American Hospital Association

# Regulatory Advisory

**July 29, 2010**

# GME Provisions in the OPPS/ASC Proposed Rule for CY 2011

## At a Glance

### The Issue:

On July 2, the Centers for Medicare & Medicaid Services (CMS) released the outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) proposed rule for calendar year (CY) 2011. This rule also implements provisions enacted by the *Patient Protection and Affordable Care Act* (PPACA), including several inpatient policies related to Medicare direct graduate medical education (DGME) and indirect medical education (IME). These provisions would:

- Redistribute 65 percent of unused residency positions for cost reporting periods beginning on or after July 1, 2011;
- Eliminate the requirement for hospitals to incur "all or substantially all" of the costs for training residents in a non-hospital setting;
- Modify the way the agency counts resident training time for didactic, scholarly and other activities, and allow payment for time spent by residents on approved leave;
- Redistribute residency cap positions from teaching hospitals that closed on or after March 23, 2008 to other area hospitals.

A separate *AHA Regulatory Advisory* summarizing the remaining provisions in the OPPS/ASC rule was distributed on July 28, and is available at www.aha.org under "What's New."

### Our Take:

The AHA is generally supportive of the changes being made to GME funding. The changes should encourage increased training of primary care physicians and general surgeons, potentially decrease hospital costs in providing this training in non-hospital settings, and provide increased flexibility in DGME and IME funding.

### What You Can Do:

- ✓ Share this advisory with your chief financial officer, residency program directors and other key physician leaders.
- ✓ Assess whether your hospital qualifies for additional Medicare-funded GME residency positions, and submit an application by the December 1, 2010 deadline.
- ✓ Consider submitting comments to CMS with concerns about the proposed rule by August 31, 2010.

### Further Questions:

Please contact Ashley Thompson, AHA director of policy, at (202) 626-2688 athompson@aha.org.

*AHA's Regulatory Advisories are produced whenever there are significant regulatory developments that affect the job you do in your community. A 14-page, in-depth examination of this issue follows.*

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# GME PROVISIONS IN THE OPPS/ASC PROPOSED RULE FOR CY 2011

## BACKGROUND

Only July 2, the Centers for Medicare & Medicaid Services (CMS) released the outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) proposed rule for calendar year (CY) 2011. The rule contains policies related to Medicare direct graduate medical education (DGME) and indirect medical education (IME), as enacted by the *Patient Protection and Affordable Care Act* of 2010 (PPACA). The proposed rule is available at http://www.ofr.gov/OFRUpload/OFRData/2010-16448_PI.pdf. It will be published in the August 3 *Federal Register*.

Comments on the proposals are due to CMS by August 31. A final rule will be published by November 1. While the final rule will take effect January 1, 2011, the majority of proposals related to graduate medical education (GME) will be implemented for cost reporting periods beginning on or after July 1, 2011.

## AT ISSUE

### *Redistribution of Unused Residency Positions (Sec. 5503)*

**Background**

Medicare makes both DGME and IME payments to hospitals that train residents in approved medical residency training programs. In general, the more full time equivalent (FTE) residents a hospital is allowed to count, the greater amount of Medicare DGME and IME payments the hospitals will receive. With limited exceptions, the *Balanced Budget Act of 1997* (BBA) capped the number of residents that Medicare will recognize for DGME and IME payment at the teaching hospital's 1996 level. Dental and podiatric residents are not included in this cap. In 2005, as required by Section 422 of the *Medicare Modernization Act* (MMA) of 2003, CMS redistributed residency positions that were "unused" by certain hospitals to other qualifying hospitals. Section 5503 of the PPACA mandates another redistribution of unused residency positions, this time to encourage increased training of primary care physicians and general surgeons.

Specifically the PPACA dictates that:

- ✓ For cost-reporting periods beginning on or after July 1, 2011, a hospital's FTE resident cap will be reduced by 65 percent of the difference between its "otherwise applicable resident limit" and its "reference resident level," based on the three most recent cost-reporting periods ending March 23, 2010.

  Qualifying hospitals may receive up to 75 additional residency positions for DGME and up to 75 additional slots for IME for portions of cost reporting periods occurring on or after July 1 2011.

- ✓ Certain hospitals, including rural teaching hospitals with fewer than 250 beds, and hospitals participating in "a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90-248" are exempt from redistribution of any of the unused positions.

- ✓ CMS must take into account the "demonstrated likelihood" that a hospital will fill the new positions within the first three cost-reporting periods beginning on or after July 1, 2011, and whether the hospital has an accredited rural training track program.

- ✓ Priority for distribution of the new positions is such that:

  - o 70 percent of positions will be allocated to hospital in states with resident-to-population ratios in the lowest quartile; and
  - o 30 percent of positions will be allocated to hospitals located in rural areas, and hospitals located in the top 10 states, territories, or Districts in terms of the ratio of population living in a health professional shortage area (HPSA) relative to the general population, as of March 23, 2010.

- ✓ For five years, hospitals receiving additional positions are required to maintain at least their current level of primary care residents in their training programs averaged over the three most recent years.

- ✓ That at least 75 percent of the increased positions be designated for primary care or general surgery (as determined by the HHS Secretary).

- ✓ The redistributed positions receive DGME and IME payments in the same manner and at the same level as for existing GME positions.

