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Medicare Program: Payments to Hospitals for Graduate Medical Education Costs

Counting Resident Time in Nonprovider Settings (Section 5504)
Following the statute, CMS redefines "all or substantially all" the costs for the training program in the nonhospital setting to mean resident salaries and fringe benefits, effective July 1, 2010. CMS will require that a hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting in order to count the time spent by those residents for both DME and IME purposes.

Hospitals will now be able to proportionally share the costs of resident training at nonhospital sites for both DME and IME purposes. Hospitals must use some reasonable basis for establishing the proportion. CMS suggests one reasonable basis could be that each hospital counts the number of FTEs for which it incurs the salary and benefit costs. Hospitals must also be able to document the amount that they are paying collectively, and this amount must equal or be at least the sum of all salary and fringe benefits of the residents for the time spent training in that site. (Salaries would vary depending on program year of the residents and specialty.)

Written agreements that only specify a lump sum payment with no break out of the residents' salaries do not provide enough information; CMS will require that hospitals determine prior to the start of nonhospital rotations (with allowance for modification by June 30 of that academic year) the total cost of salaries and fringe benefits for the proportion of the year spent in each nonhospital site. CMS states that it would be very easy to document that the hospital continues to pay salary and benefits when they rotate to nonhospital sites.

CMS further mandates that hospitals record the proportion of the FTE resident time spent training in the nonhospital site that will be counted by each hospital for purposes of DGME and IME payment, as well as the reasonable basis for the proportion, in a written agreement between the hospitals.

Since hospitals do not have to have a written agreement with the nonhospital site, but may pay concurrently, the hospital must still agree in writing to the proportion of the costs and training time they plan to incur and count, in addition to the basis for that proportion.

Proposed Changes to regulations regarding recordkeeping and Comparison to a Base Year (Section 5504(a) of ACA)
Effective July 1, 2010, hospitals must maintain records of the amount of time their residents spend in nonprovider or nonhospital settings, and to compare that time to the time spent by their residents in nonprovider sites in a base year "as the Secretary may specify." (The purpose of this is to be able to assess whether training in nonprovider settings will increase with the removal of many regulatory barriers.) To meet that requirement:

- Cost reports will be modified to include lines for this required data.
- Rotation schedules will be used to establish the time residents spend in nonhospital sites.
- Base year will be cost reporting period beginning July 1, 2009 to June 30, 2010.
- Hospitals only need to maintain records of the total unweighted direct GME FTE count (*Note: this is before the application of resident limits (caps.)*)
- Program specific counts will be required for primary care programs. For nonprimary care programs hospitals will only need to supply overall hospital numbers.

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Counting Resident Time for Didactic and Scholarly Activities and Other Activities (Section 5505 of ACA)

The reopening of settled cost reports is prohibited. As seen earlier, only those hospitals with "pending, jurisdictionally proper appeals on direct GME or IME payments" would be allowed. The appeal must be parallel, and appeal on direct GME would not allow a change to IME FTE counts, and vice or versa. Below is a chart of changes now allowed to be counted for DGME and IME purposes. For the nonhospital setting the requirement for counting resident time is that the setting must be "primarily engaged in furnishing patient care." See definition section below.

	DGME	**IME**
IN Hospital	Didactic *Research* Leave	Didactic (Jan 1, 1983+) Leave
Non Hospital site (that is primarily engaged in furnishing patient care)	Didactic (July 1, 2009+) Leave	Leave ***NO Didactic***

Definition of Nonprovider Setting That is Primarily Engaged in Furnishing Patient Care"

The statute says that in order for didactic activities to be counted for IME and DME purposes in the nonhospital setting, the setting must be "a nonprovider setting which the primary activity is the care and treatment of particular patients, as defined by the Secretary." CMS has been very clear about their definition of patient care activities in the past. This rule doesn't really change anything. It clarifies that examples of settings that would meet the definition are doctors' offices and community health clinics. Settings that would not meet the definition are those with a main mission other than patient care. It includes examples of such settings that would NOT meet the patient-care criteria as medical or dental schools, or hotels or convention centers. However, dental or medical clinics furnishing patient care that may be located on a dental or medical school campus would qualify. Previous provisions in regulation relating to documentation of one full day of such time no longer apply.

