# Graduate Medical Education – The Past, The Present, The Future

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MEDICARE PAYMENTS ASSOCIATED WITH MEDICAL RESIDENTS

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].


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 on the number of FTEs that could be counted: (i) a limit based on the number of allopathic and osteopathic residents training at the hospital in 1996, and (ii) a three-year rolling average limit.

   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. Early 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). CMS also provided relief – in the form of temporary cap adjustments – when hospitals took on residents transferring from closed hospitals (1999 rule) or closed programs (2001 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-hospital training documentation standards. 72 Fed. Reg. 26,870, 26,948-26,977 (May 11, 2007).


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 IPPS Final 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 Final Outpatient 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 IPPS Final Rules.

P. 2012 IPPS Final Rule.

CMS issued rules changing the period for establishing FTE caps for new residency programs, clarifying policies regarding redistribution of residents, and changing policies regarding preservation of cap position from closed hospitals. (77 Fed. Reg. 53258, 53415-53448 (Aug. 31, 2012)).

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.¹ As explained further below, the payment is based,

¹ 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.
in part, on the number of interns and residents in relation to the number of beds.\footnote{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.}

III. DGME Payments.

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

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 “ceilings” on 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 payment purposes, the PRA, updated for inflation, is multiplied by the “weighted” payment 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 available 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 .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 (.05) and would have an add-on payment of roughly 2.7 percent, while a hospital with 40 residents per 100 beds (.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 .05 FTEs. Conversely, the IME count is not weighted.

3. The DGME count includes residents\(^3\) 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 counted as full (or “1.0”) FTEs for DGME, while

\(^3\) 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.
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 trained in a “preliminary year” program, such as internal medicine or surgery, CMS had long stated that this initial selection determined 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 – 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.

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 hospitals may qualify for a permanent adjustment to

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 establish resident limits, or caps, the computation of which depends on when the program first begins training residents.

(i) If the hospital began training residents in its first new program before October 1, 2012, the cap is 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. The adjustment may not exceed the number of accredited slots available to the hospital for the new program. See 42 C.F.R. § 413.79(e)(1).

(ii) If the hospital begins training residents in its first new program on or after October 1, 2012, and the residents do not rotate to other hospitals, the
hospital’s cap, or resident limit, is established based on the product of: (1) the highest number of residents in any program year during the fifth year of the first program’s existence; and (2) the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program. See 42 C.F.R. § 413.79(e)(1).

(iii) If the hospital begins training residents in its first new program on or after October 1, 2012, and if residents are spending portions of a program year or years at one hospital and the remainder at another hospital(s), the cap for each hospital that qualifies as a “new” teaching hospital is established based on the products of: (1) the highest total number of FTE residents trained in any program year, during the fifth year of the first new program’s existence, at all of the hospitals to which the residents in the program rotate; (2) the number of years in which residents are expected to complete the program,
based on the minimum accredited length for each type of program; and (3) the ratio of the number of FTE residents in the new program that are trained at the hospital over the entire 5-year period to the total number of FTE residents that trained at all hospitals (in that program) over the entire 5 year period. Again, the adjustment may not exceed the number of accredited slots available to the hospital for new program(s).

(iv) 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).
4. 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 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 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 FTE caps, or limits, of all of the hospitals in the affiliated group.

f. Once the affiliation agreement ends, each hospital reverts to its prior 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 otherwise applicable resident limits, or caps, 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 limits. If a hospital’s FTE count is over its limit in a given year, it must employ the limit in that year for purposes of computing the rolling average. Unlike the limit, or cap, 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 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 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 cap, or limit, 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, 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

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4 The 1996 cap could be adjusted upward under certain circumstances related to new programs and Medicare affiliation agreements, all as discussed above.
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, 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 section 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.\(^5\)

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.\(^6\)

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.

\(^5\) 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.
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.

i. 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.

j. 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. The hospital must use all of the slots in the fifth year for new programs, or in the fourth year for expanded programs or risk losing the “unfilled” slots and past reimbursement paid associated with those unused slots.

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

l. 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 1996 limit as adjusted by the 5503 increase.

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

n. 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.

F. Redistribution of Slots from Closed Hospitals.

1. In section 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. There have been two other application periods since that date to address later hospital closings.

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 web site. See also 75 Fed. Reg. at 72212-38; 77 Fed. Reg. at 53445-53448.

G. Hospital Residents Training in Off-Site/Non-Hospital Locations.

1. Since the late 1980s, hospitals have been able to include in their DGME FTE count those residents training in non-hospital locations as long as: (i) the hospital had a written agreement with the non-hospital location stating that the residents’ compensation for time spent in the non-hospital location is to be paid by the hospital; and (ii) the residents’ time is spent on patient care activities. For the past decade or so, however, the rules have been in flux.