The agency proposes to revise the regulations to confirm to these new statutory requirements and to determine whether, and by what amount, a hospital's FTE resident cap is subject to a reduction. CMS also proposes specific criteria it will use in determining which hospitals receive the reallocated positions.

**Criteria for Resident Cap Reductions**

CMS is proposing to define a hospital's "reference resident level" as the number of unweighted allopathic and osteopathic FTE residents who are training at a hospital for a specific period and a hospital's "otherwise applicable resident limit" as the hospital's 1996 cap during its reference year.

As mandated by law, rural hospitals with fewer than 250 beds are excluded. In addition, CMS proposes that hospitals that participated in the National Voluntary Residency Reduction Plan (VRRP), the New York Medicare GME Demonstration, and the Utah Medicare GME Demonstration be excluded if they have a specific plan in place for filling unused positions by no later than March 23, 2012 and submit this plan to CMS by December 1, 2010. CMS also proposes to exclude certain hospitals that have low Medicare utilization, such as children's hospitals, under certain circumstances. Finally, CMS proposes to exclude hospitals that received increases to their caps under Section 422 of the MMA who may still be "building" their residency programs.

In determining the number of resident slots available for redistribution, CMS proposes to estimate the total number of resident slots, by hospital, that would be reduced by May 1, 2011. CMS indicates that it will provide hospitals with a time-limited opportunity to review their cap reductions before they are finalized so that hospitals may identify any technical errors. CMS recognizes that some hospitals have cost reports that are under appeal. The agency proposes not to wait for appeals to be resolved before making a final determination as to whether and by how much a hospitals' resident cap would be reduced. Rather, CMS proposes to require Medicare contractors to use the latest cost report or audited data to make their determination.

To determine whether a hospital would be subject to a DGME or IME cap reduction, CMS will first determine whether a hospital is training at or above its cap in *all* three of its most recent cost-reporting periods ending before March 23, 2010. If this is the case, the hospital will be exempt from a cap reduction. If the hospital is not training above its cap in *all* three reporting periods, CMS use the cost-reporting period with the highest FTE resident count as the "reference resident level" and reduce the hospital's resident cap by 65 percent of the difference between this level and the otherwise applicable resident limit.

In the example below, Hospital A's DGME cap would not be reduced because it is training at or above its cap in all three cost reporting periods. However, its IME cap would be reduced, based on 65 percent of the difference between 17 (its "reference resident level," or the highest level for the most recent three periods) and 18 (its "otherwise applicable resident limit for that year), or [(18-17)*0.65] =0.65.

| Cost Reporting Period | IME Unweighted FTE Count | IME FTE Cap | DGME Unweighted FTE Count | DGME FTE Cap |
|---|---|---|---|---|
| July 1, 2006-June 20, 2007 | 17 | 18 | 20 | 20 |
| July 1, 2007-June 20, 2008 | 16 | 20 | 21 | 20 |
| July 1, 2008-June 20, 2009 | 14 | 20 | 20 | 20 |

CMS indicates that this reduction will also apply to hospitals in Medicare GME affiliation agreements if they have resident levels below their resident caps. The agency states that it must do so because the law defines "reference resident level" and "otherwise applicable resident limit" with respect to "a hospital." Thus, in contrast to Section 422 of the MMA, CMS proposes that a hospital's individual resident cap would be reduced if it fails to meet the above criteria even if the Medicare GME affiliated group as a whole is training a number of residents above the group's aggregate resident cap. The AHA believes that this was not Congress' intent and has been working with Congress on a technical fix to the reform bill to mitigate this issue.

**Criteria for Resident Cap Increases**

CMS proposes a detailed application process for hospitals to receive the reallocated residency positions (see Attachment A – Draft CMS Evaluation Form – Application for the Increase in a Hospital's FTE Cap(s) under Section 5503 of the Affordable Care Act). Hospitals must submit a separate application for each residency program, although the application can request increases in IME positions or increases in DGME positions or increases in both. **Applications are due to both the CMS Central Office and the hospital's CMS Regional Office by December 1, 2010** (for certain hospitals undergoing a GME FTE audit, the application deadline is March 1, 2011)**.**

The application includes a number of requested items, including (but not limited to):

- Name and provider number of the hospital;
- Total number of FTE resident slots for DGME or IME, or both;
- A completed copy of the CMS evaluation form;
- Worksheet E, Part A, E-3 of the hospital cost report; and
- An attestation signed by an officer or administrator of the hospital certifying that the information submitted is correct.

*Demonstrated Likelihood*. CMS also proposes a lengthy process for identifying which hospitals would be eligible for the new slots and in what priority order. First, CMS proposes that hospitals must demonstrate that they will likely be able to fill the slots within the first three cost-reporting periods beginning on or after July 1, 2011 by:

- Showing that the hospital does not have sufficient room under its current FTE caps to expand an *existing* residency program;
- Showing that it does not have sufficient room under its current FTE caps to accommodate a planned *new* program; or
- Documenting that the hospital is already training a number of FTE residents at or in excess of its current FTE caps.

To meet the demonstrated likelihood criterion for expanding an existing program or planning an new program, hospitals will need to demonstrate that either the hospital's existing residency programs had a resident fill rate of at least 85 percent, or that the specialty program for which the hospital is applying has a resident fill rate either

nationally, within the state or within the Core Base Statistical Area (CBSA) in which the hospital is located, of at least 85 percent.

