GME Tables: A Guide for Users

Overview and Background

In the United States, teaching hospitals and associated ambulatory settings provide graduate medical education (GME) for resident physicians ("residents") through several years of supervised, hands-on clinical training programs in particular areas of medicine.
These teaching hospitals provide three services simultaneously:

i. Patient health care
ii. Graduate medical training
iii. Medical research

In the training of residents, teaching hospitals incur significant costs and expenses beyond those customarily associated with providing patient care or performing medical research. The Medicare program makes payments to teaching hospitals for a portion of these added costs through its graduate medical education payments.

GME Payments

There are two types of Medicare GME payments:

1) Direct Graduate Medical Education (DGME) **payments** are Medicare payments for a program's share of residents' stipends and fringe benefits, and the salaries and fringe benefits of faculty who supervise physician residents. It also covers institutional overhead costs and other exclusively GME-related administrative costs.

The DGME amount is paid as a portion of the "per resident amount" (PRA). The PRA represents the DGME costs incurred by a teaching hospital in a base period (generally 1984 or 1985) divided by the number of full-time equivalent (FTE) residents during that base year. The PRA is updated annually by an inflation factor and then multiplied by the hospital's resident count, subject to its cap. Medicare pays its portion of this amount based on the ratio of the number of total inpatient days Medicare patients spend in the hospital, divided by the hospital's total inpatient days for all patients.

In general, each hospital has two separate PRAs, because in fiscal years (FYs) 1994 and 1995, the PRAs for nonprimary care residents were not updated for inflation, while the primary care PRAs were updated. Thus, each teaching hospital receives slightly higher payments for residents training in primary care specialties and slightly lower amounts for residents in other specialties. Note that primary care specialties in this case include family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, and obstetrics/gynecology.

2) Indirect Medical Education (IME) adjustment **payments** are the additional amount Medicare pays to compensate teaching hospitals for the expected increase in operating costs by virtue of their being teaching hospitals. The IME is paid as a special adjustment to the Medicare prospective payment system (PPS). For every Medicare case paid under the operating inpatient PPS, a teaching hospital receives an additional payment, calculated as a percentage add-on to the basic price per case. The hospital's IME payment is determined by inserting its individual intern/resident-to-bed ratio

(IRB) into a formula established under Medicare statute. As a hospital's involvement in GME increases, its percentage add-on to the basic PPS payment also increases. More than 1,100 teaching hospitals receive IME payments. Because teaching hospitals are not paid directly by Medicare for treating managed care patients, an IME payment is calculated by the hospital submitting a "shadow" (no-pay) claim to Medicare that is used to calculate the IME payment.

Teaching hospitals also receive an IME payment associated with Medicare's capital PPS. This payment is based on a slightly different formula and uses residents-to-average daily census (RADC) rather than the IRB to measure teaching intensity. This "capital IME" payment is scheduled to be eliminated in FY 2010.

FTE

FTE represents the “full-time-equivalent” number of physician residents reported by teaching hospitals.

In this report, two types of FTEs are extracted:

1) Prim. Care FTE: Weighted FTE count for primary care physicians and OB/GYN residents in an allopathic or osteopathic program for the current year, including the weighted number of primary care and OB/GYN FTE residents in the initial year of new allopathic and osteopathic programs
2) Non Prim. Care FTE: Weighted FTE count for all other physicians in an allopathic or osteopathic program for the current year, including the weighted number of residents in the initial year of new allopathic and osteopathic programs

Note: Corresponding to the changes in Centers for Medicare and Medicaid Services data, the extraction formula has changed. The new FTE now accounts for the FTE in new allopathic and osteopathic programs.

Frequently Asked Questions:

1) What is presented in this table?

Answer: In this table, we present the Medicare GME payments received by teaching hospitals for fiscal years 2000 to 2010. These data were submitted by those hospitals as cost reports to the Centers for Medicare and Medicaid Services. We **include** cost reports that were being audited or those referred to as “reopened for audit.”

In addition to the hospital site number, the table also includes the name of the teaching hospital site; DGME, IME, and GME amounts; the FTE for primary care physician residents; the updated primary care PRA; the FTE for nonprimary care physician residents; and the number of beds in the hospital. The Excel and PDF files available for download contain additional hospital information: report status, fiscal year begin date, and fiscal year end date.

