PART I

MEDICARE PAYMENTS ASSOCIATED WITH MEDICAL RESIDENTS

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I. Chronological History.

A. Reasonable Cost.

1. Medicare has participated in the costs of medical education since the program’s inception in 1965. In the legislative history to the original legislation, Congress stated as follows:

Many hospitals engage in substantial education activities, including the training of medical students, internship and residency programs, the training of nurses and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net costs of such activities… should be considered as an element in the cost of patient care, to be borne, to an appropriate extent, by [Medicare Part A].

¹ This outline does not purport to provide the legal advice of the author or to express the official position of AAMC. Readers wishing to discuss this outline or the cases cited here may contact the author at lmlevin@aamc.org.
B. IME Add-On

Created as part of the original inpatient PPS rules in 1983.

C. DGME “Prospective Payment”.

Legislation implemented a basic payment “per resident amount” methodology in 1986. Rules were not promulgated, however, until 1989.

D. Caps on Resident FTEs and Non-hospital Training Rules.

1. BBA of 1997 created numerous changes.

First, it imposed two types of caps: (i) a “historic cap” based on the number of allopathic and osteopathic residents training at the hospital in 1996, and (ii) a three-year rolling average.

Second, it allowed hospitals, in essence, to “pool” their FTE cap numbers through Medicare affiliation agreements.

Third, it allowed residents training at non-hospital sites to be counted for IME, subject to the IME cap (rules had allowed for this for DGME since 1987).

2. Non-hospital training rules were modified through somewhat restrictive rules effective January 1, 1999.
E. Limiting Interpretations.

From 1999 through 2003, CMS promulgated regulations that imposed new conditions and limitations on Medicare resident limit affiliation agreements (most notably, 2002 rule) and non-hospital training (concepts of redistribution/community support, 2003 rule).


Effective October 1, 2004, CMS somewhat changed off-site training rules and policy regarding residents in “clinical base year.”

CMS also recodified DGME provisions, as reflected in the following chart.

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On April 8, 2005, CMS issued Medicare Policy “Clarifications” on Graduate Medical Education Payments for Residents Training in Non-hospital settings (the “FAQs”). The “clarifications” are also seen in the final rule.

H. Redistribution of “Unused Resident Cap Slots”.

MMA § 422 provided for reduction in resident cap slots that are “unused” by certain hospitals and their redistribution to other hospitals, effective beginning July 1, 2005.


CMS issued a final rule “clarifying” policy regarding resident time not related to “patient care activities,” taking the position that such time is not to be included in FTE counts for IME (hospital and non-hospital) and, to more limited extent, DGME (non-hospital time only).


As part of the long-term care hospital PPS final rule, CMS modified the non-hospital training rules to permit hospitals to use proxy data to satisfy the non-


CMS issued “clarification” regarding when teaching programs may be considered “new,” thereby limiting when FTEs in those programs may be included as part of the hospital’s FTE limit or “cap.” 74 Fed. Reg. 43,754, 43,908-43,917 (Aug. 27, 2009).

L. ACA Changes.

In March 2010, Congress made several changes as part of the Affordable Care Act (ACA). First, it provided for the redistribution of “unused” FTE slots, similar to what was ordered under § 422 of the MMA. It also provided for the permanent redistribution of FTE slots from closed hospitals. Additionally, Congress provided clearer guidance regarding the reimbursement of time spent in research, didactic activities, and other (e.g., vacation) activities. Finally, Congress addressed the issue of FTEs training in non-hospital sites.

M. 2010 Rule.

CMS addressed the Medicare payment distinction between residents and physicians, with a particular focus on when a Fellow is a resident and when she is not.
N. 2010 Outpatient Final PPS Rule.

CMS issued final rules implementing ACA provisions on resident limit redistribution program, resident cap slots from closed programs, residents’ training at nonhospital sites, and the claiming of resident time associated with didactic, research and other “nonpatient care” activities (75 Fed. Reg. 71799, 72133 (Nov. 24, 2010)).

O. 2011 Interim Final and Final Rules.


P. 2012 Final Rule.

CMS issued a final rule extending the amount of time a new teaching hospital has to build DGME and IME caps from 3 years to 5 years. CMS also imposed new deadlines for using slots that hospitals received under § 5503 of the ACA and modified effective date determinations and other rules regarding redistributed slots from closed hospitals under § 5506 of the ACA.
II. Current Rules – Overview.