*Priority Categories*. Second, CMS proposes to combine the categories set in statute to prioritize the allocation of the available new slots. As mandated by Congress, preference for the available new slots must go to hospitals in a state whose resident-to-population ratio is within the lowest quartile. CMS proposes to use three sources of data to identify these states: ACGME's Data Resource Book for the Academic Year 2008-2009, AOA's Journal of the American Osteopathic Association for the 2008-2009 Academic Year, and data from the Census Bureau's 2000 Census. The following table lists each state, and is sorted by resident-to-population ratio from lowest to highest. The first 13 states are those in the lowest quartile: MT, ID, AK, WY, NV, SD, ND, MS, FL, PR, IN, AZ and GA.

| State Name | Census data as of July 1, 2009 | ACGME resident data 2008-2009 | AOA resident data 2008-2009 | Total resident data | Resident to population ratio |
|---|---|---|---|---|---|
| Montana | 974,989 | 20 | 0 | 20 | 0.0021% |
| Idaho | 1,545,801 | 50 | 0 | 50 | 0.0032% |
| Alaska | 698,473 | 35 | 3 | 38 | 0.0054% |
| Wyoming | 544,270 | 40 | 4 | 44 | 0.0081% |
| Nevada | 2,643,085 | 242 | 48 | 290 | 0.0110% |
| South Dakota | 812,383 | 97 | 0 | 97 | 0.0119% |
| North Dakota | 646,844 | 107 | 0 | 107 | 0.0165% |
| Mississippi | 2,951,996 | 495 | 0 | 495 | 0.0168% |
| Florida | 18,537,969 | 3,331 | 293 | 3,624 | 0.0195% |
| Puerto Rico Commonwealth | 3,967,288 | 801 | 0 | 801 | 0.0202% |
| Indiana | 6,423,113 | 1,278 | 20 | 1,298 | 0.0202% |
| Arizona | 6,595,778 | 1,296 | 45 | 1,341 | 0.0203% |
| Georgia | 9,829,211 | 2,044 | 8 | 2,052 | 0.0209% |
| Oregon | 3,825,657 | 805 | 0 | 805 | 0.0210% |
| Colorado | 5,024,748 | 1,135 | 0 | 1,135 | 0.0226% |
| Arkansas | 2,889,450 | 703 | 3 | 706 | 0.0244% |
| South Carolina | 4,561,242 | 1,115 | 8 | 1,123 | 0.0246% |
| Utah | 2,784,572 | 687 | 0 | 687 | 0.0247% |
| Washington | 6,664,195 | 1,652 | 0 | 1,652 | 0.0248% |
| Kansas | 2,818,747 | 694 | 6 | 700 | 0.0248% |
| Oklahoma | 3,687,050 | 735 | 189 | 924 | 0.0251% |
| Alabama | 4,708,708 | 1,201 | 0 | 1,201 | 0.0255% |
| California | 36,961,664 | 9,658 | 176 | 9,834 | 0.0266% |
| Maine | 1,318,301 | 295 | 56 | 351 | 0.0266% |
| Kentucky | 4,314,113 | 1,119 | 31 | 1,150 | 0.0267% |
| New Mexico | 2,009,671 | 534 | 5 | 539 | 0.0268% |

| | | | | | |
|---|---|---|---|---|---|
| New Hampshire | 1,324,575 | 368 | 4 | 372 | 0.0281% |
| Iowa | 3,007,856 | 816 | 29 | 845 | 0.0281% |
| Texas | 24,782,302 | 6,993 | 101 | 7,094 | 0.0286% |
| Virginia | 7,882,590 | 2,229 | 46 | 2,275 | 0.0289% |
| Wisconsin | 5,654,774 | 1,660 | 21 | 1,681 | 0.0297% |
| North Carolina | 9,380,884 | 2,817 | 14 | 2,831 | 0.0302% |
| Hawaii | 1,295,178 | 415 | 0 | 415 | 0.0320% |
| Tennessee | 6,296,254 | 2,089 | 2 | 2,091 | 0.0332% |
| New Jersey | 8,707,739 | 2,731 | 319 | 3,050 | 0.0350% |
| Nebraska | 1,796,619 | 641 | 0 | 641 | 0.0357% |
| Delaware | 885,122 | 306 | 18 | 324 | 0.0366% |
| Louisiana | 4,492,076 | 1,666 | 0 | 1,666 | 0.0371% |
| West Virginia | 1,819,777 | 620 | 96 | 716 | 0.0393% |
| Minnesota | 5,266,214 | 2,144 | 0 | 2,144 | 0.0407% |
| Vermont | 621,760 | 259 | 0 | 259 | 0.0417% |
| Missouri | 5,987,580 | 2,514 | 114 | 2,628 | 0.0439% |
| Maryland | 5,699,478 | 2,632 | 0 | 2,632 | 0.0462% |
| Illinois | 12,910,409 | 5,728 | 261 | 5,989 | 0.0464% |
| Ohio | 11,542,645 | 5,293 | 565 | 5,858 | 0.0508% |
| Connecticut | 3,518,288 | 2,010 | 13 | 2,023 | 0.0575% |
| Michigan | 9,969,727 | 4,574 | 1,196 | 5,770 | 0.0579% |
| Pennsylvania | 12,604,767 | 7,236 | 737 | 7,973 | 0.0633% |
| Rhode Island | 1,053,209 | 725 | 0 | 725 | 0.0688% |
| Massachusetts | 6,593,587 | 5,195 | 14 | 5,209 | 0.0790% |
| New York | 19,541,453 | 15,821 | 489 | 16,310 | 0.0835% |
| District of Columbia | 599,657 | 1,831 | 0 | 1,831 | 0.3053% |

