

CMS STABILIZES GRADUATE MEDICAL EDUCATION PAYMENTS IN COVID-19 RULE AND EXTENDS DEADLINES FOR FTE CAP AGREEMENTS

Teaching hospitals, teaching physicians and other providers will have additional flexibility to respond to the COVID-19 public health emergency (“PHE”) under an **interim final rule** with comment period (“Rule”) that CMS published on May 8, 2020. The Rule should work to stabilize teaching hospitals’ graduate medical education (“GME”) payments during the COVID-19 PHE, and it creates no-harm options to assist teaching hospitals and other providers who engage in medical education, such as non-teaching hospitals, teaching physicians, rural health clinics and inpatient rehabilitation and psychiatric facilities. Through a separate public posting, CMS also extended the deadline for filing Medicare GME affiliation agreements to share full-time equivalent (“FTE”) cap and to file amendments of current documents.

SUMMARY

The Rule addresses primarily hospital GME payments, and also payments for inpatient rehabilitation facilities (“IRFs”), inpatient psychiatric facilities (“IPFs”) and teaching physicians. These changes last only for the duration of the PHE, which began on January 27, 2020 and does not have an established end date. Overall, these changes lessen the possible negative impact of creating surge bed capacity and allocating staff in response to public health needs.

- **Resident FTE Counts:** When calculating teaching hospitals’ resident FTE counts, CMS will allow a teaching hospital to count the time that residents spend at another hospital—teaching or non-teaching. This significant change in policy, while temporary, will help stabilize teaching hospitals’ direct graduate medical education (“DGME”) and indirect graduate medical education (“IME”) payments when they need to redeploy residents to other hospitals, including historically non-teaching hospitals, for training. Additionally, non-teaching hospitals that agree to take residents will not trigger the establishment of a per-resident amount (“PRA”) or trigger the creation of FTE caps for new program residents by allowing residents to work in the non-teaching hospital.
- **Inpatient Bed Counts and Average Daily Census:** For purposes of IME payments, CMS will consider a hospital’s bed count to be the same as it was on January 26, 2020, *i.e.*, the day before the PHE began, during the entire PHE period. With this, even a significant increase in available beds to meet COVID-19 demand will not diminish IME as it normally would. Similarly, CMS will consider the average daily census for IRFs and IPFs to be the same as it was on January 26, 2020 when calculating the facilities’ teaching status adjustment payments.
- **Teaching Physicians Operating Remotely:** In its first Interim Final Rule with Comment Period addressing COVID-19 published April 6, 2020 (“April IFC”), CMS expanded opportunities for physicians to supervise certain resident evaluation and management (“E/M”) services remotely. In this new Rule, CMS builds on this expansion by allowing virtual supervision for a broader range of E/M services, as well as for required conferences between residents and supervising physicians.
- **FTE Cap Sharing Agreements:** Adding to the flexibilities available under the Rule, on May 21, 2020, CMS announced that it will extend the deadline for teaching hospitals to submit new or amended Medicare GME affiliation agreements from July 1 to October 1, 2020. A Medicare GME affiliation agreement allows two or more teaching hospitals to share/aggregate their DGME and IME FTE resident caps to facilitate cross-training of residents. This change only delays the filing deadline and makes no other substantive changes, so teaching hospitals that are sharing FTE cap must follow all other existing procedures to submit the affiliation agreement to their Medicare Administrative Contractor and to CMS, but they will have until October 1, 2020 to do so.

FLEXIBILITIES WHEN COUNTING RESIDENT FTES

DGME and IME payments both depend on the number of resident FTEs that train at a teaching hospital and applicable non-provider locations during an academic year. Historically, for training time in the hospital, CMS has only permitted teaching hospitals to count time spent within their own hospital locations, and never time spent in another hospital (*i.e.*, a hospital with a different CCN), toward their resident FTE counts. Under the Rule, teaching hospitals will be permitted to count the time that residents spend at non-hospital sites **and other hospitals** in response to the PHE. The Rule requires that either the sending hospital or the receiving hospital be treating COVID-19 patients, that the resident from the sending hospital perform activities at the receiving hospital that are consistent with his or her approved residency program

while at the receiving hospital, that the receiving hospital cannot count the resident time if the sending hospital counts the time at the receiving hospital on the sending hospital's cost report, and that the sending hospital include the time for the residents sent to the receiving hospital immediately before or after the PHE in the sending hospital's resident FTE count. In addition, if non-hospital sites provide routine services to the hospital's inpatients under arrangements with the hospital, the hospital can count the time that residents spend at those under arrangements locations toward its FTE count, as these services are deemed to have been provided by the hospital.

