COVID-19 Waivers and Flexibilities Affecting Medicare Graduate Medical Education (GME) Payments

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AGENDA

- GME Reimbursement Overview & Payment Mechanics
- COVID-19 Waivers & Flexibilities

GME Reimbursement Overview & Payment Mechanics

Medicare GME Overview: 2 Categories of Payment

- **Direct Graduate Medical Education (DGME)**
  - Per-resident payment
  - Paid as a separate pass-through payment, independent of MS-DRG payment
  - Roughly 1/3 of total GME
- **Indirect Medical Education (IME)**
  - Not paid on a per-resident basis
  - Percentage add-on payment to basic Medicare MS-DRG payment
  - Roughly 2/3 of total GME

FTE Caps

- In the Balanced Budget Act of 1997, Congress **capped** the number of residents for which a hospital can claim DGME/IME reimbursement
- Teaching hospitals have separate FTE Caps for DGME and IME
- **Dental residents are not subject to the Medicare GME FTE caps**
  - FTE caps are statutorily limited to “allopathic and osteopathic” residents (so exclude dental and podiatry)
  - Would take a legislative change to subject dental residents to the FTE caps

3-Year Rolling Average

- Also enacted in the Balanced Budget Act of 1997
- Applies for both DGME and IME
- **RULE:** The hospital's total number of FTE residents for payment purposes is equal to the average of the actual FTE resident counts from the current cost reporting period and the preceding two cost reporting periods
- **Dental residents are subject to the 3-year rolling average**
- Effect is to delay the full realization of additional reimbursement for new residents by “phasing in” FTE increases over 3 years
- It would require a legislative fix to eliminate the 3-year rolling average

Medicare DGME payments

What are DGME payments intended to cover?

- Medicare's share of the costs directly related to educating residents, including:
  - Residents' stipends/fringe benefits
  - Salaries/fringe benefits of supervising faculty
  - Other direct costs (accreditation fees, etc.)
  - Allocated overhead costs

DGME Payment Formula

Total DGME	=	Hospital's PRA	×	FTE resident count	×	Hospital's Medicare patient load

- Step 1: Determine the hospital's per-resident amount (PRA):
  - Determine per-resident base year costs (*i.e.*, how much the hospital spent per resident back in 1984)
  - Update (to current year) for inflation; different for primary vs. non-primary care
- Step 2: Multiply the updated PRA by the number of *countable* full-time equivalent (FTE) residents in the current year, subject to:
  - FTE "cap";
  - 3-year rolling average; and
  - "Weighting" rules (see next slide)
- Step 3: Multiply by the hospital's ratio of Medicare inpatient days to total inpatient days (often called the "Medicare share")

"Weighted" FTE Count: Initial Residency Period (IRP) Affects DGME Payments

- **IRP = minimum accredited length for each specialty**
- Residents training during their IRP are counted as 1.0 FTE
- Residents training beyond their IRP are counted as 0.5 FTE
- Examples?
  - Fellowships
  - Retraining in a different specialty (depending on which specialty)
  - Repeating a year of training
- IRP is determined during a resident's first year of training and does not change
- Limited exception for preliminary and transitional-year programs, which do not lead to board certification in a specialty or subspecialty

Medicare IME payments

What are IME Payments Intended to Cover?

- "Indirect" *patient care costs* associated with having a teaching program
- Higher inpatient operating costs because of the clinical environment where teaching occurs:
  - Unmeasured patient complexity not captured by the MS-DRG system
  - Increased costs of specialized services
  - Other operating costs associated with being a teaching hospital (standby capacity, lower productivity, etc.)

