2018 Year-End Review of Graduate Medical Education Reimbursement

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In 2018, there were a number of important developments that have, will, or could impact Graduate Medical Education (GME) reimbursement requirements. All academic medical centers and teaching hospitals (AMCTH) should be aware of these new developments and should consider their impact in 2019 and beyond. Below is a brief summary of four such GME reimbursement developments including: (1) changes to the Medicare GME affiliation agreement rules; (2) recent case law opening the door to challenging predicate facts through administrative appeals; (3) the potential for increased OIG and CMS scrutiny concerning resident counting accuracy; and (4) changes to teaching physician documentation requirements.

Affiliated Groups – New Urban Teaching Hospitals

As part of the Fiscal Year 2019 Inpatient Prospective Payment System (IPPS) Final Rule, the Centers for Medicare & Medicaid Services (CMS) significantly altered a rule impacting the ability of "new" urban teaching hospitals to loan full-time equivalent (FTEs) slots to other teaching hospitals through Medicare GME affiliation agreements. 83 Fed. Reg. 41144, 41492 (Aug. 17, 2018). The change will have a major impact on urban teaching hospitals that started training allopathic and osteopathic residents after the 1996 base year.

Under 42 C.F.R. §§ 413.75, 413.79(f), and 412.105(f)(1)(vi), CMS allows hospitals that cross-train residents to combine their respective FTE caps in an affiliated group. The result of these Medicare GME affiliated groups is that hospitals can lend their unused FTEs to other hospitals for which FTE counts may exceed their FTE cap limits.

CMS defines an affiliated group as two or more hospitals that have a shared rotational arrangement and are either: (1) in the same or contiguous CBSA; (2) are jointly listed as the sponsor, primary clinical site, or are a major participating institution for one or more ACGME or AOA accredited programs; or (3) are under common ownership. A shared rotation arrangement is defined as a residency training program under which one or more residents participate in training at two or more hospitals in that program. 42 C.F.R. § 413.75. The affiliated group must enter into an affiliation agreement which satisfies numerous requirements set forth at 42 C.F.R. § 413.79(f).

Until very recently, a new urban teaching hospital that built its Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) FTE caps under 42 C.F.R. §§ 405.105(f)(1)(vii) and 413.79(f)(1) was only permitted to be part of a

Medicare GME affiliated group if the adjustment that resulted from the affiliation was an increase to its FTE cap. CMS implemented this policy to prevent gamesmanship whereby through an affiliation, an existing hospital near or over its FTE cap would obtain FTE slots from a new teaching hospital, allowing the existing hospital to work around its FTE cap.

Now, however, for Medicare GME affiliation agreements entered into on or after July 1, 2019, a new urban teaching hospital may loan its FTE slots to another new urban teaching hospital. Also effective July 1, 2019, in what was a shock to the AMCTH community, CMS changed the relevant regulation such that "a new urban teaching hospital can lend FTE cap slots to an existing teaching hospital under a Medicare GME affiliation agreement, effective with the July 1 date (the residency training year) that is at least 5 years after the start of the hospital's cost reporting period that coincides with or follows the start of the sixth program year of the first new program." 42 C.F.R. section 413.79(e)(1)(iv)(B)(2). Thus, starting July 1, 2019, urban teaching hospitals (new and existing) will have much more flexibility to share FTE slots through Medicare GME affiliation agreements.

Kaiser*, Predicate Facts, and *St. Francis

On June 29, 2018, the D.C. Circuit decided an important case concerning whether providers may contest through an appeal (as opposed to a reopening) factual determinations that are relevant to the payment year at issue but that had been made in prior years, (i.e., base year calculations that impact FTE Caps and per resident amounts (PRA)). *See St. Francis Medical Center v. Azar*, No. 17-5098 (D.C. Cir. June 29, 2018). The story of why the *St. Francis* case is important, starts over five years prior in a case brought by this law firm.

In *Kaiser Foundation Hospitals v. Sebelius*, 708 3d. 226 (D.C. Cir. 2013), providers failed to appeal resident counts set out in the hospitals' Notices of Program Reimbursement (NPR) for 1996 (the base year for resident caps) and 1998 (the first year impacted by the FTE cap). The providers argued that they were entitled to more FTEs than they were allowed under their 1996 FTE cap and that their 1999 to 2003 cost reports should be adjusted to reflect that fact, despite the 1996 and 1998 cost years having been closed. The Secretary sought to deny the request and asserted that to allow such a change to the prior determination would basically be an impermissible reopening of the closed period NPRs.

The hospitals argued that the reconsideration of predicate factual issues, which had no effect on the reimbursement for the closed years, did not, in fact, "reopen" those closed cost reports. The D.C. Circuit agreed with the hospitals, explaining that under the reopening regulation, 42 C.F.R. § 405.1885(a), there is a reopening only when there is a change in the total reimbursement determination for that year and that the determination is then subject to a three-year limit on reopening.

There is no secret that CMS was not in agreement with the *Kaiser* decision. In the 2014 Outpatient Prospective Payment System (OPPS) Final Rule, 78 Fed. Reg. 74826, 75162-75166 (Dec. 10, 2013), CMS "clarified" its "longstanding interpretation" that cost reporting periods in which predicate facts are established are also subject to the three-year reopening time limit. As such, predicate facts could not be revisited beyond the three-year period, even if it was to correct a historic error to ensure accurate reimbursement on a going-forward basis. Moreover, this rule was applied to predicate facts in both reopening contexts and appeals to the Provider Reimbursement Review Board (PRRB).

