AAMC Summaries of GME Sections of the Health Reform Bill

Sec. 5503. Redistribution of Unused Residency Slots (DGME and IME)

Summary

Medicare limits the number of residents the program will support. A hospital’s resident limit (or resident “cap”) is based on the number of FTE residents in approved allopathic or osteopathic training programs (before application of the 50 percent weighting factor used in DGME payment calculations), according to the hospital’s most recent cost reporting period ending on or before December 31, 1996. The health reform bill requires CMS to take 65 percent of the DGME and IME residency slots that have gone unused by a hospital for the past three years and to redistribute them according to certain criteria. The AAMC estimates that about 900 residency slots will be redistributed under this program, although the final number will depend on hospital data and on CMS’s interpretation of the legislation. Hospitals awarded slots under the redistribution program may be paid for those redistributed slots beginning July 1, 2011.

Reductions in Hospital Resident Caps

The DGME and IME resident caps of hospitals with three years of unused residency slots will be permanently reduced beginning July 1, 2011. To determine whether and by how many residents a particular hospital’s resident cap will be reduced, CMS will look back at the hospital’s last three settled or submitted cost reports for cost reporting periods ending before March 23, 2010. How this look-back period will be determined will need to be clarified through the regulatory process. The AAMC expects, however, that CMS will apply the regulatory interpretation the Agency used for the 2003 (Section 422) redistribution program. If CMS uses the same interpretation the Agency used before, the most recent of the three years at issue for the current redistribution program will be the most recent cost reporting period ending prior to March 23, 2010, for which (1) a cost report has been settled (CMS would use this cost report without any further audit); or (2) a cost report has been submitted (this cost report would be subject to audit by the FI/MAC). For example, the relevant period under this interpretation for a hospital with a June 30 fiscal year end that submitted a cost report for FY 2009 (July 1, 2008 – June 30, 2009), but for which this cost report had not yet been settled, would be FYs 2007, 2008, and 2009. Presuming the FY 2007 and 2008 cost reports have already been settled, only the 2009 cost
report would be subject to audit for purposes of determining whether and by how much CMS would reduce the hospital’s resident cap. Again, CMS will need to clarify the Agency’s interpretation of this time period through regulations.

CMS will use the smallest number of residency slots that went unused over the entire three year period and will reduce the hospital’s DGME and IME resident caps by 65 percent of that number. For example, if a hospital had 3 unused slots in FY 2007, 6 unused slots in FY 2008, and 4 unused slots in FY 2009, CMS would reduce the hospital’s resident limit for DGME and IME by 65 percent of 3, or 1.95 slots. Note, however, that in determining whether to reduce a hospital’s DGME and IME resident caps, CMS will not consider whether the hospital has used any residency slots it may have obtained through the prior Section 422 redistribution program.

The law does not specify whether the resident counts from the three cost reporting periods at issue may be amended (for purposes of cap reduction) to include additional didactic time that may now be counted under Section 5505 below. CMS will need to clarify this point in the Agency’s regulations implementing the redistribution program.

Note that CMS will not reduce the resident limit of the following: rural hospitals with fewer than 250 acute care inpatient beds; hospitals that participated in a voluntary residency reduction plan and that have a plan in place to fill the unused positions by March 23, 2012; and the replacement facility for the former Martin Luther King, Jr. - Harbor Hospital (Los Angeles).

\textit{Redistribution of Unused Residency Positions}

CMS is required to redistribute all of the residency positions the agency reduced through the 65 percent reduction in unused slots described above. Hospitals may apply to receive up to 75 slots under this redistribution program, and in awarding these additional positions CMS is required to consider factors including: (1) the hospital’s likelihood of filling the additional slots within the first 3 cost reporting periods beginning on or after July 1, 2011; and (2) whether the hospital has an accredited rural training track. The health reform bill also requires CMS to allocate 70 percent of the redistributed slots to hospitals in states with resident-to-population ratios in the lowest quartile and 30 percent of the redistributed slots to hospitals located in (a) the 10 states with the highest proportion of their populations living in a health professional shortage area (HPSA), and (b) rural areas.
While CMS must decide which states meet the redistribution criteria, the AAMC’s interpretation of the health reform law suggests the following [NOTE THAT THIS IS NOT AN OFFICIAL LIST – THE OFFICIAL LIST WILL BE PUBLISHED BY CMS]:

<table>
<thead>
<tr>
<th>13 States with Lowest Resident-to-Population Ratios</th>
<th>10 States with Highest Proportion of Population Living in a HPSA</th>
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<tbody>
<tr>
<td>Montana</td>
<td>Louisiana</td>
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<tr>
<td>Idaho</td>
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Hospitals receiving an increase to their resident limit may be paid for these additional slots beginning July 1, 2011. The per resident amounts used to calculate DGME payments for the redistributed slots will be equal to the per resident amount otherwise in effect for the hospital for primary care and nonprimary care. The IME adjustment factor for the redistributed slots is also set at the current 5.5 percent.

The additional slots a hospital receives through this program are subject to certain restrictions. For five years (beginning on the date the hospital’s limit was increased), the hospital may not reduce its pre-redistribution number of primary care residents below the average number of primary care residents training in the hospital during the three most recent cost reporting periods ending before March 23, 2010. For these purposes, a primary care resident is defined as a resident enrolled in an approved program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. Additionally, at least 75 percent of the additional slots a hospital receives through the redistribution program must be used for primary care or general surgery.

