

# A Primer on Medicare Graduate Medical Education Payments: What Hospitals Should Know About How the Government Calculates GME Reimbursement

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In fiscal year 2020, Medicare paid over \$16 billion to hospitals throughout the United States in the form of Graduate Medical Education (GME) payments. This article is intended to serve as both a primer covering the basic details of Medicare GME payments, and as a reminder to hospitals that understanding the methodology by which those reimbursements are calculated can potentially open the door to successful court challenges of reimbursement determinations.

## Eligibility for GME Payments

A hospital is eligible for GME payments if it is a teaching hospital (often affiliated with a medical school) with an approved and accredited residency program in medicine, osteopathy, dentistry or podiatry.

## Purpose of Medicare GME Payments

Medicare GME payments cover Medicare's share of the costs of a hospital's medical residency program. Those costs are broken down into two components: (1) the *direct* costs of operating a residency program, including stipends, supervisory physician salaries, and other administrative costs; and (2) the *indirect* costs of operating a residency program which may result in higher patient care costs in teaching as opposed to non-teaching hospitals, such as additional tests that residents may order as a result of their training.

## How Does Medicare Pay for GME?

Medicare makes separate payments for direct GME (DGME) and indirect GME (IME) costs. Both DGME and IME payments are determined by a statutory formula. GME

payments are not unlimited. Congress caps Medicare GME payments by placing limits on the number of resident full-time equivalents (FTEs) and the per resident amounts (PRAs) it will support. The number of FTEs is capped at the number of FTE residents a hospital was training in 1996. The amount Medicare will pay for an FTE is based on a hospital's costs for a resident FTE in a base year (either 1984 or 1985) as updated by an annual inflation factor.

## Direct Graduate Medical Education (DGME)

DGME payments are "pass-through" payments, not an adjustment to Medicare payments for individual hospital discharges. DGME payments are the product of a hospital's total approved DGME costs, which is a three-year rolling average of FTEs (subject to the FTE cap) multiplied by the PRA, which is then multiplied by a hospital's Medicare patient load percentage. A hospital's Medicare patient load percentage is the ratio of Medicare inpatient days to all patient days for the year. In addition, the Medicare Advantage (Part C) portion of a hospital's patient load is reduced by a specified percentage to fund nursing and allied health education (NAHE).



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Expressed as a formula, DGME payments are calculated as follows:

DGME Payment	=	Total Approved DGME Amount	x	Medicare Patient Load
		$\left( \frac{\text{Adjusted Rolling Average FTE Count}}{\text{Per Resident Amount}} \right)$		$\left( \frac{\text{Medicare Part A Inpatient Days} + \text{Medicare Part C Inpatient Days}}{\text{Total Inpatient Days}} \right) \times \text{\% reduction to fund NAHE}$

The FTE cap and PRAs are hospital-specific, however qualifying hospitals may enter into an affiliate agreement which allows a group of hospitals to share and/or redistribute FTEs among the group, allowing some affiliated hospitals to reduce their Medicare-supported FTEs so that other affiliated hospitals may increase theirs without exceeding the aggregate number of FTEs of the affiliated group. In fiscal year 2020, Medicare paid \$4.5 billion for DGME, supporting 88,247 FTEs.

**Indirect Medical Education (IME)**

IME payments are intended to cover the cost of “inefficient care” provided by residents in teaching hospitals as compared to non-teaching hospitals and are provided as an adjustment to each Medicare inpatient prospective payment system (IPPS) per-discharge payment. IME payments are add-ons to both the operating and capital portions of IPPS payments. In fiscal year 2020, Medicare paid approximately \$11.68 billion for IME, supporting 98,542 FTEs.

The IME adjustment to the operating portion of the IPPS payment is based on a statutory formula, which captures for each teaching hospital the ratio of interns and residents to beds (IRB) and applies an exponent to the IRB (0.405) which estimates the effect of teaching activity on hospital costs. In addition, the formula contains a multiplier (of 1.35) which is set by Congress in the statute, which represents a 5.5% increase in the IME payment for every 10% increase in the IRB ratio.

Expressed as a formula, the IME operating adjustment is as follows:

$$\text{IME Operating Adjustment} = 1.35 \times [(1 + \text{IRB})^{0.405} - 1]$$

The IME adjustment for the capital portion of the IPPS payment is based on the residents-to-average daily census ratio (RADC) and an estimate of the effect of teaching activity on hospital costs (0.2822).