2. In 1997, as a result of the BBA, hospitals have been able to count residents training at non-hospital locations for IME as well as DGME, subject to the same limitations that have applied historically to DGME as well as to the IME-specific 1996 caps.
3. The non-hospital requirements for both DGME and IME, were tightened, effective January 1, 1999, to require that the written agreement: (1) show, as before, that the hospital is incurring the cost of the residents’ salary and fringe benefits while the resident is training at the non-hospital site; (2) state that the hospital is providing “reasonable compensation to the non-hospital site for the supervisory teaching activities”; and (3) “indicate the compensation the hospital is providing the non-hospital site for the supervisory teaching activities.” 42 C.F.R. § 413.78(d).

4. In 2004, CMS provided an alternative to the written agreement requirement. Beginning October 1, 2004, hospitals were allowed, in lieu of having written agreements with the non-hospital sites prior to the time that the resident goes out to the non-hospital sites, to simply pay all or substantially all of the costs attributable to the training that occurs, with payment made by the third month following the month in which the training occurs. See 42 C.F.R. § 413.78(e).

5. In section 713 of the MMA, Congress put into place a moratorium for calendar year 2004 requiring the Secretary to allow hospitals to count residents in family practice programs without regard to the financial arrangements between the hospital and non-hospital sites.
CMS applied this both to training that took place during portions of cost reporting periods that occurred during 2004, and to final cost report settlements that took place in 2004. Congress did not extend that moratorium beyond 2004 or expand it to other medical specialty training programs. Note that the moratorium did not suspend the other requirements applicable to training in non-hospital sites.

6. In April 2005, CMS issued further clarifications regarding non-hospital training. Medicare Policy Clarifications on Graduate Medical Education Payments for Residents Training in Non-Hospital Settings (April 8, 2005) (FAQs). CMS specified that:

a. Hospitals were required to compensate non-hospital sites for the costs associated with teaching physicians’ activities other than the supervision of residents while furnishing billable patient care activities (i.e., “pure teaching” time).

b. The amount that the hospital was required to pay was based on the percentage of time that the physician spent on nonbillable DGME activities, multiplied by his or her salary and benefits, multiplied by the number of weeks a year that the resident trains at the location.
c. If the physician was self-employed, such that his/her compensation was based solely and directly on the number of patients he/she treated and for which he/she billed, the hospital did not need to make a payment to the physician for his/her “teaching” or “supervision” time. In most instances, however, the physician would be compensated through salary, profit sharing, or some other means, and there would have been a cost that the hospital was required to incur.

d. If hospital employed the teaching physicians, no extra compensation was necessary.

e. If sites were owned by the hospital, the hospital was still required to have an agreement and make payment.

f. If the hospital had an arrangement with an entity that ran multiple sites, such as a medical school that employs physicians, the hospital was allowed to employ a single agreement, but it was required to reflect the compensation for each site.

   a. CMS redefined “all or substantially all” of the costs for training to mean 90% of (1) the cost of the resident’s stipends and fringe benefits (including travel and lodging expenses, where applicable) and (2) the portion of teaching physicians’ salaries attributable to nonpatient care DGME activities.

   b. Hospitals were allowed, as before, to elect to have no written agreement and, instead, pay the costs of each program by the end of the third month following the month in which training occurred. If a hospital relied on this, however, it was required to be able to document that it is paying at least 90% of the cost.

   c. Hospitals could continue to use actual physician-specific salaries divided by time spent by the teaching physician in nonpatient care activities to determine the cost of training in the non-hospital site. Instead of using site-specific actual costs, however, hospitals were allowed to use proxy information as part of their calculations, as follows:
• In lieu of using time studies, the hospital could assume that the physician was spending three hours per week in nonpatient care DGME activities in each non-hospital setting.

• The hospital must have been able to determine the number of hours a week that the non-hospital site was open.

• The hospital would then take the ratio of these two numbers (3 divided by the number of hours that the non-hospital site was open) and multiply it by national average salary figure applicable to the particular specialty in which the teaching physician practice.

• This would result in the cost of the teaching physician’s DGME time which, when added to the cost of the salaries and benefits of the full-time equivalent (FTE) residents, would determine the amount of DGME costs for the program if FTE residents are rotating to a particular site throughout the whole year. If residents rotated to a non-hospital site for only a portion of the year, the ratio of three hours divided by the number of hours that a particular site was open would have needed to be further multiplied by the percentage of the year that FTE residents trained at that site.
d. The use of proxy data was further explained by CMS as follows:

- The proxy salary information must be the latest from the American Medical Group Association (AMGA Compensation and Financial Surveys) available at the beginning of the hospital’s particular cost-reporting period. Other salary proxy sources, such as RCEs, were not to be used to determine physician compensation in the non-hospital setting.

