HINSHAW

Alerts

# Health Care Reform Law Changes Medicare GME for Hospitals and Allows GME Payments for FQHCs and RHCs

**July 19, 2010**
*Health Care Alert*

This is the 12th in a series of health law alerts that Hinshaw & Culbertson LLP will publish on the topic of health care reform.

The Patient Protection and Affordable Care Act of 2010, as amended, (PPACA) significantly changes some Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement rules for hospitals, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).

**Hospital GME and IME Payments**
Under Section 5503 of PPACA, a new residency redistribution program is initiated. The full-time equivalent (FTE) resident counts at most hospitals significantly exceed their FTE caps (since 1998 hospitals have been subject to a cap on the number of FTE residents for which they can be reimbursed for under Medicare). Some hospitals are below their caps. The new redistribution program will reduce the FTE caps for hospitals with FTE resident counts below their existing caps and increase the FTE caps for hospitals with resident counts above their caps.

To determine whether a hospital will incur a cap reduction, the U.S. Secretary of Health and Human Services (Secretary) will look at the FTE count for the three most recent cost-reporting years and assess which one has the highest FTE count. If this highest count is lower than the hospital's FTE cap, the hospital will incur a reduction of 65 percent of the difference between the FTE count and the FTE cap. Certain hospitals, such as rural hospitals with fewer than 250 beds, are exempted from these reductions. The redistribution will be effective for portions of cost-reporting periods occurring on or after July 1, 2011.

The FTE slots lost by some hospitals will be redistributed to qualifying hospitals that submit an application to increase their FTEs. Consideration will be given to, and the Secretary shall take into account, the demonstrated likelihood of the qualifying hospitals' filling the positions made available within the first three cost-reporting periods beginning on or after July 1, 2011. Consideration also will be given to whether the hospital has an accredited rural educational training track.

The FTE slots are to be redistributed based on certain priorities. 70 percent will go to hospitals located in a state with a resident to population ratio in the lowest quartile (as determined by the Secretary). Hospitals located within the top 10 states, territories or District of Columbia, in terms of the ratio of total population living in a health professional shortage area to total population, will receive 30 percent of the slots. Any hospital receiving new residency slots must maintain the level of primary care FTEs for at least five years. No hospital can receive more than 75 residents. During this five-year period, 75 percent of the slots must be used for primary care or general surgery residents.

In addition to the redistribution of resident FTE slots, Section 5504 of PPACA provides that all time spent by residents in a non-provider setting will be counted if the hospital incurs 90 percent of the cost of the stipends and fringe benefits of the resident in the setting. A written agreement will no longer be required. If multiple hospitals incur the costs for the residents in the non-provider setting (directly or through a third party), then a written agreement will be required to document the proportional share of the residents' time allocable to each hospital.

**GME and IME Payments for FQHCs and RHCs**
Section 5508 of PPACA and Part C of Title VII of the Public Health Service Act, as amended by Section 5303 of PPACA, provides that the Secretary may award grants to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs (i.e. family medicine, general dentistry, geriatrics, internal medicine, internal medicine-pediatrics, obstetrics and gynecology, pediatrics, pediatric dentistry and psychiatry). The definition of teaching health centers include FQHCs and RHCs. Grants may not exceed $500,000 and are limited to three years. They must be used to cover the costs of establishing or expanding primary residency training programs, including costs associated with curriculum development, recruitment and training and retention of residents and faculty, accreditation by certain accreditation bodies, and faculty salaries during the development phases. In selecting recipients for grants, the Secretary shall give preference to applications that document an existing agreement with an area health education center program. Grants of more than $35 billion have been authorized by Congress.

PPACA also provides funding of $230 million to make GME and IME payments to teaching health centers, including FQHCs and RHCs, that operate GME programs. The payments will be similar to the GME and IME payments traditionally paid to hospitals, and the Secretary is to compute for each individually qualified teaching health center a per resident amount for direct GME costs. The Secretary is also to determine an appropriate amount for IME costs to be paid to teaching health centers and may provide for interim payments to teaching health centers, based on an estimate by him or her.

**Next Steps for Hospitals, FQHCs and RHCs Regarding Medicare GME and IME Reimbursement Payments**
Hospitals should review their current FTE caps for their specific residency programs. If there are unused slots, they may be redistributed to those facilities in need of residency slots. Further, once the slots are redistributed, there are limited options to increase their number. Hospitals that are located in states with the lowest resident to population ratios and need to increase the number of residency slots should make application to the Secretary. Such entities will be given priority with respect to the redistributed FTE slots. Hospitals that lose FTEs should consider affiliating through agreements with FQHCs and RHCs that will be expanding or starting new primary care residency programs.

FQHCs and RHCs should consider expanding or starting new primary care residency programs. They can qualify for grants and receive Medicare GME and IME payments for these residency programs. The ability of these entities to receive grants and medical education payments directly from Medicare represents a significant reimbursement opportunity under health care reform that should not be overlooked.