Office of the General Counsel

Recent Changes to Graduate Medical Education Payments:

Compliance Issues to Watch in 2011

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Presentation Roadmap

I. GME Background: Overarching Principles
II. Changes to Definition of "Resident"
III. Health Care Reform GME Changes
   A. Counting Resident Time Spent in Non-Provider Setting
   B. Counting Resident Time Spent for Research and Didactic Activities
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Relevant GME Background: Overarching Principles

- Medicare regulates payment, not operations
- GME payments have been available since 1965 (start of Medicare) and used to be cost-based
- Medicare views residents more like nurses than doctors → reimbursed under Medicare Part A (hospitals), not Part B (physicians)
- Teaching physicians can include resident services in their own billing in certain circumstances

Relevant GME Background: Overarching Principles (cont'd)

- Now, GME is prospective and includes two key payment streams:

1. **Direct graduate medical education ("DGME")**
   - Payment of Medicare's proportionate share of *direct* costs of GME activities
   - Calculation = FTE count x per resident amount x Medicare patient load
   - Paid through the Medicare cost report
   - FTEs can be counted in all areas of the hospital and hospital complex *and* in non-hospital sites that meet statutory/CMS requirements

Relevant GME Background: Overarching Principles (cont'd)

2. **Indirect graduate medical education ("IME")**
   - Payment for the *indirect* costs that teaching hospitals incur (e.g., payment for the higher case mix of the teaching hospital patient population)
   - Calculation comprised of:
     - A multiplier (set by Congress);
     - An interns/residents-to-beds ratio (a measure of teaching intensity); and
     - A logarithmic equation.
   - Paid on a per-claim basis
   - Payment is available for training in the acute care part of the hospital *and* the outpatient department, as well as certain non-hospital sites

Relevant GME Background: Overarching Principles (cont'd)

Rules Applicable to FTE Counts:

- DGME and IME counts are capped at the FTE count for cost reporting period ending on or after 12/31/96
- Separate IME cap on interns and residents to bed ratio
- Three year "rolling average"
- Hospitals that did not have any residents in 1996 have a cap of 0 (unless they subsequently establish a "new" program)

Changes to Definition of "Resident" (FY 2011 IPPS Final Rule; 75 Fed. Reg. at 50287-99)

Determining Whether an Individual is a Resident or Physician:

- Two key inquiries:
  1. Does the individual actually *need* the training in order to meet board certification requirements in *that* specialty? AND
  2. Is the individual formally participating in an organized, standardized, structured course of study?
  - Must be able to answer both in the affirmative → resident
  - An individual who participates in training after the completion of an accredited residency program is not a resident (and must bill as a physician under the MPFS)

Changes to Definition of "Resident" (cont'd)

Revision of Definition of "Resident":

- Effective for cost reporting periods on or after 10/1/10, in order to be considered a resident, the individual must:
  1. Be formally accepted and enrolled in the training program; AND
  2. Be fully participating in that training

  - Mere participation in an otherwise approved residency program is insufficient
  - Revised definition carries specific documentation requirements (e.g., letters from program sponsor; employment contract)

Changes to Definition of "Resident" (cont'd)

Revision to "Chief Resident" Policy:

- Effective for cost reporting periods on or after 10/1/10, individuals acting as chief residents *after* they have completed the accredited program and satisfied minimum requirements for board certification are not considered residents for GME/IME payment purposes

- *Surgical* chief residents will continue to be considered residents

Changes to Definition of "Resident" (cont'd)

Clarification Regarding Extended & Unaccredited Training:

- Effective for cost reporting periods on or after 10/1/10, individuals training in a program that extends beyond the minimum accredited length are not considered residents (as to the period of time beyond the minimum length)
- An individual participating in unaccredited training is categorized as a physician, not a resident, even if the training at issue is ultimately accepted by the relevant board as fulfilling certification requirements

Counting Resident Time Spent in Non-Provider Setting

- Historical statutory requirements:
  - In order for hospitals to count FTE residents, for purposes of GME and IME payments, in connection with residents' time spent in non-provider settings:
    - Time had to be spent on patient care-related activities; and
    - Hospital had to incur "all or substantially all" costs of the training in the non-hospital site
  - Significant variation in CMS' interpretation of this provision

Counting Resident Time Spent in Non-Provider Setting (cont'd)

- PPACA changes to the SSA:
  - Defines "all or substantially all" to mean the costs of residents' salaries and fringe benefits → So What?
    - A hospital may count *all* the time residents train in activities related to patient care in a non-provider setting *so long as* the hospital incurs the costs of the residents' salary and fringe benefits for the time the residents spend training in the non-provider site
    - No longer have to incur supervisory physician costs
  - As of When?
    - IME: for discharges after 7/1/10
    - DGME: for cost reporting periods beginning on or after 7/1/10