Distinguishing Between Allowed Nonpatient Care Activities and Nonallowable Research Time

Research time that is not associated with the treatment or diagnosis of a particular patient is specifically excluded from the list of allowable nonpatient care activities in the ACA. The regulation just describes such research as "usually comprises activities that are focused on developing new medical treatments, evaluating medical treatments for efficacy or safety, or elaborating upon knowledge that will contribute to the development and evaluation of new medical treatments in the future. (*Note: CAFM asked for clarification by CMS of some specific examples, but the final rule did not include further explanation*)

Approved Leaves of Absence

Each hospital must count the proportion of leave of absence time. For more than one hospital, the hospital to which the resident is assigned during the time the vacation is taken is the hospital that counts that FTE time for DGME and IME. If it is not clear the hospitals would divide and count the time proportionally. "Other" approved leave could include jury duty or voting leave, but not any leave that would prolong the total time the resident is participating in the approved training program.

Reductions and Increases to Hospitals' FTE Resident Caps for GME Payment Purposes

The proposed rule does three things related to this section of law. It proposes 1) procedures for determining which hospitals are subject to a reduction in their cap, and by how much; 2) specifies an application process for hospitals that wish to obtain an increase to their caps, and 3) outlines specific criteria CMS will use to determine which hospitals will receive increases in their caps.

In general, effective July1, 2011, a hospital's FTE resident cap will be reduced by 65% if it's "reference resident level" (loosely meaning the highest resident FTE count) is less than its "otherwise applicable resident

limit," meaning its cap. Rural hospitals with fewer than 250 acute care beds are exempt as well as hospitals that participated in a voluntary reduction or demonstration projects (more on this later.)

With respect to increasing caps, the aggregate number of new positions must not exceed the estimated aggregate reduction. In addition, a single hospital can increase its cap by no more than 75 additional FTEs (DGME and IME, each.) CMS must take into account the demonstrated likelihood of a hospital filling the new positions and whether the hospital has an accredited rural track program; it must distribute 70 % to hospitals located in States with resident-to-population ratios in the lowest quartile; distribute 30% to hospitals located in states (or territories or DC) that are among the top 10 such entities with a ratio of population living in Health Professional Shortage Areas (HPSAs) to total population.

Reduction of Hospitals' FTE Resident Caps Under the Provisions of Section 5503 of the ACA
The "reference resident level" is defined as the number of unweighted allopathic and osteopathic FTE resident count in a given cost reporting period. "Otherwise applicable resident limit" is defined as the cap that was determined based on previous statutes. In general, effective July 1, 2011, a hospital's FTE resident cap will be reduced by 65% if it's "reference resident level" is less than its "otherwise applicable resident limit." This applies to both DME and IME FTE numbers. As mentioned above, the aggregate number of positions that will be reduced is an estimated number. CMS proposes to have those figures from their intermediaries by May 16, 2011. If after May 16, 2011 the estimated number varies from the actual, the actual number will be used to reduce a cap on a specific hospital, but the estimated number will still be used to determine the aggregate number to be redistributed. In addition, the final determination of any possible reduction to the cap is not subject to appeal. The only relief proposed by CMS is that all cap determinations made through audits after July 1, 2011 through December 2011 will apply retroactively to July 1, 2011.

Exemption From FTE Resident Cap Reduction for Certain Rural Hospitals
Certain rural hospitals are exempt from this reduction. Rural has previously been defined as outside of Metropolitian Statistical Areas (non-MSA) and a few other non-urban areas in New England that are defined differently. MSA is now no longer is use and has been replaced by Core-Based Statistical Area (CBSA.) The number of beds will be determined by using the hospitals' most recent cost reporting period ending on or before March 23, 2010.

