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PPACA: New GME/IME Provisions

The recently enacted Patient Protection and Affordable Care Act (PPACA) contains several provisions affecting Medicare reimbursement for graduate medical education. Some of these provisions are effective now; others will be effective very soon but will require implementing instructions or regulations in the next several weeks or months. Some of the provisions contain welcome changes. Other changes, however, will be less well-received by providers.

Training in Non-provider Settings

The most welcome change for most providers is the elimination of the restrictive rules and timekeeping requirements associated with claiming resident time in non-provider settings. Under section 5504 of PPACA, all time spent by a resident in a non-provider 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. No longer will it be necessary to enter into agreements with, or establish a payment trail to, the teaching physicians providing services in the non-hospital settings. Thus, for both direct graduate medical education (DGME) and indirect medical education (IME) FTE counts, the hospital will need to demonstrate only that it is incurring the cost of the residents' stipends and fringe benefits while the residents are in the non-hospital setting.

In some instances, however, an agreement will be required. 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.

These rules are effective for cost-reporting periods beginning on or after July 1, 2010.

Rules for Counting Resident Time for Didactic and ScholarlyActivities; Research; and Vacation, Sick Leave or Other Approved Leave

Section 5505 of PPACA affects the Medicare GME and IME payment rules pertaining to didactic and research activities, as well as vacation, sick leave and other approved leave.

Didactic time: Effective for cost-reporting periods beginning on or after July 1, 2009, didactic time spent in *non-provider settings* is counted as part of the FTE computation for GME as long as that setting is primarily engaged in furnishing patient care (that is, where the primary activity is the care and treatment of patients). That time is not counted, however, for IME.

For IME, effective retroactively to January 1, 1983, time spent in didactic activities *in the hospital* is counted as part of the FTE computation. This essentially reverses CMS's current didactic time policy associated with counting FTEs for IME in hospital settings.

Research time:: Effective for cost-reporting periods beginning on or after October 1, 2001, time spent by residents in research activities not associated with the diagnosis or treatment of a particular patient is not counted for IME purposes. This provision essentially ratifies the current regulations.

Vacation, Sick or Other Approved Leave: Effective January 1, 1983, all time spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave shall be counted as part of the FTE count for both IME and GME as long as that leave does not prolong the total time that the resident is participating in the approved program.

Redistribution of FTE Slots

Congress again has authorized the redistribution of FTE slots, as it did in section 422 of the Medicare Modernization Act of 2003. This time, Congress will look at the cost-reporting periods for the last three years for which a cost report has been settled (or, if not settled, submitted subject to audit) prior to the date of enactment. HHS will then take the highest resident level in any of those three years and compare it to the hospital's historic limit or cap. If the hospital's highest count falls below the historic limit, HHS is to reduce the limit by 65 percent of the difference and redistribute the "unused" FTE slots to other hospitals. The reduction does not apply to rural hospitals, but for other hospitals that have been consistently operating below their limits, this could be bad news.

The good news is for hospitals that need additional FTEs, particularly those that are in states with low medical residents-to-population ratios. Hospitals that qualify to obtain redistributed FTEs are those (1) located in the state with a medical resident-to-population ratio in the lowest quartile of the nation; (2) located in a state, territory, or the District of Columbia in the top ten of states whose population is located in a Health Professional Shortage Area (HPSA) relative to the state's total population; or (3) located in a rural area. Seventy percent of the redistributed residents are to go to hospitals in Category 1. At least 75 percent of the redistributed slots must be used to train residents in a primary care or general surgery specialty for at least five years, and no more than 75 slots may go to any one hospital. In awarding the additional slots, CMS is to consider (1) the likelihood that the hospital will be able to fill the added slots within three cost reporting periods and (2) whether the hospital has an accredited rural track training program. These CMS determinations are not subject to administrative or judicial review.

The transfer of residents is to take place July 1, 2011, and implementing instructions should be issued soon.

Redistribution of Resident Slots After a Hospital Closes

Under section 5506 of PPACA, HHS is to establish a process by which FTE slots of a hospital that closes are to be redistributed to other hospitals in the area, increasing those hospitals' limits. The residents are to go: first, to hospitals in the same or contiguous Core-Based Statistical Area (CBSA); second, to hospitals in the same state as the hospital that closed; third, to the hospitals in the same region as the closed hospital; and fourth, to hospitals in accordance with the redistribution formula set forth in section 5503 of PPACA. The receiving hospital must be able to fill the slots within three years.

This provision requires reallocation of the FTEs from hospitals that closed on or after two years prior to enactment (that is, on or after March 2008). Implementing regulations will be necessary.

Ober|Kaler's Comments: The new provisions are, on the whole, beneficial to teaching hospitals. Hospitals will be relieved of the burden of preparing the non-hospital training calculations that have burdened them for years. Additionally, hospitals in states with (1) low resident-to-population ratios, (2) significant percentages of population in HPSAs, (3) rural areas, or (4) closed hospitals, may be able to increase their caps, getting new FTEs. Instructions clarifying these provisions should be issued soon.