- In many instances, there may have been multiple teaching physicians and multiple residents located at a particular site. Unless the hospital could document otherwise, CMS would assume that all physicians at that site are supervising residents at some point during the training. For purposes of determining the 90% threshold, CMS would allow hospitals to apply a maximum of a one-to-one resident-to-teaching physician ratio to determine the total DGME costs applicable to a program at the non-hospital site.

- If the physicians were in different specialties, different proxy salary data were employed, and the hospital was required to use a weighted average.
• If a hospital had more than one program utilizing a particular non-hospital site, a separate computation was to be made for each program at each site.

• If more than one hospital utilized a single nonhospital training site, it was highly unlikely either hospital would have been able to claim time there since the rule required a hospital to incur all or substantially all of the direct GME costs at a particular nonhospital setting in order to claim time.

e. A hospital was allowed to use a combination of actual information and proxy information. A hospital, for example, could choose to use actual physician salary information but use the rate of three hours over the number of hours a particular non-hospital site was open to determine the percentage of time spent on teaching.

f. If, because of particular circumstances, the ratio of “3 hours divided by the number of hours a site is open” resulted in an unusually high number, CMS allowed the hospital to employ a ratio cap of 7.5%.

g. If hospitals chose not to use the proxies, CMS would not accept attestations from teaching physicians without supporting documentation. Physicians could provide the hospital with a signed document specifying, based on actual records kept, the amount of time spent with
residents. The physicians, however, would then have been expected to document this assertion with time studies, which the physicians were to have completed over a two-week period at two different points during the academic year (or, if a teaching physician supervised residents for the equivalent of a month or less in an academic year, a single one-week time study). If actual time were used, physicians were allowed to initially employ estimated percentages of time, based on the prior year’s rotations. The estimated percentages of time, as well as the 90% threshold of cost calculation, could be modified during the academic year, with that modification completed by June 30 of the academic year.

h. No proxy data was to be used for resident stipends and fringe benefits. Rather, actual costs of resident stipends and fringe benefits were required to be utilized. In arriving at these costs, the actual stipends and fringe benefits for each FTE resident that trains in the non-hospital site were to be used, and these costs could vary from resident to resident. CMS would not allow an “average” stipend figure to be employed.

i. Under the 2007 rule, if the parties entered into a written agreement, that agreement was required to specify the total compensation amount that the hospital incurred in paying resident stipends and fringe benefits to meet the 90% “all or substantially all” thresholds. The agreement was to specify the total amount of non-hospital training cost for that site and specify what costs are included in that amount.
j. If residents trained in various medical school clinics, the hospital was required to have a written agreement or multiple agreements reflecting the compensation for each clinic, with each agreement breaking out resident stipends and fringe benefits and a portion of teaching physician salaries attributable to DGME activities at the specific non-hospital site.

k. If a hospital was training FTEs in excess of its cap, the hospital could elect not to pay for the cost related to the training of residents in a non-hospital site and thus not include those FTE residents in its FTE count.

l. CMS stated in the regulation’s preamble that the “revised policy is relatively simple, easy to administer, and eliminates the documentation burdens.” 72 Fed. Reg. at 26,963.

8. In § 5504 of the ACA, Congress relaxed the rules governing training in non-hospital sites. It defined “all or substantially all” to mean just the cost of the residents’ stipends and fringe benefits. Thus, in most cases, it is no longer necessary, under the GME payment rules, to enter into agreements with, or establish a payment trail to, the teaching physicians providing supervision in the non-hospital sites. The change is effective for discharges after July 1, 2010 for IME, and for cost reporting periods beginning on or after July 1, 2010 for DGME.

a. In general, a hospital or hospitals must either “concurrently” incur the costs of the salaries and fringe benefits of the residents during the time the residents spend
in the nonprovider setting in accordance with 42 CFR 413.78(g)(3)(i), or have a written agreement between the hospital or hospitals and the outside entity that the hospitals are paying for the residents’ salaries and fringe benefits during the training at the nonprovider setting. If hospitals employ residents, there is likely no need for a written agreement with the nonhospital site but hospitals still must demonstrate that they are incurring the costs “concurrently” with the nonhospital training, 42 CFR 413.78(g)(3)(1). If payments are for multiple items, CMS will require, as before, that the portion attributable to residents’ stipends be separately identified, and that payments be further identified by program.

b. Multiple hospitals may count time for resident training at a single site, but there must be an agreement showing the proportional share of time allocable to each hospital. The hospitals’ agreement needs to memorialize that their payments for training at the site are at least equal, in the aggregate, to the residents’ stipend and fringe benefit costs while at the site. The residents’ stipend and fringe benefit costs must be broken out by program.

c. CMS asserts that these provisions have no retroactive effect.

d. The ACA requires additional recordkeeping to allow comparison of non-hospital training time in a given year against the base year training level. The base year is the cost reporting period beginning on or after July 1, 2009. CMS will rely on rotation schedules for documentation of
time spent in non-provider sites. Hospitals may use data reflecting the aggregate number of FTEs training in non-provider settings for non-primary care programs. For primary care, however, the data must be program-specific. CMS has amended the Medicare cost reports to allow the reporting of this information.

