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MEMORANDUM

To: PPSV Clients and Friends

From: Powers, Pyles, Sutter & Verville, P.C.

Date: July 13, 2010

Re: Proposed Rule Implementing GME Amendments in the Affordable Care Act

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As part of the rule proposing changes to the hospital outpatient prospective payment system for 2011, the Centers for Medicare and Medicaid Services (CMS) published proposed rules to implement the amendments to the payment methodology for direct graduate medical education (DGME) and indirect medical education (IME) required by the recently enacted health reform legislation.[1] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010). CMS's proposed rule contains changes to the methodology for counting full-time equivalent residents (FTEs) in hospital and non-hospital settings. CMS also proposes to redistribute unused FTE cap slots and cap slots from closed hospitals. The proposed rule will be published in the Federal Register on August 3 and comments are due no later than 5 p.m. on August 31, 2010.

I. Counting Time in Non-Provider Settings

CMS proposes to add a new paragraph (g) to 42 C.F.R. § 413.78 to address the counting of time in non-provider settings for cost reporting periods beginning on or after July 1, 2010. Consistent with PPACA, the proposed rule specifies that a hospital or hospitals must incur the costs of the salaries and fringe benefits of the residents during the time that they spend in the non-provider setting. CMS clarified that this eliminates the requirement that a hospital must pay other training costs. CMS would require either that a hospital pay the cost of the stipends and fringe benefits "by the end of the third month following the month in which the training in the

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[1] Available at http://www.federalregister.gov/inspection.aspx#special. The GME/IME discussion begins at page 627.

nonhospital site occurred" or that the hospital and the non-provider setting enter into a written agreement specifying that the hospital will incur these costs.

CMS would also require that hospitals apportion FTEs in non-provider settings when more than one hospital shares the cost of the stipends and fringe benefits. Such hospitals would also have to maintain written agreements specifying that the stipends and fringe benefits would be paid by the hospitals. A "global agreement" that specifies a lump-sum payment encompassing stipends and fringe benefits as well as other expenses would not be acceptable unless the agreement specifies the portion of the payment encompassing the salaries and fringe benefits. The written agreement would also have to apportion the time on a "reasonable basis." CMS states in the preamble that one "reasonable basis" would be to share the FTEs proportionally to the costs incurred by each hospital.

In addition, CMS proposes to implement PPACA's documentation requirement as a condition of counting the non-provider FTEs. Hospitals would have to maintain and make available to CMS's contractors documentation supporting the non-provider FTE count. This is so that CMS can compare non-provider time to a base year, which would be July 1, 2009 through June 30, 2010.

II. Non-Patient Care Activities

Certain non-patient care activities, such as didactic conferences and seminars, will be includable in the IME FTE count if the activities occur in a hospital setting. This provision is retroactive to cost reporting periods beginning on or after January 1, 1983. Research not involving the treatment or diagnosis of individual patients would not be countable. A hospital setting is defined as either 1) portions of the hospital subject to the prospective payment system; 2) outpatient departments of the hospital that meet the provider-based rules of 42 C.F.R. § 413.65(a)(2); or 3) portions of a hospital that are reimbursed under a reimbursement system authorized under section 1814(b)(3) of the Social Security Act (an alternate reimbursement scheme currently implemented only in Maryland).

Non-patient care activities, such as didactic conferences in seminars, that occur in certain non-provider settings would also be included in the DGME FTE count. To be included, these activities must be in a non-provider setting that is "primarily engaged in providing patient care." Patient care in this context would be defined at the existing 42 C.F.R. § 413.77 as "the care and treatment of particular patients, including services for which a physician or other practitioner may bill," including orientation activities. Examples of non-provider settings that are primarily engaged in patient care include freestanding clinics, nursing homes, and physicians' offices. Medical schools would not qualify, nor would time spent in didactic conferences or seminars at hotels or convention centers. Research not involving the care of particular patients would not be includable even if conducted in a non-provider setting that is primarily engaged in patient care activities.

Vacation, sick leave, and other approved leave that does not lengthen a resident's training program would also be included in the DGME and IME FTE counts. This provision would be retroactive to cost reporting periods beginning on or after January 1, 1983.

III Redistribution of Unused Cap Slots

Section 5503 of PPACA provides for reductions in hospital FTE resident caps for both DGME and IME payment purposes. It also authorizes a redistribution to other hospitals for the estimated number of FTE resident slots resulting from the reductions. The proposed rule establishes criteria for determining which hospitals will receive a reduction to their resident caps, which will receive redistributed resident caps and criteria for retaining those caps.