A. What are DGME and IME Payments?

Medicare makes two payments with an education label: the direct graduate medical education payment (DGME) and the indirect medical education payment (IME).

These payments, as their names suggest, are intended to compensate teaching hospitals for different kinds of costs.

B. DGME.

1. Purpose – DGME payments help compensate hospitals for the “direct” costs of having a teaching program. Those costs include such expenses as residents’ salaries and fringe benefits; salary and fringe benefits of “teaching” physicians, i.e., those faculty physicians who supervise the residents; the costs of hospital staff who work in administering the program; and overhead costs (space, electricity, and the like) associated with the program.

2. Payment – DGME payments are paid as a “pass-through” outside of the DRG payment made under inpatient PPS. The payment, as explained below, is based on a hospital-specific per resident amount (PRA) multiplied by an FTE resident count, multiplied by the hospital’s Medicare “patient load.”
C. IME.

1. Purpose – IME payments help compensate hospitals for the “indirect” patient care costs associated with having a teaching program. Teaching hospitals generally have higher patient care costs than non-teaching hospitals. This is due to two things: first, teaching hospitals generally treat patients whose illnesses are more severe; and, second, teaching hospitals incur costs that are difficult to quantify (such things as the residents ordering extra tests, standby requirements for trauma centers and burn units, etc.).

2. Payment – The IME payment is an adjustment to the hospital’s DRG payment. As explained further below, the payment is based, in part, on the number of interns and residents in relation to the number of beds.

III. DGME Payments.

The DGME payment methodology, as noted above, is based on the hospital’s PRA x FTE count x patient load. See 42 USC § 1395ww(h); 42 C.F.R. § 413.76.

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2 IME adjustments are also included as part of the inpatient rehabilitation and inpatient psychiatric facility prospective payment systems. See August 15, 2005, rehab PPS final rule and November 15, 2004, psych PPS final rule.

3 It is worth noting, however, that the IME adjustments in the capital, rehabilitation and psychiatric prospective payment systems relate the resident count in connection with the hospital’s average daily census rather than beds.
A. Per Resident Amount.

1. The per resident amount (PRA) is hospital-specific and, in general, is determined by the hospital’s 1984 (or, in some instances, 1985) costs of medical education divided by its then resident count, updated for inflation. 42 C.F.R. § 413.77.

2. PRAs differ for OB/GYN and primary care residents (family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, and general osteopathic medicine), on the one hand, and non-primary care residents, on the other. This is due to a congressional freeze on inflation updates on PRAs for non-primary care residents in 1994 and 1995.

3. For new teaching hospitals, the PRA is determined by the LOWER of their actual DGME costs per resident or the weighted average of the PRAs of surrounding teaching hospitals. 67 Fed. Reg. 49,982, 50,067 (Aug. 1, 2002); 42 C.F.R. § 413.77(e). Note, while not explicit in the regulations, the PRA calculation is triggered as soon as a resident rotates to a nonteaching hospital. This is true even if the hospital does not have a cap and is not seeking DGME or IME payments associated with the rotation.

4. Beginning in FFY 2001, Congress imposed “floors” and “freezes” on certain PRAs. Each hospital’s PRA is compared to a locality-adjusted national average PRA (reflecting both primary and non-primary care PRAs). If hospital had a PRA that was less than 70 percent of the
locality–adjusted national average, its PRA was increased to 70 percent of that average in FFY 2001, and 85 percent in FFY 2002. Those PRAs are then updated annually for inflation. See 66 Fed. Reg. at 39,896 (Aug. 1, 2001). Conversely, if a hospital had a PRA above 140 percent of the locality-adjusted national average PRA, its inflation updates – and thus its PRAs – were frozen for 2001 and 2002; in 2003, its PRA was updated by CPI-U minus two percent; and FFYs 2004-2013, the rates are again frozen. See MMA § 711; 42 C.F.R. § 413.77(d). Note that these provisions only apply to teaching hospitals in existence at the time of the law’s enactment and not to new teaching hospitals.