9. In 2003, CMS added the concepts of redistribution and community support to the off-site training rules. See 42 C.F.R. § 413.81.

a. Under the 2003 “redistribution/community support” rules, hospitals must continue to comply with the rules regarding non-hospital training costs. In addition, the hospital must be able to demonstrate that, as of January 1, 1999 (or before, at the Medicare contractor’s election), it incurred at least “some” of the costs associated with the training of FTEs in each program at each site and that it has been doing so since the date the residents first began training in that program at that site. What this means is that if an institution other than the hospital assumed the full cost of training for that program at any time from 1999 to date, the FTEs, according to the rule, cannot be claimed.

b. Additionally, CMS clarified that hospitals are required to incur all or substantially all of the cost of all of the
residents training in a particular non-hospital site in a particular program in order to count any FTEs training there in that program for purposes of IME and DGME payment. It is permissible, however, for a hospital to count new FTEs for whom the hospital incurs the direct cost of training – i.e., those residents that are added to an existing program – even though the hospital may not be permitted to count the “old, redistributed” FTEs already training in the program.

c. These rules, in combination, require the application of two distinct requirements for counting residents training in non-hospital sites:

- First, the hospital, in the current year, must incur all or substantially all the costs for all of the residents participating in the training program at the site. A hospital would be prohibited from counting any FTEs in the current year — including new FTEs added to an existing program at the non-hospital site — unless the hospital incurs all or substantially all of the costs of training all of the residents in that program at that setting in that year.
• Second, in order to count the FTEs in the non-hospital sites, the hospital must not have violated the redistribution or community support principles, meaning that the hospital must have incurred some of the costs related to those residents in that program for all past periods.

d. The 2003 “redistribution/community support” rules apply to training in hospital-based as well as off-site locations. It will be rare, however, for a hospital not to have incurred some costs associated with hospital-based training.

e. The 2003 rules include as “community support” what CMS terms “ordinary state or local appropriations,” but exclude “grants, gifts, and endowments” from the term’s ambit. Thus, if an off-site or hospital-based program was once entirely funded by a state or local appropriations, the redistribution/community support principle is triggered, and the hospital may not be reimbursed for the training even if it fully incurs the training costs now. Funding through grants, gifts or endorsements, however, will not have tainted the program.
f. The redistribution/community support rules were effective October 1, 2003, but exceptions were made for residents training in existing programs as of that date. Those residents were “grandfathered” for their completion of their training or for three years, whichever was less.

10. While a hospital may count residents training at a non-hospital location, this authority does not include the counting of residents training at a second hospital, even if the first hospital is incurring the total costs of that training. Only the second hospital may claim FTEs associated with training at its hospital. See 42 C.F.R. 412.105 and 413.78.

H. Research, Didactic and Other Leave Time.

1. In August 2001, CMS “clarified” its policy regarding research to provide that it will not include residents in the IME count “to the extent that the residents are not involved in furnishing patient care but are instead engaged exclusively in research,” that is, in “research … not associated with the treatment or diagnosis of a particular patient of the hospital.” CMS policy, however, allowed the FTE to be counted for DGME if the resident was engaged in research as part of an approved program and was in the hospital (but not non-hospital) setting.
2. In 2006, CMS further “clarified” its position, excluding from the IME count (for both hospital and non-hospital settings) and the DGME count (for non-hospital sites) resident time spent in “didactic” activities. Didactic time is time spent by residents in journal clubs, seminars, classroom lectures, and other scholarly pursuits. See August 18, 2006 Federal Register at 48,080-94.

3. In § 5505 of the ACA, Congress addressed CMS’s rules for research time, didactic time, and vacation, sick and other leave, as follows:

   a. Research time – Effective for cost reporting periods beginning on or after October 1, 2001, time spent by residents in activities associated with the diagnosis or treatment of a particular patient is not to be counted for IME no matter where it takes place and is not to be counted for DMGE in non-hospital sites. The legislation “shall not give rise to any inference” regarding CMS’s policy as applied to years before 2001 and whether that policy is proper as applied to those years.
b. Didactic time.