A Criteria for Cap Reductions

With respect to the reduction in FTE caps, effective July 1, 2011, a hospital's FTE cap will be reduced if its "reference resident level" is less than its "otherwise applicable resident limit." The amount of the reduction will be 65 percent of the difference between these two figures. The "reference resident level" is defined as the resident level for the one cost reporting period out of the three most recent cost reporting periods ending before March 23, 2010 with the highest resident level. The "otherwise applicable resident limit" is defined as the hospital's FTE cap, as adjusted for new programs, participation in a GME or Emergency GME affiliation agreement, a hospital merger, or an accredited rural training track program. A separate determination would be made regarding a reduction to a hospital's DGME cap and IME cap.

Certain hospitals are exempt from the reductions. These include rural hospitals with fewer than 250 acute care inpatient beds and certain hospitals that participate in demonstration projects or voluntary residency reduction programs. CMS is also proposing to exempt any hospital that trains at or above its FTE cap in all of its three most recent cost reporting periods ending before March 23, 2010.

CMS is proposing to determine the number of resident positions available for redistribution by estimating the expected reductions to hospitals' FTE resident caps. If the aggregate number of FTE resident reductions differs from the number CMS initially estimated, the slots in the redistribution pool would not be affected.

CMS proposes to determine a hospital's reference resident level by May 1, 2011. If Medicare contractors have not completed audits by that date, CMS proposes to estimate the amount of any reduction. Hospitals will have a time-limited opportunity to review cap reduction determinations for "technical errors" before they are finalized. Because section 5503 specifies that there is "no administrative or judicial review… with respect to determinations" under that section, CMS is proposing to not wait for appeals of reference period cost reports to be resolved before making a final determination as to whether and by how much a hospital's FTE resident cap will be reduced. It is also proposing to require Medicare contractors to use the latest available cost report or audit data when they make determinations. Therefore, if an appeal has been resolved as of the time the contractor is making its determination, it would use the FTE resident level that will be reflected in the revised notice of program reimbursement issued pursuant to the appeal resolution.

For hospitals that participate in Medicare affiliated groups, CMS is proposing that, in contrast to the implementation of the FTE cap reductions under section 422 of the Medicare Modernization Act (MMA), it will not determine the applicability of any reductions under

section 5503 based on the aggregate experience of the affiliated group, but rather the determination will be made on an individual hospital basis. A hospital's "otherwise applicable resident limit," i.e., its FTE cap, will be adjusted, however, to reflect any affiliation agreements for purposes of comparison to its reference resident level.

For hospitals that merge on or after March 23, 2010, CMS proposes that they be treated as if they were merged during the three most recent cost reporting periods prior to that date and that their FTE resident counts and caps be combined to determine if there should be a reduction to the merged facility's FTE caps. With respect to hospitals that had their FTE caps reduced or increased under section 422 of the MMA, CMS believes that PPACA only authorizes it to take into account any such reductions, but not increases, in determining whether a cap reduction is required under section 5503.

B. Criteria for Distribution of FTE Cap Slots

CMS has proposed an evaluation form for applying for a redistribution. The criteria (and, correspondingly, the application) are divided into three sections. The form and instructions are at pages 746-55 of the electronic rule.

1. Demonstrated Likelihood of Filling Slots

A hospital must show a demonstrated likelihood of filling redistributed resident slots because it either: 1) does not have sufficient slots in its FTE cap for a new residency program that will begin training residents within its first three cost reporting periods beginning on or after July 1, 2011; 2) does not have sufficient slots in its FTE cap to expand an existing residency program within its first three cost reporting periods beginning on or after July 1, 2011; or 3) is already training residents in excess of its FTE caps. A hospital that applies under one of the first two criteria has to submit documentation of its resident "fill rate" or national, State or CBSA fill rates for the program.

2. Priority Categories

Hospitals that "pass" Section A are then prioritized in the following categories:

- 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 HPS to population ratio is in the top 10 States, or the hospital is located in a rural area.

States whose resident-to-population ratio is within the lowest quartile are: Montana, Idaho, Alaska, Wyoming, Nevada, South Dakota, North Dakota, Mississippi, Florida, Puerto Rico, Indiana, Arizona and Georgia. States whose Primary Care HPSA population-to-state-population ratio is in the top 10 are: Louisiana, Mississippi, Puerto Rico, New Mexico, South Dakota, District of Columbia, Montana, North Dakota, Wyoming and Alabama.

CMS will distribute 70% of the residency slots to hospitals in the first three categories and 30% to hospitals in the second two categories. Resident slots will be distributed to each category sequentially, *i.e.*, resident slots will be distributed to all hospitals in the "First Level Priority Category" before they are distributed to the "Second Level Priority Category" hospitals.