B. Number of FTEs.

For DGME purposes, the PRA, updated for inflation, is multiplied by the “weighted” number of FTEs training at the hospital and, under certain circumstances, at non-hospital locations. The “weighted” number means that residents in their initial residency period (IRP) (i.e., the minimum number of years necessary for specialty Board eligibility) are each counted as a full, or 1.0, FTE, while residents beyond this period are each counted as a half, or 0.5, FTE. The determination of the number of years for which Medicare will count the resident occurs when the resident begins training. The IRP does not change even if a resident changes specialties (see further discussion below).

C. Medicare Patient Load.
The product of the PRA and the resident count is then multiplied by the hospital’s Medicare patient “load,” defined as Medicare inpatient days divided by total hospital inpatient days, to arrive at the final DGME payment. 42 C.F.R. § 413.75(b).

IV. IME Payments.

The IME payment methodology is related to the teaching intensity of the hospital, measured by the ratio of the number of interns and residents to the number of beds at the hospital (the IRB ratio or IRB).

The payment is based on a statutory formula and is reflected as an add-on to each Medicare case’s DRG payment. See 42 USC § 1395ww(d)(5)(B); 42 C.F.R. § 412.105.

A. The IME Formula.

1. The percentage add-on payment is determined by employing the hospital’s IRB ratio as part of a statutory formula. The formula is as follows:

   \[ \text{IME Multiplier} \times \left[ (1+\text{IRB ratio})^{0.405} - 1 \right] \]

2. The multiplier in the formula varies from time to time, and it is set by Congress. In FY 2003, the multiplier was 1.35. In the MMA, Congress directed that the multiplier be 1.47 for April – September 2004; 1.42 for FFY 2005; 1.37 for FFY 2006; 1.32 for FFY 2007; and 1.35 for FFY 2008 and beyond.
3. Each part of the formula is significant. For example, a multiplier of 1.35 means that for every 10 residents per 100 beds (IRB of 0.10), a hospital would receive an add-on payment of roughly 5.5 percent of the base DRG payment. A hospital with 5 residents per 100 beds would have a lower IRB (0.05) and would have an add-on payment of roughly 2.7 percent, while a hospital with 40 residents per 100 beds (0.40 IRB) would have an add-on payment of just above 20 percent. Note that, unlike DGME, the resident count is not weighted for purposes of calculating IME payments.

4. IRB Ratio Limit.

At the same time that resident limits were imposed (see below), Congress also “capped” a hospital’s IRB ratio to the ratio in the hospital’s most recent prior cost-reporting period. This means that the IRB used in the current year is essentially capped by the hospital’s prior year’s actual IRB, and there is a resulting one-year lag in payment updates. This limitation, however, has exceptions for affiliated groups (discussed later), new programs, and closed hospitals or programs.

V. Resident Counts.

A. General.

1. For both DGME and IME, the correct count of full-time equivalent interns and residents (FTEs) is essential to accurate reimbursement. As noted above, for DGME, payment is based primarily on the FTE count times the
PRA times the Medicare patient load, while for IME, payment is based on an equation, central to which is the ratio of the number of resident FTEs per hospital bed.

2. Also as noted above, the FTE count for DGME is “weighted,” with residents in their “initial residency period” (the minimum number of years required for specialty board eligibility) counted as 1.0 FTEs, and residents beyond this period counted as 0.50 FTEs. Conversely, the IME count is not weighted.

3. The DGME count includes residents\(^4\) in an approved program working in all areas of the hospital complex and, under certain circumstances, in non-hospital locations. The IME count includes residents enrolled in an approved teaching program and assigned to: (a) those portions of the hospital subject to IPPS; (b) the hospital’s outpatient departments; and (c) under certain circumstances, on or after October 1, 1997, to non-hospital settings.

B. Initial Residency Period.

1. The answer to the question of whether one is in his or her “initial residency period” is not always clear. The answer has real consequences because those who are still in their “initial residency period” can be

\(^4\) Under CMS’s definition, a resident is an “intern, resident or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board.” 42 C.F.R. § 413.75(b). Physicians who have completed those requirements and who are not part of another approved program but who continue training to enhance their skills are “physicians” but not residents under CMS’s definition.
counted as full (or “1.0”) FTEs for DGME, while those who are not are counted as “0.5” FTEs. The issue that has led to disagreement is how the initial residency period is determined for residents in certain specialties, e.g., radiology or anesthesiology, that require an initial year of general training (the “clinical base year”) in addition to more specialized training.

