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HEALTH LAW NEWS

FEBRUARY 20, 2017

LACK OF WRITTEN AGREEMENT FATAL TO HOSPITAL REIMBURSEMENT FOR MEDICAL RESIDENT OFF-SITE TRAINING; IS YOUR HOSPITAL SHARING RESIDENT COSTS AT NONPROVIDER SITES NOW?

Recently, the U.S. Court of Appeals for the District of Columbia Circuit ruled against two Michigan hospitals, holding that their written agreements regarding their medical residents' off-site training programs failed to comply with the Centers for Medicare & Medicaid Services' ("CMS") requirements for graduate medical education ("GME") reimbursement. While the laws applicable in this case have changed, Section 5504 of the Affordable Care Act ("ACA") modified but continued a written agreement requirement relating to resident costs for nonprovider site training, as discussed below, so continued diligence around non-hospital site training time documentation is prudent.

Background

During the cost reporting period at issue for this Court decision (2000-2004), a hospital was permitted to count time its medical residents spent performing patient care activities in approved residency programs in non-hospital settings toward their full-time equivalent ("FTE") resident counts, provided that it incurred "all, or substantially all, of the costs for the training program in that setting."[1] Additionally, in order to be eligible to count that time toward the FTE count, there must have existed a written agreement between the hospital and non-hospital site indicating: (i) that the hospital would incur residents' salaries and fringe benefits costs while they were training at the nonhospital site; (ii) that the hospital would provide reasonable compensation to the non-hospital site for supervisory teaching activities; and (iii) the compensation the hospital would provide for those supervisory teaching activities.[2] This law was changed by the ACA.

D.C. Circuit Decision

At issue in this case was a "written agreement" requirement. The two hospitals presented a collection of documents asserting compliance with CMS's "written agreement" requirement, but the Court was not persuaded. First, the Court reviewed, and rejected, a 1973 consortium agreement between two hospitals establishing a non-profit organization. The Court held that the 1973 consortium agreement failed to meet the written agreement requirement because the agreement was not between a hospital and a non-hospital site. Further, the agreement's only description of financing ("the parties shall provide [the non-profit] with financing to carry out its purpose as negotiated on a yearly basis") failed to adequately specify that either hospital will incur the cost of the resident's salary, fringe benefits or other required expenses under the regulation.

Second, the Court reviewed affiliation agreements between the hospitals and the non-profit's successor organization. The Court again found these arrangements inadequate for lack of specificity. The affiliation agreements stated that the hospitals would share "joint and equal responsibility for providing [the non-profit] with sufficient financing to carry out its programs as negotiated on a yearly basis." However, this was not the only source of funding for the non-profit. It also received millions of dollars of revenue from other sources, such as revenue from patient care, support from a university and funds from contracts and grants. Thus, the arrangement required the hospitals to equally divide a lump-sum payment to cover any of the non-profit's expenses exceeding what was available from other sources. The Court found that the hospitals were obligated to provide lump-sum payments to finance the non-profit's programs but failed to specify which programs the hospitals were financing or how the funds would be used. Additionally, because the non-profit received millions of dollars of support from other sources, the Court determined "it is impossible to know which source is funding the residency programs."

Lastly, the Court rejected the hospitals' attempt to demonstrate compliance based on their conduct, as evidenced by financial records. Similar to the affiliation agreements, the Court held that the financial records lacked the required specificity. While the records showed total support given to the non-profit from the hospitals along with total expenses from each year, they failed to provide any details regarding how the funds were allocated to the residency programs. Furthermore, the Court noted that the records made no mention of the hospitals' incurring the costs for their resident's salaries and fringe benefits or the compensation the non-profit received for supervisory teaching activities.

A full copy of the court's opinion is available here.

"Written Agreement" Requirements Post ACA

Today, in order for two hospitals to share resident training costs and FTE counts for time spent in a nonprovider setting (here, "non-hospital" and "nonprovider" are largely interchangeable), the ACA and corresponding regulations require that a hospital incur only the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting: the ACA removed the teaching costs requirement. However, when two or more hospitals share the costs of residents in nonprovider settings, each hospital can only count a proportional share of the time that residents train at the nonprovider setting(s) as recorded in a ***written agreement between the hospitals***: "If more than one hospital incurs these costs, either directly or through a third party, the hospitals must count a proportional share of the time that residents train at the nonprovider setting(s) as recorded in a written agreement between the hospitals."[3]

More specifically, the hospitals must also have a reasonable basis for establishing the proportion of the cost and the FTE time that each hospital will incur and count.[4] And even if the hospitals choose to pay the nonprovider site concurrently, the hospitals must still record the proportion of the cost and FTE time they are incurring and counting in a written agreement between the hospitals.[5] If the hospitals have also executed a written agreement with the non-hospital site, that agreement should also describe the proportion of payment and FTE time allotted between the hospitals, but the written agreements with the nonprovider sites are no substitute for the requirement that there also be a written agreement between the hospitals.[6]

Other recordkeeping requirements include: 1) actual payment of required costs; and 2) detailed information about rotation schedules. Hospitals should also ensure compliance with these requirements and maintain documentation to support compliance.

Practical Takeaways

The D.C. Circuit's decision makes it clear that CMS continues to focus on written agreement requirements to support GME reimbursement payments. Accordingly, hospitals should carefully review their current medical resident off-site training arrangements and consider restructuring, if necessary, to clearly document how the hospital is incurring the costs of resident salary and fringe benefits. Additionally, hospitals should maintain documentation of rotation records to demonstrate the claimed FTE resident count for time spent at non-hospital/nonprovider sites. Finally, if two or more hospitals participate in a GME consortium or otherwise potentially share resident costs at the same non-hospital site, there should be a written agreement directly between the hospitals that clearly provides a reasonable basis for the allotment of FTEs and the specifics of the costs.

If you have questions or would like additional information about this topic, please contact:

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[1] 42 U.S.C. § 1395ww(d)(5)(B)(iv)(I).

[2] 42 C.F.R. § 413.86(f)(4) (2000); see also 42 C.F.R. § 413.78(d) (2014).

[3] 42 C.F.R. § 413.78(g)(2).

[4] 42 C.F.R. § 413.78(g)(2)(i).

[5] 42 C.F.R. § 413.78(g)(2)(iii)

[6] 42 C.F.R. § 413.78(g)(2)(ii).