REIMBURSEMENT

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ALLIED HEALTH & EDUCATION

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TODAY'S PRESENTERS

COLIN CONKLIN
Senior Consultant - Reimbursement

Colin previously held a position as a senior reimbursement analyst at a major medical university. His hands on experience affords him the unique ability to relate to our clients and understand their needs and objectives.

RAYMOND A. LUEBBERT, CHFP
Senior Director - Reimbursement

Ray brings 9 years of healthcare third-party reimbursement experience to hospitals and multi-specialty health systems. His experience includes Medicare Administrative Contractor audit engagements as well as hospital system Medicare and Medicaid cost report preparation. Ray specializes in finding process improvements and data analysis.

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KEY LEARNING OBJECTIVES

1. Allied Health – 5 Criteria of Provider Operated Programs, Allowable Costs, & Audits
2. Medical Education – Brief Overview.
3. Medical Education – A case study looking at occupancy rate.
4. Medical Education – A Look at shadow billing
5. Medical Education – What rotations should be included in the FTE count?

ALLIED HEALTH PROGRAMS

Program Classifications

- Provider operated
  - Must meet the five criteria established by CMS in § 413.85(f)
  - MACs cannot rely on a diploma issued by hospital as proof of being provider operated

- Non-provider operated
  - Special exception to criteria for provider operated programs
  - Separate set of criteria to meet listed in § 413.85(g)

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Five Criteria of Provider Operated Programs

1. Directly incur the training costs

➢Includes clinical training and classroom instruction where applicable

- Allowable costs
  - Trainee stipends
  - Faculty Salary
  - Books and other educational supplies

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Classroom Instruction Costs

- Costs associated with formal instruction on a specific topic who meet regularly where the student receives a grade upon completion

Clinical Training Costs

- Costs for acquisition and use of a nursing or allied health professional in a clinical environment in which the student will use the skills learned after graduation

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Five Criteria of Provider Operated Programs

- Non-allowable costs
  - Patient Care
  - Costs incurred by related organization
  - Redistribution of costs
  - Costs provided through Community Support

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Redistribution of Costs

- Providers attempt to increase amount or types of the cost of allowable educational activities
- Typically try to claim costs incurred by a related organization, such as an educational institution

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Community Support

- Funding provided through community that includes state and local appropriations, generally includes all non-Medicare funding sources
- Excludes individual patient payments
- Excludes grants, gifts, and endowments not required to be offset

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Five Criteria of Provider Operated Programs

2. Direct Control of the program curriculum

- Provider responsible for specialized courses required for diploma
  - If in agreement with educational institution, college can provide general education
  - Provider cannot claim costs incurred by educational institution

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Five Criteria of Provider Operated Programs

3. Control the administration of the program

- Collection of tuition
- Maintain payroll records
- Day-to-day operations

- Can contract with another entity to perform some administrative functions
  - Not recommended, needs provider oversight on every function

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Five Criteria of Provider Operated Programs

4. Employ the teaching staff
- Best way to demonstrate this is to have staff on payroll
- Regulations offer little guidance on the definition of “employ”

5. Provide and control both classroom instructions and clinical training
- If classroom instruction is required
- Similar other criteria, a provider can contract with an educational institution

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Non-provider-operated Programs Criteria

- Training must occur on the premise, within 250 yards
- Must have claimed and been paid on the most recent cost reporting period that ended on or before October 1, 1989
- Percentage of clinical training costs to total allowable costs cannot exceed the percentage on the most recent cost reporting period that ended on or before October 1, 1989

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Non-provider-operated Programs Criteria Cont.

- Students must provide benefit to community through clinical services
- Training costs must be incurred by provider or a related educational organization if the institution is under common control
- Costs cannot exceed amount the provider would incur if it was the only operator

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Net Cost Reimbursement

- Deduct the total revenues received from the total approved educational activities
- Revenues include tuition and student fees
- Allowable educational costs include stipends, faculty compensation, and step-down costs

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Approved Educational Activity Requirements

- Be recognized by a national approving body or State licensing authority
- Hospital meets the five criteria of a provider operated program
- Enhance the quality of healthcare at the provider

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Educational Activities Deemed as Operating Costs

- Orientation and on-the-job-training
- Part-time education for full-time employees
- Seminars, workshops and continuing education
- Maintenance of a Medical Library

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Audit - William Beaumont Hosp.-Royal Oak v. Price

- MAC requested support via time studies for clinical training costs for 4+ year olds cost report reporting years
- Provider was reimbursed for over 15+ years with no issue
- Provider required to provide adequate data
  - Used student rosters, nurse time estimates, database of student hours
  - Job descriptions for administration costs

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Audit Preparation

- Know the Five Criteria for provider operated programs
- Understand the difference between educational and normal operating costs
- Keep adequate support for costs and revenues
- If in contract with another entity, revisit language of contract to make sure the provider has authority

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Overview of Medicare Reimbursement

- Medicare has two payments for Medical Education. There is the Indirect Medical Education payment (IME) and the Direct Graduate Medical Education payment (DGME or GME).
- Both include a method of allocating the Medicare portion of costs based on Medicare volume.
- In total, CMS is the largest funding source in the world for residency programs.