2. CMS’s general rule is that the IRP is set at the time the resident enters a residency program and that it does not change.

3. If training is in a separately accredited “transitional year” program, CMS has maintained that the initial residency period selection does not occur until the resident’s second residency year, when the resident enters the specialty program. The transitional year would count as part of the initial residency period, but it would not determine the duration of the initial residency period.

4. Conversely, if the resident trains in a “preliminary year” program, such as internal medicine or surgery, CMS has historically stated that this initial selection determines the specialty – and duration – of the initial residency period.

5. In its final FY 2005 inpatient PPS rule, however, CMS modified its IRP policy somewhat to address circumstances such as those just described. 69 Fed. Reg. 48,916, 49,170-49,174. Effective October 1, 2004, the initial residency period is determined based on the specialty in which the resident trains in his second year in the cases of “simultaneous matches,” that is,
when a medical student simultaneously matches to a preliminary year program and second year specialty program. 42 C.F.R. § 413.79(a)(10). The FY 2006 final rule, issued in August 2005, provided that effective October 1, 2005, if the hospital can show that the resident matched to the second year specialty program prior to beginning the first year of residency training (even if the resident did not “simultaneously” match to a first year program), the IRP will be determined by the second year specialty program. That IRP will apply effective with the first year of training.

C. Resident FTE Limits – “Historic” or “1996” Caps.

1. Originally, there was no limit to the number of residents for which Medicare would pay a hospital. In the BBA of 1997, however, Congress “capped” the numbers of FTEs that each hospital could claim for DGME and IME payment purposes. Generally, the BBA limits the numbers of allopathic and osteopathic (but not dental or podiatry) residents that Medicare will reimburse to the number of residents counted on the hospital’s most recent cost-report period ending on or before December 31, 1996.

2. There are separate limits for IME and DGME. During the limits’ “base year” – 1996 – FTEs training in non-hospital locations and IPPS-exempt units could be counted for DGME but not for IME.
3. The resident limits or caps are based on the unweighted resident count (i.e., without regard to whether the resident is in initial residency period).

4. The 1996 limits are subject to several exceptions.
   
   a. Urban hospitals that started or received accreditation for residency programs between January 1, 1995, and August 5, 1997, could have their resident limits adjusted upwards to reflect the residents in these programs. After August 5, 1997, however, resident limits for urban teaching hospitals that have 1996 caps may not be increased to reflect new programs or expansions of existing programs unless the program is a rural training track program. (See item 4.f. below for new teaching hospitals.)

   b. Hospitals located in urban areas that send residents to train in rural areas as part of a rural training track program may have their limits adjusted upward to reflect the time these additional residents spend at the urban hospital. 42 C.F.R. § 413.79(k)(2); 66 Fed. Reg. at 39,902 (Aug. 1, 2001); 68 Fed. Reg. 45,454 (Aug. 1, 2003).

   c. The resident limits for rural teaching hospitals were increased by the BBRA to 130 percent of the 1996 resident caps. In addition, resident limits for rural teaching hospitals are adjusted upward to reflect new residency programs, regardless of when they begin. Note, however, that rural hospitals do not receive additional caps associated with expansions of existing programs.
d. Hospitals that assume the training of residents from hospitals or residency programs that have closed are eligible to receive temporary adjustments to their resident limits. See 64 Fed. Reg. at 41,522 (Jul. 30, 1999) (hospital closures), and 66 Fed. Reg. at 39,899 (Aug. 1, 2001) (residency program closures). The adjustments last only as long as is necessary for the affected residents to complete their training. CMS rules in this area reflect a practical approach to addressing the common problem of closed hospitals and programs and how to treat residents associated with those hospitals and programs. In addition, these (and other) hospitals may qualify for a permanent adjustment to their cap numbers under § 5506 of the ACA. 75 Fed. Reg. 71800, 72212-38 (Nov. 24, 2010) (see subsection H below).

e. Hospitals that had no teaching program in 1996, and thus have an FTE cap of zero, but that later start new program(s) and become teaching hospitals, may have a resident limit established based on the product of (1) the highest number of residents in any program year during the third year of the first program’s existence and (2) the number of years for the residents’ initial residency periods. See 42 C.F.R. § 413.79(e)(1).