Also, as mandated by statute, preference must go to hospitals in the top 10 states/districts/territory in terms of Primary Care HPSA-to-population ratio. Using data obtained from the Health Resources and Services Administration for HPSA information and data from the Census Bureau, CMS proposes that the following 10 states qualify: LA, MS, PR, NM, SD, DC, MT, ND, WY and AL.

| State Name | Census data as of July 1, 2009 | Primary Care HPSA | Primary Care HPSA to Population Ratio |
|---|---|---|---|
| Louisiana | 4,492,076 | 3,119,598 | 69.4467% |
| Mississippi | 2,951,996 | 1,781,774 | 60.3583% |
| Puerto Rico Commonwealth | 3,967,288 | 2,282,408 | 57.5307% |
| New Mexico | 2,009,671 | 1,036,774 | 51.5892% |
| South Dakota | 812,383 | 351,926 | 43.3202% |
| District of Columbia | 599,657 | 257,377 | 42.9207% |
| Montana | 974,989 | 384,030 | 39.3881% |
| North Dakota | 646,844 | 239,550 | 37.0337% |
| Wyoming | 544,270 | 199,656 | 36.6833% |
| Alabama | 4,708,708 | 1,725,293 | 36.6405% |
| Arizona | 6,595,778 | 1,981,387 | 30.0402% |
| Illinois | 12,910,409 | 3,858,062 | 29.8833% |
| Missouri | 5,987,580 | 1,780,841 | 29.7422% |
| Idaho | 1,545,801 | 453,347 | 29.3276% |
| Kentucky | 4,314,113 | 1,155,928 | 26.7941% |
| South Carolina | 4,561,242 | 1,159,709 | 25.4253% |
| Texas | 24,782,302 | 6,040,714 | 24.3751% |
| Delaware | 885,122 | 215,060 | 24.2972% |
| New York | 19,541,453 | 4,691,714 | 24.0090% |
| Oklahoma | 3,687,050 | 866,358 | 23.4973% |
| Georgia | 9,829,211 | 2,276,546 | 23.1610% |
| Florida | 18,537,969 | 4,287,169 | 23.1264% |
| Tennessee | 6,296,254 | 1,455,365 | 23.1148% |
| Alaska | 698,473 | 153,999 | 22.0480% |
| Kansas | 2,818,747 | 570,639 | 20.2444% |
| Colorado | 5,024,748 | 970,145 | 19.3073% |
| Michigan | 9,969,727 | 1,916,653 | 19.2247% |
| Nevada | 2,643,085 | 504,174 | 19.0752% |
| North Carolina | 9,380,884 | 1,673,482 | 17.8393% |
| Iowa | 3,007,856 | 536,519 | 17.8373% |
| Wisconsin | 5,654,774 | 998,920 | 17.6651% |
| West Virginia | 1,819,777 | 318,133 | 17.4820% |
| Arkansas | 2,889,450 | 501,208 | 17.3461% |
| Utah | 2,784,572 | 477,193 | 17.1370% |
| Washington | 6,664,195 | 1,140,882 | 17.1196% |
| California | 36,961,664 | 6,014,851 | 16.2732% |
| Virginia | 7,882,590 | 1,222,771 | 15.5123% |
| Oregon | 3,825,657 | 579,368 | 15.1443% |
| Rhode Island | 1,053,209 | 156,064 | 14.8180% |
| Connecticut | 3,518,288 | 477,837 | 13.5815% |
| Massachusetts | 6,593,587 | 893,375 | 13.5492% |
| Indiana | 6,423,113 | 816,234 | 12.7078% |

| | | | |
|---|---|---|---|
| Maine | 1,318,301 | 156,116 | 11.8422% |
| Ohio | 11,542,645 | 1,326,610 | 11.4931% |
| Pennsylvania | 12,604,767 | 1,431,314 | 11.3553% |
| Minnesota | 5,266,214 | 493,764 | 9.3761% |
| Maryland | 5,699,478 | 523,260 | 9.1808% |
| Nebraska | 1,796,619 | 146,196 | 8.1373% |
| Hawaii | 1,295,178 | 93,107 | 7.1887% |
| Vermont | 621,760 | 40,313 | 6.4837% |
| New Hampshire | 1,324,575 | 84,038 | 6.3445% |
| New Jersey | 8,707,739 | 376,405 | 4.3226% |

CMS also is required to give preference to hospitals located in rural areas. CMS proposes to define "rural" as any hospital not located in a Metropolitan Statistical Area (MSA), regardless of whether the hospital has reclassified.

Given the framework of the PPACA, CMS proposes to create the following five levels of priority categories to determine the order in which hospitals would be eligible to receive increases in their FTE resident caps. CMS proposes that slots would not be given to hospitals that do not fit within any of these categories.

1. **First Level Priority Category**: The hospital is in a state whose resident-to-population ratio is within the lowest quartile, AND the hospital is in a state whose Primary Care HPSA-to-population ratio is in the top 10 states, AND the hospital is located in a rural area.

2. **Second Level Priority Category**: The hospital is in a state whose resident-to-population ratio is within the lowest quartile, AND is either in a state whose primary care HPSA-to-population ratio is in the top 10 states, or it is located in a rural area, or is an urban hospital and has or will have as of July 1, 2010, a rural training track.

