AKIN GUMP STRAUSS HAUER & FELD LLP
Attorneys at Law

March 5, 2007

HEALTH INDUSTRY ALERT

MEDICARE GME PAYMENTS: CMS FINALLY PROPOSES POSITIVE CHANGES REGARDING THE COUNT OF RESIDENTS AT NONHOSPITAL SITES

The Medicare Act provides that time spent by residents in an approved training program in a nonhospital setting shall be included in the direct graduate medical education (GME) and indirect medical education (IME) FTE counts if the residents are engaged in patient care activities and "the hospital incurs all, or substantially all, of the costs of the training program in that setting." *See* 42 U.S.C. §1395ww(h)(4)(E) (GME provisions); 42 U.S.C. §1395ww(d)(5)(B)(iv) (IME provisions). One large problem, however, is that over the past 20 years the Centers for Medicare & Medicaid Services (CMS) has done a poor job at both defining "all, or substantially all, of the costs of training" and how providers should quantify and support such costs. After many millions of lost or disallowed reimbursement dollars, not to mention the associated appeals and litigation, it looks like conditions are about to improve.

In a Proposed Rule having much more to do with payments to long-term-care hospitals than with medical education payments to acute care hospital providers, CMS has finally proposed to define "all, or substantially all, of the costs of training" at nonhospital sites and provided a roadmap and process for determining these costs. *See* 72 Fed. Reg. 4776, 4818-29 (Feb. 1, 2007). It is notable that CMS has apparently decided to propose these changes now in direct response to concerns raised by the teaching hospital community.

The Federal Register preamble provides a succinct description of the relevant evolving CMS guidance and rules, including with regard to the nonhospital written agreement or concurrent payment requirements, which ground will not be retread here. *See id.* at 4818-20. A couple of quick points, however, are worth mentioning. Prior to 1999, it appeared that as long as a hospital incurred the residents' salaries and fringe benefits for the time associated with the training at the nonhospital site, the resident FTEs were allowable. After that date, in general, CMS changed the rules to require that the resident FTEs could only be included in the counts if the hospital paid both the residents' compensation and reasonable compensation to the nonhospital site for the supervisory teaching activities of the physicians. *See id.; see also* 42 C.F.R. § 413.78; 42 C.F.R. § 412.105(f)(1)(ii)(C). Although bedlam ensued, clarity has arrived, and here are the highlights.

THE NEW 90 PERCENT THRESHOLD

In its Proposed Rule, CMS is proposing to define "all, or substantially all" to mean "at least *90 percent of the total of the costs* of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to direct GME." 72 Fed. Reg. at 4821 (emphasis added). As with the current policy, overhead costs are not included in this definition. CMS believes that this revised policy will "further encourage hospitals to shift training to nonhospital settings." CMS' current policy and its burdensome requirements have had the opposite impact, and the Medicare Program seems to be recognizing that phenomenon in this Proposed Rule. Although CMS has proposed to implement this new policy effective with cost reporting periods beginning on or after July 1, 2007, it has asked for comments on whether the policy should instead be effective immediately for portions of cost reporting periods occurring on or after July 1, 2007.

Perhaps the most beneficial aspect to this policy change is that a hospital would not have to demonstrate that it has incurred any of the costs associated with the teaching physicians' time if "it has otherwise incurred at least 90 percent of the nonhospital site training costs by paying the residents' salaries and fringe benefits (including travel and lodging where applicable) during the time spent training at the site." *Id.* If the "90 percent threshold" is not met by the residents' salaries, then the hospital would need to compensate the nonhospital site for some portion of its costs until the 90 percent mark is achieved. Despite the foregoing, CMS reiterated that in the case of a solo practitioner, or in the relatively rare group practice arrangement where the physicians do not have a form of predetermined compensation, these nonhospital sites do not have resident supervision costs that need to be covered by the hospital.