(i) A “new program” is defined in the regulations as “a new medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on
or after January 1, 1995.” 42 C.F.R. § 413.79(l). In 2009, however, CMS “clarified” that certain programs that receive “initial accreditation by the appropriate accrediting body” may be considered by the agency not to be “new,” and thus not able to qualify for a new FTE cap. 74 Fed. Reg. 43,754, 43,908-17 (Aug. 27, 2009).

5. Medicare GME Affiliation Agreements

   a. To provide for flexibility within the 1996 caps for hospitals that cross-train residents, hospitals may combine their respective FTE caps in a Medicare GME “affiliated group.” The resident limits of the hospitals in the affiliated group are then measured against the group’s aggregate cap. In this fashion, hospitals that cross-train residents may, in essence, lend their “unused” FTEs to other hospitals in the group whose FTE counts may exceed their limits.

   b. The rules regarding affiliations are strict. See 42 C.F.R. §§ 413.75 and 413.79(f).

       (i) CMS allows affiliation agreements only between or among members of affiliated groups, which it defines as:

          — Two or more hospitals that are located in the same or contiguous CBSA and that have a shared rotational arrangement;
— Two or more hospitals that are not located in the same or contiguous CBSA, have a shared rotational arrangement, and are jointly listed:

- as the sponsor, primary clinical site, or major participating institution for one or more programs as these terms are used on the Accreditation Council for Graduate Medical Education (ACGME) website’s list of accredited and sponsoring institutions (http://www.acgme.org/adspublic), or

- as the sponsor or listed under “affiliation and outside rotations” for one or more programs in operation as listed on the American Osteopathic Association’s (AOA) website Opportunities – AOA Approved Internships and Residencies (http://opportunities.osteopathic.org)

— Two or more hospitals that are under common ownership and that have a shared rotational arrangement.

(ii) Each hospital in the affiliated group must have a shared rotational arrangement with at least one other hospital
within the affiliated group, and all of the hospitals within the affiliated group must be connected by a series of such shared rotational arrangements. A “shared rotational arrangement” is defined as a residency training program under which one or more residents participate in training at two or more hospitals in that program.

(iii) The Medicare GME affiliation agreement must have the following qualities:

— The agreement must be written, signed, and dated by responsible representatives of each hospital in the affiliated group.

— The agreement must be entered into by July 1 of the year in which it starts. As a practical matter, this means that negotiations about an affiliation agreement must be initiated well before July 1 of each year so that the terms of that agreement may be reached and submitted to the Medicare contractors, with a copy to CMS, no later than July 1 of that year. Backdating of agreements or entering into agreements “as of July 1” is not authorized.
— The agreement must specify its term of years, which must be at least one year and must begin on July 1. Although agreements must be for at least a one-year term, longer terms are permissible.

— The agreement must specify each participating hospital’s DGME and IME FTE caps in effect prior to the affiliation (i.e., the “historic” caps). The agreement must note the total adjustment to each hospital’s FTE caps for both DGME and IME in each year the affiliation agreement is in place. This adjustment must reflect that a positive adjustment to one hospital’s DGME and IME FTE caps is offset by a negative adjustment of at least the same amount to the other hospital’s (or hospitals’) DGME and IME FTE caps. To ensure that the FIs are satisfied by the affiliation agreement’s language, it is advisable to state affirmatively in the agreement something like the following: “Any positive adjustment to one hospital’s FTE caps will be offset by a negative adjustment(s) to other hospitals’ FTE caps of at least the same amount.”

— The agreement must show the adjustment to each participating hospital’s FTE counts resulting from
the FTE residents’ participation in a shared rotational arrangement with other hospitals in the affiliated group for each year the affiliation agreement is in effect. This adjustment to each participating hospital’s FTE count is to be reflected as well in the total adjustment to each hospital’s DGME and IME caps. These adjustments, as well as the historic caps and the adjustment of the FTE caps in each year, may be satisfied by a chart showing these numbers or by a narrative discussion.