3. **Third Level Priority Category**: The hospital is in a state whose resident-to-population ratio is within the lowest quartile.

4. **Fourth Level Priority Category**: The hospital is in a state whose primary care HPSA-to-population ratio is in the top 10 states, AND either the hospital is located in a rural area or the hospital is an urban hospital and has, or will have as of July 1, 2010, a rural training track.

5. **Fifth 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.

*Evaluation Criteria*. Third, CMS proposes to use an additional set of evaluation criteria to delineate within each level priority category above which hospitals would receive priority for the redistributed slots. CMS proposes to assign a certain number of points to

certain evaluation criteria to create an overall "score." These evaluation criteria and point values are delineated below:

1. **Evaluation Criterion One**. The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization above 60 percent, as reflected in at least two of the hospital's last three most recent audited cost-reporting periods for which there is a settled cost report. 5 POINTS.

2. **Evaluation Criterion Two**. The hospital will use the additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program. 5 POINTS.

3. **Evaluation Criterion Three**. 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.

4. **Evaluation Criterion Four**. 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. **Evaluation Criterion Five**. The hospital is located in a Primary Care HPSA. 2 POINTS.

6. **Evaluation Criterion Six**. The hospital is in a rural area 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 allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011. 1 POINT.

If there are slots that are not redistributed by July 1, 2011, CMS proposes to alert the public through another round of notice and comment rulemaking, and to establish a new application timeframe, process and other relevant information at that time.

### *Counting Resident Time in Non-Provider Settings (Sec. 5504)*

Historically, hospitals have needed to provide "all or substantially all" (defined as 90 percent) of the costs for training programs in non-hospital settings, including the cost of resident salaries and benefits and a portion of the teaching physician's salary and benefits, and have in place a written financial agreement with the non-hospital site in order to count resident time in non-provider settings for DGME and IME payment. Additionally, CMS has allowed only one hospital to count the time spent by residents training at non-hospital sites, even if multiple hospitals are sharing the costs of training their respective residents in the same programs at the same non-hospital site.

In order to help promote resident training in outpatient settings, the Section 5504 of the PPACA provides increased flexibility to hospitals governing GME funding. Specifically:

- ✓ It eliminates the "all or substantially all" language, and states that if a hospital continues to incur the costs of a resident's stipend and benefits, then all the time spent by a resident in patient care activities in a non-hospital setting will count towards the calculation of Medicare DGME and IME payments.

- ✓ It allows hospitals to share the costs of resident training at non-hospital sites, as long as the hospitals divide the resident time proportionally according to a written agreement.

- ✓ It requires hospitals to maintain records indicating the amount of time residents spend training at non-hospital sites relative to a base year, and to make those documents available to the HHS Secretary.

- ✓ It specifies that this provision will be implemented without reopening hospital cost reports unless a prior appeal on DGME or IME payments is pending as of March 23, 2010.

CMS proposes to revise the regulations to confirm to these new statutory requirements. First, effective for cost-reporting periods beginning on or after July 1, 2010 (for DGME) and for discharges occurring on or after July 1, 2010 (for IME), CMS proposes to allow a hospital to count all the time that a resident trains at a non-hospital site, so long as the hospital incurs the costs of the resident's salary and benefits for the time that the resident spends training at the non-hospital site. Hospitals no longer have to incur other training costs at the non-hospital site in order to count such time for DGME and IME purposes.

Second, effective for cost-reporting periods beginning on or after July 1, 2010 (for DGME) and for discharges occurring on or after July 1, 2010 (for IME), CMS proposes to allow hospitals to share the costs of resident training at non-hospital sites, as long as the hospitals divide the resident time proportionally according to a written agreement. CMS proposes that hospitals have some reasonable basis for establishing that proportion, such as based on the number of FTEs, as well as be able to document the amount they are paying collectively. This documentation must take the form of a written agreement between the hospitals, and must be available for CMS review and auditing purposes.

Third, CMS proposes a number of changes in response to the PPACA requirement for hospitals to maintain records containing the amount of time residents are training at non-hospital sites. This will help CMS identify whether barriers to resident training at non-hospital sites remain. Specifically, CMS proposes:

- To use rotation schedules as the source for establishing the amount of time that residents spend training at non-hospital sites, both in the base year and subsequent years.
- To require hospitals to only maintain records of the total unweighted DGME FTE count of resident training time in non-hospital settings.
- To use cost-reporting periods beginning on or after July 1, 2009 and before June 30, 2010 as the base year.
- To add lines to the Medicare cost report so that hospitals may submit data on a program-specific basis for their primary care programs, and on an overall hospital basis for their non-primary care programs.

Finally, the statute indicates that this provision should not result in the reopening of settled cost reports except where the provider has a "pending, jurisdictionally proper appeal." CMS proposes to interpret this language to mean that in order for a hospital to request a change to its FTE count, the appeal must be specific to an issue affecting DGME payments, such as the initial residency period or the Medicare patient load, or IME payments, such as FTEs or the available bed count.

### *Counting Resident Time for Didactic and Scholarly Activities (Sec. 5505)*

Currently the time spent by residents in non-hospital settings in non-patient care activities is not included for Medicare DGME or IME reimbursement purposes. Section 5505 of the PPACA amends these policies such that:

- ✓ Effective for cost-reporting periods beginning on or after July 1, 2009, hospitals may count certain non-patient care activities for DGME purposes if those activities occur in non-provider settings, including conferences and seminars, but may not count research unless that research is associated with the treatment or diagnosis of a particular patient.

