

CHGME Payment Methodology

Direct Medical Education (DME) payments cover the direct cost of GME such as stipends and fringe benefits for residents, and salaries and fringe benefits for faculty; and, Indirect Medical Education (IME) payments cover expenses associated with treatment of severely ill patients and the additional costs related to teaching residents in approved GME training programs. IME payments consider variation in case mix and number of FTE residents in GME programs.

Freestanding children's hospitals that apply for CHGME Payment Program funds receive monthly grant payments, a portion of it for DME and a portion of it for IME. The total appropriated and available funds are split for disbursement of DME and IME payments. One-third of the funds are set aside for DME grant payments and two-thirds are allocated for IME grant payments. This split between DME and IME funds mirror the split delineated by the Congressional authorization for the program. Public law 109-307 reauthorizes the program at \$330 million for each Federal fiscal year, with \$110 million allocated for DME payments and \$220 million allocated for IME payments. The Congressionally appropriated funds may vary each Federal fiscal year.

A zero sum game model is utilized to ensure that each of the freestanding children's hospital receive a *share* of the DME and IME grant funds respectively while ensuring that the total disbursements does not exceed available funds.

The statutory mandate for the CHGME Payment Program requires interim monthly payments to be made during the beginning of each fiscal year with a 25 percent withhold of DME and IME funds respectively until the "Secretary has determined the final FTE resident counts for which payment should be made." Application for funds are submitted, reviewed, and processed prior to the beginning of each fiscal year. Interim grant payments are made during October through June of the Federal fiscal year. Fiscal intermediaries, under contract, assess the number of residents reported by each of the freestanding children's hospitals in their initial application. This assessment is completed each spring, and each hospital submits a reconciliation application used to make the final determination of payments. At the completion of this process, final monthly DME and IME payments are made.

The following documents provide details on the formulas used to compute the share of DME and IME that each hospital receives based on their application for funds and illustrate the payment process.

Direct Medical Education (DME) Payment Incorporating §422 of the Medicare Modernization Act (MMA) of 2003

The DME payments to individual hospitals are determined using a zero sum game model and, as such, each hospital receives a share of the appropriated DME funds. A hospital share of the appropriated funds is based on the updated national per-resident amount as determined under subsection (c)(2) of 340E; the rolling average number of resident FTEs in the hospital's approved graduate medical education residency program as determined under section 1886(h)(2) of the Social Security Act; and, geographic variations as captured by measures of labor related share and wage index as required under section 1886(h)(4) and derived by Medicare.

A hospital's rolling average of the resident FTE counts reported by the hospital for the (1) most recently filed Medicare Cost Report (MCR) [or the most recently completed Medicare cost reporting period], and (2) the two previously filed MCRs [or two previously completed Medicare cost reporting periods].

The number of resident FTEs claimed for DME payment purposes is subject to the 1996 resident FTE cap and §422 of the Medicare Modernization Act (MMA) of 2003 (hereinafter “§422 cap”), when applicable. Furthermore, the number of resident FTEs are weighted, allowing a full count of an FTE for those residents in their initial residency period (weight =1), and a count of a “half” of a FTEs (weight =0.5) for those residents that are beyond their initial residency period.

Thus, DME payments are calculated as follows:

$$DMEPAY_i = \frac{Z_{DME} * X * (WFTE_{1996capi} + WFTE_{\S422capi}) * (LRS * WI_i + NLRS)}{X * \sum (WFTE_{1996capi} + WFTE_{\S422capi}) * (LRS * WI_i + NLRS)}$$

Where:

DMEPAY _i	Direct Graduate Medical Education (DME) payments to an individual hospital “i”
“i”	Indicates an individual hospital “i”
Z _{DME}	Appropriated funds for DME payments (1/3 of appropriated funds available for disbursement.)
X	National average per-resident amount
WFTE _{1996capi}	Three year rolling average of weighted resident FTE counts subject to the 1996 FTE resident cap required by the BBA of 1997.
WFTE _{\S422capi}	Weighted resident FTE counts subject to the §422 cap for the most recently filed (or most recently completed) MCR
LRS	Labor Related Share
WI	Wage index for hospital I (for the area in which the hospital is located)
NLRS	Non-labor related share
n	Number of children's hospitals participating in the program

Indirect Medical Education (IME) Payment Incorporating §422 of the Medicare Modernization Act (MMA) of 2003

IME payments to individual hospitals are determined using a zero sum game model and, as such, each hospital receives a share of the IME available funds. In other words, the total funds available are shared among all the participating hospitals so that one hospital's increase in payments means that the other hospitals have a decrease in payments and vice versa, one hospital's decrease means that other hospitals share in an increased pool. The IME share of the appropriated funds is determined as a function of the:

- Capacity to treat patients as captured by the number of inpatient discharges from the most recently filed MCR [or the most recently completed Medicare cost reporting period]
- Severity of illness of inpatient care as measured by a "case mix index" computed using discharges from the most recently filed MCR [or the most recently completed Medicare cost reporting period] excluding healthy newborns from healthy newborn nursery; and the
- Intern and resident to bed (IRB) ratios adjusted, as mandated, using two teaching intensity multipliers (see "ADJUST_i" below).

