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HALL RENDER DETAILED CHECK-UP: 2013 GME UPDATE

The graduate medical education ("GME") landscape continues to evolve, even as the basic structure of Medicare GME reimbursement remains in place. Recently, noteworthy proposals and changes include proposed legislation that would provide for 15,000 new residency positions over five years to increase the number of residents in training and a change to the regulations that alters the period for setting the full-time equivalent ("FTE") cap for new teaching hospitals. This article:

- Summarizes S. 577 - Resident Physician Shortage Reduction Act of 2013, a bill introduced by Congress on March 14, 2013;
- Reviews important provisions of the fiscal year 2013 Inpatient Prospective Payment System ("IPPS") Final Rule;
- Discusses two Provider Reimbursement Review Board ("PRRB") decisions on the "new program" problem;
- Provides an overview of the 2014 IPPS Proposed Rule changes for DGME/IME; and
- Concludes with some industry trend observations.

PROPOSED LEGISLATION: S. 577 - RESIDENT PHYSICIAN SHORTAGE REDUCTION ACT OF 2013

On March 14, 2013, Senator Bill Nelson (D-FL) introduced S. 577, entitled the Resident Physician Shortage Reduction Act of 2013, a bill to amend the Medicare Statute to provide for the distribution of 15,000 additional FTE residency positions over five years from 2015-2019 (the "Bill"). Currently, the Bill has been referred to the Senate Committee on Finance and recently added another sponsor, but it has not yet been reported out of committee.

The Bill provides for an additional 3,000 residency slots per year for five years starting in fiscal year ("FY") 2015. At least half or 1,500 residency slots per year would be reserved for residents training in a "shortage specialty residency program," defined as a specialty area with an anticipated shortage of active physicians to fill the projected needs in such specialty area for the period 2005 through 2020, as determined initially by the Health Resources and Services Administration (commonly known as HRSA) and then later by a National Health Care Workforce Commission Report mandated by the Bill. Any new residency slots not distributed in a particular FY would be added to the aggregate number of slots available for distribution in the following FY. Further, residency slots not distributed by the end of the five-year period ending in 2019 would be made available for subsequent FYs until the aggregate number of residency slots distributed reaches 15,000.

To determine the hospitals eligible for an increase in their residency FTE caps, the Secretary of Health and Human Services (the "Secretary") would consider the hospitals most likely to be able to fill the slots within the five cost reporting periods. Further, hospitals making application for additional FTE residency slots would be prioritized as follows:

1. Hospitals in states with new medical schools or hospitals in states with additional locations and branch campuses established by accredited medical schools;
2. Hospitals where the number of residents exceeded the resident cap during the most recent cost reporting period ending on or before the date of enactment of the Bill;
3. Hospitals that emphasize training in community health centers or community-based settings or in hospital outpatient departments;
4. Hospitals eligible for electronic health record incentive payments as of the date the hospital submits an application for additional residency slots; and finally
5. All other hospitals.

A hospital that receives additional residency slots must ensure that:

- At least 50% of the new slots are used to train FTE residents in a shortage specialty residency program;

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- The total number of FTE residents does not decrease before the additional slots are added (i.e., this is not "cap relief"); and
- The ratio of FTE residents in a shortage specialty residency program does not decrease before the additional slots are added.

If a hospital fails to meet the criteria for an increase in residency slots, the Secretary must remove and then again redistribute the additional slots allotted.

The Bill imposes certain limits on the total number of new residency slots a hospital can receive. Generally, a hospital may not receive more than 75 FTE additional residency slots in the aggregate over FYs 2015-2019 *unless* there is a surplus of slots not otherwise distributable. As to indirect medical education or IME payments, the Bill specifies that the IME payments for the new slots will be the same as for other existing slots, and presumably the direct graduate medical education ("DGME") payments will be the same as well.

Finally, the Bill commissions certain studies and reports to determine physician specialty shortage areas and strategies for increasing diversity of the health professional workforce.