There are four variables that are important to the determination of whether a hospital has satisfied the 90 percent threshold and, under the proposed policy, will be deemed to have incurred "all, or substantially all" of the costs at the nonhospital site. These variables, which are discussed in more detail below, are as follows: (1) the teaching physician salaries, (2) the resident salaries and fringe benefits, (3) the number of hours per week spent by the physicians in teaching and supervising residents, and (4) the number of hours that the nonhospital site is open each week.

TEACHING PHYSICIAN SALARIES

The hospital industry's greatest complaint about the Medicare Program's current policy is the "untenable documentation burden since many physicians are reluctant to disclose their salary information to the hospitals." *Id.* at 4822. However, CMS is now proposing to relieve that burden. Although a hospital is still free to obtain, if possible, actual physician salary information, CMS is now proposing that hospitals may "use physician compensation survey data as a proxy to determine the teaching physician costs associated with GME in a program at a particular nonhospital site." *Id.* at 4823. CMS has proposed using the American Medical Group Association's (AMGA's) *2006 Medical Group Compensation and Financial Survey* for this purpose. However, CMS is requesting comments on whether AMGA's data should be used and whether the mean or median compensation amounts should be utilized.

In determining which proxy salary amount to use, CMS has proposed that "the specialty of the teaching physician is the relevant criterion, not the specialty of the residents that the teaching physician is training." *Id.* at 4824. Moreover, to maintain "administrative simplicity," CMS is proposing to allow hospitals to "apply a maximum of a 1:1 resident-to teaching physician ratio 'limit' in determining the total GME costs applicable to a program at a nonhospital site." *Id.* at 4825. Therefore, regardless of the number of supervising physicians at a nonhospital site, *unless the hospital can and wants to document otherwise,* the 90 percent threshold will be met by looking at the salaries and fringe benefits associated with the number of residents at the site and the same number of supervising physicians. If the supervising physicians have different specialties (with different average salaries), the hospital would "calculate the average national salary of the mix of physician specialties in the practice." *Id.*

Notably, to the extent that a hospital can document that only some of the physicians at a nonhospital site are training residents, especially where such physicians number fewer than the number of residents rotating to that site, it may want to consider doing so. This would more accurately represent the structure and costs of the training at that site and make it easier to hit the 90 percent threshold.

RESIDENT SALARIES AND FRINGE BENEFITS

The second and simplest of the variables is the cost associated with resident salaries and fringe benefits. Since hospitals usually pay these costs directly (or indirectly by reimbursing another entity, such as a medical school), there should continue to be little problem identifying such costs.

HOURS SPENT BY PHYSICIANS IN GME ACTIVITIES

The third variable is the amount of time that the teaching physician spends in GME (nonpatient care) activities, such as "conferences, practice management, lectures, and administrative activities like resident evaluations," at the nonhospital site in a week. *Id.* at 4826. Both hospitals and teaching physicians have decried the "burdensome time studies" that are needed to document this time under the current CMS policy. *Id.* at 4822. Hospitals that are able to obtain actual information and time studies from teaching physicians are still free to do so. CMS is now proposing, however, "to use a standard of 3 hours per week" as a proxy for the number of hours spent by physicians at nonhospital sites in nonpatient care GME activities. *Id.* at 4826.

To be sure, the use of such a proxy is welcome and will often prove very helpful to hospitals as they establish whether they have satisfied the 90 percent threshold. However, it seems that the three-hour proxy may often be too high. If a hospital is able to document, through time studies or otherwise, that the teaching physicians at a nonhospital site spend less than three hours a week in GME activities, this will obviously make it even easier to prove that the 90 percent threshold has been satisfied through nothing more than payment of the resident salaries and fringe benefits.