— The agreement must state the names of the participating hospitals and their provider numbers.

c. The executed affiliation agreement must be submitted to each hospital’s Medicare contractor and to the CMS central office no later than July 1 of the residency training year during which the affiliation agreement will be in effect. Additionally, if hospitals in the affiliated group have affiliation agreements with other hospitals as part of other affiliated groups, the hospitals must also include copies of those agreements with their submission to CMS and to the Medicare FIs/MACs.

d. Affiliation agreements are not cast in stone. Providers may extend the term of the affiliation agreements or may make modifications
to the hospitals’ FTE allocations to reflect the changing needs of the participating hospitals. (The total number of FTEs affected by the agreement, however, may not be modified.) These extensions and other modifications of the agreements must be in writing, with the revisions submitted to CMS and to each hospital’s FI by June 30 of the current residency training year.

e. The aggregate of the hospitals’ FTE counts as a result of the affiliation agreement may not exceed the aggregate historic FTE limits of all of the hospitals in the affiliated group.

f. Once the affiliation agreement ends, each hospital reverts to its historic limits. This means that once the affiliation agreement ends, hospitals may no longer keep the FTEs that they have “borrowed” through the agreement.

g. In two interim rules with comment periods published in the Federal Register on April 12, 2006, and November 27, 2007, CMS provided for emergency GME affiliation agreements to address when residents are displaced and trained by other hospitals during times of national emergencies. 71 Fed. Reg. 18,654 and 72 Fed. Reg. 66,893.
D. Resident FTE Limits – Rolling Averages.

1. In addition to the 1996 historic resident limits, a hospital’s DGME-related and IME-related FTE counts in a given year are based on the average of the count in the current year and the counts in the two prior years (the “rolling average”). The rolling average works in conjunction with the historic limits. If a hospital’s FTE count is over its historic limit in a given year, it must employ its historic limit in that year for purposes of computing the rolling average. Unlike the historic limit, the rolling average applies to dental and podiatry residents in addition to residents training in allopathic and osteopathic programs.

2. Although the affiliation agreement rules permit an adjustment only to the hospital’s historic limit in a given year, a hospital’s rolling average count may be affected by a Medicare GME affiliation agreement. If Hospital A transfers residents to Hospital B through an affiliation agreement, the historic limit for each will be temporarily adjusted in the current year. Each hospital’s rolling average, however, will be based on the current year’s FTE count, adjusted as a result of the affiliation agreement, plus each hospital’s FTE counts in the prior two years, divided by three. Thus, while the affiliation agreement will provide relief from a hospital’s historic cap, that relief may be dampened a bit by the rolling average.
E. Redistribution of Unused Resident Slots.

In recent times, certain hospitals expressed concern that they were training residents above their caps (therefore not receiving any Medicare support), and they requested relief from that situation. Congress has addressed these requests in two different pieces of legislation.

1. First, in Section 422 of the MMA, Congress addressed the issue by allowing for a “one time” redistribution of “unused resident positions.”

   a. Section 422 provided that if a hospital’s IME or DGME “reference resident level” was less than its corresponding cap, its cap was to be reduced by 75 percent of the difference between the cap, subject to certain adjustments,5 and the “reference resident level.” The “reference resident level” was based on the hospital’s most recent cost-reporting period ending on or before September 30, 2002, for which a cost report had been settled (or, if not settled, submitted but subject to audit). In some cases the reference resident level was based on the cost report that included July 1, 2003, if the hospital could show that it had started new residency programs or expanded residency programs that were not reflected on their 2002 cost report. Thus, if CMS determined that the FTE count for a hospital’s 2002 cost-reporting period (or, under certain circumstances, its 2003 period) was below the historic or 1996 cap,

5 The 1996 cap could be adjusted upward under certain circumstances related to new programs and Medicare affiliation agreements, all as discussed above.
as adjusted, CMS was to reduce the hospital’s IME and DGME caps to remove 75 percent of the “unused slots.” (Rural hospitals with less than 250 beds were exempt from a reduction.)

b. The fact that a hospital may have claimed a certain number of FTEs in its reference cost report was not necessarily determinative of whether it was able to avoid a reduction. CMS made clear that a hospital’s FTE resident counts that were used for purposes of determining the possible FTE cap reductions were subject to audit by the fiscal intermediary, with the fiscal intermediaries performing desk reviews or more detailed audits. See CMS Transmittal No. 77 (April 30, 2004).