Other exempt entities are hospitals that participated (not necessarily completed) a voluntary residency reduction plan approved by CMS, as well as the New York Medicare GME Demonstration and the Utah Medicare GME Demonstration. They will need to file their plans specifying how they would fill their unused slots in the next two years to CMS by January 21, 2011, in order to be exempt from a cap reduction. CMS will also allow hospitals that participated in the NY demonstration, the Utah demonstration, or a voluntary reduction plan demonstrate that they are filling unused slots by March 23, 2012 by showing that a resident has matched into a program by that date and will begin training by July 1, 2012.

Determining the Possible Reduction to a Hospital's FTE Resident Cap
Determinations of cap levels are separate for DME and IME. A hospital might have its cap reduced for one, but not the other. CMS will use the last three cost reporting periods submitted prior to March 23, 2010 to determine possible reductions: July 1, 2006 to June 30, 2007, July 1, 2007 to June 30, 2008, and July 1, 2008 to July 1, 2009. If, in each of those years the resident reference level is at or above the cap, there would be no reduction. If, in each of those years, the resident reference level falls below the cap, the year with the highest reference level will be used. Again, these determinations would be made separately for DME and IME. If a cost report has been submitted, but not yet settled, the Medicare contractor may conduct a desk or onsite audit. Teaching hospitals that 1) do not yet have a cap established under Medicare because they are in the middle of their 3 year cap building period or, 2) new teaching hospitals that has submitted cost reports but do not yet have a cap applied in all three cost reporting years, would be exempt from a cap reduction.

Medicare GME Affiliation Agreements
In contrast to the previous statutory language for redistribution, included in the Medicare Modernization Act (MMA), also known as Section 422, this statute did not include any language regarding treating the reference levels and caps of hospitals involved in affiliation agreements as one unit. Instead, CMS mandates that the contractor would look at each hospital's reference level in relation to its cap -- as adjusted by its affiliation agreement, and make a determination on a hospital by hospital basis, rather than as a group. The hospital that is transferring some of its FTE cap would not be penalized if the hospital to which it temporarily transferred some of its FTE cap slots is training below its adjusted cap during its reference cost reporting period. (*Note: there is new statutory language to remedy this lack. It has passed the Senate, but is awaiting action in the House. Should it pass in time for implementation of this section, one would assume it would be incorporated into these rules.*)

Additional exceptions for irregular situations:
Exceptions exist for certain hospitals that don't fit the general mold, and how CMS would handle them. For example, for hospitals that have merged, CMS would combine the reference levels and caps for each of the three years listed above, to determine whether they should be reduced. If they hadn't merged prior to the three years of cost reporting periods, CMS would handle each hospital separately. Other instances include hospitals that file Low Utilization Medicare cost reports, some with Medicare caps in place, others without. In addition, hospitals whose caps were reduced or increased due to Section 422 of the MMA will also be treated differently.

Criteria for Determining Hospitals That Will Receive Increases in Their FTE Resident Caps
Because the statute requires the hospital to show a "demonstrated likelihood" that they can fill new slots, CMS proposes to use that as an eligibility criterion. A hospital must meet that test before they would be considered further for an increase in its cap. There is an application process with a form included in the proposed rule. The forms are due to CMS by January 21, 2011. However, if the hospital is informed it is being audited for reductions, the hospital has until March 1, 2011 to submit an application. The hospital must include the total number of positions requested (up to 75 each for DME and IME.) Other documents are required, including an attestation document.

The hospital must meet at least one of two criteria, along with many sub-criteria and documentation requirements. The hospital must submit an application for each program it intends to request positions for as the applications are program specific. Once granted however, they would no longer be program specific (this is similar to the Sec. 422 process.)

