Medical Education and Research Cost (MERC) Grant

CLINICAL TRAINING EXPENDITURE CATEGORIES

Procedure

In November, the Minnesota Department of Health (MDH) will collect clinical training expenditure as noted in Step 2 of the Medical Education and Research Cost (MERC) grant application process. Clinical training sites who hosted eligible clinical trainees during FY2018 must subscribe to MERC GovDelivery Notifications as indicated in the initial application.

Further notifications and instructions for reporting clinical training expenditures will be sent to applicants using MERC GovDelivery Notifications in mid-November. The expenditure report must be completed and submitted no later than December 20, 2019.

Grantees are responsible for maintaining records (including but not limited to time certifications or time studies, payroll and purchasing records) that verify all expenses, whether categorized as direct or indirect, for six years from the end of the grant.

The following expense categories can be reported on the MERC expenditure report:

Direct Costs

Direct costs are costs for activities, goods, or services that benefit, and can be traced, to a specific project. As much as possible, grant funds should support direct costs that correspond with program activities (as opposed to direct costs that correspond with administrative activities, as described in ‘administrative costs’).

Trainee Stipends and Benefits

Trainee stipends are the salary or allowance paid to the residents/students of the program(s). Benefits are compensation provided to the residents/students in addition to their salary or allowance.

1. Only expenditures for trainees associated with the MERC grant application can be claimed.
Faculty Stipends and Benefits

Salary and benefits paid to preceptors of the program(s) for direct clinical training.

1. Preceptor time factor – The percent of time the preceptor spends in direct training.
   a. Generally, the salary and benefits paid to those who serve as faculty/preceptor are not solely for teaching, and often their other duties include other clinical or administrative services; therefore, the time factor for clinical training is less than 100%. The exception to this is when the cost of teaching reflects the Medicare Cost Report where the calculations have already been adjusted and the costs associated with other services removed.

2. Preceptor Training Costs – Training costs associated with train-the-trainer for precepting, this does not apply to other training for the preceptor. (The time factor does not affect this amount.)

3. Faculty FTE – A preloaded formula calculates the faculty FTE based on the FTE trainee count multiplied by the faculty time factor.

4. Faculty stipend and benefits rate – The average annual salary/benefits for preceptors. If there are multiple preceptors, add their annual salary together and determine the average by dividing the total annual salary by the number of preceptors.

5. Flat teaching stipend (paid by a teaching hospital) – If the preceptors receive a flat stipend specifically for time spent in direct teaching, enter the amount. The time factor does not affect this amount.

6. Calculated faculty costs – portion of faculty stipends/benefits attributed to direct training plus any flat preceptor training stipends.

Reporting Methodology

Training sites must identify the methodology used in reporting their time factor.

Methodology A:

Extra Time Added to the Preceptor’s Clinical Day for Precepting

- Formula calculation:

<table>
<thead>
<tr>
<th>Regular Hours (no precepting)</th>
<th>Regular Hours</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Hours + Precepting Hours</td>
<td>RH + PH</td>
<td>9</td>
</tr>
<tr>
<td>Number of Precepting Hours</td>
<td>(RH + PH) - RH</td>
<td>1</td>
</tr>
</tbody>
</table>

\[
\text{Time Factor} = \frac{1 \text{ Precepting Hour}}{8 \text{ Regular Hours}} = 12.5\% \\
12.50\%
\]

In this example, precepting added an extra hour per day to the length of the providers workday (extending an 8-hour day by one hour). This example also works if, instead of working an extra hour, the preceptor saw fewer patients during their regular hours due to precepting (or seeing the same number of patients in the day when precepting takes place would add an extra hour per day).
Methodology B: Hospital Medicare Cost Report

- Formula calculation:

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Resident Teaching Salaries</td>
<td>$4,000,000</td>
</tr>
<tr>
<td>(LESS) Resident Salaries</td>
<td>($1,500,000)</td>
</tr>
<tr>
<td>Other Salaries</td>
<td>$0</td>
</tr>
<tr>
<td>(LESS) Part B Physicians</td>
<td>($1,000,000)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,500,000</td>
</tr>
</tbody>
</table>

The cost of teaching reflects the Medicare Cost Report where the calculations have already been adjusted and the costs associated with other services removed. Allowable teaching cost on the cost report are based on time studies. Time factor will be 100%. In this example, the faculty/stipend benefit rate will be $60,000.

Methodology C: Patient Care Department Data /Preceptor Time Studies

- Formula calculation:

<table>
<thead>
<tr>
<th>Training Hours</th>
<th>200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divided by FTE Hours of Preceptor</td>
<td>2,080</td>
</tr>
<tr>
<td>Training Time Factor</td>
<td>9.62%</td>
</tr>
</tbody>
</table>

In this example, teaching time factor for [trainee type] in a [hospital] is estimated at a minimum of [200] hours per trainee based on time studies.