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Overview of Medicare Reimbursement

- The GME payment is intended to cover the direct costs of medical education, such as the salaries for residents. It is based on a per resident amount multiplied by the number of residents and the utilization rate.

- The IME payment is intended to address the costs of using residents to provide patient care, including an increased Length of Stay and extra diagnostic steps that a more experienced physician would not take.

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Overview of Medicare Reimbursement

- In practice, the GME payment does not accurately address the direct costs of residency programs because it includes an outdated base rate rolled forward based on a calculation that does not account for regional changes in costs over the last 20 years.

- For most hospitals the GME payment is well short of actual costs, but when the program brings in additional volume to the hospital, the program can still provide documentable “Community Benefit” for non-profit entities, and when combined with the IME payment can in some cases be financially advantageous as well.

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Overview of Medicare Reimbursement

- In practice, the IME payment overpays for programs that result in large numbers of billable procedures (surgeries and tests) and underpays for other programs.
- The IME payment does not distinguish between the very different costs of care for certain specialties. Example: a Family Practice residency probably does not increase the cost of care the same way an Internal Medicine residency would.

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Overview of Medicare Reimbursement

- The IME payment includes a calculation to address the count of residents in relation to the count of available beds in the facility.
- The bed days available on S-3, Part I of the Medicare Cost Report is used as a factor in IME payments. If beds are increased, the payment is reduced.
- The IME payment is roughly equal to the total dollar amount of Medicare charges multiplied by the resident to bed ratio multiplied by an adjustment factor.

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Overview of Medicare Reimbursement

- Unfortunately, some facilities over-report available beds when obtaining state certification, resulting in lower payments.
- Additionally, retaining more available beds as a cushion for high volume peak times may be dilutive to payments.
- It is useful to make sure that the bed count is accurate, but also to look at the average and peak occupancy rates to determine if having fewer beds available could actually increase payments.

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Case study on occupancy

- An example hospital has 150 inpatient beds and a 3 year residency program with 10 slots per year. Let’s call it Memorial Hospital.
- The combined IPPS charges for Traditional and HMO Medicare total $30M for an average year.
- The Full Time Equivalent (FTE) count after all in and out rotations is 26 and the cap is 26
- After the reduction for observation bed days the ‘available beds’ calculation yields 145

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Case study on occupancy

- The Resident to Bed Ratio is 26 / 145 = 0.17
- IME Adjustment Factor is $((1+0.17)^{0.405} -1) *(1.35) = 0.088630$
- $30M DRG * Adj. Factor = 2,658,893

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Case study on occupancy

- An average 150 bed hospital has an occupancy rate of about 72%
- Memorial Hospital has an average occupancy rate of 62%
- If 15 beds are taken out of service how would this impact the IME payment?

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Case study on occupancy

- The Resident to Bed Ratio is 26 / 130 = 0.20 `
- IME Adjustment Factor is $((1+0.20)^{0.405} -1) *(1.35) = 0.103457$
- $30M DRG * Adj Factor = 3,103,709 **Difference = $444,816**

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Shadow Billing Errors Can Be Costly

- If your organization has a Residency program for Graduate Medical Education you probably have a good process in place to make sure that every identified Medicare Advantage (MA) patient bill triggers a shadow bill to the Medicare Administrative Contractor (MAC).
- The potential point of process improvement is to make sure that any patient accounts which are manually re-billed to a MA payer also trigger a shadow bill.

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Shadow Billing Errors Can Be Costly

- A patient is part of an Anthem Medicare Advantage plan
- They are admitted to the hospital, but the wrong Anthem plan is selected as the payer.
- The MA shadow bill is not generated in the billing system.
- The bill is sent to Anthem, denied, and then manually resubmitted.
- The MA shadow bill is never generated.