IME Payment Formula

$$\text{Total IME} = 1.35 \times \left[\left(1 + \text{IRB}\right)^{0.405} - 1\right] \times \text{MS-DRG Pmts}$$

- IME adjustment is based on statistical analysis
- Critical factor is hospital's ratio of interns-and-residents-to-beds (IRB)
  - Proxy for teaching intensity
  - Capped at lesser of current or previous year's ratio
- Exponent of 0.405 meant to account for effect of teaching activity on inpatient operating costs
- For FFY 2019, Multiplier = 1.35
- Note: There is no IME add-on to Medicare outpatient payments
- **Shorthand for IME: Hospitals get about a 5.5% increase in MS-DRG payments for every 10-resident increase per 100 beds**

Calculating the IME Payment

- Step 1: Determine the IRB ratio

  Example: 85 resident FTEs / 333 beds = 0.255

  (Note: IME resident counts are NOT weighted)

- Step 2: Use statistical formula and IRB to calculate IME add-on

  $1.35 \times [(1 + 0.255)^{0.405} - 1] = 0.13$ (or 13%)

- Step 3: Calculate the IME payment for each case

  EXAMPLE: IME add-on payment for MS-DRG 470 (major joint replacement) =

  ($14,213 × 13%) = $1,847.69

Counting Resident Time

CMS Rules for Counting Resident Time

- Factors affecting how resident time may be counted include:
  - Costs hospitals must bear to count resident time in nonprovider sites
  - Activities in which the resident participates—*e.g.*, patient care, didactic, research, approved leave
  - Documentation and recordkeeping requirements

What Resident Time Counts for Medicare DGME and IME Payments?

	Hospital		Nonprovider Site	
Time	**DGME**	**IME**	**DGME**	**IME**
Patient Care	Yes	Yes	Yes	Yes
Vacation/Sick	Yes	Yes	Yes	Yes
Didactic	**Yes**	**Yes**	**Some***	**No**
Research	**Yes**	No	**No**	No

* To count didactic time in nonprovider settings, didactic training must occur in dental clinic and not in dental school

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COVID-19 GME Issues

Resident Supervision via Telemedicine

General Rules

- To bill Medicare for services furnished with dental residents, **teaching dentists must be present during the key or critical portions** of any service or procedure in which a resident participates.
- For the **interpretation of diagnostic radiology or other diagnostic tests**, the teaching dentist must perform or review the resident's interpretation.

Resident Supervision via Telemedicine

CMS Flexibility During the COVID-19 PHE

- **Teaching dentists may fulfill the presence requirement by providing direct supervision by interactive telecommunications technology.**
- CMS will allow payment for teaching dentist services when a resident in quarantine furnishes services via telehealth under the direct supervision of the teaching dentist by interactive telecommunications technology.
- **Exceptions:** The relaxed teaching dentist presence rules do not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services.

Claiming Time for Residents Furnishing Telehealth Services from Homes or Other Clinical Sites

- Pre-COVID-19, no DGME or IME for resident time spent working in own home or in a patient's home.
- During COVID-19, a hospital paying the resident's salary and fringe benefits **may claim time a resident spends working at home or in an established hospital patient's home for IME and DGME purposes.**
- Hospitals must claim resident FTE time for telehealth services provided by a resident who is **physically located in a nonprovider setting** where the hospital is paying the salary and fringe benefits (even if the patient is located elsewhere).

Resident Moonlighting

- **General rule: the services of residents in hospitals where they train in their approved GME program are not separately billable.**
  - **Exception:** residents may moonlight and bill separately for services that are **unrelated** to their approved GME program in an **outpatient department** or **ED** in which they have their training program.
  - **During the COVID PHE**, residents may moonlight in the inpatient setting of the hospital where they train if:
    - (1) the service is **separately identifiable** and meets the conditions for fee schedule payment;
    - (2) the **resident is fully licensed to practice dentistry by the state** in which the services are performed; and
    - (3) the services **are not performed as part of the approved GME program.**

Training Delays Due to COVID-19

- If **dental residents' graduations are delayed because of COVID-19,** CMS will continue GME payments through the date the residents graduate without reducing DGME.
  - CMS will treat the residents as though they are still within their IRP.
- If **residents have to extend their training because of COVID-19** and a program ends up having more than the usual number of residents (because some residents have to continue on while other residents enter the program), any additional residents are still subject to the three-year rolling average and IRB ratio cap because these are statutory requirements.

Questions

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Thank you

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