Compliance Issues Arising Out of Graduate Medical Education (GME)

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Today’s Agenda

• Brief GME Funding and Historical Background
  – Sources of GME reimbursement
  – Historical regulatory changes

• GME Compliance Areas Requiring Focus
  – Programmatic
    • Non-provider agreements
    • Rotations in/out
    • Approved program activities
  – Reimbursement
    • Interns and Residents Information System process
    • Usual and customary documentation
    • Total allowable counts

• Overview of Cost Report Re-Openings and Appeals

• Questions and Answers
GME Funding Review

The GME payment methodology was enacted in 1983, replacing reimbursement based on “reasonable cost”.

Direct Medical Education (DME) + Indirect Medical Education (IME) + Additional Support for GME = Total Reimbursement for GME

Per Resident Amounts

Formula Driven

Total federal GME payments were over $8 billion in FY06

- Medical Schools
- Faculty practice plans
- Medicaid FFS
- Children’s GME
- VA/DOD
DME and IME payments are specific to each hospital, and are tied to the portion of Medicare patients seen.

<table>
<thead>
<tr>
<th>DME Payments</th>
<th>IME Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are meant to cover resident salaries and benefits, faculty teaching, administrative, and overhead costs.</td>
<td>Are meant to cover the additional, non-quantifiable costs hospitals incur by participating in GME.</td>
</tr>
<tr>
<td>• Based on a per resident amount varying greatly</td>
<td>• Based on a regulatory factor, which has been steadily declining since 1996</td>
</tr>
<tr>
<td>• Multiplied by Medicare utilization percent</td>
<td>• Incorporates level of teaching intensity</td>
</tr>
<tr>
<td>•Weighted by half if resident exceeds IRP</td>
<td>• Multiplied by total DRG and Medicare Managed Care payments</td>
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DME and IME reimbursement is dependent on where the resident trains, and the type of activity performed at that site.

The regulatory and policy changes over the past several years have combined to create a challenging environment for GME compliance.

**BBA 1997**
- Resident count limits 1999
- Rolling averages
- IME payment reductions

**MMA 2003**
- FTE redistribution/422 Slots
- IME factor changes

**IME Count Change 1998**
- Non-hospital settings
- All or substantially all costs

**Policy Impacts**
- Research
- “Volunteer” faculty
- Didactic time

**BBA Relief 1999**
- Temporary IME benefit
- PRA floor/ceilings set
Over time, you can see how a hospital that has had no changes in its number of residents or beds has been impacted by the IME factor changes.

While the IME reductions are significant, MedPAC believes that IME should be less than half of what it will be in 2008.

Key conclusions about where we are today, given the current regulations and rates of reimbursement:

- The historical regulations and policy changes have been devised to reduce overall levels of reimbursement to teaching hospitals.

- While there have been steady reductions in reimbursement over the past several years, there is still the belief at the federal level that teaching hospitals are overpaid.

- Some relief has been provided through the reallocation of unused resident positions, not through the addition of incremental cap slots.

- How residents are deployed, and whether or not they can be claimed for reimbursement, needs to be better understood and managed in order to optimize allowable reimbursement and to mitigate risk.
Focal Areas for GME Compliance

Several areas need to be considered and orchestrated in order to successfully comply with GME regulations, policies, and cost reporting.

<table>
<thead>
<tr>
<th>Programmatic</th>
<th>Reimbursement</th>
</tr>
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<tbody>
<tr>
<td>Resident Deployment and Activities</td>
<td>Resident Count Claim</td>
</tr>
<tr>
<td>Non-Provider Agreements</td>
<td>IRIS Process</td>
</tr>
<tr>
<td>Rotations In/Out</td>
<td>Usual and Customary Documents</td>
</tr>
<tr>
<td>Approved Program Activities</td>
<td>Total Allowable Counts</td>
</tr>
</tbody>
</table>

From a process perspective, what is done programatically is often not understood financially until an audit adjustment is made- then it can be too late, or entails more time and money to fix.
Where a resident trains and the activity performed dictates what is necessary to substantiate reimbursement claims.