While unlikely to pass without significant changes, the President's current budget proposal calls for $10 billion in GME cuts over ten years and a one-time $177 million cut in Children's Hospital GME ("CHGME") in 2014. If history is a guide, we believe it is unlikely that the ultimate GME cuts will be as deep as proposed or that the one-time 2014 CHGME cut will be finalized. Nonetheless, the proposed GME reduction and deficit reduction debate, overall, certainly calls into question the viability of S. 577, even while there has never been a more critical time for assisting teaching hospitals with their GME costs, given the projected shortage of primary care and some specialty physicians and mid-level practitioners in the future. Interested stakeholders may wish to consider lobbying for passage of S. 577.

2013 IPPS FINAL RULE

On August 31, 2012, the Centers for Medicare and Medicaid Services ("CMS") published the Final Rule for the federal FY 2013 IPPS. Notwithstanding the fact that we are well into FY 2013, the IPPS Final Rule for 2013 sets forth a number of important revisions that teaching hospitals, especially new teaching hospitals, and their counsel will want to understand. The Final Rule brings clarifications and updates to the timely filing requirements, a revision to the calculation of the Interns and Residents to Bed ("IRB") ratio for labor and delivery beds, extension of the cap-building period from three years to five years and modifications to the 5503 and 5506 process for retaining hospital cap. The adjustment factor for IME remains the same.

A. IME Adjustment Remains the Same

Under the IPPS, hospitals with approved GME programs receive an additional payment to reflect the higher indirect patient care costs of teaching hospitals. The regulations regarding this payment can be found at 42 C.F.R. § 412.105. The higher payment amount is determined by the use of a statutorily specified adjustment factor, known as the IME adjustment, found at § 1886(d)(5)(B) of the Social Security Act, which states that, for discharges occurring during FY 2008 and thereafter, the IME multiplier is 1.35. In federal FY 2013, the IME adjustment continues to be 1.35. CMS estimates that the multiplier will yield 5.5% in additional IPPS payments for every 10% increase in the IRB ratio.

B. Clarifications and Updates to Timely Filing Requirements for "No-Pay Bills"

In the Final Rule, CMS clarified that the timely filing requirements, found at 42 C.F.R. § 424.44, which mandate that for services furnished on or after January 1, 2010, the claim must be filed no later than the close of the period ending one calendar year after the date of service (with some exceptions), apply to "no-pay bills" submitted by hospitals that receive IME, DGME and nursing or allied health education payments. No-pay bills, or "shadow claims," are claims for Medicare Advantage ("MA") beneficiaries that are submitted to Medicare Part A and the fiscal intermediary and that trigger CMS to make additional payments to hospitals for IME and DGME costs incurred while furnishing services to individuals enrolled in MA, and to hospitals that operate nursing or allied health education programs. CMS continues to require that no-pay bills be submitted for processing using the UB-04 form.

Further, CMS extended the timely filing requirements to apply to no-pay bills associated with calculating the Disproportionate Share Hospital ("DSH") payments. CMS explained that it extended the rule because it found that hospitals may not have an incentive to submit no-pay bills in the same timely manner as they would fee-for-service claims, and CMS wanted to ensure no-pay bills were properly incorporated into the DSH calculation.

C. Labor and Delivery Beds Included in the IRB Ratio

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CMS finalized a proposed policy change to include labor and delivery beds for purposes of computing the IRB ratio. This policy is a result of another recent CMS policy change in FY 2010 to include labor and delivery days in the DSH calculation. As a result of this change, labor and delivery beds will be removed from the exclusion list at 42 C.F.R. § 412.105(b)(4). CMS stated that it wanted to be consistent between counting patient days for DSH purposes and available beds for IME purposes. CMS also stated that the services furnished to labor and delivery patients are generally considered to be payable under the IPPS. Therefore, labor and delivery beds will now be considered available beds for IME purposes, and as the relative number of available beds increases as resident numbers stay the same, IME payments decline.

