BNA's

MEDICARE REPORT

BNA Employee-Owned Since 1947

The Impact of Health Care Reform on Graduate Medical Education Reimbursement

ANDREW B. ROTH AND NILI S. YOLIN

The Centers for Medicare & Medicaid Services reimburses academic medical centers and teaching hospitals under the Medicare program for the costs incurred in training resident physicians through its direct graduate medical education (DGME) payment and indirect medical education (IME) adjustment.[1] CMS places two limitations on the extent of such Medicare graduate medical education (GME) reimbursement, based on the number of residents in training and on the dollar amount payable per resident. These limits are institution-specific. The Patient Protection and Affordable Care Act (PPACA),[2] enacted on March 23, 2010, introduced three principal changes to this particular area of the graduate medical education landscape that may directly impact a hospital's Medicare GME reimbursement rates: (1) the resident cap reduction and redistribution program; (2) the inclusion of training time in non-hospital settings and didactic time in a hospital's FTE resident count; and (3) the preservation of cap slots from closed hospitals.

On July 2, CMS released the proposed rule that would implement the GME provisions of the PPACA, which purports to answer some of the questions raised by the new legislation. The proposed rule is scheduled to be published in the Aug. 3 *Federal Register*. [3].

Andrew B. Roth is a partner and Nili S. Yolin is an associate in the New York office of Mintz, Levin, Cohn, Ferris, Glovsky and Popeo P.C., focusing on health industry regulatory and transactional matters, including graduate medical education accreditation and reimbursement. Roth can be reached at (212) 692-6889 or ARoth@mintz.com. Yolin can be reached at (212) 692-6799 or NSYolin@mintz.com.

GME Reimbursement: Background

Teaching hospitals and academic medical centers that train residents incur significant costs and expenses beyond those commonly associated with patient care.

Consequently, the Medicare program reimburses these hospitals with DGME payments and an IME adjustment. DGME payments cover the direct cost of resident training, such as resident and teaching faculty salaries and fringe benefits.

[1] *See* Balanced Budget Act of 1997, 42 U.S.C. § 1395w-21 *et seq.*

[2] Pub. L. No. 111-148 (2010).

[3] A prepublication copy of the proposed rule is available at http://www.ofr.gov/OFRUpload/OFRData/2010-16448_PI.pdf.

 ISSN 1049-7986

The IME adjustment is a percentage add-on to the prospective payment system payment rates for the teaching hospital, and was established to recognize the higher patient care costs and investments that teaching hospitals make to enhance resident education.

Briefly, DGME payments are calculated by multiplying the hospital's base year average ''per resident amount''[4] by the weighted number of full time equivalent (FTE) residents working in all areas of the hospital (and non-hospital sites, when applicable), subject to a cap,[5] and the hospital's Medicare share of total inpatient days. IME payments are based on a formula that raises inpatient payments by a percentage that is based on the ratio of residents-to-hospital beds. As with the DGME formula, the resident count used in the IME formula is capped.

Because GME reimbursement is tied to a hospital's resident cap, many hospitals seek additional cap space, and point to institutions that do not or cannot fill their slots as the appropriate sources from which such additional cap space should be drawn.

The PPACA, therefore, with its cap redistribution program and new calculations of resident time for GME reimbursement purposes, presents significant opportunities for teaching hospitals to increase their resident limits.

Resident Cap Reduction and Redistribution Program

Beginning July 1, 2011, a hospital's resident cap will be permanently reduced if the hospital has three years of unused residency slots, subject to certain exceptions.[6] CMS will look at the hospital's last three settled or submitted cost reports for cost reporting periods ending before March 23, 2010, to determine how many slots will be eliminated.

CMS then will use the smallest number of residency slots that went unutilized during the three year period and reduce the hospital's cap by 65 percent of that number.

For example, if a hospital had five unused slots in fiscal year 2007, four unused slots in fiscal year 2008, and six unused slots in fiscal year 2009, CMS will reduce the hospital's cap by 65 percent of four, or 2.6 slots.