Fast forward to the *St. Francis* case where a number of hospitals argued that prospective payment rates for several appealable cost reporting periods were based on errors embedded in 1981 cost reporting data that was used to calculate standardized amounts in 1983. Specifically, the 1981 cost reporting data used to calculate the standardized amounts in 1983 erroneously characterized transfers of patients from one hospital to another as "patient discharges." This led to an overstatement of the number of discharges and an understatement in the allowable operating costs per discharge, which in turn led to an understatement of the standardized payment amounts in 1983. These understated standardized amounts from 1983 were used to determine Medicare prospective payment rates for every year thereafter, meaning those Medicare payments were also understated.

The PRRB and a federal district court dismissed the hospitals' challenge, on the grounds that CMS's amended reopening rules, which provide that a request to reopen a determination must be received no later than three years after the date of the determination that is the subject of the reopening, prevented the hospitals from challenging factual determinations that

fell outside the 3-year window, even if the hospitals were only challenging the effects of the determination on appealable years. The D.C. Circuit, however, reversed, finding that the reopening regulation applies only to reconsiderations and not to administrative appeals, and remanded the case back to the District Court.

The ultimate result of this jurisdictional decision is that when a hospital has the opportunity to file an appeal of its cost report (or add an issue to an existing appeal), it may appeal "predicate facts." As such, *St. Francis* has opened the door for AMCTHs to potentially receive additional Medicare reimbursement where past erroneous predicate facts, such as errors in GME reimbursement base year calculations for FTEs or PRAs, have been carried forward over time.

Of course, this might not be the end of the story, as CMS might do to *St. Francis*, what it did to *Kaiser*, but for now, AMCTHs should evaluate the status of their cost reports to determine whether any of their "base year" predicate fact determinations are based on erroneous data. If so, they might consider appealing those predicate facts in current and/or future appeals.

OIG Report Concerning Compliance with GME Reimbursement Requirements

The Office of Inspector General of the U.S. Department of Health and Human Services (OIG) issued a report in November 2018 concerning whether CMS ensured that hospitals complied with Medicare GME reimbursement requirements. *See* OIG Report, CMS Did Not Always Ensure Hospitals Complied With Medicare Reimbursement Requirements for Graduate Medical Education (A-02-17-01017), November 2018. The report summarized the findings of eight prior OIG audits covering the periods between 2006 and 2013, which found that hospitals in six Medicare Administrative Contractor (MAC) jurisdictions counted residents (including interns) as more than one FTE and, as a result, received excess Medicare GME reimbursement.

The OIG found that hospitals in the six MAC jurisdictions claimed GME reimbursement for residents who were claimed by more than one hospital for the same period and whose total FTE count exceeded one, totaling almost $4 million in excess Medicare GME reimbursement. The basis for the overstated FTE counts was due to CMS not having adequate procedures in place to ensure that hospitals did not count residents as more than one FTE. For example, CMS did not review resident data to detect whether a resident had overlapping rotational assignments nor did CMS require MACs to perform such a review.

CMS agreed with the OIG and indicated that it has begun implementing a new national database that hospitals will use to collect and report information on residents. As such, AMCTHs should be aware that CMS plans to increase scrutiny on the counting of residents, making accurate counting all the more important now and into the future.

Changes to Teaching Physician Documentation Requirements

New documentation rules for medical students

Effective January 1, 2018, CMS revised the Medicare Claims Processing Manual, Chapter 12, section 100.1.1.B concerning Evaluation and Management (E/M) service documentation provided by medical students. The change allowed teaching physicians to verify in the medical record any student documentation of E/M service components performed by the teaching physicians, whereas before, the physicians had to re-document the record. Although the rule has changed for Medicare, it is important to determine whether the same change was made with regard to each state's Medicaid program (as for example, California has thus far decided against extending the rule to Medi-Cal).

Teaching Physician E/M Documentation Requirements

CMS recently revised certain E/M documentation requirements for teaching physicians in an effort to reduce administrative burdens. *See* 42 C.F.R. §§415.172(b) and 415.174. These changes were made in the Medicare Physician Fee Schedule Final Rule, 83 Fed. Reg. 59452 (Nov. 23, 2018), and are effective for January 1, 2019.

CMS has loosened the reins on how a teaching physician's presence during E/M services can be demonstrated. Specifically, the teaching physician no longer has to document his or her participation in the review and direction of the E/M services furnished, but now the extent of the teaching physician's participation in the review and direction of services furnished may be demonstrated solely from the notes in the medical records made by a physician, medical resident, or nurse.

CMS made these two changes in an effort to reduce administrative hurdles for teaching physicians. AMCTHs should consider incorporating these new rules into their operations to reduce teaching physicians' obligations when performing and documenting E/M services.

The above are some of the most impactful GME reimbursement developments of 2018. Hooper, Lundy & Bookman's Academic Medical Center/Teaching Hospital Working Group provides assistance to academic medical centers and teaching hospitals in all aspects of medical education compliance, including concerning GME reimbursement. For assistance relating to any of the above, please contact David Vernon in Washington, D.C. at 202.580.7713; Amy Joseph in Boston at 617.532.2702; Lloyd Bookman in Los Angeles at 310.551.8111, or your regular Hooper, Lundy & Bookman contact.

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