This location flexibility represents a significant shift on CMS's part. Historically, teaching hospitals have only been permitted to count the time that residents spend in the teaching hospital's own facilities toward their FTE counts, and never in another hospital, except in limited circumstances. As stated in the Rule, CMS expects that these changes will give teaching hospitals flexibility to determine resident training on an emergency basis and to help address hospital workforce shortfalls without triggering potentially negative GME financial results. CMS stressed that it is granting this flexibility only during the PHE and in response to the unprecedented nature of the COVID-19 pandemic.

INPATIENT BED COUNTS AND AVERAGE DAILY CENSUS

A teaching hospital's IME payments vary with the number of inpatient beds that the hospital operates, and with all else being equal, more beds will lead to lower payments. In the Rule, CMS expressed a desire to hold teaching hospitals harmless from increases in inpatient capacity that occur as a result of the PHE. To do so, CMS revised its regulations to provide that a teaching hospital's available bed count will be considered to be the same as it was on the day before the PHE was declared (*i.e.*, January 26, 2020). Beds added during the PHE will be excluded from the calculations to determine IME payment amounts, so a hospital that adds beds to address surge capacity during the PHE will not experience a reduction in IME relating to the bed count factor.

In a similar manner, IRF and IPF teaching status adjustments vary with each facility's average daily census. Through the Rule, CMS will hold IRFs and IPFs harmless from any increase in their average daily census during the PHE by locking in each facility's teaching status adjustment payment at the rate that was in place on January 26, 2020.

By making these changes, CMS removes financial barriers that could prevent hospitals and other providers from making the most efficient use of their resources during the PHE, and it will not reduce payments that would otherwise be reduced by a formula for hospitals that increased capacity already. Notably, CMS did not establish any limits on which teaching hospitals, IRFs or IPFs will benefit from these changes. Additionally, it appears at this time that this process will be automatic, *i.e.*, providers will not have to notify CMS of their desire to use the January 26, 2020 figures when calculating their increased payments, but they will need to report the data consistent with the new flexibility on the applicable cost reports to receive the benefits.

TEACHING PHYSICIANS SUPERVISING THROUGH VIDEOCONFERENCING

a. Changes in April Interim Final Rule

Historically, the general Physicians At Teaching Hospitals ("PATH") rule provides that a teaching physician can only bill for services involving residents if the teaching physician and resident are together and physically present with the patient. In the April IFC, CMS modified its billing rules to allow a teaching physician to bill for services supervised via teleconferencing technology. Notably, in the preamble to the April IFC, CMS stated that the videoconferencing exception would **not** apply to surgical, high-risk, interventional or other high-risk procedures (*i.e.*, for those services the physician must be physically present under the historic PATH billing rule to bill for the services). So, while CMS's revised regulation which permits the teaching physician to bill for a "service **or procedure**" for which payment is sought, the scope of the allowed procedures is limited by the procedure's level of risk to the patient.

Also in the April IFC, CMS made a similar change to the primary care exception to the PATH billing rule. Under the historical primary care exception, a physician could bill for low- and mid-level E/M services provided by up to 4 residents under the physician's supervision at one time if the physician directly supervised the service by being immediately available to assist and consulted with the resident during or immediately after the service. In the April IFC, CMS expanded on the primary care exception by allowing the teaching physician to supervise the E/M service through audio/video real-time communications technology, and by allowing the primary care exception to be used for all office/outpatient E/M levels during the PHE.

b. Changes in the Rule

In the Rule, CMS expanded upon the flexibilities in the primary care exception. Most significantly, during the PHE, CMS will allow physicians

to meet the requirement to review the service with the resident during or immediately after the E/M service is provided via audio/video real-time communications technology. As a result of this change, physicians will be able to bill for more services provided by their residents, including via telehealth, when their interaction with the resident is completely remote. Also in the Rule, CMS further expanded the list of E/M services that a resident can provide, and a teaching physician can bill for, under the primary care exception to include an array of telephone/virtual E/M services. The Rule also codifies technical changes to CMS's regulations for diagnostic radiology and psychiatric teaching settings to reflect the requirement that remote supervision be provided through real-time audio/video technology.

PRACTICAL TAKEAWAYS

The flexibility that CMS provided through the Rule will allow teaching hospitals, other teaching providers and teaching physicians to respond nimbly to the ongoing PHE. Hospitals can consider transitioning residents to other facilities to meet internal needs and the needs of the community without a significant risk that doing so will negatively impact their GME payments, and similarly, they can expand bed capacity as needed without experiencing decreased IME payments. When taking these steps and others, hospitals and other providers should be cognizant of other regulatory requirements that may exist, including, for example, directives under the fraud and abuse laws that require fair market value payments for physician services, which have also been altered under the PHE.

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