(i) Effective for cost reporting periods beginning on or after July 1, 2009, didactic time spent in non-hospital settings is counted as part of the FTE computation for DGME as long as the setting is primarily engaged in furnishing patient care. Stated another way, the site must be one in which the primary activity is the care and treatment of patients. Didactic time in non-hospital settings is not counted, however, for IME.

(ii) Effective January 1, 1983, time spent in didactic activities in the hospital is to be counted for IME purposes.

c. Vacation, Sick and Other Approved Leave

Effective January 1, 1983, such leave is included in the IME and DGME counts provided that it does not prolong the normal duration of the resident’s program. If a resident is spending time at multiple hospitals, those hospitals should proportionately divide vacation time if the rotation schedule does not indicate in which hospital the resident is training when the vacation is taken.
d. One Workday Rule

As part of the original didactic time “clarification,” CMS implemented a “One Workday Rule”. That rule had allowed hospitals some flexibility in how they documented didactic vs. patient care time. Although Congress did not address the issue in implementing § 5505 of the ACA, CMS terminated the use of the one workday rule for didactic time and declined to implement such a rule for research time. 75 Fed. Reg. at 71800, 72145 (Nov. 24, 2010).

I. DGME and IME Payments Associated with Medicare Managed Care Enrollees.

1. Prior to 1998, if teaching hospitals treated Medicare beneficiaries that were enrolled in managed care plans, they received no explicit DGME or IME payments associated with those patients (a portion reflecting teaching costs was included in the capitated rates paid to the managed care organizations). The BBA of 1997, however, carved out the teaching portion from the managed care rates and, instead, provided for Medicare to make DGME and IME payments directly to teaching hospitals, simulating the DGME and IME payments made under Part A.
2. The payments were phased in over a five-year period, and hospitals now receive full payments for the managed care patients.


J. DGME (not IME) Payments to Non-hospital Sites.

1. Prior to the BBA, only hospitals typically were eligible to receive DGME payments. The BBA, however, permits CMS to make DGME payments to “qualified non-hospital providers.” IME payments, however, are not authorized.

2. Under the BBA, “qualified non-hospital providers” include:
   
   a. Federally qualified health centers
   
   b. Rural health clinics
   
   c. Medicare + Choice organizations
   
   d. Other providers as designated by the Secretary.

3. The Medicare Fiscal Year 1999 PPS proposed and final rules set forth criteria and methodologies for these payments. See 63 Fed.

VI. Audit Issues.

Most of the audit issues for IME and DGME relate to the count of resident FTEs. This, in turn, raises a number of issues, identified below.

A. Generic, Non-Policy Grounds for Disallowance.

1. Programs are not approved.

2. Resident has completed training.

3. Initial Residency Period is wrong.

4. Problems with documentation, particularly in failing to document where and when training takes place.
   a. CMS considers rotation schedules (not IRIS) as main documentation for justifying resident count.
   b. CMS has not been very specific about how those rotation schedules must be kept.

5. Foreign Medical Graduate training documentation.
   a. ECFMG documentation.
b. Activities prior to arrival at hospital.

B. Research Time.

For IME, disallowances have been based on CMS’s belief that the FTE was engaged in non-patient care activities (principally, bench research).

1. In the 2001 inpatient PPS final rule preamble, CMS “clarified” its policy to state that time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable. 66 Fed. Reg. at 39,896 (July 1, 2001).

2. CMS had earlier stated in manual issuances that residents were excluded from the IME count if they were engaged exclusively in research. This is because costs incurred for research purposes, over and above usual patient care, are not included as allowable Medicare costs (42 C.F.R. § 413.90). CMS equates this with the resident’s time not being related to patient care, which CMS maintains is required consistent with the principles of 42 C.F.R. § 413.9.

3. In 2006, CMS extended the “not related to patient care” principle to disallow time related to journal clubs, seminars, and other didactic time. The ACA, however, effectively reversed CMS’s
4. CMS policy, pre-ACA, was that virtually all IME time and all non-hospital DGME time must be spent in patient care activities, i.e., “the care and treatment of particular patients,” with residents providing “services for which a physician or other practitioner may bill.” Post-ACA, CMS policy imposes this requirement only for research time (and for didactic time in non-hospital sites for IME).