**Programmatic**

- Reimbursement for hospital-based rotations is based on site-of-service, not who pays the costs.
- However, if a resident trains at a non-hospital site such as a nursing home, private doctor’s office, or community health center, costs are paramount.
- Non-hospital based rotations are a whole separate matter, with several stipulations that need to be considered in order to claim IME and DME time.

The Centers for Medicare and Medicaid Services (CMS), as well as the Office of Inspector General, have spent significant time addressing compliance with the non-provider regulation.

Over the past several years the requirements to claim non-provider rotations have become more explicit but costly.

**Non-Provider Rotations**

- **After 10/1/97:**
  - IME can be claimed in addition to DME
  - Patient care activity is performed at the non-provider site
  - Written agreement must indicate that the resident’s compensation for training time to be paid for by the hospital

- **Between 1/1/99 and 10/1/04:**
  - All of the above, plus:
    - Written agreement must indicate hospital will incur resident and physician cost, and amount it is paying to the physician
    - Hospital must incur all or substantially all of the costs for the training program at the site

- **After 10/1/04 and before 7/1/07:**
  - All of the above, but can prove 3 month payment window in lieu of written agreement

- **After 7/1/07:**
  - All of above, can use 90% cost threshold and national data to arrive at payment amount

There are very few instances where CMS believes there are no faculty costs for non-provider rotations, notably solo practitioners.
An example of the new non-provider methodology for a family medicine rotation, with three hours of teaching time as a proxy:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Median Salary</th>
<th>Hours</th>
<th>Cost of Teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>$327,902</td>
<td>40</td>
<td>$24,593</td>
</tr>
</tbody>
</table>

**Total Teaching Costs** $24,593

- Faculty costs in the community vary greatly by specialty. The range of median salaries is from $162,192 (Pediatrics & Adolescent-Developmental Behavioral) to $579,400 (Orthopedic Surgery – Spine).

<table>
<thead>
<tr>
<th>Program</th>
<th>PGY Level</th>
<th>Salary and Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family medicine</td>
<td>1</td>
<td>$55,914</td>
</tr>
</tbody>
</table>

**Total Resident Costs** $55,914

**Total Program Costs** $80,506

90% of Amount: $72,456

**Total teaching costs to be paid** $16,542

Note: Median salary data from the 2007 American Medical Group Association Compensation Survey Data Report.

Rotations into a hospital or out to another hospital are treated differently, depending on which hospital trains the resident.

- The hospital training the resident claims reimbursement, so long as the resident is in an approved program, and demographic information specific to the resident is reported.
- The sending hospital, though incurring direct costs of the trainee, cannot claim any time spent at another Medicare provider.
  - Economic arrangements between the two hospitals can be entered into, but are not required or monitored.

Even if a hospital is over its resident limits or caps, it still is required to claim time associated with approved program training.
Recent policy “clarifications” and changes are affecting whether a hospital can claim reimbursement for certain resident activities.

In conjunction with the regulatory reductions in funding, policies around what a resident does and how it gets documented are also impacting reimbursement, even if the activity is required and approved.

The connection between what residents do and how a hospital gets reimbursed is through the IRIS and audit process.

While the errors and overlaps report can vet out certain counting errors, it is not until the intermediary/contractor audits the cost report when an assessment is made about what is claimable versus non-claimable.
An assessment of what is claimable versus non-claimable should be done in the context of a hospital’s resident caps.

**Base Year Caps**
- Limit the number of DME and IME FTEs that can be reimbursed by a hospital.
- Can train residents above the caps, but won’t get paid for them.
- FTEs claimed based on a three-year rolling average.
- They are **not** by program, they are in aggregate.

**Teaching Intensity Cap**
- For IME, must use the lower of the prior or current year’s ratio of interns and residents to beds.
- In conjunction with rolling averages, can delay full reimbursement.