D. Period for Setting the FTE Cap Increases from Three Years to Five Years

CMS finalized its May 11, 2012 IPPS Proposed Rule to extend the cap-building period for new teaching hospitals from three years to five years. Under the previous regulations, at 42 C.F.R. § 413.79(3)(1), there was a three-year period in which a new teaching hospital could grow its residency programs for the purpose of establishing its FTE resident cap (referred to as the "three-year window"). Under the previous regulation, the cap was based on the highest number of resident FTEs training in any program year during the third year of the first new program, multiplied by the minimum accredited length of each program (and subject to a limit based on the maximum number of approved FTE slots). In response to concern from the provider community that three years does not provide a sufficient amount of time for a new teaching hospital to grow all of its new residency programs and to establish FTE caps that are properly reflective of the number of FTE residents that the hospital will ultimately train, CMS expanded the three-year window to five years and set the cap permanently at the end of the fifth year of the first new program.

The amended cap calculation is based on the product of the highest number of resident FTEs training in any program year during the fifth year of the first new program, multiplied by the number of years in the program (and subject to the number of accredited slots for the program). The policy change applies to the establishment of a hospital's cap for both DGME and IME payment purposes and will be applied to both caps beginning with the sixth academic year of the first new program, effective for hospitals that first begin to train residents in their first new program on or after October 1, 2012.

CMS also amended the regulation at 42 C.F.R. § 413.79(e) for calculating the DGME and IME caps when residents in a new residency program at a new teaching hospital rotate to more than one hospital during the five-year window. Specifically, CMS will apportion the potential new FTE cap among the hospitals that train the residents based on the percentage of resident FTEs that each hospital trains over the entire five-year window. The new formula will be based on the sum of the products of the following three factors: (1) the highest total number of FTE residents trained in any program year during the fifth year of the first new program's existence at all of the hospitals to which the residents in that program rotate; (2) the number of years in which residents are expected to complete the program, based on the minimum accredited length for each type of program; and (3) the ratio of the number of FTE residents in the new program that trained at the hospital over the entire five-year period to the total number of FTE residents that trained at all hospitals over the entire five-year period.

For new teaching hospitals that will need to rotate residents to other hospitals during the cap-building period, this new apportionment process will be very important as rotations to other hospitals will necessarily decrease the new teaching hospital's resulting FTE cap. Under this new apportionment rule (which CMS describes as long-standing practice, even though nothing like this has ever been included in regulatory text), the resident experiences at other hospitals during the five-year period will proportionally decrease the new teaching hospital's cap, whether the other hospitals are themselves new teaching hospitals (having their own caps set) or already existing teaching hospitals with established FTE caps. While away rotations are at times unavoidable to meet accreditation and education needs, the extent that they can be limited during the initial five years of new teaching hospitals will be key to building a sufficient cap.

E. Changes to Section 5503 Process for Retaining Redistributed Hospital Cap

Section 5503 of the Patient Protection and Affordable Care Act ("ACA") provided for a redistribution of resident cap slots from hospitals that were below their caps to other hospitals that applied to CMS for the slots for use in expanding primary care and general surgery programs. Once the teaching hospitals received new slots under Section 5503, they had to meet certain requirements to keep the slots. These requirements are referred to as the "Primary Care Average," which requires that the hospital maintain the number of FTE primary care residents the hospital had before the increase at or above the average number of FTE primary care residents during the three most recent cost reporting periods ending before March 23, 2010, and the "75% Threshold," which requires that the hospital ensure that not less than 75% of the positions attributable to the cap increase are in a primary care or general surgery residency.