- ✓ Effective for cost-reporting periods beginning on or after January 1, 1983, hospitals may count certain non-patient care activities that occur in non-provider settings – including conferences and seminars – for IME payment purposes. Research activities that are not associated with the treatment or diagnosis of a particular patient have been excluded from the allowable IME count of FTE residents since October 1, 2001.

- ✓ Effective for cost-reporting periods beginning on or after January 1, 1983, hospitals may count residents' vacation, sick leave and other approved leave time towards the hospital's DGME and IME FTE resident count, so long as the leave does not prolong the total time the resident participates in his or her approved program.

In addition, similar to Section 5504 above, the law specifies that this provision will be implemented without reopening settled hospital cost reports, unless a prior appeal on DGME or IME payments is pending as of March 23, 2010. (CMS' proposed interpretation of "jurisdictionally proper appeal pending" is exactly the same as that under Section 5504 above.)

Under this provision, CMS proposes to define "non-provider setting that is primarily engaged in furnishing patient care" to exclude those settings with a main mission other than patient care (such as medical schools, dental schools, hotels or convention centers). In addition, CMS proposes that "other approved leave time" include jury duty, other court leave or voting leave.

***Preservation of Resident Cap Positions from Closed Hospitals (Sec. 5506)***

Under existing regulations, a hospital that trains residents displaced by the closure of another teaching hospital may receive a temporary increase in its FTE cap so that it may receive DGME and IME payments associated with the displaced residents. However, once the residents complete their training program, the hospital's temporary cap increase is removed. The result is that when teaching hospitals close, their GME and IME resident cap slots are eliminated.

The new health care reform law mandates that, effective for medical residency programs that closed on or after March 23, 2008 (two years prior to enactment of the legislation), the resident cap positions from closed hospitals be distributed to other hospitals based on the following priority order: hospitals located in the same or contiguous CBSA; hospitals located in the same state; hospitals located in the same region of the country; and the priorities determined under the section on redistribution of unused GME positions (see above). In addition, preference will be given within each category to hospitals that are members of the same affiliated group as the closed hospital. The statute does not place a limit on the number of slots an applying hospital may request.

In the rule, CMS proposes to define "same Medicare GME affiliated group" as hospitals that have entered into a Medicare GME affiliation agreement for cross-training residents and/or to make temporary adjustments to their respective individual FTE resident caps. CMS proposes to refer to the most recent Medicare GME affiliation agreement of which the closed hospital was a member.

Similar to the implementation of Section 5503, CMS proposes a detailed application process (see Attachment B – CMS Evaluation Form – Cap Slots form Teaching Hospitals that Close). CMS proposes that **applications be due to both the CMS Central Office and the hospital's CMS Regional Office by January 1, 2011.** For future teaching hospital closures, CMS proposes to inform the public "through an appropriate medium" that increases to a hospitals' FTE resident caps are available, and to set an application deadline of four months from issuance of the notice to the public.

Also, similar to the implementation of Section 5503, CMS proposes that hospitals demonstrate the likelihood of filling the positions within three years. However, in implementing this provision, CMS does not propose to establish a point system. Rather, within each of the first three statutory category (CBSA, state and region), CMS proposes to use the following ranking criteria to distribute slots from the closed hospital:

1. **Ranking Criterion One**. The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, same program director, same (or many of the same) teaching staff).

2. **Ranking Criterion Two**. The applying hospital was listed as a participant of a Medicare GME-affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement.

3. **Ranking Criterion Three**. The applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training (that is, the applying hospital is permanently expanding its own existing programs).

4. **Ranking Criterion Four**. The applying hospital does not fit into Ranking Criteria 1, 2 or 3, and will use additional slots to establish a new or expand an existing *geriatrics* residency program.

5. **Ranking Criterion Five**. The applying hospital does not fit into Ranking Criteria 1, 2 or 3, is located in a *Primary Care HPSA*, and will use all the additional slots to establish a new or expand an existing primary care residency program.

6. **Ranking Criterion Six**. The applying hospital does not fit into Ranking Criteria 1, 2 or 3, and will use all the additional slots to establish a new or expand an existing *primary care* residency program.

7. **Ranking Criterion Seven**. The applying hospital does not fit into Ranking Criteria 1, 2 or 3, and will use all the additional slots to establish a new or expand an existing *general surgery* residency program.

8. **Ranking Criterion Eight**. The applying hospital does not fit into Ranking Criteria 1 through 7.

Note that CMS proposes to assign slots first to hospitals that fall within the first ranking category (CBSA) before assigning slots to those that fall within the second (state) or third (region) ranking category. CMS proposes not to use these ranking criteria for the fourth priority category. Rather, the agency would use the process established under Section 5503.

## ***NEXT STEPS***

The AHA encourages you to submit timely applications to CMS to apply for additional Medicare-funded residency positions. We also encourage you to submit comments to CMS outlining how the agency's proposals will affect your facilities. Watch for more information from AHA that may assist you in preparing your organization's comment letter.

Comments are due to CMS by August 31 and may be submitted electronically at http://www.regulations.gov. Follow the instructions under the "More Search Options" tab.