<table>
<thead>
<tr>
<th>Year</th>
<th>Cap FY06</th>
<th>Cap FY07</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY06</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>FY07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY08</td>
<td>99.00</td>
<td></td>
</tr>
<tr>
<td>FY09</td>
<td>95.00</td>
<td>95.00</td>
</tr>
<tr>
<td>FY10</td>
<td>95.00</td>
<td>98.00</td>
</tr>
<tr>
<td>FY11</td>
<td>98.00</td>
<td>99.00</td>
</tr>
</tbody>
</table>

Teaching Intensity Cap levels of all teaching hospitals were recently assessed by CMS. Those under their caps permanently lost slots, that were put into a reallocation pool. These “422” slots are limited to 25, and are at reduced reimbursement rates.

It is imperative that hospitals compile thorough and accurate data to support its resident count claims.

**Reimbursement**
- The IRIS file is just the basis for reimbursement, with several pieces of information that may be necessary to substantiate the resident count claim, such as:
  - Rotation schedules
  - Curriculum vitae
  - Non-provider agreements
  - Medicare GME Affiliation Agreements
  - ECFMG Certificates
  - Approval letters (ACGME, AOA, ABMS, ADA, APMA)

There are no standards set by CMS, listing each document needed to be kept to support the IRIS claim, but it is best to keep contemporaneous documentation on hand to optimize allowable reimbursement.
As part of cost report filings, hospitals may increase their total allowable counts through specific, technical adjustments.

- Should a hospital or GME program close, displaced residents can train at another hospital, allowing the receiving hospital to temporarily increase its caps until the displaced residents complete their training.
  - The sending hospital must agree to reduce its caps commensurately
- Rural hospitals can grow new programs at any time.
- Hospitals that do not have a cap, or never engaged in teaching, can grow its own caps after a three year build-up period.

On a year-to-year basis, hospitals may also aggregate their caps to allow for one hospital under its caps to share cap space with a hospital above its caps.

GME Affiliated Group

- 42 CFR, §413.75(b) defines a Medicare GME Affiliated Group as:
  1) Two or more hospitals that are located in the same urban or rural area (as those terms are defined in subpart D of Part 412 of this subchapter) or in a contiguous area and meet the rotation requirements in 42 CFR, §413.79(f)(2).
  2) Two or more hospitals that are not located in the same or in a contiguous urban or rural area, but meet the rotation requirement in 42 CFR §413.79(f)(2), and are jointly listed —
    - (i) As the sponsor, primary clinical site, or major participating institution for one or more programs as these terms are used in the most current publication of the Graduate Medical Education Directory, or
    - (ii) As the sponsor or is listed under “affiliations and outside rotations” for one or more programs in operation in Opportunities, Directory of Osteopathic Postdoctoral Education Programs.
  3) Two or more hospitals that are under common ownership and, effective for all Medicare GME affiliation agreements beginning July 1, 2003, meet the rotation requirement in 42 CFR, §413.79(f)(2).
Affiliated Group Requirements

• The requirements to be included in an affiliated group are defined in 42 CFR, §413.79(f):
  – (1) Each hospital in the Medicare GME affiliated group must submit the Medicare GME affiliation agreement, as defined under 42 CFR §413.75(b) of this section, to the CMS fiscal intermediary servicing the hospital and send a copy to CMS’s Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.
  – (2) Each hospital in the Medicare GME affiliated group must have a shared rotational arrangement, as defined in 42 CFR §413.75(b), with at least one other hospital within the Medicare GME affiliated group, and all of the hospitals within the Medicare GME affiliated group must be connected by a series of such shared rotational arrangements.
  – (3) During the shared rotational arrangements under a Medicare GME affiliation agreement, as defined in 42 CFR §413.75(b), more than one of the hospitals in the Medicare GME affiliated group must count the proportionate amount of the time spent by the resident(s) in its FTE resident counts. No resident may be counted in the aggregate as more than one FTE.
  – (4) The net effect of the adjustments (positive or negative) on the Medicare GME affiliated hospitals’ aggregate FTE cap for each Medicare GME affiliation agreement must not exceed zero.
  – (5) If the Medicare GME affiliation agreement terminates for any reason, the FTE cap of each hospital in the Medicare GME affiliated group will revert to the individual hospital’s pre-affiliation FTE cap that is determined under the provisions of paragraph (c) of this section.