5. CMS’s policies on research time have generated challenges. Several cases involving IME have been litigated and decided, with mixed results. Four district court cases have been decided in the providers’ favor. *Riverside Methodist Hospital v. Thompson*, 2003 U.S. Dist. LEXIS 15163 (S.D. Ohio 2003); *University Medical Center v. Leavitt*, 2007 U.S. Dist. LEXIS 20556 (D. Ariz. 2007); *University of Chicago Medical Center v. Sebelius*, 645 F. Supp. 2nd 648 (N.D. Ill. 2009), aff’d, 618 F.3d 739 (7th Cir. 2010); *Henry Ford Health System v. Sebelius*, 2009 U.S. Dist., LEXIS 121443 (E.D. Mich. 2009). See also, *Rhode Island Hospital v. Sebelius*, 2009 WL 406240 (Nov. 24, 2009) (requiring Secretary to explain criteria used to determine if time is related to patient care). The courts of appeals are split. First, the United States Court of
Appeals for the First Circuit ruled in the Secretary’s favor. *Rhode Island Hosp. v. Leavitt*, 2008 W.L. 4899530 (1st Cir. 2008). Then, the United States Court of Appeals for the Seventh Circuit ruled in the provider’s favor. *University of Chicago Medical Center v. Sebelius*, 618 F.3d 739 (7th Cir. 2010). Then, the United States Court of Appeals for the Sixth Circuit ruled for the government in the *Henry Ford Health System* case, 654 F.3d 660 (6th Cir. 2011).

Although the cases have all involved years prior to both the 2001 change in regulation and the ACA, both the Seventh and Sixth Circuits found the ACA’s language informative and largely relied on that language in reaching their decisions.

6. Providers’ Arguments:

   a. CMS’s position is inconsistent with statutory language.

      (Providers’ argument is stronger for IME activity taking place in the hospital).

      (i) CMS can point to no language that contains a patient care-related requirement for in-hospital services. For non-hospital site training, however, CMS can point to statutory language.
(ii) For DGME, the statutory language is that the hospital must incur all or substantially all of the costs of non-hospital training and the time must be spent in “activities relating to patient care.” 42 U.S.C. § 1395ww(h)(4)(E). Similarly, for IME, the hospital must incur all or substantially all of the cost of the non-hospital training, and the time must be spent in “patient care activities.” 42 U.S.C. § 1395ww(d)(5)(B)(iv). (The language, however, may help support providers’ “in hospital” position under common rules of statutory construction.)

(iii) CMS’s position is inconsistent with CMS’s regulations in place at the time services were furnished.

(iv) CMS policy is inconsistent with the intent of Congress. (Again, providers’ argument may appear stronger for in-hospital time.) CMS contends that its policy, for in-hospital time, is “rooted in the creation and purpose of the IME adjustment … [which is to pay] teaching hospitals for [their] higher costs of care.” This requires, according to
CMS, a showing that the individual residents are engaged in patient care. The IME adjustment, however, is only a proxy to calculate the higher costs associated with the hospitals being “teaching hospitals.” That proxy does not require a showing of relationship to patient care.

(v) Even if a showing of related to patient care is required, the term “related to patient care” has a broader meaning under Part A than the meaning that CMS gives it. CMS equates “related to patient care” as requiring the furnishing of services that would generate a Part B bill.

(vi) The application of the policy to periods prior to 2001 violates the APA. 2001 research policy is not a clarification, but rather reflects new policy. The policy is inconsistent with past articulations of policy, both for IME and DGME and both for in-hospital and non-hospital training. See, e.g., 1999 letter from CMS. Thus, retroactive application of policy is inappropriate.
(vii) CMS’s position is inconsistent with ACA’s treatment of time not related to patient care pre-2001.

7. Secretary’s Arguments:

a. The pre-ACA statute, regulation, and legislative history are ambiguous. Secretary has broad authority to interpret.

b. The Secretary’s requirement that resident be “integrated into a hospital unit” reimbursed under PPS is permissible.

c. Residents engaged in research do not contribute to added costs.

d. Although the statute, both before and after the ACA, did not directly answer the question of whether pure research time is countable prior to October 1, 2001, Congress, in the ACA, delegated to the Secretary authority to define nonpatient care activities to be excluded from the IME FTE count. ACA § 5505(b). That provision is retroactive to 1983. CMS, in its 2010 regulation implementing this ACA authority, excluded pure research from the count, and the distinction drawn is reasonable.
C. Non-hospital Training (Pre-ACA)  As noted above, the ACA greatly simplified the rules for non-hospital rotations. In the pre-ACA era, however, many disallowances resulted from CMS’s belief that hospitals had failed to comply with the non-hospital training rules, and those disallowances are still being questioned. The issues raised involve many different questions.

1. Is resident engaged in patient care at the site – that is, is this a “clinical site” of training?

2. Is there a written agreement or, if not, has payment been timely made? Not required by statute, but has been required by regulation.

   a. Is agreement required?

      (i) What if teaching site is owned by a related party, e.g., the medical school?