IME payments for each hospital (i) are determined using the following formula:

$$\text{IMEPAY}_i = \frac{Z_{\text{IME}} * \text{NoD}_i * \text{CMI}_i * (\text{LRS} * \text{WI}_i + \text{NLRS}) * \text{ADJUST}_i}{\sum_{i=1}^n \text{NoD}_i * \text{CMI}_i * (\text{LRS} * \text{WI}_i + \text{NLRS}) * \text{ADJUST}_i}$$

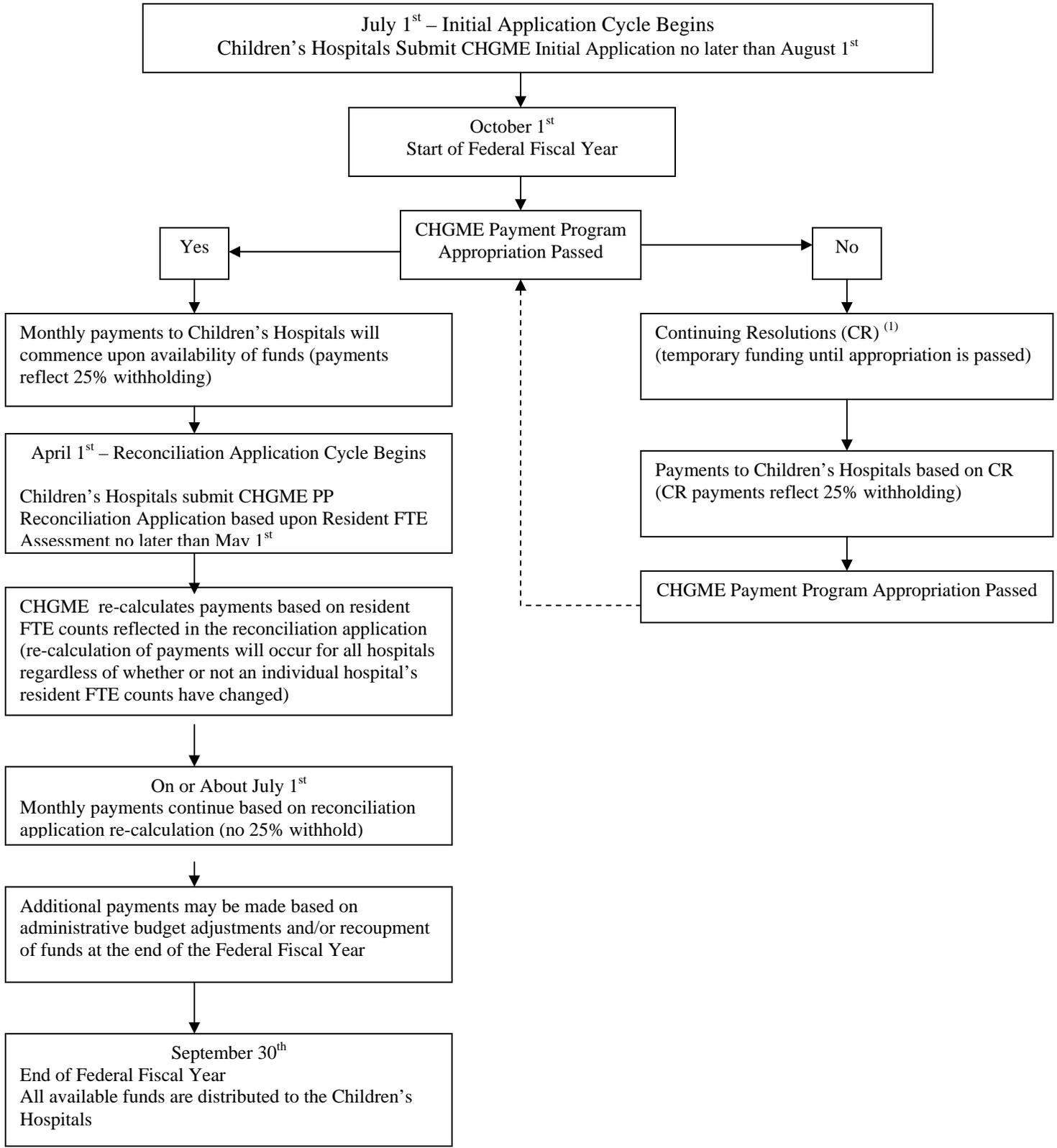
Where:

i	Indicates an individual hospital "i"
Z _{IME}	Appropriated funds for IME payments
NoD _i	Total number of discharges from the most recently filed MCR [or the most recently completed Medicare cost reporting period] for hospital "i"
CMI _i	Case Mix Index determined using discharges from the most recently filed MCR [or the most recently completed Medicare cost reporting period], excluding healthy newborns from the healthy newborn nursery for hospital "i"
LRS	Labor Related Share
WI _i	Wage index (for the area in which the hospital "i" is located)
NLRS	Non labor related share
n	Number of children's hospitals participating in the program, and
ADJUST _i	{1.35 ^(see note) * [(1 + IRB _{1996capi}) ^{0.405} - 1]} + {0.66 * [(1 + IRB _{§422capi}) ^{0.405} - 1]}
	<small>ADJUST_i factor of 1.35 subject to statutory change</small>

Where the "IRB" is the ratio of the three years rolling average of the unweighted number of residents FTE to the number of available beds subject to both (1) the 1996 FTE resident cap and to the "IRB cap", and to (2) the §422 cap, but not subject to the IRB cap as appropriate.

The denominator in the formula is that sum of the indicated variables for all hospitals.

CHGME Payment Process Flow Chart



⁽¹⁾ CRs are based upon a specified period of time and may vary from CR to CR. Amount of funds provided under each CR may also vary.