c. CMS then redistributed the number of unused resident slots to other hospitals, giving priority, first, to rural hospitals; second, to hospitals in small urban areas; third, to hospitals that were the only hospitals with a particular specialty residency program in the state; and fourth, to hospitals in large urban areas. No hospital was allowed to gain more than 25 new cap slots. The procedures for the application process were detailed in the CMS’s final inpatient PPS rule. 69 Fed. Reg. 49,112-49,169 (Aug. 11, 2004).

d. A hospital’s “Section 422” transferred residents cap slots are reimbursed using a methodology that is different than that employed to calculate the reimbursement for the hospital’s non-
Section 422 residents. The MMA provided that, for DGME payments, the additional slots awarded under Section 422 are paid for using locality-adjusted national average per resident amounts, instead of hospital-specific PRAs. The IME payments are made based on a multiplier of “0.66,” the equivalent of about a 2.7 percent add on, well below the IME multiplier used to pay for a hospital’s other FTE residents.

e. The Section 422 FTEs are not included in the three-year rolling average computation or the prior year’s IRB ratio computation. See 69 Fed. Reg. 49,154.

f. The provision is effective for portions of cost-reporting periods beginning on or after July 1, 2005.

g. Notably, the determinations made by CMS under Section 422, including the audit findings, are exempt from administrative or judicial review.

2. Second, in § 5503 of the ACA, as modified by § 203 of the Medicare and Medicaid Extenders Act of 2010, Congress provided for a permanent redistribution in the DGME and IME FTE caps, effective July 1, 2011, for certain hospitals.

a. The redistribution applied if the hospital’s “reference residence level” – that is, its FTE count for a given cost reporting period—
was less than its “otherwise applicable resident limit.” The “otherwise applicable resident limit,” in turn, was the hospital’s FTE cap for any of the 3 most recent settled or submitted cost reports for cost reporting periods ending before March 23, 2010.6

b. Certain hospitals, such as rural hospitals with fewer than 250 beds and new teaching hospitals, were exempt.

c. CMS determined which of the 3 years had the highest resident count (with separate determinations for DGME and IME counts). If the highest resident count was below the hospital’s cap, CMS then reduced the hospital’s cap or limit by 65% of the difference between the cap and the FTE count in that year. If a hospital’s cap varied due to participation in an affiliation agreement, CMS reduced the hospital’s cap based on the year in which the variance between the FTE count and cap was the smallest.7

d. CMS estimated the number of slots available for redistribution by May 16, 2011. Auditors were allowed to continue to audit and adjust “actual” counts through 2011, with numbers retroactive to July 1, 2011 for purposes of the reduction. But the “redistribution” number estimated as of May 16, 2011 was not adjusted.

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6 The otherwise applicable resident limit was the hospital’s FTE cap in its reference cost reporting period, which could have been any of the hospital’s 3 most recent cost reporting periods ending prior to March 23, 2010 for which a cost report had been settled or submitted to the Medicare contractor by March 23, 2010.

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e. If a hospital was part of a Medicare affiliation agreement or emergency affiliation agreement, CMS looked at the whole affiliated group to see if the entire group was above the aggregate cap. If the group, as a whole, was over the cap, there was no reduction. The reference resident level with each hospital in the group was the reference resident level with respect to the cost reporting period that resulted in the smallest difference between the reference resident level and the otherwise applicable resident limit. See 76 Fed. Reg. 51476, 51714-24 (Aug. 18, 2011).

f. If hospitals merged during the 3-year period, CMS treated the hospitals as if they had been merged for all 3 years. If the merger occurred after March 23, 2010, CMS analyzed each hospital’s reduction separately and combined the reduced caps.

g. If a hospital received additional FTE slots under § 422, those slots were not counted as part of the “unused” slots analysis. 75 Fed. Reg. 72,167 (Nov. 24, 2010).

h. The unused slots were redistributed 70% to hospitals in states with resident-to-population ratios in the lowest quartile in the country, and 30% to hospitals in the top 10 states with populations in HPSAs and to rural hospitals. 75 Fed. Reg. 72,181 (Nov. 24, 2010). The redistribution, as noted, was effective July 1, 2011.
Applying hospitals were required to demonstrate that they were likely to use slots within 3 years. CMS employed criteria contained in a detailed evaluation form. No hospital was to be awarded more than 75 slots.