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In the IPPS Final Rule, CMS implemented a policy that differs from the policy it proposed in the May 11, 2012 IPPS Proposed Rule. Unlike the Proposed Rule, in which CMS proposed to remove all 5503 slots if a hospital did not fill at least half of its slots within the first three cost reporting periods, CMS finalized a policy that requires a hospital to use all of its 5503 slots by the end of the fourth cost reporting period, or risk losing the unused slots permanently in the fifth cost reporting period.

Additionally, CMS reiterated that 5503 slots are not intended to be used for "cap relief" or to cover existing residency positions, but they are to be used to create new residency positions either through starting new programs or expanding existing programs. However, CMS noted that in light of the 75% Threshold, arguably 25% of the remaining 5503 slots can, under a technical reading of the statute, be used for cap relief related to non-primary care programs, and CMS stated that it is not instructing contractors to automatically disallow the portion of slots used for cap relief if the 75% Threshold and the Primary Care Average are met. CMS cautioned that hospitals are still responsible for meeting the 75% Threshold based on the amount of 5503 cap increases reported on the cost report. Moreover, if a hospital fails to meet the 75% Threshold or the Primary Care Average, the hospital will lose all of its 5503 slots dating back to the earliest cost reporting period that is reopenable in which it could be determined that the hospital did not meet the requirements. CMS will update the hospital cost report to accommodate reporting of 5503 slots. The five-year evaluation period for use of 5503 slots is between July 1, 2011 and June 30, 2016. The Primary Care Average applied immediately on July 1, 2011, regardless of when a hospital began to use its 5503 slots.

F. Changes to Section 5506 Application Process for Closed Hospital Cap

On November 24, 2010, CMS issued regulations implementing Section 5506 of the ACA, which directed CMS to redistribute FTE cap slots from closed hospitals. In the Final Rule, CMS shortened the deadline for hospitals to apply for Section 5506 cap slots from four months from the date following CMS's public notice of a hospital's closure and the availability of resident slots from the closed hospital to 90 days following the notice. The change came in response to comments from providers that the four-month application period unduly delayed the redistribution process.

CMS also modified the criteria for ranking applications for cap slots from closed hospitals. CMS currently uses seven criteria ranked in order of priority. Due to the high volume of applications that fell under Ranking Criterion Seven, which was the catch-all provision for applications that did not fit within any of the other six criteria, CMS decided to split Ranking Criterion Seven into two separate criteria, to create an additional criterion, Ranking Criterion Eight.

In addition, CMS has clarified the effective dates of the slots awarded under Section 5506 and stated that the effective dates of the various ranking criteria are driven by the reasons for which the slots are awarded and by when the slots are needed. For instance, slots awarded under Ranking Criterion Two are effective as of the date of the hospital closure. Slots awarded under Ranking Criteria One and Three become effective as of the time of a displaced resident's graduation. Slots awarded for Ranking Criteria Four through Seven become effective as of the date the hospital can demonstrate to Medicare that the slots have been filled. For Ranking Criterion Eight, if the slots are for starting or expanding a non-primary care program, the slots are effective as of the date the hospital can demonstrate that the slots have been filled. However, if the slots are for cap relief, the effective date is the later of the date CMS awards the slots or the July 1 after displaced residents have completed their training.

Finally, CMS clarified the relationship between some of the ranking criteria and made changes to its evaluation form for Section 5506 applications to clarify requirements on the form. The deadline to apply for newly available resident slots under Section 5506 was October 29, 2012.

You can find the Final Rule here.

PRRB DECISIONS REGARDING NEW GME PROGRAM DESIGNATIONS

On August 27, 2009, CMS released guidance in the Federal Register detailing the criteria for a "new GME program." Since that time, many providers have questioned, or have been questioned by CMS or a Fiscal Intermediary ("FI")/Medicare Administrative Contractor ("MAC"), whether their programs meet all the necessary elements to qualify as a new program. Recently, there have been two PRRB decisions interpreting CMS guidance.