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Shadow Billing Errors Can Be Costly

- Under the IME payment model, the shadow billing must be generated in order for the payment to be included for MA volume.
- The shadow bill is submitted to the MAC and then the charges are shown on the PS&R report type 118.
- In 2019 New York State had 39% of Medicare beneficiaries on Medicare Advantage plans.

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Shadow Billing Errors Can Be Costly

- When shadow bills aren’t generated the immediate impact may not be obvious, but it can be meaningful at cost report settlement.
- The difference can also impact GME payments and Allied Health payments as these are also based on Medicare Utilization rates.

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Shadow Billing Errors Can Be Costly

- In general, there is a 12 month time limit on submitting shadow bills.
- If the Standard Insurance Payer Group is not identified as Medicare HMO before the initial bill is processed, a special process may need to be put into place in order to force the shadow bill to be generated later when the payer data is corrected.

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Shadow Billing Errors Can Be Costly

- In the example of Memorial Hospital with $30M of volume subject to IME payments, if 40% of that is Medicare HMO volume that means $12M in HMO volume at risk for being missed in shadow billing.

- If 10% of the Medicare HMO patients are mis-identified as a different plan from the same carrier, that means that about **$124K** in IME payments might be missed.

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Which Rotations Should Be Counted?

- The Affordable Care Act changed the requirements of hospitals counting rotations at non-hospital sites.
- IME and GME rotations can be counted for a variety of locations provided that the location specific rules are followed.
- For most purposes, an FTE is equal to 40 hours per week times 52 weeks = 2080 **BUT not for residents**. For residents an FTE is the amount of time needed to fill a “residency slot”.

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Which Rotations Should Be Counted?

- A residency slot for an approved program might have the individual on site for 60 or more hours per week.
- The FTE count is usually determined by the number of days from the start of an allowable rotation to the end of it (including regularly scheduled days off), divided by the number of days in the year.
- The calculation is more complex if the resident is part time, or has completed the full term of the program and is staying on for fellowship time.

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Which Rotations Should Be Counted?

- The hospital should count as allowable rotations any rotations that are:
  - Patient care related on the hospital campus in non-excluded areas
  - Patient care related and at a non-hospital site, such as a private practice, skilled nursing facility or an off-site clinic, provided that the hospital covers ***all or substantially all*** of the costs of the residency program at these locations.

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Which Rotations Should Be Counted?

- To meet the ***All or Substantially All*** requirement, the hospital must pay the resident salaries and fringe benefits during these rotations as well as potentially some stipend to the teaching physicians.
- One MAC guideline puts a threshold at 90% of total costs, but this isn't the official CMS rule, nor is it applicable for every case.
- An **affiliation agreement** or **letter of agreement** is strongly recommended to establish the guidelines for which entity is paying for the residency program at non-hospital sites.

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Which Rotations Should Be Counted?

- An affiliation agreement for the distribution of FTE cap slots from one hospital to another **DOES NOT** need to match the actual movement of residents from one hospital to another. Example: Hospital 1 has 50 residents, and their program for Internal Medicine has 40 cap slots. An affiliation agreement with Hospital 2 sends 5 cap slots to hospital 1, but some residents rotate from Hospital 1 to Hospital 2 for a specialty that is not available at Hospital 1.

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Which Rotations Should Be Counted?

- **Patient-specific research** rotations can be counted for both IME and GME. For example, research on treatment of a specific kind of cancer that follows the treatment of an individual patient or group of patients

- **General research** that is not patient-specific can be counted only for GME. For example, a radiology study looking at hundreds of patient x-rays.

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Which Rotations Should Be Counted?

- For GME only, rotations should also be counted for on-campus **didactic instruction** that is part of the approved program. This is typically seminars or conferences.
- Rotations to **another hospital** cannot be counted for IME or GME regardless of which hospital is paying for the residents.
- **A non-GME Hospital** that takes in residents for rotations MUST count these FTEs for the Medicare cost report and is at risk of having a zero PRA and zero FTE cap set. This is most likely to occur at provider based clinics.

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Which Rotations Should Be Counted?

- The Interns and Residents Information System (**IRIS**) data must not overlap for hospitals that are involved in training the same resident in the same year.

- Example: A resident spends half of April at an Emergency Department rotation in Hospital 1 and then the second half of April at Hospital 2 for a Pediatrics rotation. Hospital 1 claims all of April at 50% of time. Hospital 2 claims the second half of April at 100% of time. This gives the appearance of an overlap, and must be resolved before these hospital cost reports can be settled.

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More Information:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Indirect-Medical-Education-IME

https://www.acgme.org/Newsroom

https://www.aamc.org/advocacy-policy

QUESTIONS?

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