Training Program Operating Costs

Expenses directly related to training MERC eligible trainees.

1. Trainee On-Boarding Costs: Include initial and recurring costs related to ACGME, certification, testing, lab coats, computer equipment, software, cell, pager, recruitment, and advertising.
2. Administrative Support Costs: Include costs related to administrative record keeping, administrative materials, administrative support staff, supplies, postage, and printing.
3. Clinical Trainee Costs: Include costs related to malpractice insurance, conference training and travels, dues, subscriptions, books, food, parking and mileage, skills labs and simulation center, student/resident housing stipends, orientations, receptions, retreats, library, and IT/email/software licensing.
4. Operating Costs: Include costs related to fees paid to program sponsor(s), call room lease, security, housekeeping, non-preceptor clinical support staff related training, and MMCGME fees.
Costs Incurred by Other Organizations

This section only applies to costs incurred by teaching hospitals, and are expenses that have been incurred during the course of the clinical training cycle that were paid by a third party.

If the third-party organization has also applied for the grant, only one applicant, not both, can report expenses. MDH recommends that expenses related to trainee FTEs be reported under the clinical training site where the training occurred; this ensures the costs associated with the trainees have a defined accounting trail.

The third-party organization must be named on the expenditure report.

Examples of costs incurred by other organizations:

a. Trainee stipends and benefits incurred by the teaching hospital for an outlying clinic.

b. Hosting fees incurred by teaching hospital for an outlying clinic.

Administrative Costs

Administrative costs are a type of cost that fall into either direct costs or indirect costs; they are not a separate category of costs. Administrative costs are those for activities, goods, or services that correspond with administrative functions of an organization.

Sometimes, when administrative costs benefit and can be traced to a specific project, they should be categorized as direct costs. Other times, administrative costs benefit more than one project and cannot be traced to a specific program. In those cases, they should be categorized as indirect costs.

Grantees should minimize administrative costs so that grant funds support direct costs that are related to program activities.

Examples of administrative costs categorized as direct costs:

a. A portion of the organization’s administrative support, accounting or human resources, calculated by tracking time spent by staff on the grant program.

b. A portion of the organization’s occupancy costs, calculated by applying a square footage cost total to the amount of physical space used solely for grant program management and activities.

Examples of administrative costs categorized as indirect costs:

a. A portion of the organization’s administrative support, accounting or human resources, when an internal system does not allow time to be tracked by project.

b. A portion of the organization’s occupancy costs, when it is not feasible or reasonable to calculate by project.
Indirect Costs

Indirect costs are costs for activities, goods, or services that benefit more than one project and cannot be traced to a specific program. These costs are often allocated across an entire agency and multiple programs. In accordance with federal and state requirements, MDH has limits on the amount of indirect costs that can be billed to each grant so grant funds can be used to support direct costs related to program activities.

a. As much as possible, grant funds should support direct costs.

b. Grant applicants cannot submit only indirect costs.

c. Operating expenses reported under direct costs must not be duplicated under indirect costs.

Indirect Cost Rate

An indirect cost rate is a percentage used to distribute indirect costs to all of an organization’s programs that benefit from them. Grantees cannot claim indirect costs in excess of the indirect cost rate that applies to their organization. Grantees must submit and retain on-file the corresponding documentation of that indirect cost rate as outlined below:

1. Grantees with a federally negotiated indirect cost rate can use grant funds for indirect costs in an amount up to but not exceeding that rate as applied to the grant’s modified total direct costs.
   a. Grantees must submit proof of the federally negotiated indirect cost rate agreement.
   b. Grantees are responsible for ensuring that the rate is not applied to direct costs that are excluded from the indirect rate.

2. Grantees without a federally negotiated indirect cost rate can use grant funds for indirect costs in an amount up to but not exceeding 10% of the grantee’s modified total direct costs.
   a. Grantees must disclose expenses that are included in the indirect portion of the expenses.
   b. Modified total direct costs (MTDC) consists of direct salaries, wages, and fringe benefits. MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs and the portion of sub-awards that exceeds $25,000, as applicable.
   c. Grantees are responsible for making sure costs are consistently charged to avoid charging the same eligible expense to the grant twice or ‘double dipping.’
Funding/Support Received

Clinical Education & Training Support Received (Non-MERC)

Financial resources provided by the government, person, or organization to support the training of residents/students at the clinical training site. The funding the organization receives from these sources reduces the clinical training expenditures claimed for the grant. Previous MERC grants should not be included.

Examples of clinical education and training support:

  a. Medicare direct medical education.
  b. Federal or State GME grants or GME support.
  c. GME donations.
  d. GME private grants.

Contact Info

For MERC expenditure questions or to obtain this information in a different format, call 651-201-3856.

Email: health.merc@state.mn.us

11/18/2019