In December 2011, the PRRB upheld a new GME program designation in *Oakwood Annapolis Wayne Hospital v. BlueCross BlueShield Association/National Government Services, Inc.*, PRRB Decision 2012-D4. In that case, the FI initially determined that the family medicine program at Oakwood Annapolis Hospital ("OAH") in Wayne, Michigan was a new program but then subsequently determined that the

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program did not meet the additional 2009 new program requirements issued by CMS and rescinded the new program designation and recouped all prior payments for the program.

On appeal, the PRRB found that OAH's program was indeed a new program because it met the original regulatory definition of a new residency training program. The FI argued that "clarifications" to the new program guidance issued by CMS in the August 27, 2009 Federal Register would show that the program was not new because it had previously operated at another hospital and because faculty, curriculum, non-hospital site rotations and residents were the same. The PRRB found that the 2009 guidance from CMS was not a clarification but rather a new definition of a new program and to apply the new definition to OAH's program would constitute impermissible retroactive rulemaking.

More recently, in a February 2012 case, the PRRB found that a program that previously received new program status approval from the FI was not, in fact, a new program. However, in this case, *Doctors Medical Center of Modesto v. Wisconsin Physicians Service*, PRRB Decision 2012-D11, the PRRB based its determination on the fact that the program in question had received "continued accreditation" status from the Accreditation Council for Graduate Medical Education ("ACGME") after it relocated. Because there was no initial accreditation from the ACGME, the PRRB found that the program was not new.

While the above PRRB decisions are not that new, the question of what elements are necessary to comprise a new GME program has never been completely clarified by CMS or the courts, despite the additional guidance that was issued in 2009. According to at least some PRRB decisions, the 2009 guidance from CMS constitutes a new definition of a new program, including new factors assessing whether the program had previously operated at another hospital and whether faculty and curriculum are new. As new teaching hospitals continue to contest any conclusions that their programs are not "new programs," we may see more focus on this area.

2014 IPPS PROPOSED RULE

On April 26, 2013, CMS released the federal FY 2014 Proposed Rule for the annual changes to Medicare hospital regulations and policies, and included in the 2014 Proposed Rule are a number of changes affecting Medicare DGME/IME. Below is a brief outline of the topics discussed in the 2014 Proposed Rule for interested providers who may want to assess the potential effect of the proposed changes on operations and reimbursement or to determine if additional analysis is required or if comments should be submitted to try to alter the proposed changes. The comment period closes at 5:00 PM EDT on June 25, 2013.

- *IME Multiplier*. For 2014, CMS is proposing to maintain the IME multiplier at 1.35 (see above for more explanation of the IME multiplier).
- *Labor and Delivery Beds*. Following on the 2013 change discussed above to include labor and delivery beds in the IRB ratio for IME purposes, for 2014, CMS is proposing that patient days relating to the labor and delivery beds will also be included in the calculation of the "Medicare patient load" or "Medicare utilization rate" (i.e., the ratio of the total number of hospital inpatient days attributable to Part A patients, divided by total hospital inpatient days). Since few of the patients being treated in labor and delivery beds have Medicare Part A coverage, the inclusion of the labor and delivery bed days in the numerator and denominator will necessarily reduce the DGME payments (since the days will be in the denominator but not in the numerator).
- *Critical Access Hospitals ("CAHs")*. In the 2014 Proposed Rule, CMS reduces the options for how CAH locations can participate in GME funded by Medicare, proposing for 2014 that CAHs can only participate as hospital locations (including provider-based departments) being reimbursed at 101% of their Medicare reasonable direct education costs. In the 2014 Proposed Rule preamble, CMS discusses that previously, CMS has allowed CAHs two options for participating in Medicare-funded education: (1) to participate as ***non-hospital sites*** for other acute care hospitals being paid DGME/IME, on the theory that while CAHs are technically hospitals, they are not subject to IPPS; or (2) to be cost reimbursed for 101% of the reasonable Medicare costs of direct education incurred by the CAH. In a change of policy for 2014, CMS will no longer consider CAHs eligible non-hospital sites for other providers.
- *PRA Freeze Lifts*. For providers lucky enough to have been caught by the Balanced Budget Refinement Act ("BBRA") limitations on the Per Resident Amounts ("PRAs"), since 2004, hospitals whose PRAs exceeded the ceiling were capped and did not receive annual Consumer Price Index ("CPI") increases to the PRAs (most hospitals' PRAs increase each year at a designated CPI rate). That cap expires beginning FY 2014, so going forward, at least for now, all PRAs will increase by the annual CPI amount.
- *Distribution of the Closed Hospital FTE Cap from Peninsula Hospital Center.* Under another round of closed hospital FTE cap redistribution created by Section 5506 of the ACA, CMS is distributing 28.32 IME cap slots and 36.34 DGME cap slots from Peninsula Hospital Center in Far Rockaway, New York, which closed as a Medicare provider effective April 9, 2013 (see above for a discussion of the