The DGME payments for the new FTEs are based on the hospital-specific per resident amount. 75 Fed. Reg. 72,192 (Nov. 24, 2010). The IME calculation for these FTEs employs the same multiplier as used for FTEs under the 1996 cap. Special rules apply if a hospital has received additional slots by virtue of both a Section 422 and a Section 5503 redistribution. In effect, if a hospital has received slots through both programs, the only residents for which the hospital would be paid at the lower 422 rate would be those in excess of the historic limit as adjusted by the 5503 increase.

The new slots are subject to the three-year rolling average and the prior year’s IRB ratio computation.

Applications for new slots were due January 21, 2011. On August 15, 2011, CMS posted reductions and additions to hospitals’ FTE cap numbers.

There is a five-year restriction on the use of the redistributed slots. Hospitals that receive additional Section 5503 slots may not use them as part of a Medicare GME affiliation agreement during that...
period. 75 Fed. Reg. a 72194. The hospital must use 75% of the slots for primary care or general surgery. The number of primary care slots cannot be less than the average during the three most recent cost reports submitted by March 23, 2010.

F. Redistribution of Slots from Closed Hospitals.

1. In § 5506 of the ACA, Congress addressed the fact that when teaching hospitals close, their FTE slots are permanently “lost.” Congress directed that when teaching hospitals close, their FTE slots are to be redistributed to other qualifying hospitals, with priority given: first, to hospitals in the same or contiguous CBSA as the closed hospital; second, to hospitals in the same state as the closed hospital; and, third, to hospitals in the same region.

2. The new provision applies to hospitals that closed on or after March 23, 2008. For hospital closures that occurred between March 23, 2008, and August 3, 2010, applications for the slots were due by April 1, 2011.

3. Within each priority category, the resident slots are to be redistributed according to a formula that gives priority to hospitals in the following order: (a) first, hospitals that have taken an entire GME program(s) from the closed hospital and made a commitment to continue to train residents in that program(s); (b) second, hospitals that received FTEs under the terms of a Medicare GME affiliation agreement from the closed hospital;
and (c) hospitals that permanently took a portion of, but not an entire program, from the closed hospital.

4. The hospital must be able to fill the requested slots within 3 years and, as in the case of the redistributed residents obtained under § 5503, those slots may not be used by the hospital as part of its FTE resident caps in a Medicare affiliation agreement for a period 5 years. 75 Fed. Reg. at 72221.

5. CMS has a detailed evaluation form, similar to that used for applying for slots available under § 5503 of the ACA; it is available on the CMS website. See also 75 Fed. Reg. at 72212-38.

G. New Programs.

1. In certain instances, regulations allow for adjustment to GME and IME caps if provider establishes a “new medical residency training program.”

2. CMS regulation defines a “new medical residency training program” as one that “receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.” 42 C.F.R. § 413.79(1).

3. One might assume that this means that as long as the program receives its initial accreditation from the ACGME or AOA, the program will be considered new.

4. CMS, however, took the position in 2009 that initial accreditation, alone, may not suffice to allow the program to be considered “new” by CMS.
The agency states that the program must be “truly new,” that is, one that has no vestiges in a prior program at another hospital. 74 Fed. Reg. 43,908-43,917 (Aug. 27, 2009).

5. If the program that was accredited at one entity ceases to operate and then is opened and operated at a new entity, CMS says the program will not be considered new, “even if it is accredited as a new program at the second entity.”

6. CMS says that one must consider not only the characterization by the accrediting body, but also:
   – whether there are new program directors;
   – whether there are new teaching staff;
   – whether there are “only new residents”;
   – the relationship between the hospitals at which “new” and “old” programs are located (e.g., common ownership, shared medical school);
   – whether the hospital with the original program continues to operate or, alternatively, has been closed;
   – if the hospital has closed, whether the program was part of the closed hospital’s cap determination, and, if so, whether the FTEs in that program are now part of any existing hospitals’ cap determination.

These factors – and others not articulated – may be relied upon by CMS to deny new program status.

7. CMS’s position is that this is a “clarification” of existing policy. CMS did not change the text of the governing regulation.