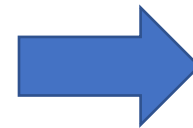
	Per Resident Reimbursement Amounts					
	IPPS Hospital		MDH		SCH	
DGME	\$	50,218	\$	50,218	\$	50,218
IME FFS	\$	118,440	\$	29,610	\$	-
IME HMO		53,604		53,604		53,604
Total IME	\$	172,044	\$	83,214	\$	53,604
Total GME	\$	222,262	\$	133,432	\$	103,822
Variance to IPPS	\$	-	\$	88,830	\$	118,440

# 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.**

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

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

<sup>1</sup> 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.

<sup>2</sup> If research is with an individual patient or leads to the diagnosis of an individual patient, then IME can be claimed.

# 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

- Average payment per resident was approximately \$79,813 in FY22.
- Payments made to freestanding children's hospitals.

## THC

- Current payment set at \$160,000 per resident.
- Limited number of programs supported.

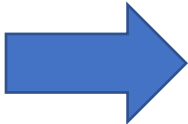
## Key financial considerations:

- **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.



# 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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# Rural Residency Planning and Development and Teaching Health Center Planning and Development Technical Assistance Centers

A partnership between

