

Budgeting for GME Programs

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Issues to address

- Budgeting for programs
- Rotation schedules
- Clinic and didactic time
- Rotations to non-providers
- CMS Audits

Before you build a budget

- Know your reimbursement from all sources for GME
 - ◆ Several ways to show return on investment
 - ◆ Administration tends to look at bottom line

Budgeting for programs

- Develop a standardized form
- Use it across all programs
- Make coordinators and Program Directors responsible

Budgeting (continued)

- IMPERATIVE that budgeting is as transparent as possible

Budgeting (continued)

- Data points to collect
 - ◆ Resident salaries + benefits
(Fellow reimbursement 50% IME)
 - ◆ Faculty salaries + benefits

Budgeting (continued)

◆ Supplies

- Drugs, IV, Med/Surg supplies,
- Office supplies
- Forms
- Postage
- Minor Equipment
- Recruitment material
- Lab coats

Budgeting (continued)

- Medical Specialist Fees (preceptors)
- Purchased Services (moonlighting)
- Dues & Memberships
- Periodicals/Books
- Travel & Education
- Meetings and Food
- Licenses
- Miscellaneous (e.g., graduation expenses, poster preparation, flowersetc...)

Rotation Schedules

- Variables you need to capture

- Type of rotation

- Preceptor's name

- Provider or non-provider rotation

- Time on the service

- Vacation, sick, conference time

Rotation Schedules (continued)

- Disallowed activities

- ◆ Conference time (when out of house)

- ◆ Sick time

- ◆ Maternity leave

- ◆ *No final ruling on vacation time yet*

Clinic and Didactic Time

- Clinic time is billable as is didactic time that is part of the “normal” day
- “One Day Work Threshold”
 - Currently, if a resident “touches” a patient, you can claim the resident for that day
 - Be sure residents log the patient contact for that day.

Rotations to Non-Provider Sites

- These are ambulatory and/or non-hospital out-rotations
- GME payments only made to hospitals or health centers (physician’s office can’t receive CMS payment)
- Hospital must bear supervision cost (physician teaching)

Rotations to Non-providers (cont)

- As of August 2003, CMS requires that all providers be compensated for teaching services.
- Further, CMS now looking at whether “fair market value” is being used to set reimbursement rates.

Rotations to Non-providers

- Solo provider can waive reimbursement
- Group practices must be compensated.
- As of 10/1/04, provider agreements became optional (but I would urge you to have them).
- Need to capture resident actual time at the site.

CMS Audits

- IRIS (Intern Resident Information System) is filed quarterly with CMS
- IRIS is dependent on rotation schedule
- Using an electronic system can generate this for you.

CMS Audits (continued)

- Variables captured
 - Resident name
 - Assignment (rotation #1,2,3, etc.)
 - SS #
 - Residency Code (Program)
 - Years Completed (since med. School)

CMS Audit (continued)

Medical School Code

Graduation Date (Medical School)

Foreign Certification Date

CMS Audit (continued)

- Hard part is under “Assignment”

This is where you claim:

FTE status,

% IME Time

% GME Time

CMS Audit (continued)

- Residents will be 100% FTE
- If in-house rotation, 100% IME and 100% GME time will be claimed
- If on an out-rotation, but come back for ½ day clinic, claim 20% IME & DME
(remember “one day rule”)

CMS Audit (continued)

- During an audit, CMS will be looking for discrepancies on the IRIS
- Do years in training align with years out of medical school?

CMS Audit (continued)

- Do IME & GME % add up (including out-rotations)
- Can you show how time was spent on rotation?
- Did resident “touch” a patient a day?
- Did you pay preceptors?

CMS Audit (continued)

It all comes down to supporting documentation

If you have detailed rotation schedules, agreements, and show payment, would be likely to fair well in an audit.

Conclusions

- Keep in mind this is a moving target (what is allowed/disallowed)
- CMS fairly delinquent in audits
(I was just audited for FY 2004)
- Current regulations can be applied retrospectively during an audit