Medicare Reimbursement Principles for Medical Education
Indirect Medical Education Reimbursement: Overview

• Indirect Medical Education Reimbursement, also referred to as IME reimbursement, is intended to reimburse hospitals for the indirect costs of having a medical education program.

• These costs are the result of the residents’ inefficient practice of medicine such as running duplicate or unnecessary tests or wasting of supplies.

• The Medicare program recognizes these costs as a real and necessary part of training our next generation of physicians.
Variables Used to Calculate IME Reimbursement for Medicare

The following variables all impact Medicare IME reimbursement:

• Number of Medicare discharges
• Hospital’s Case Mix Index (average of all patient’s DRG weights)
• Total Interns and Residents FTEs assigned to the Hospital
• Total available beds within the hospital (not counting excluded units nor nursery bassinets)

With the exception of available beds, higher variables above generate higher reimbursement
Medicare Reimbursement Overview

Medicare reimbursement (exclusive of outliers) for an individual patient is comprised of several variables:

- Geographical region where hospital is located
- Weight of DRG assigned
- Was the hospital a DSH hospital (Does it treat a disproportionately large number of indigent patients)
- Was the hospital an accredited teaching hospital
Medicare Reimbursement Overview

• The geographical region where the care was given establishes the “Base Rate”. For Chicago area hospitals, the current operating Base Rate is $5,686.22

• The Base Rate is multiplied by the DRG weight to derive a Weighted Base Payment

• The Weighted Base Payment is then multiplied by a hospital specific DSH factor to calculate the DSH add-on and/or by a hospital specific IME factor to calculate the IME add-on if applicable

• The amount of IME Reimbursement varies based upon geographical regions and case weight but the IME multiplier is not dependent on any DSH determination. The multiplier will be addressed later in the presentation
Medicare Reimbursement Overview

A sample patient’s voucher reimbursement would be calculated as follows for Acute Myocardial Infarction (DRG 282):

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Base Rate</td>
<td>$5,686.22</td>
</tr>
<tr>
<td>Times DRG Weight</td>
<td>x 0.7463</td>
</tr>
<tr>
<td>Capital Base Rate</td>
<td>$460.24</td>
</tr>
<tr>
<td>Times DRG Weight</td>
<td>x 0.7463</td>
</tr>
<tr>
<td>Weighted Base Payment</td>
<td>$4,243.62</td>
</tr>
<tr>
<td>Capital Payment</td>
<td>$343.48</td>
</tr>
<tr>
<td>IME Add-on: Operating IME Factor</td>
<td>.191616</td>
</tr>
<tr>
<td>Weighted Base Payment x $4,243.62</td>
<td>$813.15</td>
</tr>
<tr>
<td>Capital IME Add-on</td>
<td>$46.24</td>
</tr>
<tr>
<td>Calculated IME Add-on</td>
<td>$813.15</td>
</tr>
</tbody>
</table>

• Above sample IME factors are actual factors from a Chicago area hospital.
• Hospital Readmission Factor and Value Based Purchasing excluded from above example.
IME Reimbursement Variables

• A calculation similar to the IME add-on would be performed to calculate the DSH add-on

• Total reimbursement shown on a voucher would be the sum of the operating and capital weighted base payments, IME payments and DSH payments, adjusted for Readmissions Factor and VBP

• While the IME Adjustment Factor used in this example is what everyone focuses on when discussing Medicare IME reimbursement, it is important to also understand that the IME Adjustment Factor needs to be multiplied against the hospital’s Base Rate and patient’s Case Weight

• The total hospital’s IME reimbursement is simply the sum of each Medicare patient’s IME reimbursement, so the more Medicare patients a facility has, the more IME reimbursement that will be generated
IME Adjustment Factor

The IME Adjustment Factor is calculated as follows:

\[ 1.35 \times (1 + (\text{Residents}/\text{Beds}))^{0.405} - 1) \]

- “Residents” represents the number of FTE Interns and Residents in approved training programs at your hospital in the applicable fiscal year.
- “Beds” represents the average number of beds that your hospital is physically able to operate in the applicable fiscal year. This number may not be the same as licensed beds nor Staffed beds.
- The factor - thus your reimbursement - increases with either the addition of FTEs or the reduction of available beds.
Resident Count

- The resident count represents resident FTEs located at your hospital or hospital-based clinics regardless of whether or not they are in a program that you sponsor. They must however be in an accredited program. This allows you to count electives coming to your facility.

