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HEALTH INDUSTRY ALERT

RESIDENT ROTATIONS TO NONHOSPITAL SITES: EXPECT INCREASED SCRUTINY OF GME AND IME PAYMENTS

During every Medicare cost report audit for the foreseeable future, hospitals should expect their fiscal intermediaries to focus close attention upon their claimed graduate medical education (GME) reimbursements and indirect medical education (IME) adjustments. Given the substantial reimbursements that are often at issue, many hospitals across the country have already experienced an increase in audit scrutiny and adjustments involving such payments, which often result in the loss of significant Medicare funds. This is the first in our series of *Health Industry Alerts* regarding Medicare GME and IME payments that aim to assist hospitals in their efforts to obtain all of the medical education reimbursements to which they are entitled.

In this *Alert*, we address one situation that is receiving heightened attention by both the Medicare Program and the Department of Health and Human Services' Office of Inspector General (OIG): the inclusion of time spent by residents who rotate to nonhospital sites, such as physician offices, nursing homes or clinics, in the full time equivalent (FTE) resident counts for both GME and IME payment purposes. Notably, the Acting Principal Deputy Inspector General, Dara Corrigan, has targeted this issue, which is also highlighted in the OIG's *FY 2004 Work Plan*, as a top area for review. The rules related to GME and IME reimbursement are complex, and the guidance from the Centers for Medicare & Medicaid Services (CMS) is evolving and often unclear. However, because of the high payments involved, we encourage hospitals with medical residency training programs to review their arrangements with nonhospital sites to ensure that they comply with Medicare regulations.

DOES THE HOSPITAL HAVE A WRITTEN AGREEMENT WITH THE NONHOSPITAL SITE?

As an initial matter, under the Medicare rules, in order to count time spent by residents at a nonhospital site in its FTE counts, a hospital must have a written agreement with the nonhospital site. Notably, the Medicare Act does not mandate such a written agreement. The Act simply provides that the time spent by residents in an approved training program in a nonhos-

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pital setting *shall* be included in the GME and IME FTE counts if the residents are engaged in patient care activity and "the hospital incurs all, or substantially all, of the costs for the training program in that setting." *See* 42 U.S.C. § 1395ww(d)(5)(B)(iv) (IME provisions); 42 U.S.C. § 1395ww(h)(4)(E) (GME provisions). CMS has interpreted this statutory language broadly, however, and has established the following requirements, effective for portions of cost reporting periods occurring on or after January 1, 1999, which hospitals must satisfy in order to count time spent by residents at nonhospital sites for GME and IME payment purposes —

- The residents must be in an approved training program
- The residents must be engaged in patient care activities at the nonhospital site
- There must be a written agreement signed by both the hospital and the nonhospital site regarding the rotation of residents to the nonhospital site
- The written agreement must provide that the hospital will incur all or substantially all of the costs for the training program at the nonhospital site. In that regard, the written agreement must indicate the following:
    - The hospital is actually incurring the cost of the residents' salaries and fringe benefits (including travel and lodging where applicable) while the residents are training at the nonhospital site
    - The hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The written agreement must also indicate the compensation (cash or in-kind) the hospital is providing for such teaching activities
- Effective with portions of cost reporting periods occurring on or after October 1, 2003, principles of community support and redistribution of costs will apparently be strictly applied. Specifically, if the community has undertaken to bear the direct costs of medical education, such costs are not considered to be medical education costs to the hospital. Moreover, if the direct costs of training residents had previously been borne by an educational institution, and have since been redistributed to a hospital, such costs are not considered graduate medical education costs to the hospital. In practice, this means that, with limited exceptions, in order to count resident time spent at a nonhospital site, some hospital must have continuously incurred the costs of residents training in the particular program at that site since the date that residents first began training in such program at such site.

See 42 C.F.R. § 413.86(f)(3), (4) (pertaining to GME) and § 412.105(f)(1)(ii)(C) (pertaining to IME). Although these requirements seem fairly straightforward, a number of factors must be considered in evaluating whether a hospital's arrangements comply with these requirements.

IS ANY COMPENSATION PROVIDED FOR SUPERVISORY TEACHING ACTIVITIES?

One important aspect of the regulations is that CMS requires hospitals to compensate the nonhospital sites for their supervisory teaching activities. Significantly, CMS did not always require hospitals to compensate nonhospital sites for these services. The earlier policy, which was in effect for portions of cost reporting periods occurring prior to January 1, 1999, seems to have been based upon the finding that the salaries and fringe benefits of the residents training at the nonhospital site constituted all or substantially all of the costs of the training program at the site. However, effective for portions of cost reporting periods occurring on or after January 1, 1999, CMS has changed its policy.

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Thus, although the agreement need not specify the nonhospital site's costs related to teaching activities, it must state that reasonable compensation is being provided for such activities and must specify the amount of that compensation.

