



# MEDICARE REPORT



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## Graduate Medical Education Reimbursement Under the Patient Protection and Affordable Care Act



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**O**n Nov. 24, 2010, the Centers for Medicare & Medicaid Services published the Final Rule implementing the graduate medical education (GME) provisions of the Patient Protection and Affordable Care Act.<sup>1</sup>

Most of the GME provisions in the Final Rule are unchanged from those that were set forth in CMS's Aug. 3, 2010, Proposed Rule.<sup>2</sup> However, CMS made several key clarifications in an effort to answer some of the questions raised by the PPACA and the Proposed Rule. The Final Rule went into effect on Jan. 1, 2011.

### The GME Landscape

Medicare reimburses teaching hospitals and academic medical centers that train residents in approved

<sup>1</sup> Pub. L. No. 111-148 (March 21, 2010).

<sup>2</sup> We discussed the Proposed Rule in our article entitled "The Impact of Health Care Reform on Graduate Medical Education Reimbursement," *BNA's Medicare Report*, July 16, 2010 (21 MCR 793, 7/16/10).

residency programs for both their direct and indirect costs and expenses.

Direct graduate medical education (DGME) payments cover the direct costs of resident training, such as salaries and fringe benefits, and the indirect medical education (IME) adjustment is a percentage add-on to the prospective payment system payment rates for hospitals in recognition of the higher patient care costs and investments to enhance resident education.

Hospital GME payments are subject to a cap based upon, among other things, the number of full time equivalent (FTE) residents set forth in the hospital's most recent pre-Dec. 31, 1996, cost reporting period. As a result, hospitals often seek additional cap space, and point to institutions that do not or cannot fill their own slots as sources from which such additional cap space can be drawn.

The Final Rule implements provisions of the PPACA that call for a redistribution of resident slots to qualified hospitals as a result of cap reductions applied to institutions with excess training capacity. Thus, for the first time in nearly two decades, teaching hospitals are presented with significant opportunities to increase the reimbursement they receive for their residents in training.

The Final Rule also eliminates some of the restrictive timekeeping and other requirements that had applied to resident time spent in non-provider settings. Lastly, the Final Rule addresses the preservation of resident slots from closed hospitals.

### **Resident Cap Reduction for Hospitals with Excess Training Capacity**

Section 5503 of the PPACA calls for reductions in the statutory FTE resident caps for certain hospitals and authorizes a "redistribution" of the slots resulting from the reductions to qualified hospitals. The Final Rule implements these resident redistribution provisions.

Effective for portions of cost reporting periods occurring on or after July 1, 2011, a hospital's FTE resident cap will be reduced by 65 percent of its excess slots.

To determine whether a hospital is subject to this cap reduction, CMS will look at whether the hospital had been training residents at or above its "otherwise applicable resident limit" in the three most recent cost reporting periods ending before March 23, 2010.

If a hospital is found to have been training below its limit in all three cost reporting periods, it will be subject to a cap reduction.

CMS made two important clarifications in connection with the resident cap reduction program.

First, new teaching hospitals will not be subject to the cap reduction program if they are in the middle of their three-year cap building period or have an established FTE resident cap but are still in the process of growing their residency programs (because, for example, the initial residency period of a training program may be greater than three years).

Second, CMS addressed the fact that some hospitals training fewer residents than allowed under their FTE caps have entered into Medicare GME affiliation agreements with other hospitals, which caused the hospitals to exceed their FTE resident caps.

CMS stated that in determining a hospital's otherwise applicable resident limit in these situations it will look at the hospital individually, rather than the affiliated group as a whole, and subject the hospital to a reduction even if the Medicare GME affiliated group as a

whole is training a number of residents above the group's aggregate FTE resident cap.

### **Resident Cap Redistribution**

CMS will determine whether a hospital is eligible for the slots made available from the 65 percent reduction by examining the likelihood of the hospital filling the slots within the first three cost reporting periods after July 1, 2011, and whether the hospital has an accredited rural training track.

CMS also is required to allocate 70 percent of the redistributed slots to hospitals in states with resident-to-population ratios in the lowest quartile and 30 percent to hospitals located in (i) the 10 states with the highest proportion of their populations living in a health professional shortage area (HPSA), and (ii) rural areas.

A hospital awarded slots under the redistribution program may not reduce its pre-redistribution number of primary care residents below the average number of primary care residents training during the three most recent cost reporting period ending before March 23, 2010, and at least 75 percent of the additional slots must be used for primary care or general surgery.

CMS had proposed originally that a hospital identify on its application which of five "Priority Categories" it will meet, which CMS then would use to rank the applications.

In the Final Rule, CMS revised the Priority Categories and reduced the number of categories, so that a hospital located only in a state with a resident-to-population ratio in the lowest quartile does not have its chance of receiving slots diminished by hospitals in states that fall within multiple Priority Categories (i.e., the hospital is in a state whose resident-to-population ratio is within the lowest quartile *and* in a state whose Primary Care HPSA to population ratio is in the top 10 states *and/or* in a rural area).

In addition, CMS revisited its determination in the Proposed Rule that hospitals that receive additional slots under the redistribution program cannot use these slots as part of the aggregate cap in a Medicare GME affiliation agreement. CMS concurred with certain commenters' complaints that training needs can change over time and that there may be a need to cross-train residents in different hospital settings.