Counting Resident Time Spent in Non-Provider Setting (cont'd)

- What if more than one hospital incurs costs of residency training in the same non-provider setting?
  - Multiple hospitals can count time proportionally, so long as there is a written agreement in place
    - Agreement must have a "reasonable basis" for allocating time
    - Agreement must include payments being made to the non-provider site that, in the aggregate, equal the sum of the residents' salaries and fringe benefits (for the amount of time residents are training in that site)
      - Payments must be broken out by program

Counting Resident Time Spent for Research & Didactic Activities

1. **Research**
   - 2002 regulations interpreted to exclude from IME FTE count time spent in research activities not related to diagnosis/treatment of a particular patient
   - PPACA (§ 5505) solidifies CMS' position: as of 10/1/01, research not associated with diagnosis or treatment of a particular patient is to be *excluded* from the FTE count for both: (1) IME; and (2) time spent in non-hospital settings for DGME
     - Includes activities focused on developing new medical treatments, evaluating medical treatments for safety or efficacy, etc
     - No one workday exception for research activities

Counting Resident Time Spent for Research & Didactic Activities (cont'd)

II. Didactic Activities

- FFY 2007 rule: CMS clarified that its policy excluding time related to non-patient care-related activities extended beyond research to include didactic activities (e.g., seminars, journal club) for IME and, in non-hospital settings, DGME
- PPACA (§ 5505) allows didactic activities to be included in FTE count for IME and, in non-hospital settings, for DGME
  - Non-hospital site must be *primarily engaged in furnishing patient care* (even if activity is not)
  - Effective: cost reporting periods ending on or after 7/1/09 for DGME; from 1/1/83 for IME

Counting Resident Time Spent for Research & Didactic Activities (cont'd)

II. **Didactic Activities (cont'd)**

- Cost reports *can* be reopened if there is a jurisdictionally proper appeal in place
- Medical and dental schools are <u>not</u> primarily engaged in patient care activities → didactic activities in a medical/dental school must be excluded
  - BUT, didactic activities that occurred in the school *clinics* are properly included (with proper documentation)
- Termination of the one workday rule for didactic time, effective for cost reporting periods beginning on or after 1/1/11

Counting Resident Time Spent for Research & Didactic Activities (cont'd)

III. Leaves of Absence

- PPACA (§ 5505) includes time associated with vacation, sick leave and other approved leave (e.g., jury duty) in the IME and DGME FTE counts, provided it does not prolong the normal duration of the resident program
  - Effective 1/1/83
- When a resident is training at 2 hospitals, hospital to which resident is assigned when vacation/leave is taken counts the FTE time (or, without any assignment, hospitals make a pro rata allocation based on total time for that FTE)

Counting Resident Time Spent for Research & Didactic Activities (cont'd)

Resident Time Counted vs. Not Counted

DGME

Hospital	Non-Hospital
Patient Care	Patient Care
Vacation/Sick	Vacation/Sick
Didactic	**Didactic (7/1/09+)**
Research	NOT Research

IME

Hospital	Non-Hospital
Patient Care	Patient Care
Vacation/Sick	Vacation/Sick
Didactic (1/1/83+)	NOT Didactic
NOT Research (1/1/01+)	NOT Research

Bold = PPACA changes

Redistribution of Unfilled Residency Slots

- PPACA (§ 5503) amends the SSA to provide for reductions in the statutory FTE resident caps for GME and IME in certain hospitals and authorizes a "redistribution" of those FTE slots to other hospitals
- Effective July 1, 2011, a hospital's FTE cap will be *permanently* reduced if its "reference resident level" (e.g., FTE count for a given cost reporting period) is less than its "otherwise applicable resident limit" (e.g., a hospital's statutorily-established FTE cap as adjusted by Section 422) for *any* of the 3 most recent settled or submitted cost reports for cost reporting periods ending before 3/23/10
  - Reduction = 65% of unused FTE slots

Redistribution of Unfilled Residency Slots (cont'd)

- Will CMS reduce your FTE cap?
  1. Do you meet an exception? (If yes to any, no reduction)
     - Rural hospital with < 250 beds
     - Voluntary reduction plan participants (National VRRP, NY Medicare GME Demo, and Utah Medicare GME Demo) who submit, by 1/21/11, a plan to fill the slots by 3/23/12 (*see* 75 Fed. Reg. at 72150)
     - MLK replacement facility
     - New teaching hospitals in their 3-year cap building period
     - Low utilization hospitals without a cap
  2. Are you at or over your cap for *all* three years? (If yes, no reduction)
  3. If no exception and not at/over cap in <u>all 3 years</u>, your cap will be reduced

Redistribution of Unfilled Residency Slots (cont'd)