Teaching hospitals are required to report their data to Centers for Medicare and Medicaid Services for every fiscal year, or when they change ownership or corporate control. They include Medicare program payments only, NOT Medicaid and NOT payments from state agencies. These are payments to individual teaching hospital sites and NOT payments to aggregated hospital systems that may own or control multiple teaching hospital sites. Many hospital systems have multiple sites. Teaching hospitals report their "cost reports" by hospital site. Each hospital site is identified by a unique number. Thus, a hospital system made up of three hospitals at three different sites completes a cost report for each site using each site's own unique identification number. In addition, these are NOT payments going to the individual residency programs that may be affiliated with a teaching hospital system or hospital site.

2) How do I find the information for my teaching hospital?

Answer: To perform a basic search, type a year, hospital site identification number, hospital name, or state, and select *Submit*. To perform another search, select *Reset*.

To perform an advanced search, select the *Advanced Search* tab at the top of the form and enter a hospital site identification number, or select a hospital name, state, or year, and select *Submit*. To perform another search, select *Reset*.

3) How can this information help my program?

Answer: This table allows program directors to compare the information collected by the Centers for Medicare and Medicaid Services from hospitals receiving Medicare payments. Studies have shown that many residency directors do not know how much teaching hospitals receive for their residents.

This table should provide credible estimates of the amount of funds teaching hospital sites received from Medicare. It is meant to provide some layer of transparency in understanding the funds going into graduate medical education.

The information provided in the table can be used:

i. By residency directors to review reported GME payments to the hospital for primary care and nonprimary care resident FTE.
ii. To provide both IME and DGME breakdowns.
iii. To compare a program to other local, state, or national programs.
iv. To review trends or changes in GME, DGME, IME, or FTE.

4) Why does CMS support the cost of graduate medical education?

Answer: In 1965, legislators determined that it was an important investment to secure the education of health care providers in the founding of Medicare.

5) How does CMS gather the information?

Answer: In order to receive DME and IME payment from CMS, a hospital must supply CMS with an annual fiscal cost report. The annual cost report is sent to an intermediary agency that reviews the initial report, and then it is submitted to CMS. The information may then be audited by CMS-approved financial auditors.

6) Where do the data in this table come from?

Answer: The data are retrieved from the CMS website's Cost Report section. They consist of worksheets that are part of the Healthcare Cost Report Information System (HCRIS) dataset. The

dataset consists of every data element included in the HCRIS extract created for CMS by a provider's fiscal intermediary.

7) Why are the data available not more recent?

Answer: An annual cost report submitted by a teaching hospital each fiscal year is reviewed by its Medicare fiscal intermediary. The intermediary then forwards the information to CMS. During this time, if there are questions regarding the report submitted by a hospital, it may be returned from the intermediary for reconciliation. That process requires time.

8) How do you extract the data?

Answer: We download hospital cost reports from the CMS website. Due to the size of the files and the complexity of the organization, we use appropriate software to filter through the raw data to find the information of interest.

To simplify access to and interpretation of this data, we have used SAS version 9.1., but other acceptable programs are Oracle, SPSS Statistical Package, Microsoft SQL Server, and DB2. Values presented in the raw data are identified by cell number corresponding to a particular cell from the worksheets and tables that are completed by various hospitals. We work with CMS staff to ensure that the correct cells are being used to extract the information presented in our tables. This is an important step, because there may be changes in the worksheets from year to year that lead to changes in the cells from which data are retrieved. We do not alter or recalculate any of the information obtained from CMS. For the GME value, we simply sum the reported IME and DGME.

9) The information you provide does not reflect what my information shows. Why is there a discrepancy?

Answer:

A. Adjustments were made to accurately account for FTE (formula provided by CMS).
B. You need to be sure that your data are from teaching hospital sites — institutions are sometimes composed of multiple programs — and NOT just from a single residency program or a subset of the programs in a teaching hospital site.
C. The initial values are provided by the hospital. We simply take the values provided, extract them from the raw data sheets, and present them in a user-friendly format. However, some sources of discrepancy may be:
    i. The information available from CMS may not be complete. Due to audits and reconciliation of reports, the values may change. You may want to look at data that are three years old or older to see trends.
    ii. The information you have may be different from what was reported on the worksheets provided to CMS.

10) How often do you plan to update this table?

Answer: Cost reports are filed annually by facilities according to their individual reporting years, and the HCRIS dataset is updated quarterly by CMS. Cost reports are generally available 6 to 9 months from the close of a hospital's fiscal year. ***Update frequency: TBD.***

11) Is there another site that presents similar information?

Answer: Yes, you can refer to CMS' Cost Report webpage.