HOW LONG THE NONHOSPITAL SITE IS OPEN

The fourth and final variable in this proposed methodology is the number of hours that the nonhospital site is open in a week. Given the three-hour proxy discussed above, this factor seems odd. CMS has decided, however, that since only a percentage of a teaching physician's salary can be attributed to GME activities at the nonhospital site, and that this percentage is necessarily based on the time devoted to such activities, the only way to determine accurately this percentage is by "dividing the standard number of hours spent in nonpatient care GME activities [*i.e.,* 3 hours] by the number of hours the *specific* nonhospital site is open each week." *Id.* at 4827. If residents rotate to a given nonhospital site for only a portion of the year, then this ratio would be further multiplied by the percentage of the year that the FTE residents train at that site.

Again, hospitals always have the option of documenting and paying teaching physician costs using actual salary and time information. CMS is creating this proxy methodology for hospitals that are unable or unwilling to do so. CMS is also seeking comments on alternative proxies that might be more appropriate than the ratio of three hours to the number of hours a nonhospital site is open per week.

AN EXAMPLE

Although the Proposed Rule contains a number of examples, here is one to illustrate how this new policy would work in practice. Assume there is one family practice teaching physician who is supervising one FTE resident in a nonhospital

site for one residency year. Using the physician compensation survey data, the national average salary of a family practice physician is $120,000. As this clinic is open 60 hours per week, the physician supervising time is three hours of the 60 hour week (five percent). The cost associated with the physician's training is five percent of the $120,000 salary ($6,000). This cost is added to the resident's salary and fringe benefits ($60,000) to calculate the total cost of the training at the nonhospital site ($66,000). In order for the hospital to meet the proposed new definition of "all, or substantially all," the hospital would be required to pay at least 90 percent of the costs of the training program at the nonhospital site. In this example, the 90 percent threshold is $59,400. Since the cost of the resident's salary and fringe benefits is $60,000, the hospital reached that threshold simply by incurring the resident's salary and fringe benefits during training at the nonhospital site. In this example, the hospital does not have to provide any compensation to the nonhospital site in order to count the resident FTEs.

THE WRITTEN AGREEMENT

Under this new policy, all written agreements with nonhospital sites should indicate that the hospital will incur at least 90 percent of the total costs associated with resident training at the nonhospital site. If compensation is being made to the nonhospital site, that amount should be set forth (including the value of any in-kind compensation, assuming such compensation is coming directly from the hospital). The written agreement should set forth the calculations supporting that the 90 percent threshold has been met. If no payment is being made to the nonhospital site, as the 90 percent threshold is met through the payment of the residents' salaries and fringe benefits, this fact should be made clear in the agreement.

CONCLUSION

Hospitals will often be able to show that they have satisfied the 90 percent threshold without paying any compensation to the nonhospital site, which makes this proposed policy a welcome development for hospitals. In many respects, it does clarify and streamline the process by which a hospital can support that it has incurred "all, or substantially all" of the costs at a nonhospital site and claim the associated resident FTEs in its GME and IME FTE counts.

In sum, hospitals will be able to meet the 90 percent threshold more easily if they either use the proxies addressed above or if they can support the following: higher resident salaries (and fringe benefits), lower physician salary amounts, longer clinic hours and shorter supervisory time amounts. To the extent that a hospital can document that reality is more favorable than a given proxy figure, it will be easier to show that the 90 percent threshold has been met and, therefore, that the hospital need not provide additional compensation to the nonhospital site.

CMS will be accepting comments on this Proposed Rule until March 26, 2007 (an erroneous comment due date of April 2, 2007, was corrected by a later notice). The Final Rule will be published later this spring.

CONTACT INFORMATION

If you have any questions about this Proposed Rule, would like assistance with the submission of comments, or have other questions regarding the count of FTE residents for IME and GME purposes, please contact:

John R. Jacob ..... 202.887.4582 ..... jjacob@akingump.com ..... Washington, D.C.
Elizabeth H. Goldman ..... 202.887.4423 ..... egoldman@akingump.com ..... Washington, D.C.

Austin Beijing Dallas Dubai Houston London Los Angeles Moscow
New York Philadelphia San Antonio San Francisco Silicon Valley Taipei Washington, D.C.