      CMS Program Memorandum A-98-44 (December 1998) states that an agreement is required and that payment must actually be made. See also FAQs; Covenant Medical Center v. Sebelius, 424 Fed. Appx. 434, 2011 WL 1976837 (6th Cir.).
(ii) What if teaching physicians are employees of hospital? CMS still requires agreement with the non-hospital site. See FAQs.

(iii) What about training taking place in provider-based clinics or in non-hospital sites owned by the hospital?

If training takes place exclusively in hospital (including hospital-based clinics), no agreement is required, but if training takes place in a non-hospital site, must have agreement. FAQs. If the hospital owns the non-hospital site, an agreement is required, but the level of detail contained in the agreement may be reduced (no need to specify total costs or amount of costs the hospital will incur). 72 Fed. Reg. at 26,974 (May 11, 2007).

(iv) What if there are multiple non-hospital sites?

Must have agreement with each site. If operated by the same entity (e.g., Medical School), under single agreement, agreement must state compensation for each clinic. FAQs.
What if more than one hospital “claims” costs of program at single non-hospital site? CMS maintains that a single hospital would have to incur all or substantially all of the costs.

b. With whom must provider enter into an agreement?

(i) The regulations require that the agreement be with the non-hospital site and reflect the compensation the hospital is providing to the site for the supervisory teaching activities. 42 C.F.R. § 413.78(d)(2). There has been some confusion, however, about how this works in the “real world.” See, Alternative Medicare Payment Methodologies for Costs of Training Medical Residents in Non-hospital Settings. OIG Rpt. No. A-02-04-01012 (Dec. 8, 2004).

(ii) If physician is self-employed, physician and “site” are usually the same. Agreement is with physician. FAQs.

(iii) If physician is employee or must report to another official of non-hospital site, then the written
agreement is between hospital and authorized representative of non-hospital site.

(iv) What if non-hospital site does not pay physician’s compensation; another entity does, and the site is merely where training takes place? The agreement with the non-hospital site may state that there are no supervisory physician costs because clinic does not bear those costs, but that another entity bears the costs. The hospital, in this instance, should pay the other entity. FAQs; 72 Fed. Reg. at 26,974 (May 11, 2007).

c. What is the timing of the agreement and its execution?

CMS takes position that agreement must be in place prior to training taking place. 69 Fed. Reg. at 49,176, 49,181 (Aug. 11, 2004).

d. Has agreement been updated to conform to changes to regulations and “clarifications?” Has agreement been updated to reflect current appropriate “compensation” requirements?
3. Compensation – Does agreement state the amount of compensation to be paid to supervisory physicians for training in non-hospital location?

a. Required by regulation since 1999 as part of the requirement that hospital incur “all or substantially all” of the costs of training. Not required, however, by statute.

b. Compensation may be cash or “in kind” consideration. CMS’s December 1998 Program Memorandum states that in-kind consideration must be identified in the agreement, but value need not be assigned in the agreement. Alternatively the in-kind compensation must be provided or made available by the end of the third month following the month in which the training takes place. CMS statements suggest that, at a minimum, the hospital must be able, on audit, to support the reasonableness of the “in-kind” compensation.

c. In-kind compensation – particularly if furnished in lieu of written agreement – can be troubling. CMS has said “in-kind” compensation may include professional and educational support, as well as office space, with value substituted for compensation. But questions may arise
about how activities are “valued.” If there is no agreement, how do you show this?

d. The December 1998 Program Memorandum states that the “written agreement should be reflective of the actual costs incurred for resident compensation and supervisory teaching activities.” If compensation is part of lump sum payment for a “bundle” of activities, the hospital should determine the percentage of non-patient time spent training residents, either through time studies or through use of proxy method. See 72 Fed. Reg. at 26,968 (May 11, 2007).

4. Compensation – What Must Be Paid?

a. Originally, the regulation imposed a requirement that teaching physician compensation be “reasonable,” but did not define what that meant. Early on, CMS appeared to have a “hands-off” approach to the issue. In preamble to 1998 Federal Register, CMS stated that hospital is not required to “report the non-hospital site’s GME costs.” Indeed, in December 1998 Program Memorandum, CMS stated that “reasonableness” is up to hospital and non-hospital site to decide and that intermediaries were not to involve themselves unless “there is evidence that a hospital
is not incurring costs consistent with the written agreement.”

b. Later, however, CMS took a different position and set strict standards for “reasonableness.” See December 7, 2004 memorandum from Mark McClellan at CMS to Joseph Vengrin (OIG) (“[T]he hospital must pay the non-hospital site for the costs attributable to supervising residents at the non-hospital site. For example, if a teaching physician employed on a salaried basis by the non-hospital site spends 10 percent of his or her time supervising residents, then the hospital must pay the non-hospital site 10 percent of the supervisory physician’s salary.”). See also 69 Fed. Reg. at 49,176 (Aug. 11, 2004); FAQs.