Under the Final Rule, hospitals will be permitted to use redistributed slots as part of Medicare GME affiliation agreements after five years, which would coincide with the end of the time period of other restrictions applicable to slots awarded under the redistribution program. Thus, slots awarded under the redistribution program could be used first as part of Medicare GME affiliation agreements for the academic year beginning July 1, 2016.

However, CMS cautioned that slots used in Medicare GME affiliation agreements after that date are at risk for removal by the Medicare contractor from those affiliation agreements if, while auditing a cost report that falls within the five-year period, the Medicare contractor finds that the hospital did not meet the primary care average or the requirement that 75 percent of the slots be used for primary care or general surgery.

### **Calculating Resident Time: Training in Non-Provider Settings and Didactic Time**

Prior to the enactment of PPACA, hospitals could count resident training time in non-hospital sites for

purposes of GME reimbursement if the residents spent their time in patient care activities and there was a written agreement between the hospital and the non-provider entity stating that the hospital would incur “all or substantially all” of the costs of the program.

CMS had defined “all or substantially all” to mean at least 90 percent of the total costs of the residents’ salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of the teaching physician’s salaries attributable to GME.

Now, time spent by a resident in a non-hospital setting will be counted if the hospital incurs the cost of the stipends and fringe benefits of the resident during the time the resident spends in that setting.<sup>3</sup> The PPACA also specifies that if more than one hospital incurs the residency training costs in a non-provider setting, those hospitals are to count a proportional share of the training time as determined by written agreement between the hospitals, whereas previously only a single hospital was permitted to incur the costs of a particular training program and count the time residents that trained in a particular non-provider setting.

Hospitals must maintain documentation indicating the amount of time the residents spend training in non-provider sites relative to a base year that the secretary of health and human services will specify and to make those documents available to the secretary.

In the Final Rule, CMS clarified that the term “non-provider site” is a setting that does not qualify as a provider-based facility or organization in accordance with the criteria set forth in 42 CFR 413.65. Thus, the term “nonprovider site” would not apply to, and resident time could not be counted for, a situation in which residents in a family practice program rotate to a physician’s office but accompany the doctor to a separate, nonteaching hospital.

PPACA also changed the rules for calculating resident didactic time.<sup>4</sup> Prior to the passage of health care reform, hospitals were paid only for resident didactic training that took place in the hospital itself and then it could be counted only for DGME payment purposes, not the IME adjustment.

Now, effective for cost reporting periods beginning on July 1, 2009, didactic time spent in non-provider settings may be counted as part of the FTE computation for DGME purposes.

## Preservation of Resident Slots from Closed Hospitals

Prior to the enactment of PPACA, the Medicare regulations included a process for the *temporary* transfer of Medicare-reimbursable resident slots from a closed hospital to a “receiving hospital” taking over the train-

ing of residents who were “displaced” as a result of the hospital’s closure.<sup>5</sup>

PPACA introduced a mechanism for hospitals to *permanently* transfer their resident slots when a teaching hospital closes. Those slots may be redistributed only to hospitals that can demonstrate a likelihood of filling them within three years. In addition, CMS is tasked with ensuring that there is no duplication of slots for hospitals that receive permanent cap adjustments and those that receive temporary cap adjustments to accommodate displaced residents.

Like the Proposed Rule, the Final Rule states that CMS will distribute the slots in the following priority order: (1) hospitals located in the same core based statistical area (CBSA) as the closed hospital or in a CBSA contiguous to the closed hospital; (2) hospitals located in the same state as the closed hospital; (3) hospitals located in the same region of the country as the closed hospital; and (4) only if none of the above is possible, to other hospitals using the criteria set forth in the redistribution program.

Since CMS defines “hospital closure” as including the termination of a hospital’s Medicare provider agreement and surrender of its Medicare provider number, in a hospital acquisition involving a buyer that declines assignment of the hospital’s Medicare provider number, the acquiror is not automatically entitled to the transfer of the hospital’s resident slots.

However, CMS confirmed in the Final Rule that a hospital which “closes” due to a change in ownership transaction in which the purchaser does not take assignment of the hospital’s Medicare liabilities, but in fact does not close on an operational level, would be first in line to obtain the “closed” hospital’s resident slots.

In the Final Rule, CMS established April 1, 2011, as the application deadline for the permanent transfer of resident slots from hospitals that closed between March 23, 2008, and Aug. 3, 2010 (the date of the Proposed Rule). Hospitals that close at any point after Aug. 3, 2010, will fall into a second category for which CMS will provide separate notice with a future application deadline.

## Conclusion

Many of the PPACA provisions affecting Medicare GME reimbursement offer relief for hospitals that are over their long-standing resident caps.

These hospitals should examine their resident slots and caps and determine whether they are eligible to receive additional slots under the various GME provisions of the new legislation and the Final Rule.

Conversely, hospitals with residency programs that have unutilized residency slots should examine their cost reports to determine whether any of those slots are subject to reduction and distribution to other institutions.

Finally, hospitals incurring costs relating to resident training spent in non-provider settings and didactics can look forward to the less restrictive rules and time-keeping requirements applicable to claiming resident time in these areas.

<sup>3</sup> See PPACA § 5504.

<sup>4</sup> *Id.* at § 5505. Didactic time generally refers to conferences and seminars not related to the care of a particular patient.

<sup>5</sup> See 42 C.F.R. § 413.79. A “displaced resident” is a resident who was training at a hospital or residency program up to the point that the hospital itself closed or the hospital ceased training all residents in the residency program in which the resident was training.