- It excludes residents that are outside of your facility on elective rotations unless they are at a private physician office and your hospital pays a substantial portion of the training cost to the private physician.

- The resident count for any program cannot exceed your ACGME approved number of residency slots.
FTE Limits for IME Reimbursement

• Vouchered IME reimbursement received from Medicare is an interim rate that gets final settled with the year-end cost report.

• The cost reporting process validates the resident count as well as the bed counts – You should all be familiar with supplying documentation such as rotation schedules, ECFMG certificates and biographical data for the cost reporting process.

• The cost report contains a base year FTE cap that was originally established in 1996 and has had a few updates over the years. Medicare will not reimburse for any FTEs in excess of this cap.

• The cost report then averages the current year FTE count subject to the cap, with the two proceeding years’ approved FTE counts to create a 3-year rolling average.
FTE Limits for IME Reimbursement

• The three year rolling average is then divided by the available bed count to calculate the resident to bed ratio – recall the formula \[1.35x((1+(Residents/Beds))^{0.405}-1)\]

• The above calculated resident to bed ratio is then compared to the prior year’s resident to bed ratio and the lesser of the two is used in the IME Adjustment Factor calculation. There is no magic to using the lesser of the two ratios – it is just a way for Medicare to slow payment growth

• The cost report then multiplies the IME adjustment factor by the total weighted base payments received in the fiscal year to calculate the total IME reimbursement
Direct Graduate Medical Education Reimbursement: Overview

• Direct Graduate Medical Education Reimbursement, also referred to as GME reimbursement, is intended to reimburse hospitals for the direct costs of having a medical education program.

• These costs are derived from the resident’s salaries, teaching stipends paid to physicians and the cost of general program operations.

• The Medicare program reimburses these costs on a per resident FTE basis as a result of detailed audits performed at each hospital with a Medical Education program back in the early 1990’s. The per resident amounts are hospital specific.

• Each hospital’s per resident reimbursement rate has been updated annually for inflation. All hospitals with the same fiscal year end will have the same update factor applied.
Resident Count for GME Reimbursement

• The GME resident count is similar to the IME resident count in most respects. The exceptions are as follows:
  • Any resident who is beyond their initial residency’s approved number of years is weighted down to a one-half FTE. This includes fellows, anyone who chooses to stay beyond their initial residency program’s required years to receive additional training, or residents who may change specialties and thus require added years of training
  • Differentiation is made between “Primary Care” (i.e. Internal Medicine, Geriatric Medicine) and “Specialists” (i.e. Surgery, Radiology) with Primary Care receiving slightly higher per resident reimbursement to encourage hospitals to train more Primary Care physicians
FTE Limits for GME Reimbursement

• Like IME, GME also has a base year cap that if exceeded, FTEs beyond the cap cannot be reimbursed for by Medicare.

• Additionally, GME also uses a three year rolling average count in the cost report. This has the impact of slowing the reimbursement growth or reductions based upon changes in the FTE count.

• Unlike IME, there is no comparison to prior year ratios so there is no built in penalty for FTE changes (the ‘lesser of current year or prior year’ calculation used in IME acts as a built in penalty).
Determination of GME Reimbursement

• The hospital specific per resident amount is multiplied by the weighted FTE count to arrive at a gross reimbursement amount for both Primary Care and Specialists

• This gross reimbursement amount is then multiplied by the hospital’s Medicare utilization (calculated by dividing Medicare days by total patient days in the cost reporting period)

• Thus GME reimbursement is a factor of the 3-year rolling average resident count, the facility specific per resident reimbursement rate and the overall Medicare utilization

• Also remember that the resident count is weighted for any resident who has exceeded their initial residency period
Miscellaneous Items of Note

• Podiatric and Dental programs are specifically excluded from the 1996 base year caps for both IME and GME

• IME reimbursement is based upon the total Medicare payments received, but GME is based upon the percentage of total days that are Medicare days. So, while eliminating non-Medicare days would have no impact on IME reimbursement, it would actually increase the GME reimbursement

• If a facility has excess “available” beds, taking them out of service can increase IME reimbursement

• Affiliation agreements can be entered into to allow transfer of FTE caps between hospitals that share a program. All Health Systems should have an affiliation agreement in place to maximize reimbursement.