CMS also accepts written comments via regular or overnight/express mail at the following addresses:

**Via regular mail**
Centers for Medicare & Medicaid Services
Dept. of Health and Human Services
Attention: CMS-1504-P
P.O. Box 8013
Baltimore, MD 21244-1850

**Via overnight or express mail**
Centers for Medicare & Medicaid Services
Dept. of Health and Human Services
Attention: CMS-1504-P
Mailstop: C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

# Draft CMS Evaluation Form

## As Part of the Application for the Increase in a Hospital's FTE Cap(s) under Section 5503 of the Affordable Care Act

**Directions: Please fill out the information below for each residency program for which the applicant hospital intends to use the increase in its FTE cap(s). The applicant hospital is responsible for complying with the other requirements listed in the CY 2011 Hospital Outpatient Prospective Payment System Final Rule with Comment Period in order to complete its application for the increase in its FTE cap(s) under section 5503 of The Affordable Care Act, Pub. L. 111-148.**

**NAME OF HOSPITAL: _____**

**MEDICARE PROVIDER NUMBER: _____**

NAME OF MEDICARE CONTRACTOR: _____

**NAME OF SPECIALTY TRAINING PROGRAM**: **_____**

**(Check one):** □ Allopathic Program □ Osteopathic Program

**NUMBER OF FTE SLOTS REQUESTED FOR PROGRAM:**

**Direct GME: _____ IME: _____**

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**Section A: Demonstrated Likelihood of Filling the FTE Slots**

**(Place an "X" in the box for the applicable criterion and subcriteria.)**

A1: Demonstrated Likelihood Criterion 1. The hospital does not have sufficient room under its FTE cap for a new residency program that it intends to establish on or after July 1, 2011 (that is, a newly approved program that begins training residents at any point within the hospital's first three cost reporting periods beginning on or after July 1, 2011).

(1) Hospital will establish this newly approved residency program. **(The hospital must check at least one of the following, if applicable.)**

☐ Application for approval of the new residency program has been submitted to the ACGME, AOA or the ABMS by December 1, 2010. **(The hospital must attach a copy.)**

☐ The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program by December 1, 2010. **(The hospital must attach a copy.)**

☐ The hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). **(The hospital must attach a copy.)**

(2) Hospital will likely fill the slots requested. **(The hospital must check at least one of the following, if applicable.)**

☐ The hospital does not have sufficient room under its FTE cap, and the hospital's existing residency programs had a resident fill rate of at least 85 percent in each of program years 2007 through 2009. **(The hospital must attach documentation.)**

☐ The hospital does not have sufficient room under its FTE cap, and the specialty program for which the hospital is applying has a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. **(The hospital must attach documentation.)**

☐ A2: Demonstrated Likelihood Criterion 2. The hospital does not have sufficient room under its FTE cap, and the hospital intends to use the additional FTEs to expand an existing residency training program within the hospital's first three cost reporting periods beginning on or after July 1, 2011.

☐ (1) Hospital intends to expand an existing program. **(The hospital must check at least one of the following, if applicable.)**

☐ The appropriate accrediting body (the ACGME, AOA or ABMS) has approved the hospital's expansion of the number of FTE residents in the program. **(The hospital must attach documentation.)**

☐ The American Osteopathic Association Residency Match Program has accepted or will be accepting the hospital's participation in the match for the existing program that will include additional resident slots in that residency training program. **(The hospital must attach documentation.)**

☐ The hospital has submitted an institutional review document or program information form for the expansion of the existing residency training program by December 1, 2010. **(The hospital must attach documentation).**

☐ (2) Hospital will likely fill the slots of the expanded residency program. (**Check at least one of the following, if applicable.)**

☐ The hospital does not have sufficient room under its FTE cap, and the hospital has other previously established residency programs, with a resident fill rate of at least 85 percent in each of program years 2007 through 2009.) **(The hospital must attach documentation.)**

☐ The hospital does not have sufficient room under its FTE cap, and the hospital is expanding an existing program in a particular specialty with a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. **(The hospital must attach documentation.)**

☐ A3: Demonstrated Likelihood Criterion 3. Hospital is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both. **(Copies of EACH of the following must be attached.)**

- Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor by July 1, 2010 documenting on Worksheet E, Part A, Worksheet E-3, Part VI, and Worksheet E-3, Part VI the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

- Copies of the 2010 residency match information concerning the number of residents at the hospital in its existing programs.

- Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

**Section B. Level Priority Category**

**(Place an "X" in the appropriate box that is applicable to the level priority category that describes the applicant hospital.)**

€ First Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND the hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND the hospital is located in a rural area.

€ Second Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND is either in a State whose Primary Care HPSA to population ratio is in the top 10 States, or it is located in a rural area, or is an urban hospital and has or will have as of July 1, 2010, a rural training track.

€ Third Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile.

€ Fourth Level Priority Category: The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND either the hospital is located in a rural area or the hospital is an urban hospital and has, or will have as of July 1, 2010, a rural training track.

€ Fifth 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.

**Section C. Evaluation Criteria**

**(Place an "X" in the box for each criterion that is appropriate for the applicant hospital and for the program for which the increase in the FTE cap is requested.)**

€ Evaluation Criterion One. *The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report.* 5 POINTS.

€ Evaluation Criterion Two. *The hospital will use the additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program.* 5 POINTS.

€ Evaluation Criterion Three. *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.

€ Evaluation Criterion Four. *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.