c. There may be little cost associated with supervising physician. CMS has stated that the teaching physicians must be paid only for costs associated with the physician’s “activities provided in connection with an approved residency program other than the supervision of residents while furnishing billable patient care services.” FAQs.

d. Nevertheless, CMS’s current position essentially requires that hospital obtain wage information, data regarding hours
spent in certain activities (time studies), and total hours worked per year. Alternatively, CMS allows hospitals to use certain surrogate or proxy data. The proxy formula, however, is complicated, and one has to make that calculation for each DGME program at each non-hospital site. 72 Fed. Reg. at 26,970.

e. CMS: “We believe our revised policy is relatively simple to administer, and eliminates documentation binders cited … as being associated with current policy.” 72 Fed. Reg. at 26,963.

5. Volunteer Supervisory Physicians.

a. In 1998 Federal Register discussion, CMS stated: “We do not believe that the lack of explicit compensation for teaching activities means that physicians are necessarily volunteering their time. . . Nevertheless, for purposes of satisfying the requirement of a written agreement, the written agreement between a hospital and a non-hospital site may specify that there is no payment to the clinic for supervisory activities because the clinic does not have these costs.” 63 Fed. Reg. at 40,996 (July 31, 1998). See also 64 Fed. Reg. at 41,518 (July 30, 1999).
b. December 1998 Program Memorandum makes clear that a physician may “voluntarily participat[e] in training” under certain circumstances, such as in a physician’s own “private office.” Program Memorandum A-98-44.

c. But if third-party is compensating the physician for his or her time, is the physician’s time his or her own to “volunteer?” CMS states that the answer is “no.” CMS has said the portion of the teaching physician’s compensation paid by the non-hospital site attributable to time spent supervising and teaching residents remains a “cost” to the non-hospital clinic. CMS expects the non-hospital sites to determine, and the hospital to pay, an amount that reflects the actual costs of supervisory physician activities, regardless of whether the teaching physician is “volunteering” his time. Memo from Mark B. McClellan (CMS) to Joseph Vengrin (OIG) dated December 7, 2004. Medicare Policy Clarifications on Graduate Medical Education Payments for Residents Training in Non-hospital Settings, April 8, 2005. The issue, according to CMS, is “not volunteerism but whether there is a cost to the non-hospital site for supervising the residents.”
d. Thus, situations where there are no teaching costs, in CMS’s eyes, are limited. See 69 Fed. Reg. at 49,178-49,179; 69 Fed. Reg. at 49,182; FAQs.

e. Is a nominal amount of compensation sufficient? No, the hospital must pay costs. “A determination of costs must be made, and the hospital must pay the non-hospital site for those costs as long as those teaching physician costs exist.” Dr. McClellan’s letter.

f. But what if whole group – or practice – volunteers its time? Is this permissible? Is there then a “cost”? CMS maintains that there is a cost and that payment must be made. 72 Fed. Reg. at 26,954 (May 11, 2007).

D. Clinical Base Year (also known as “Preliminary Year”).

1. CMS’s historic position: By entering a clinical base year of generalized training, a resident has selected the residency program by which the initial residency period is measured. This typically leads to a reduction in the hospital’s weighted count of FTEs. Once residents complete the number of training years mandated by the clinical base year selection (e.g., internal medicine, three years) and have additional years of training left in the specialty program
(e.g., anesthesiology total years including clinical base year), the resident is counted as a half FTE.

2. CMS softened its position in 2004 for simultaneous matches and, in 2005, for matches that occur prior to the beginning of the first year of training. CMS applies these changes prospectively only.

3. Providers challenge this position as contrary to statutory definition of the initial residency period. Providers also maintain that CMS’s position is arbitrary and capricious.

E. New Programs.

1. In certain instances, regulations allow for adjustment to GME andIME 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.

F. Carry Forward Effect of Adjustments.

1. Some contractors are asserting that even if an adjustment to the FTE count is recognized in a given year, the effect of that adjustment in future years will not be recognized unless the “carry forward” issue has been specifically identified as an appeal item. This potentially affects the IME cap calculation in the year following the year of the FTE adjustment, because the IRB ratio is capped at the prior year’s ratio (see 42 C.F.R. § 412.105(a)(1)(i)). It could also affect the rolling average.

2. Even if one accepts the contractor’s position, the position raises questions about how and when the “carry forward” issue must be identified. If you have an issue regarding the count in 2009, for example, is it sufficient to assert in your 2009 appeal that any adjustment must be given effect in future years or must you appeal 2010 and 2011 to protect your rights?