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CMS Releases Proposed Rule for IME/GME Provisions in the Health Care Reform Legislation

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CMS's 2011 OPPS Proposed Rule gives effect to the IME/GME provisions contained in the new health care reform legislation. The Proposed Rule follows the framework laid out in the legislation, which we discussed previously. Nevertheless, teaching hospitals will be interested in the details of CMS's plan to implement the changes under the legislation, particularly those pertaining to the redistribution of residents from closed hospitals and from hospitals that have not "used" all of their FTE slots. The Proposed Rule will be published in the Federal Register on August 3, and CMS will accept comments through August 31.

Training in Non-Provider Settings

The health care reform legislation removed the onerous payment and reporting obligations that CMS has imposed on providers when their residents train in non-provider settings. A provider no longer has to reimburse a non-provider site for its training costs, so long as the provider covers all costs for the residents' salaries (or stipends) and fringe benefits.

The new legislation eliminates most of the written agreement and documentation requirements associated with training residents in non-hospital sites. An exception to this relief from the written agreement requirement exists if multiple providers share the costs of training residents in a single site. In such case, CMS will require a written agreement detailing the providers' proportional share of training costs. The legislation gives hospitals wide discretion to determine their relative share of the costs, but the Proposed Rule would require that each provider's share of the costs be established using "some reasonable basis," such as the number of FTEs training in the non-provider setting. The sum of payments (across all providers) for resident training in the non-provider setting would have to be at least as much as the sum of the salary and fringe benefits for all residents for the time spent in such training.

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The Proposed Rule would require hospitals to maintain a record of the amount of time that residents spend training in non-provider settings. CMS would require hospitals to utilize resident rotation schedules as the basis for such records.

Resident Time in Didactic and Scholarly Activities; Research; and Vacation, Sick Leave or Other Approved Leave

The Proposed Rule mirrors the health care reform legislation's treatment of resident time spent in certain non-patient care activities. Under the Proposed Rule, effective January 1, 1983, didactic time is to be included in the FTE count for IME purposes as long as the didactic activities occur in the hospital. Effective July 1, 2009, the Proposed Rule would include in the FTE count for GME purposes resident time associated with didactic activities that occur in non-hospital settings, so long as the non-hospital setting is "primarily engaged in furnishing patient care."

As established by the health care reform legislation, the Proposed Rule would also exclude from the FTE count any resident research time that is "not associated with the treatment or diagnosis of a particular patient," retroactive to October 1, 2001. The Proposed Rule offers examples of characteristics that distinguish research time from didactic activities. CMS identifies research activity by characteristics such as its focus on: (1) developing new medical treatments, (2) testing the efficacy and safety of existing medical treatments, or (3) establishing a knowledge base that will contribute to new medical treatments in the future.

Effective January 1, 1983, vacation, sick, or other approved leave are to be included in the FTE count for both IME and GME purposes under the health care reform legislation. The Proposed Rule gives jury duty or voting leave as examples of "other approved leave" that would be included in the FTE count. If a resident is assigned to multiple hospitals over the course of a year, the Proposed Rule would include allowable leave in the FTE count of the hospital to which the resident is assigned at the time that he or she utilizes the leave.

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Redistribution of FTE Slots

The Proposed Rule would give effect to the redistribution of FTE slots for both GME and IME purposes, as required under the health care reform legislation. CMS will determine whether a hospital has been utilizing fewer FTEs than are available under its existing caps by examining the highest number of FTEs utilized in the three most recently settled cost reports (or, if not settled, submitted subject to audit) as of March 23, 2010. If a hospital has been operating below its historic FTE limit, it will lose 65% of the difference between the historic FTE limit and the number of FTEs utilized.

Under the Proposed Rule, CMS would calculate the number of FTE slots available for redistribution on May 1, 2011. The preliminary estimate of a hospital's captured FTEs will be revised if new information becomes available regarding a such hospital's utilization of FTE slots after May 1, 2011, but before July 1, 2011 (e.g., a cost report that was submitted before March 2010 is settled in June 2011, and the hospital's FTE count is higher than on any cost report settled before May 1, 2011). The total FTEs in the redistribution pool, however, will not be changed after May 1, 2011. CMS will not take into account the fact that a provider has a pending appeal from a settled cost report when determining the number of FTE slots to be captured. Thus, a provider with an outstanding appeal regarding its FTE count will have to reach a resolution, including the issuance of a revised NPR, prior to July 1, 2011 in order to avoid redistribution of its FTE slots if it is under its current FTE limit.

Under the legislation, 70% of the redistributed residents are to go to hospitals in states with a resident-to-population ratio in the lowest quartile nationally. The remaining slots are to go to hospitals located in those states, territories or the District of Columbia that are among the top 10 whose population, relative to total population, is in a health professional shortage area, and to hospitals in rural areas. Whereas the health care reform legislation only specified the states or territories in which hospitals are eligible to receive the redistributed FTE slots, the Proposed Rule expands upon the statutory mandate and establishes criteria for determining whether hospitals are eligible to receive FTE slots. Under the Proposed Rule,

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providers would have to provide specific documentation showing that they meet at least one of the following criteria in order to receive additional FTE slots:

- the provider will establish a new residency program, which is likely to utilize the added FTE slots;
- the provider does not have a sufficient number of FTE slots, and intends to expand an existing residency program within three years of July 1, 2011;
- the provider's FTE count currently exceeds its available FTE slots.

The Proposed Rule would also establish evaluation criteria that would be used to determine which hospitals receive additional FTE slots, assuming, as is almost certain, that an insufficient number of slots will be available to meet the demand. Hospitals that meet one or more of the following evaluation criteria would receive preferential consideration for FTE slots under the Proposed Rule:

- the hospital has Medicare utilization in excess of 60%;
- the hospital will use additional slots to establish a new (or add slots to an existing) geriatrics residency program;
- the hospital will use additional slots to establish a new (or add slots to an existing) primary care residency program;
- the hospital will use all the additional slots to establish a new (or add slots to an existing) primary care or general surgery residency program;
- the hospital is located in a primary care health professional shortage area;
- the hospital is located in a rural area, is a training site for a rural track program, and does not have sufficient FTE slots to account for the rural track residents.

In order to qualify for additional FTE slots, hospitals must submit their applications by December 1, 2010.

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Redistribution of Resident Slots after a Hospital Closes

The health care reform legislation provided separate rules for the redistribution of FTE slots from teaching hospitals that closed. FTEs from such hospitals are to be redistributed to hospitals in the same or contiguous CBSA or, if slots remain, to hospitals in the state or region, all in accordance with a point ranking system.

Ober|Kaler's Comments

The Proposed Rule adds significant detail to the health care reform legislation. For providers that train residents in multiple non-provider settings, the elimination of the written agreement requirement will offer a welcome respite from the documentation hassles under CMS's rules. The treatment of non-patient care activities, long a point of contention between CMS and providers, would largely be settled under the Proposed Rule (and largely in providers' favor). Finally, some providers will see an increase in FTE caps, while others will see a reduction, all as a consequence of the redistribution of FTEs.

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