Demonstrated Likelihood of Filling – Criterion 1
Hospital is already exceeding its cap or doesn't have sufficient room under its cap to start a new residency program by July 1, 2011. The hospital must begin training residents at any point within the first three cost reporting periods beginning on or after July 1, 2011.
A. Hospital doesn't have room under its current cap for a new residency scheduled to be established on or after July 1, 2011. Hospital would select one of the following:

- Application must be submitted to accrediting body by January 21, 2011 (must attach copy)
- Hospital has submitted an institutional review document or PIF concerning the new program in an application for approval by January 21, 2011 (must attach copy)
- Hospital has written correspondence from accrediting body acknowledging receipt of the application or other correspondences (eg. notification of site visit.) (must attach copy)
- Hospital is training residents in excess of either of its caps or both (GME, IME) It must submit copy of its most recent Medicare cost report by January 21, 2011.

B. Hospital will likely fill the slots requested (select one of the following, if applicable)

- Not sufficient room under its FTE cap, or is exceeding its cap, and existing programs have a combined fill rate of at least 85% in each of program years 2007-2009 (show documentation)
- Not sufficient room under its cap, or is exceeding its cap, and the specialty program for which the hospital is applying has a fill rate either nationally, within the State, or within the CBSA of at least 85% (attach documentation)
- Hospital is training residents in excess of either of its caps or both (GME, IME) It must submit copy of its most recent Medicare cost report by January 21, 2011.

Demonstrated Likelihood of Filling – Criterion 2
Hospital doesn't have room under its cap and the hospital intends to expand an existing residency program.
A. Hospital intends to expand an existing program. Hospital must check at least one of the following:

- Not sufficient room under its cap and appropriate accrediting body has approved the hospital's expansion of the number of FTE residents in the program
- Not sufficient room under its cap and AOA match program has accepted or will be accepting the hospital's participation in the match for the new slots (documentation needed)
- Not sufficient room under its cap and hospital has submitted an institutional review document or PIF for the expansion by December 1, 2010 (documentation needed)
- Hospital may submit documentation demonstrating that it has made a commitment to start a new program. One example of such a commitment would be for the hospital to provide the minutes from

the meeting at which the hospital's GME committee gave approval for the hospital to proceed with the process of applying to the accrediting agency for approval to start a new program.

B. Hospital will likely fill the slots of the expanded existing residency program. Hospital must select at least one of the following:
   - Not sufficient room under its cap and hospital has other previously established programs, with a fill rate of at least 85% in each of years 2007-2009 (documentation needed.)
   - Not sufficient room under its cap and the specialty program for which the hospital is applying has a fill rate either nationally, within the State, or within the CBSA of at least 85% (attach documentation)
   - Hospital is training residents in excess of either of its caps or both (GME, IME) It must submit copy of its most recent Medicare cost report by January 21, 2011.

Geriatrics program will be given special consideration in meeting fill rates. They will be able to use the fill rates for FM or GIM rather than geriatrics alone.

CMS Evaluation of Applications for Increases in FTE Resident Caps

Once a hospital meets the demonstrated likelihood criteria, CMS needs to prioritize applications.

1. CMS is giving preference to urban hospitals that have an accredited rural training track, based on the statutory language, over hospitals without rural training tracks.
2. Whether a hospital is located in a state with a resident-to-population ration in the lowest quartile. For the numerator CMS will add the number of residents included in the ACGME table, "Number of Residents in Core and Subspecialty Programs, by State" to the number of residents provided by AOA to CMS. For 2008-2009, the combined number is 114,416. They are counting actual residents for this measure, not FTEs. CMS will use census data for the state population number (the denominator). A table is included in the proposed rule with the following states listed in ranked order in the lowest quartile: Montana, Idaho, Alaska, Wyoming, Nevada, South Dakota, North Dakota, Mississippi, Florida, Puerto Rico, Indiana, Arizona, and Georgia. Hospitals in these states would have preference over hospitals in other states, with those ranked lower having preference over those ranked higher in the quartile.
3. Whether a hospital is located in a state, territory, etc. that is in the top 10 with a ratio of residents living in HPSAs. CMS proposes to use only primary care HPSAs to include in the numerator. They are using similar census data for total population figures to that above. The top 10 states are: Louisiana, Mississippi, Puerto Rico, New Mexico, South Dakota, DC, Montana, North Dakota, Wyoming and Alabama, with the states with those ranked higher in the top 10 (eg. Louisiana) having preference over those lower in the list.
4. Whether a hospital is located in a rural area. Any hospital that is not in an MSA will be considered rural, even though CMS no longer uses that definition.