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closed hospital FTE cap rules, and see the 2014 Proposed Rule preamble for additional important details). Hospitals interested in applying for some or all of this FTE cap need to submit the required application to CMS by no later than about July 24, 2013 (it may be sooner, so check the official version of the 2014 Proposed Rule to be published in the Federal Register on May 10, 2013).

You can find a display copy of the 2014 IPPS Proposed Rule here.

INDUSTRY OBSERVATIONS

The number of physicians who practice as hospitalists is growing in number, and hospitalist programs are having an ever-increasing presence in hospitals. Accompanying that change, hospitalists may now have an increasing role as teaching physicians in hospitals, and as a result, many hospitalists are now receiving payment for teaching services in addition to the payments they receive for their non-teaching work at the hospital. If the hospitalist payment includes elements of payment for teaching, then those costs should be accounted for by the hospital as direct teaching costs and reported on the Medicare cost report as a DGME cost. While actual costs don't currently determine payment amounts, having accurate costs reported is important. We anticipate the number of hospitalists to continue to grow, and therefore it may be prudent for teaching hospitals to reassess their hospitalist arrangements in this light.

Finally, a note about the Physician Payments Sunshine Act (the "Sunshine Act"). The Sunshine Act, Section 6002 of the ACA, includes two separate transparency reporting requirements with respect to payment by drug and device manufacturers for direct and indirect payments and transfers of value to physicians and teaching hospitals. While the details of the Sunshine Act and its implementing rules are beyond the scope of this publication[1], we do mention how the Sunshine Act rules look at residents, as well as noting that the definition of "teaching hospitals" under the Sunshine Act rule may be broader than many think. First, it is worth noting that graduate medical residents, even though they likely are "physicians" as defined by the Sunshine Act rules, will generally be excluded from the reporting requirements. However, if a resident "moonlights" outside of the program and obtains direct Medicare billing privileges, and in addition receives any payments or other transfers of value from applicable manufacturers, then reporting by the manufacturer may be possible.

Second, under the Sunshine Act rules, applicable manufacturers are required to report payments and other transfers of value made to "covered recipients," which include physicians and teaching hospitals. For purposes of the Sunshine Act rules, a "teaching hospital" is any hospital that receives any IME or DGME funding, no matter how much or how little. So, while most academic teaching settings will be well aware of the covered recipient status of the major teaching hospitals, community-based and smaller teaching hospitals may not immediately realize their covered recipient statuses. While covered recipients themselves need do nothing under the Sunshine Act rules, knowing that manufacturers may be disclosing to CMS, and ultimately the public, information about payments and other transfers of value is worth noting.

CMS posted the initial list of "teaching hospitals" who will be subject to manufacturer reporting, which is included on the CMS Teaching Hospitals Sunshine Act resource page.

If you have questions regarding the updated GME rules or this article, or if you wish to obtain information about lobbying Congress for passage of the Resident Physician Shortage Reduction Act of 2013, please contact:

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