CMS has determined that compensation to the nonhospital site may be in the form of nonmonetary or in-kind arrangements, such as continuing education or professional and educational support. *See Program Memorandum No*. A-98-44 (Dec. 1998). However, if the hospital's arrangements involve such compensation, the written agreement must describe it, even though the agreement does not have to assign a monetary value to the compensation.

Many hospitals historically have not compensated nonhospital sites for teaching activities because the supervising physicians perform the services on a volunteer basis. Indeed, one might argue that nonhospital sites do not actually incur any costs related to supervisory teaching activities. Accordingly, CMS may still allow volunteer arrangements where the agreement specifies that there are no payments from the hospital to the nonhospital site because the site does not incur any costs relating to teaching activities and that the physicians agree to participate voluntarily. However, CMS has instructed intermediaries to evaluate and differentiate between situations where "there is no explicit compensation for supervisory teaching physician activities, from those where there are truly no costs." *See Program Memorandum No*. A-98-44.

Based on this guidance, many intermediaries do accept volunteer arrangements as valid. However, other intermediaries have disallowed resident time spent in nonhospital sites, especially clinics or group practices, if no cash or in-kind compensation is being paid to the nonhospital site. In these instances, the intermediaries have apparently determined, often without support, that the nonhospital sites actually did incur costs related to teaching activities that should have been compensated by the hospitals.

In guidance published earlier this month, CMS has further explained that since the Medicare regulations require a hospital to "incur all or substantially all of the direct GME costs, including those associated with the teaching physician, regardless of whether the written agreement states that the teaching physician is 'volunteering,' we have required that the hospital must pay these costs in order to count FTE residents training in the nonhospital site, *as long as such teaching costs exist*." *See CMS Transmittal* 61, *Change Request* 3071 (Mar. 12, 2004) (emphasis added). In sum, although volunteer arrangements are still arguably valid, based on the CMS guidance, it is likely that the intermediary will not treat volunteer arrangements favorably if it finds that the nonhospital site did incur costs associated with its teaching activities that were not paid by the hospital.

Significantly, in the recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress provided that, during the one-year period between January 1, 2004, and December 31, 2004, hospitals will be allowed to count family practice residents training in nonhospital settings regardless of the financial arrangement between the hospital and the nonhospital site. *See* Pub. L. No. 108-173, § 713. This moratorium applies to prior year cost reports that are settled in 2004 or to portions of cost reporting periods occurring during January 1, 2004, through December 31, 2004, if the residency program at issue was in existence as of January 1, 2002. *See CMS Transmittal* 61, *Change Request* 3071 (Mar. 12, 2004). Although this moratorium only affects family practice programs and a limited number of cost reporting periods, it may help hospitals retain medical education reimbursements in situations where the intermediary would have otherwise disallowed the FTEs because the hospital was not compensating the nonhospital site for its teaching activities.

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DO MULTIPLE HOSPITALS ROTATE RESIDENTS TO THE SAME NONHOSPITAL SITE?

CMS also recently announced what appears to be a new policy that may significantly limit a hospital's ability to claim FTEs for time spent in nonhospital settings. Specifically, CMS has interpreted the statutory directive that a hospital must incur all, or substantially all, of the costs for the training program in the nonhospital setting, to require hospitals to "assume financial responsibility for the *full* complement of residents training in a nonhospital site in a particular program in order to count any FTE residents training there . . . . A hospital cannot count any FTE residents if it incurs 'all or substantially all of the costs' for only a portion of the FTE residents in that program training setting." 68 Fed. Reg. 45,346, 45,439 (Aug. 1, 2003) (emphasis in original).

Under this policy, if more than one hospital rotates residents to the same nonhospital site as part of the same residency training program, CMS is taking the position that *neither* hospital is allowed to claim *any* of the FTEs at that site (even where the hospital is incurring all or substantially all of the costs associated with the training of its residents at the site). CMS has not issued guidance regarding how this policy would be applied in situations where residents from one hospital rotate to a nonhospital site in one month (or year) and residents from another hospital rotate to that site in the next month (or year). In any event, absent further positive clarification of this policy from CMS, increased scrutiny of hospital arrangements is likely to lead to reductions in hospital FTE counts in these circumstances.

These are a few of the key issues that you should address when evaluating whether your arrangements with nonhospital sites are in compliance with the Medicare rules.

CONTACT INFORMATION

If you would like assistance with reviewing your arrangements and agreements with nonhospital sites, counseling on general GME or IME reimbursement issues, or if you require representation before the Provider Reimbursement Review Board or the intermediary on related matters, please contact us:

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Finally, look for our upcoming *Health Industry Alerts* regarding other important Medicare GME and IME issues.

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