3. Evaluation Criteria

After the hospital program is categorized under Section B, CMS will assign points to each hospital under proposed evaluation criteria. The criteria and corresponding points are:

- Hospital has a Medicare utilization rate over 60%, as shown in at least two of the hospital's three most recent audited and settled cost reports (5 points);
- Hospital will use the additional slots to establish or expand a geriatrics residency program (5 points);
- Hospital will use the additional slots to establish or expand a primary care program, with a focus on training residents to pursue a primary care career, rather than a nonprimary subspecialty (3 points);
- Hospital will use all additional slots to establish or expand a primary care or general surgery residency program (5 points);
- Hospital is located in a Primary Care HPSA (2 points); and
- Hospital is in a rural area and is, or will be, a training site for a rural track residency program, but is unable to count all of the rural track residents due to the hospital's FTE cap for portions of cost reporting periods on or after July 1, 2011 (1 point).

Within each Section B category, a hospital with more points has priority over a hospital with fewer points. Again, however, CMS plans to distribute the slots to all hospitals within a category before distributing slots in the next category. Therefore, a Category A hospital with no points will receive slots before a Category B hospital with points.

C. Retaining Resident Slots

In order to keep the redistributed resident slots, the number of the hospital's FTE primary care residents (excluding the additional positions) for the five year period from July 1, 2011 to June 30, 2016 must be equal to or greater than the average number of FTE primary care residents during the three most recent cost reporting periods ending before March 23, 2010. In addition,

for the same five year period, the hospital must use at least 75% of the increased slots for primary care or general surgery programs. If a hospital does not meet the requirements, all of resident slots that it received under the redistribution are forfeited.

D. Related Issues

A hospital has to submit a separate evaluation form for each residency program, although after the slots are awarded, they are not program specific. Applications are due December 1, 2010, but this deadline is extended to March 1, 2011 for hospitals that are undergoing an audit for purposes of a provider cap redistribution. The documentation required to support the form is discussed in detail in the preamble.

Hospitals that receive redistributed resident slots will count residents in those slots in the same way that they count residents under their original 1996 FTE cap. Stated differently, these residents will not be subject to the reimbursement reductions applicable to section 422 redistributed resident slots. The redistributed resident slots will be subject to the GME and IME rolling average and IME prior year resident-to-bed ratio cap. A hospital may receive up to 75 additional residency slots.

IV. Redistribution of Resident Slots from Closed Hospitals

CMS will distribute unused DGME and IME cap slots from hospitals that closed on or after March 23, 2008. Closure of a hospital would be defined as termination of the hospital's provider agreement. Cap slots would be redistributed in the following priority:

1. Hospitals in the same core-based statistical area ("CBSA") as the closed hospital. The CBSA would be the same as used for the wage index without regard to reclassifications.

2. Hospitals in the same state (including the District of Columbia and Puerto Rico) as the closed hospital.

3. Hospitals in the same region as the closed hospital. Region would be defined as a Census Region.

4. Any remaining slots would be distributed using the criteria for redistribution of unused cap slots.

CMS proposes to employ eight additional "ranking criteria." The first three would apply to the above three general categories, and ranking criteria four through eight would apply within category four above. The ranking criteria would be as follows.

1. The applying hospital assumed the entire program or programs of the closed hospital.

2. The applying hospital received cap slots as part of the same Medicare GME affiliated group as the closed hospital, and the applying hospital will use the cap slots to train at least the number of residents as under the affiliation agreement.

3. The applying hospital took in residents, but not a whole program of the closed hospital, and will use the cap slots to train residents in the same type of program.

4. The applying hospital will use the additional slots to establish a new or expanded geriatrics program.

5. The applying hospital is located in a Primary Care HPSA and will use the additional slots to establish a new or expanded primary care residency program.

6. The applying hospital will use all additional slots to establish a new or expanded primary care residency program.

7. The applying hospital will use all additional slots to establish a new or expanded primary care general surgery program.

8. All other hospitals

Hospitals would have to provide documentation to demonstrate the likelihood that they would use the cap slots within the first three academic years following the application deadline. The first applications for cap slots would be due by January 1, 2011. After that, CMS would periodically announce the availability of cap slots for closed hospitals, with an application due date of four months after the announcement. Additional cap slots would be subject to the DGME and IME rolling average calculations and the cap in the IME resident-to-bed ratio. A hospital would use its existing DGME per resident amount and IME multiplier. Additional slots would not be available to be shared as part of a GME affiliation agreement.

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If you have any questions, please call Barbara Straub Williams, Susan Philp, Ronald Connelly or the attorney with whom you usually work at (202) 466-6550.