



## STAYING COMPLIANT WITH MEDICARE GME AND IME REGULATIONS EQUALS HIGHER REIMBURSEMENT

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Medicare provides payments to hospitals with approved graduate medical education (GME) programs to compensate them for the Medicare portion of costs directly and indirectly related to the training of residents. The direct costs of GME programs include the residents' salaries and fringe benefits, salaries and fringe benefits of the teaching physicians who supervise the residents, and other direct costs. In addition to providing direct medical education (DGME) payments, Medicare compensates hospitals for their increased costs due to immeasurable differences in patients' severity of illness, greater use of newer technologies, and increased ancillary testing (residents learn by doing). This payment is known as the indirect medical education (IME) adjustment. Both payments are based, in part, on the number of full-time equivalent (FTE) residents a hospital claims as does the direct GME payment.

**That being said, does your hospital maintain rotation schedules or other documentation that indicates in detail where the residents spend time and how much time they've spent there? Does your documentation differentiate time the residents spend in patient care activities from time spent in non-patient care activities (i.e. research and didactic)? Are you losing FTEs, and therefore losing revenue, during your audits due to this lack of documentation?**

Well, the short of it is that teaching hospitals need to maintain ample documentation of the time that residents spend training in approved teaching programs. Some of the documentation that a hospital must maintain for each resident includes:

1. The name and social security number of the resident,
2. The type of residency program in which the resident participates,
3. The name and date of the medical, osteopathic, dental, or podiatric school from which the resident graduated,
4. Whether the resident is a foreign medical graduate and whether they satisfied the regulatory requirements at 42 C.F.R. §413.80,
5. The number of years the resident completed in all types of residency programs,
6. The resident's employer and salary,
7. The resident's full time/part time status,
8. The dates and amount of time the resident is assigned to the hospital and hospital-based providers/departments,
9. The dates and amount of time the resident is assigned to other hospitals, or other freestanding providers (including those owned by your hospital system),
10. The dates and amount of time the resident is assigned any non-provider setting (i.e., physician offices),
11. The dates, the amount of time, and in what setting, the resident is assigned to orientation,
12. The dates, the amount of time, and in what setting, the resident is assigned to non-patient care services (i.e., didactic time, research, leave of absence).

In addition to the above, hospitals also need to have agreements for each of the non-hospital sites to which their residents rotate that documents the teaching cost for each location, even if the arrangement is part of a medical school agreement, or be able to document that they've paid "all or substantially all of the costs for the training program in each non-hospital site during a month by the end of the third month following the month in which the training in the non-hospital site occurred"<sup>1</sup>.

Another important statistic that can cause a substantial loss in revenue without the proper documentation is a hospital's maintained beds, as this too is part of the IME payment calculation for a hospital with an approved teaching program. The add-on percentage for each case paid under the IPSS depends on the ratio of residents to beds. Effective for discharges on or after October 1, 2004, if a hospital wants to exclude certain beds within a unit, they will have to maintain documentation by bed, not by unit, in order to satisfy the requirements set by CMS<sup>2</sup>.

Teaching hospitals know that the information about the dates and times that residents are assigned to specific locations and what they are doing there is very difficult to acquire and is the most problematic documentation to maintain. Although, a hospital's maintained bed documentation and non-hospital site rotation requirements is no "walk in the park" either.

But the fact is that it is very important for hospitals to put their "best foot forward" when it comes to their graduate medical education documentation. And why is this so important? Because graduate medical education payments are under constant scrutiny and hospitals will have to continue to defend their position and the need for this funding. And losing much needed GME funding due to lack of documentation will not help your argument.

Most recently, CMS exercised their regulatory authority to eliminate capital IME payments. Under 42 CFR §412.322(c), the IME capital adjustment factor in federal fiscal year 2009 will be equal to one-half the amount that would have otherwise been computed under 42 CFR §412.322(b). Moreover, for fiscal year 2010 and beyond, there is no separate payment for inpatient IME capital costs as stated under 42 C.F.R. §412.322(d)<sup>3</sup>. Capital IME payments were 6 percent of the total IME payments in 2007.

In addition to the elimination of the IME capital adjustment, it appears that hospitals could be faced with a reduction in their operating IME adjustment if the recommendations of the Medicare Payment Advisory Commissions (Medpac) are passed by Congress. In their March 2009 Report to Congress, Medpac recommended a 1 % reduction in the operating IME adjustment (from 5.5% to 4.5% per 10 percent increment in the resident-to-bed ratio) in 2010. Medpac recommends that the funds obtained from this reduction be used to fund a quality incentive payment program.

In conclusion, we have seen, and will most likely continue to see, increased intermediary cost report audit adjustments relative to GME and IME reimbursement. Most of these adjustments are due to disallowed FTEs for lack of documentation, insufficient non-hospital site agreements, insufficient hospital

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<sup>1</sup> See Federal Register / Vol. 72, No. 91 / Friday, May 11, 2007 / Rules and Regulations for details.

<sup>2</sup> See Federal Register / Vol. 69, No. 154 / Wednesday, August 11, 2004 / Rules and Regulations for details.

<sup>3</sup> On January 16, 2009, the House Ways and Means Committee introduced H.R. 598. The bill is entitled "American Recovery and Reinvestment Tax Act of 2009." One of the provisions included affects Indirect Medical Education. Specifically, Section 4501 imposes a delay for a phase-out of the capital Indirect Medical Education (IME) adjustment factor in fiscal year 2009. H.R. 598 requires the Secretary to re-compute payments for discharges occurring on or after October 1, 2008, without regard to 412.322(c). However, no relief is provided for federal fiscal year 2010 and beyond.

maintained bed documentation, or all of the above. And, because of the three year averaging requirements, the FTE audit adjustments are very rarely one year issues. The loss of only a few FTEs over multiple years can quickly escalate into a financial impact of over six figures. So, hospitals relying on Medicare GME and IME reimbursement will be well served to review their current practices and conform to the requirements set forth by CMS. The new academic year fast approaching, so now is the time to review your processes and implement any changes that are needed.

Staying compliant with Medicare GME and IME regulations is a tedious ongoing process that requires the support and cooperation of all that are involved with the program.....