Using the above preference categories, CMS describes a priority ranking order as follows:

1. *First Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND it is an urban hospital that has, or will have as of July 1, 2011, a rural training track.
2. *Second Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile.
3. *Third Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND the hospital is an urban hospital that has, or will have as of July 1, 2011, a rural training track.
4. *Fourth Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, OR the hospital is located in a rural area.

Priority Level Categories 1 and 2 are for distributing slots in the 70-percent pool, and Priority Level Categories 3 and 4 are for distributing slots in the 30-percent pool. For a hospital that is located in a State that falls into both priority categories, its application would be evaluated first based on its Evaluation Criteria within the context of the First and Second Level Priority Categories. If there are not enough slots left in the 70-percent pool to satisfy the hospital's request, the hospital will receive the remainder of its otherwise deserved slots from the 30-percent pool, based on its Evaluation Criteria within the context of the Third and Fourth Level Priority Categories. In distributing the slots from both the 70-percent and the 30-percent pools, CMS will ensure that a hospital that falls into both priority categories should not be at a greater disadvantage than a hospital that only is in a State that is in the lowest quartile for resident-to-population ratios.

In a situation where the remaining slots are not enough to be distributed to the next set of ranked hospitals, (based on the Evaluation Criteria below) CMS will prorate the remaining amount of slots in the "70-percent pool", and distribute an equal share of slots to these hospitals of equal rank. If a similar situation occurs within

the “30-percent pool”, we also proposed to prorate the remaining amount of slots in the “30-percent pool”, and distribute an equal share of slots to hospitals of equal rank.

No slots will be given to hospitals that do not fit one of these categories.

CMS Evaluation of Application for Increases in FTE Resident Caps – Evaluation Criteria
CMS anticipates a smaller number of positions will be available than were for Section 422, and are making the evaluation criteria more rigorous and competitive to help separate out the applications. They are giving points to different criteria – similar to HRSA giving priority points for certain items in an application. Then the scores will be added up. The Eight Evaluation Criteria are as follows:

1. The hospital requesting an increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent. (5 points.)
2. The hospital will use additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program. (5 points)
3. The hospital will use additional slots to establish a new or expand an existing primary care program with a demonstrated focus on training residents to pursue careers in primary care, rather than in non-primary subspecialties of those primary care programs (for example, the hospital has an internal medicine program with a designated primary care track). (3 points) *(Note: the hospital must demonstrate an outcome of primary care production of over 50%)*
4. The hospital will use all the additional slots to establish a new or expand an existing primary care residency program or general surgery program. (5 points)
5. The hospital is located in a Primary Care HPSA. (2 points)
6. The hospital is in a rural area (non-MSA) and is (or will be on or after July 1, 2011), a training site for a rural track residency program, but is unable to count all of the FTE residents training in the rural track because the rural hospital’s FTE cap is lower than its unweighted count of residents from cost reports on or after July 1, 2011. (1 point)
7. The hospital is requesting slots to expand an existing program(s) for which the hospital can demonstrate that more than 50 percent of residents completing the program(s) go on to practice in a rural area or a Primary Care HPSA or a Medically Underserved Area (MUA) (1 point)
8. The hospital is requesting slots to expand an existing emergency medicine program in which the residents train in Primary Care HPSAs. (1 point)