Expressed as a formula, the IME capital adjustment is as follows:

$$\text{IME Capital Adjustment} = [e^{(0.2822 \times \text{RADC})} - 1]$$

**Increasing Medicare-Supported Residency Position**

As of this writing, a teaching hospital’s options to increase its number of Medicare-supported residency positions are limited. One method for doing so is for a hospital with an existing residency program to establish a “new” program, which is defined in regulation. A second method is for a hospital without a residency program to start one. Additionally, an urban hospital can start a new Rural Training Track to train residents in a rural area. The final method is for Congress to enact legislation to increase the number of Medicare-supported residency positions. In fact, Congress recently increased new Medicare-supported GME positions by 1,000 slots. Phasing in 200 slots per year over five years, the distribution of these new residency positions will prioritize teaching hospitals in rural areas, hospitals training residents over their cap, hospitals in states with new medical schools, and hospitals that care for underserved communities.

**Recent Successful Hospital Appeal in *Hershey Medical Center v. Becerra***

In the recent United States District Court case of *Milton S. Hershey Medical Center v. Becerra*, Civil Action No. 19-2680, a number of teaching hospitals challenged one of the elements that the Secretary of Health and Human Services (HHS) used in fiscal years dating back to 2005 to determine a hospital’s DGME payment: specifically, each hospital’s weighted number of FTE residents. After students graduate from medical school, they often continue their training in an initial residency period (IRP) which, by statute, is defined to last five years.<sup>i</sup> Some residents additionally complete a fellowship which typically occurs outside the 5-year IRP. Under the Medicare statute, the rules for calculating the weighted average number of FTEs are required to provide a weighing factor of 1.00 for a resident who is in the resident’s IRP, and a weighing factor of .50 for a resident who is not in the resident’s IRP.<sup>ii</sup> Thus, the Medicare statute requires that a *resident’s* time be fully counted but only one-half of a *fellow’s* time be counted for purposes of the FTE calculation.

In addition, in 1997, Congress amended the Medicare statute to set a limit on how many FTEs a hospital may factor into its count before application of the weighing factors. That limit was capped at the hospital’s 1996 levels.

In 1998, the HHS Secretary amended the agency’s regula-

tion which effectively reduced the weighted number of FTEs a hospital may claim for reimbursement when the hospital's unweighted FTE count exceeds its 1996 cap.<sup>iii</sup> When a hospital exceeds the cap, its weighted FTE count is reduced commensurate with the amount by which the hospital exceeds the cap. As the *Hershey* Court explained, assuming a hospital's cap of 100 which is met by employing 90 residents and 10 fellows, after weighing the fellows at 0.5, the hospital's post-weighted FTE count is 95. The math is as follows:

$$\frac{100}{100} \times 95 = 95$$

However, if that hospital adds ten more fellows (for a total of 90 residents and 20 fellows), thereby exceeding the cap, its post-regulation weighted FTE count is reduced to 90.91. The math is as follows:

$$\frac{100}{110} \times 100 = 90.91$$

Recognizing, under the rules of statutory construction set forth in *Chevron v. Nat'l Resource Defense Council*,<sup>iv</sup> that it owed no deference to the HHS Secretary's interpretation of the Medicare statute because the statutory language speaks to the precise issue and is clear, the *Hershey* Court held that the express text of the Medicare statute did not give the Secretary the latitude to decide, when a hospital exceeds its cap or not, to change the weights that Congress assigned to residents and fellows when calculating the FTE residents for each hospital. Consequently, the Court struck down the agency's regulation, and thus, the DGME calculation, because it violated the express language of the Medicare statute.

### Conclusion

With billions of dollars going each year to hospitals throughout the United States for GME payments, and with Congress increasing the number of available GME slots, hospitals are wise to pay close attention not only to the means of calculating DGME and IME, but also how the federal government applies these formulae each year, and how the new GME slots are to be allocated. Now more than ever, courts seem

receptive to challenges by providers taking issue with how the federal government calculates reimbursement for GME and other federal healthcare programs. As a result, aggrieved hospitals are in as good a position as they have ever been to challenge the methodology and calculations made to determine hospital reimbursement. Thus, hospitals should continue to monitor how the federal government carries out its responsibilities under the Medicare statute to ensure its actions are consistent with the law.

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### Footnotes

<sup>i</sup>42 U.S.C. § 1395ww(h)(4)(C); 42 U.S.C. § 1395ww(h)(5)(F).  
<sup>ii</sup>42 U.S.C. § 1395ww(h)(4)(C).  
<sup>iii</sup>63 Fed. Reg. 26,318, 26,330 (May 12, 1998); 42 C.F.R. § 413.79(c)(2)(iii).  
<sup>iv</sup>467 U.S. 837 (1984).