€ Evaluation Criterion Five. *The hospital is located in a Primary Care HPSA.* 2 POINTS.

€ Evaluation Criterion Six. *The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is or will be on or after July 1, 2011, a training site for a rural track residency program (as specified under §413.79(k)), 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 allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011.* 1 POINT.

# CMS Evaluation Form
# As Part of the Application for the Increase in a Hospital's FTE Cap(s) Under Section 5506 of the Affordable Care Act: Preservation of FTE Cap Slots from Teaching Hospitals that Close

**Directions: Please fill out the information below for each residency program for which the applicant hospital intends to use the increase in its FTE cap(s). The applicant hospital is responsible for complying with the other requirements listed in the CY 2011 Hospital Outpatient Prospective Payment System rule in order to complete its application for the increase in its FTE cap(s) under section 5506 of Public Law 111-148.**

**NAME OF HOSPITAL: _____**

**MEDICARE PROVIDER NUMBER: _____**

**NAME OF MEDICARE CONTRACTOR**: _____

**NAME OF SPECIALTY TRAINING PROGRAM**: _____

**(Check one):** □ Allopathic Program □ Osteopathic Program

**NUMBER OF FTE SLOTS REQUESTED FOR PROGRAM:**

**Direct GME: _____ IME: _____**

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## Section A: Demonstrated Likelihood of Filling the FTE Slots

Demonstrated Likelihood: Hospital must provide documentation to demonstrate the likelihood of filling requested slots under section 5506 within 3 years. For example, the applying hospital would document that it does not have sufficient room under its FTE resident caps to take in the additional residents, and has approval from the relevant accrediting body to take over the closed hospital's residency program(s), or expand its own residency program(s) to reflect a permanent commitment to train additional residents.

(1) Hospital will establish this newly approved residency program or will expand an existing residency program. **(The hospital must check at least one of the following, if applicable.)**

☐ Application for approval of the new residency program has been submitted to the ACGME, AOA or the ABMS. **(The hospital must attach a copy.)**

☐ The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program. **(The hospital must attach a copy.)**

☐ The hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the new or expanded program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). **(The hospital must attach a copy.)**

(2) Hospital does not have sufficient room under its direct GME FTE cap or IME FTE cap, or both, and has or is seeking approval from the relevant accrediting body to take over the closed hospital's residency program(s), or expand its own residency program(s) to reflect a permanent commitment to train additional residents. (**The hospital must check at least one of the following, if applicable.)**

☐ Application for approval of the residency program has been submitted to the ACGME, AOA or the ABMS. **(The hospital must attach a copy.)**

☐ The hospital has submitted an institutional review document or program information form concerning the program in an application for approval of the program. **(The hospital must attach a copy.)**

☐ The hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the program, or other types of communication from the accrediting bodies concerning the program approval process (such as notification of site visit). **(The hospital must attach a copy.)**

(3) Hospital will likely fill the slots requested. **(The hospital must check the following, if applicable.)**

☐ The hospital does not have sufficient room under its direct GME FTE cap or IME FTE cap, or both. **(Copies of EACH of the following must be attached.)**

● Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor documenting on Worksheet E, Part A, Worksheet E-3, Part VI, and Worksheet E-3, Part VI the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

● Copies of the most recent residency match information concerning the number of residents at the hospital in its existing programs.

● Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

(4) Applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. **(Copies of EACH of the following must be attached.)**

● Copies of the most recent Medicare GME affiliation agreement of which the applying hospital and the closed hospital were a member of before the hospital closed.

● Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor documenting on Worksheet E, Part A, Worksheet E-3, Part VI, and Worksheet E-3, Part VI the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

● Copies of the most recent accreditation letters for all of the hospital's training programs in which the hospital had a shared rotational arrangement (as defined at §413.75(b)) with the closed hospital.

## Section B. Level Priority Category

**(Place an "X" in the appropriate box that is applicable to the level priority category that describes the applicant hospital.)**

a) □ First, to hospitals located in the same core-based statistical area (CBSA) as, or in a CBSA contiguous to, the hospital that closed.

b) □ Second, to hospitals located in the same State as the closed hospital.

c) □ Third, to hospitals located in the same region as the hospital that closed.

d) □ Fourth, if the slots have not yet been fully distributed, to qualifying hospitals in accordance with the criteria established under section 5503, "Distribution of Additional Residency Positions"

**Section C. Evaluation Criteria**

**(Place an "X" in the box for each criterion that is appropriate for the applicant hospital and for the program for which the increase in the FTE cap is requested.)**

☐ Ranking Criterion One. *The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, same program director, same (or many of the same) teaching staff)*

☐ Ranking Criterion Two. *The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement.*

☐ Ranking Criterion Three. *The applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will*

*use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training (that is, the applying hospital is permanently expanding its own existing programs).*

☐ Ranking Criterion Four.- *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, and will use additional slots to establish a new or expand an existing geriatrics residency program.*

☐ Ranking Criterion Five.- *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, is located in a Primary Care HPSA, and will use all the additional slots to establish a new or expand an existing primary care residency program.*

☐ Ranking Criterion Six.- *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, and will use all the additional slots to establish a new or expand an existing primary care residency program.*

☐ Ranking Criterion Seven.- *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, and will use all the additional slots to establish a new or expand an existing general surgery residency program.*

☐ Ranking Criterion Eight.- *The applying hospital does not fit into Ranking Criteria 1 through 7.*