Once a hospital's cap has been reduced through the 65 percent reduction formula, CMS will redistribute the slots to qualifying hospitals, which may apply for up to 75 slots (Redistribution Program).[7] CMS will determine whether a hospital is eligible for the slots by examining the hospital's likelihood of filling the slots within the first three cost reporting periods beginning on or 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, and (ii) rural areas.

According to CMS, hospitals that do not fit within these categories will not be eligible to receive slots through the Redistribution Program. [8]

Slots that are redistributed through the Redistribution Program are subject to certain restrictions. For example, for five years the receiving hospital 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.

In addition, at least 75 percent of the additional slots must be used for primary care or general surgery. Failure to comply with these requirements will result in the hospital's loss of all of the additional slots that it received under the Redistribution Program.

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

One of the most anticipated changes in the PPACA is the elimination of the restrictive rules and timekeeping requirements related to claiming resident time in non-provider settings.[9] Previously, hospitals could count resident time for residents training in non-hospital sites only if the hospital incurred ''all or substantially all'' of the associated training costs. Under the PPACA, effective for cost-reporting periods beginning on or after July 1, 2010, 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.

Thus, it will no longer be necessary to enter into agreements which document the payment trail to teaching physicians providing services in the non-hospital settings. Instead, the hospital need only demonstrate that it is incurring the cost of the residents' stipends and fringe benefits while the residents are in the non-hospital setting.

In certain circumstances, an agreement still will be required. For example, if more than one hospital incurs the costs of training either directly or through a third party, the hospitals will be able to count the proportional share of the time only if that share is memorialized in a written agreement between the hospitals.

---

[4] Each hospital has a specific ''per resident amount'' based on 1985 costs that is updated annually by an inflation factor. If a hospital did not have an approved residency training program during that base period, the fiscal intermediary will establish a per resident amount based on the hospital's first cost reporting period immediately following the cost reporting period in which the hospital began training residents. *See* 42 C.F.R. § 413.77.

[5] A hospital's resident limit, or cap, is based on the number of full time equivalent residents in approved residency training programs as set forth in the hospital's most recent cost reporting period ending on or before Dec. 31, 1996.

[6] *See* PPCA § 5503. The following hospitals have been carved out of the resident cap reduction program: rural hospitals with fewer than 250 acute care beds, hospitals that participated in a voluntary residency reduction plan and that have a plan to fill the unused positions by March 23, 2012, and the former Martin Luther King, Jr.-Harbor Hospital in Los Angeles.

[7] *See id.*

[8] Under the proposed rule, CMS indicates that the states in the lowest quartile are Alaska, Arizona, Georgia, Idaho, Indiana, Florida, Mississippi, Montana, Nevada, North Dakota, South Dakota, Puerto Rico (which, together with the District of Columbia, is considered a ''state'' for purposes of the new legislation), and Wyoming. The 10 states with the highest proportion of their populations living in a HPSA are Alabama, the District of Columbia, Louisiana, Montana, Mississippi, New Mexico, North Dakota, South Dakota, Puerto Rico, and Wyoming (*see* Proposed Rule at pp. 703-707).

[9] *See* PPACA § 5504.

  MCR ISSN 1049-7986

Another welcome change for teaching hospitals relates to the rules for calculating resident didactic time.[10] Prior to the passage of health care reform, hospitals were paid only for resident didactic training that took place in the hospital, and then it could only be counted for DGME payment purposes, not the IME adjustment.