Miscellaneous conforming provisions:
- Hospital applicants that win new slots cannot use these slots as part of the aggregate cap in a GME affiliation agreement, until July 1, 2016
- Hospital applicants that win new slots will include those new residents in the three year rolling average calculation and the cap on IME resident-to-bed ratio.
- Rural hospitals may already establish new residency programs; if one wishes to expand an existing program and doesn’t have enough positions under its cap, it may apply under this section.
- Hospitals that are not teaching hospitals may not apply under this section as they can apply for a permanent cap set based on establishing new programs. However, urban non-teaching hospitals that becomes a site for rotating residents it may apply for additional slots under this section and it would not be pre-empted from later getting a new cap adjustment for starting a new program
- If a hospital closes on or after enactment date, its positions will be redistributed under a separate program, not this section.

Requirements for Hospitals That Receive Additional Slots Under Section 5503
Hospitals are required to maintain its current number of primary care residents for at least five years after receiving new positions. Not less than 75% of the new positions must be in primary care or general surgery. Primary care specialties are defined as: family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. Hospitals would be required to submit data form the 3 most recent cost reporting periods on the number of unweighted FTE residents in primary care programs. Hospitals are required to report totals, not by specialty. Hospitals should use their rotation schedules to compute those numbers and show documentation. Medicare contractors will check through normal audits and provide remedies should a hospital not be in compliance. Hospitals must separately ensure that at least 75% of the increased FTE cap slots are in primary care or general surgery. Hospitals must show for each of the five years that they are in compliance, but a review of more than one year would allow some leeway – they won’t necessarily lose their positions if they are not in compliance during one year.

Preservation of Resident Cap Positions From Closed Hospitals (Section 5506)
Medicare contractors will inform CMS of hospitals that have closed since March 23, 2010, and prior to Aug 3, 2010, and will include the number of IME and DME FTE cap positions available to be redistributed. A hospital is considered closed if/when it terminates its Medicare provider agreement. Hospitals that are acquired would give up their FTE positions as CMS considers the Medicare provider agreement would be retired, however it could apply for those positions under this section.

FTE positions would be distributed in the following priority order:

1. Hospitals located in the same CBSA or in a CBSA contiguous to the hospital that closed.
2. Hospitals located in the same state
3. Hospitals located in the same region.
4. If the slots haven't been fully distributed, CMS would then apply the section 5503 criteria.

Applications should be received by April 1, 2011. For future teaching hospital closures, there would be four months for applications to be sent in following notification to the public that positions are available. Applicants must provide documentation to demonstrate the likelihood of filling new slots within three years. Unlike the previous section, only brand new hospitals that take over a program will have to include the new residents in the three year rolling average calculation and the cap on IME resident-to-bed ratio and they cannot use these slots as part of the aggregate cap in a GME affiliation agreement.

Ranking criteria are different from section 5503. All new positions would be distributed to the first category before going to the second category, and the same for the third category.

Ranking Criterion One
The applying hospital is requesting the increase in its FTE resident caps because it is assuming an entire program(s) (at least 90% of the FTEs) from the hospital that closed and the hospital is continuing to operate the programs with the same residents.
Ranking Criterion Two
The applying hospital was listed as a participant of a Medicare GME affiliated group, and it received slots from the hospital that closed and will use them to continue to train that number of residents.
Ranking Criterion Three
The applying hospital took in residents displaced by the closure of the hospital, but is not assuming the entire program.

The following four ranking criteria would apply only if there are there are left over FTE slots.
- Ranking Criterion Four: Applicant hospital does not fit into Ranking Criteria One, Two, or Three, and will use additional slots to establish a new or expand an existing geriatrics residency program.
- Ranking Criterion Five: Applicant hospital does not meet Ranking Criterion One, Two, or Three, is located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program.
- Ranking Criterion Six: Applicant hospital does not meet Ranking Criterion One, Two, or Three, is not located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program.
- Ranking Criterion Seven: Applicant hospital seeks the slots for purposes that do not fit into any of the above ranking criteria.