- How much will your FTE cap be reduced?
  - Look at the single year with the "highest" resident count→ CMS will reduce your cap by 65% of the difference between your cap and your FTE count in the year with the "highest" count

Example:

Year	DGME Count	DGME Cap
FY 2007	14	18
FY 2008	14	15
FY 2009	12	15

  - "Highest" count is 14 (use FY 2008, representing smallest difference between cap & count) → DGME cap is reduced by 65% of 1 slot = .65 FTE
  - Repeat same process for IME slots

Redistribution of Unfilled Residency Slots (cont'd)

- CMS will *estimate* the number of slots likely to be available for redistribution (by 5/16/11)
- What if your hospital is part of a GME affiliation agreement or emergency affiliation agreement (and shares cap slots with other hospital(s))?
  - (As of 12/9/10) CMS must look *first* at the affiliated group as a whole (as the agency did under Section 422) to see if the entire group has exceeded its aggregate cap; if affiliated group is over its cap → no reduction of individual hospitals' resident caps

Redistribution of Unfilled Residency Slots (cont'd)

- What if your hospital has merged?
  - If the merger occurred on or after 3/23/10:
    - CMS will treat hospitals separately, and will combine any cap reductions
  - If merger occurred during any year of the 3-year look back period:
    - CMS will treat hospitals as if they had merged during all 3 years

Redistribution of Unfilled Residency Slots (cont'd)

- Where will the redistributed slots go? Per PPACA:
  - 70% of slots →
    - To states with resident-to-population ratios in the lowest quartile
  - 30% of slots →
    - To states that are in the top 10 states in terms of population in HPSAs
    - Rural hospitals
- Max of 75 new slots per hospital

Redistribution of Unfilled Residency Slots (cont'd)

CMS' Final Lists (for 70% and 30% categories)

13 States with Lowest Resident-to-Population Ratios ("Res-Pop List")		10 States with Highest Proportion of Population Living in a HPSA ("HPSA List")
Montana	Idaho	Louisiana
Alaska	Wyoming	Mississippi
South Dakota	Nevada	Puerto Rico
North Dakota	Mississippi	New Mexico
Indiana	Puerto Rico	South Dakota
Florida	Georgia	D.C.
Arizona		Montana
		North Dakota
		Wyoming
		Alabama

Redistribution of Unfilled Residency Slots (cont'd)

- What if you don't fit into either (70% or 30%) category?
  - You are *ineligible* to apply for redistributed slots (e.g., if you are not located in one of the states identified on the previous slide and are not a rural hospital, you will *not* receive any additional slots)
- Rigorous evaluation process; applications were due **January 21, 2011**
- What if slots remain after CMS goes through the prioritization and distribution process?
  - New round of applications will take place 7/1/11; CMS will establish criteria for that second round

Redistribution of Unfilled Residency Slots (cont'd)

5 year Restrictions on Use of Redistributed Slots:

- 5 year period begins 7/1/11
- Post-distribution, the # of primary care residents cannot be less than the *average* during the 3 most recent cost reports submitted by March 23, 2010
- Must use 75% of additional slots for primary care or general surgery
- NEW: auditor can look at *average* performance over cumulative years (75 Fed. Reg. at 72199) and there is no judicial review
- Lose slots *permanently* if requirements not met (and slots then redistributed)

Preserving Cap Slots from Closed Hospitals

- PPACA (§ 5506) *permanently* redistributes resident caps from hospitals that close on or after March 23, 2008
- "Closed hospital" defined to mean:
  - Hospital terminates Medicare provider agreement, and
  - Cap slots of closed hospital no longer exist as part of any other hospital's permanent resident cap
  - *See* 75 Fed. Reg. at 72230 for list (> 700 slots)
- Does not *include*: hospitals that declared bankruptcy; closure of a residency program only; and merger (where no provider agreement is retired)

Preserving Cap Slots from Closed Hospitals (cont'd)

- First application deadline (for closure between 3/23/08 and 8/31/10): **April 1, 2011**
- Complicated slot distribution and prioritization process; hospitals must demonstrate likelihood of filling new slots within 3 years

Other Key GME Compliance Issues

- Treatment of fellows in unapproved fellowship programs
- Resident duty hours: new ACGME standards effective July 1, 2011
- Operational issues presented by resident moonlighting
- FICA: Supreme Court upheld 2005 IRS regulation that excluded residents from student exemption
- MedPAC recommendations

Key Audit Issues for IME and DGME

- General Grounds for Disallowance
  - Programs not approved
  - Initial residency period is wrong
  - Documentation problems
- Research & Didactic Time
  - Bench research
  - Policy reversal re: didactic time
- Non-Hospital Training (pre-PPACA)
  - Issues with the written agreement
- Clinical Base Year
- New Programs
  - Must be “new” new

Questions?

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