Now, effective for cost reporting periods beginning on or after July 1, 2009, didactic time spent in nonprovider settings may be counted as part of the FTE computation for DGME purposes. Although this didactic time is still not counted for IME purposes, effective for cost reporting periods beginning on or after Jan. 1, 1983, an IME adjustment will be permitted if the didactic time takes place in the hospital setting.[11]

Preservation of Cap Slots from Closed Hospitals

Prior to the enactment of the PPACA, when a teaching hospital closed, the resident slots and the overall cap associated with that hospital could not be redistributed to other hospitals, with one exception: the Medicare regulations provide for a *temporary* transfer of Medicare-reimbursable resident slots from a closed hospital to a ''receiving hospital'' taking over the training of residents who have been ''displaced'' as a result of the hospital's closure.[12] The receiving hospital's cap is temporarily increased by the number of displaced residents that it accepts for the duration of the time for such residents to complete their training.

The PPACA introduced a mechanism for hospitals to *permanently* transfer their resident slots when a teaching hospital closes. According to the legislation, CMS is authorized to establish a process by which the slots of a hospital that closes or has closed on or after March 23, 2008, are redistributed to other hospitals in the area, increasing those hospitals' resident caps.

CMS is required to 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.

CMS may redistribute slots only to hospitals that can demonstrate the 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.

Note that CMS defines ''hospital closure'' as including the termination of a hospital's Medicare provider agreement and surrender of its Medicare provider number. This is a very important consideration to the parties in a hospital acquisition involving a buyer that declines assignment of the hospital's Medicare provider number:[13] since a hospital's resident cap is tied to its Medicare provider number for purposes of Medicare GME reimbursement, an acquiror that does not take assignment of a hospital's Medicare number generally is not entitled to the transfer of that hospital's resident cap.

Therefore, prior to the enactment of the PPACA, if a purchaser did not accept the hospital's Medicare provider number as part of the transaction, the hospital, even though operational, would be deemed to have closed, automatically have a resident cap of zero, and consequently not be eligible to receive Medicare GME reimbursement for any of its residents in training.

Now that the PPACA addresses where and how a ''closed'' hospital's residency slots get distributed, CMS was tasked with addressing whether 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 the first in line to obtain the ''closed'' hospital's resident cap.

The proposed rule indicates that such a hospital will, in fact, be in ''ranking criteria one'' and receive preference when applying for the ''closed'' hospital's slots. [14]

The proposed rule also attempts to provide guidance as to how the slots will be distributed within each level of priority. For example, CMS is proposing to use the same pre-reclassification CBSAs that are used for wage index purposes under the Inpatient Prospective Payment System in determining which hospitals are located in the same or contiguous CMSAs as the CBSA in which the hospital that closed was located.[15]

Conclusion

Many of the PPACA provisions affecting Medicare reimbursement for graduate medical education will be viewed positively by teaching hospitals and academic medical centers with large training programs.

For one thing, the legislation offers potential relief for hospitals that are over a resident cap that has been in place for more than 10 years. At the same time, it has been reported that there are fewer than 1,000 slots available under the Redistribution Program, and hospital closures are relatively infrequent events.[16] The extent to which hospitals will benefit from this aspect of the new legislation remains to be seen, as much will depend on the hospital data calculations of unused slots and didactic time, as well as CMS's interpretation of the legislation to be reflected in the regulations it will promulgate.

---

[10] *Id*. at § 5505. Didactic time generally refers to conferences and seminars not related to the care of a particular patient.

[11] Resident research time is also addressed in the PPACA. Although there were no substantive changes, the PPACA clarifies that resident research time conducted in the non-hospital setting does not count for either DGME or IME payment purposes.

[12] *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.

[13] Declining assignment of a hospital's Medicare provider number provides the buyer with protection against liabilities related to the hospital's pre-transaction Medicare participation.

[14] Also in ''ranking criteria one'' are hospitals that took in displaced residents and will continue to train residents in the same programs as the displaced residents even after the displaced residents complete their training. *See* Proposed Rule at pp. 764-765.

[15] *See* Proposed Rule at p. 761.

[16] *See* Association of American Medical Colleges, *AAMC Summaries of GME Sections of the Health Reform Bill*, at http://www.aamc.org/reform/summary/dgmeime.pdf.