Emergency GME Affiliated Group

• Effective 8-29-2005, hospitals can form Emergency Medicare GME affiliated groups
  – The emergency Medicare GME affiliation agreements may be made effective beginning on or after the first day of a section 1135 emergency period*
  – must terminate no later than at the conclusion of 4 academic years following the academic year during which the section 1135 emergency period began.

* Section 1135 emergency period is a period during which, there exists —
  (i) An emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and
  (ii) A public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act.
Requirements for GME Affiliation Agreement

- Must be in writing
- Signed and dated by responsible representatives from each hospital in the Medicare GME affiliated group

Provisions of a GME Affiliation Agreement

- Must contain the following provisions
  - The term of the Medicare GME affiliation agreement (which, at a minimum is 1 year), beginning on July 1 of a year;
  - Each participating hospital's direct and indirect GME FTE caps in effect prior to the Medicare GME affiliation;
  - The total adjustment to each hospital's FTE caps in each year that the Medicare GME affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to one hospital's direct and indirect FTE caps that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount;
  - The adjustment to each participating hospital's FTE counts resulting from the FTE resident's (or residents') participation in a shared rotational arrangement at each hospital participating in the Medicare GME affiliated group for each year the Medicare GME affiliation agreement is in effect. This adjustment to each participating hospital's FTE count is also reflected in the total adjustment to each hospital's FTE caps (in accordance with paragraph (3) of this definition); and
  - The names of the participating hospitals and their Medicare provider numbers.
### Affiliation Agreement Example

<table>
<thead>
<tr>
<th></th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GME Cap</td>
<td>145</td>
<td>190</td>
<td>335</td>
</tr>
<tr>
<td>IME Cap</td>
<td>150</td>
<td>200</td>
<td>350</td>
</tr>
<tr>
<td>Actual GME FTEs</td>
<td>155</td>
<td>175</td>
<td>330</td>
</tr>
<tr>
<td>Actual IME FTEs</td>
<td>162</td>
<td>180</td>
<td>342</td>
</tr>
<tr>
<td>GME FTEs (&gt;)/&lt; Cap</td>
<td>(10)</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>IME FTEs (&gt;)/&lt; Cap</td>
<td>(12)</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>GME Affiliation</td>
<td>10</td>
<td>(10)</td>
<td>0</td>
</tr>
<tr>
<td>IME Affiliation</td>
<td>12</td>
<td>(12)</td>
<td>0</td>
</tr>
<tr>
<td>Adjusted GME Cap</td>
<td>155</td>
<td>180</td>
<td>335</td>
</tr>
<tr>
<td>Adjusted IME Cap</td>
<td>162</td>
<td>188</td>
<td>350</td>
</tr>
<tr>
<td>GME FTEs (&gt;)/&lt; Cap</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>IME FTEs (&gt;)/&lt; Cap</td>
<td>0</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

### Cost Report Appeals and Reopenings
Cost Report Reopenings
CMS PUB 15-1, §2931ff

- Cost report reopenings can be initiated by:
  - Fiscal Intermediary / MAC
    - CMS and/or Secretary of HHS may instruct FI to reopen if FI's determination was inconsistent with applicable laws, regulations or Program instructions
  - An intermediary's initial determination on the amount of program payment contained in a notice of amount of program reimbursement (NPR), which is otherwise final, may be reopened by the intermediary within 3 years of the date of such notice.
  - A determination or decision will be reopened and corrected at any time if it is found that such determination or decision was procured by fraud or similar fault by any party to the determination or decision.

- Providers can request a reopening but final decision to initiate a reopening lies with FI/MAC/CMS/HHS Secretary
  - No administrative recourse if reopening is denied
  - Whether or not the intermediary will reopen a determination, otherwise final, will depend upon
    - whether new and material evidence has been submitted
    - a clear and obvious error was made
    - the determination is found to be inconsistent with the law, regulations and rulings, or general instructions
  - Information submitted in support of an amended cost report or the audit findings on a previously unaudited cost report could provide new and material evidence on which to base a reopening.
• Two types of administrative appeals to resolve cost report payment disputes:
  – Intermediary Hearing

  Medicare reimbursement impact of single provider’s disputed issues in aggregate is less than $10,000 per cost reporting period or less than $50,000 for group appeal

  – Provider Reimbursement Review Board (PRRB) Hearing

  Medicare reimbursement impact of single provider’s disputed issues in aggregate is greater than $10,000 per cost reporting period or greater than $50,000 for group appeal

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Cost Report Appeals
Requirements for Intermediary Hearing (CMS PUB 15-1, §2911)

• Amount(s) in dispute must be greater than $1,000 and less than $10,000
• Request for hearing must be in writing and be signed by a responsible official or employee of the provider or by a duly authorized representative of the provider
• Request for hearing must be filed with the intermediary no later than the 180th calendar day following the date of the provider’s receipt of the NPR
Cost Report Appeals

Provider may request a PRRB hearing if the following conditions are met: (CMS PUB 15-1, §2920)

- dissatisfied with a final determination of the intermediary with respect to Medicare reimbursement and the amount in controversy is at least $10,000 per cost reporting period; or the intermediary has failed to issue a Notice of Amount of Program Reimbursement (NPR) within 12 months of receiving your perfected (final) or amended cost report, and the cause of the delay was not occasioned by you, but was due to the intermediary's failure to act timely (See 42 CFR §405.1835.).

- Amount in dispute is greater than $10,000 in the aggregate.

- The request for a Board hearing is filed with the PRRB no later than the 180th calendar day following the date of receipt by you of the final determination rendered by the intermediary or, where the NPR has not been sent to you timely (see CMS PUB 15-1, §2905.1), the request for hearing is filed with the Board no later than the 180th calendar day after the expiration of the 12-month period described in CMS PUB 15-1, §2905.1.

Cost Report Appeals

- Request for PRRB hearing
  - Must be in writing
  - It must be signed by a responsible official or employee or a duly authorized representative of the provider
  - must simultaneously submit a copy of the request for a Board hearing or for expedited judicial review to your intermediary

- Instructions for completion and submission of a PRRB hearing request and other information about the Board's procedures are available on the CMS Internet site at www.cms.hhs.gov/medicare

- You may also obtain a copy by contacting the Board at (410) 786-2671

- Instructions may also be obtained from your intermediary
Cost Report Appeals

Alternatives to resolving issues via the PRRB hearing process

- Mediation
  - Requested after submission and acceptance of request for PRRB hearing

- Expedited Judicial Review
  - May be requested in conjunction with submission of request for PRRB hearing or anytime during the hearing process

Cost Report Appeals

Mediation

- Either the Provider or Intermediary can request
- Both parties must agree to mediation
- Must continue to meet PRRB’s filing deadlines until notified the appeal has been accepted into medication program
- If the parties voluntarily reach a resolution on some or all of the issues, they draft a settlement agreement
- Any unresolved issues may be pursued through the PRRB hearing process
Cost Report Appeals

Expedited Judicial Review

- Providers may bypass the hearing process and obtain Expedited Judicial Review (EJR) of a final reimbursement/payment determination of an intermediary that involves the validity of a governing law, regulation, or CMS Ruling if the Board has jurisdiction over your appeal.
- Providers cannot obtain EJR for factual or legal issues that the Board has the authority to decide or for an issue or issues over which the Board does not have jurisdiction.

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