Take, for example, a hospital with a resident limit of 100 DGME residency positions, of which 55 were used for primary care in FY 2007, 65 were used for primary care in FY 2008, and 60 were used for primary care in FY 2009. If this hospital receives additional 4 residency positions through the redistribution program, for 5 years it must: (1) not allow the number of primary care residents it trains to drop below 60 \((\frac{55 + 65 + 60}{3} = 60)\); and (2) use at least 3 of its 4 new slots for primary care or general surgery.
Failure to comply with these requirements will result in the hospital’s losing all of the additional slots it gained through the redistribution program, slots CMS must then redistribute again to other hospitals.

Text of Health Reform Law

SEC. 5503. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking “paragraph (7)” and inserting “paragraphs (7) and (8)”;
(2) in paragraph (4)(H)(i), by striking “paragraph (7)” and inserting “paragraphs (7) and (8)”;
(3) in paragraph (7)(E), by inserting “or paragraph (8)” before the period at the end; and
(4) by adding at the end the following new paragraph:

“(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

“(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

“(i) IN GENERAL.—Except as provided in clause (ii), if a hospital’s reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(iii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise applicable resident limit and such reference resident level.

“(ii) EXCEPTIONS.—This subparagraph shall not apply to—

“(I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds;
“(II) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90–248, if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph; or
“(III) a hospital described in paragraph(4)(H)(v).

“(B) DISTRIBUTION.—

“(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (as estimated by the Secretary).
“(ii) REQUIREMENTS.—Subject to clause (iii), a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

“(I) the number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph; and

“(II) not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

“(iii) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case where the Secretary determines that a hospital described in clause (ii) does not meet either of the requirements under subclause (I) or (II) of such clause, the Secretary shall—

“(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

“(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

“(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—

“(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

“(ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

“(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), subject to subparagraph (E), the Secretary shall distribute the increase to hospitals based on the following factors:

“(i) Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary).

“(ii) Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of—

“(I) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to
“(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).

“(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

“(E) RESERVATION OF POSITIONS FOR CERTAIN HOSPITALS.—

“(i) IN GENERAL.—Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

“(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

“(II) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

“(ii) EXCEPTION IF POSITIONS NOT REDISTRIBUTED BY JULY 1, 2011.—In the case where the Secretary does not distribute positions to hospitals in accordance with clause (i) by July 1, 2011, the Secretary shall distribute such positions to other hospitals in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D).

“(F) LIMITATION.—A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

“(G) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

“(H) DEFINITIONS.—In this paragraph:

“(i) REFERENCE RESIDENT LEVEL.—The term ‘reference resident level’ means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

“(ii) RESIDENT LEVEL.—The term ‘resident level’ has the meaning given such term in paragraph (7)(C)(i).

“(iii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term ‘otherwise applicable resident limit’ means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).”.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

(A) by striking “subsection (h)(7)” and inserting “subsections (h)(7) and (h)(8)”;

and

(B) by striking “it applies” and inserting “they apply”.

(2) CONFORMING AMENDMENT.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:
“(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.”.

(c) CONFORMING AMENDMENT.—Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by striking “section 1886(h)(7)” and all that follows and inserting “paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act”.

Redline Version of Medicare Statute

DGME: § 1886(h)

(h) Payments for Direct Graduate Medical Education Costs.—

…

(4) Determination of full-time-equivalent resident.—

(F) Limitation on number of residents in allopathic and osteopathic medicine.—In general.—

(i) Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, subject to paragraph (7) paragraphs (7) and (8), the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital’s approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital’s most recent cost reporting period ending on or before December 31, 1996.

(H) Special rules for application of subparagraphs (f) and (g).—

(i) New facilities.—The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and subject to paragraph (7) paragraphs (7) and (8), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

(7) Redistribution of unused resident positions—
(E) Judicial review.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this paragraph, paragraph (8), or paragraph (4)(H)(vi).

(8) Distribution of additional residency positions.—

(A) Reductions in limit based on unused positions.—In general—Except as provided in clause (ii), if a hospital’s reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(ii) Exceptions.—This subparagraph shall not apply to—

(I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds;

(II) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90–248, if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph, or

(III) a hospital described in paragraph (4)(H)(v).

(B) Distribution.—(i) In general.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after
July 1, 2011. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (as estimated by the Secretary).

(ii) Requirements.—Subject to clause (iii), a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

(I) the number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph, and

(II) not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary). The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

(iii) Redistribution of positions if hospital no longer meets certain requirements.—In the case where the Secretary determines that a hospital described in clause (ii) does not meet either of the requirements under subclause (I) or (II) of such clause, the Secretary shall—

(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

(C) Considerations in redistribution.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—
(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

(ii) whether the hospital has an accredited rural training track (as described in paragraph (d)(ii)(iv)).

(D) Priority for certain areas.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), subject to subparagraph (E), the Secretary shall distribute the increase to hospitals based on the following factors:

(i) whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary).

(ii) whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of—

(I) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to

(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).

(iii) whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

(E) Reservation of positions for certain hospitals.—(i) in general.—Subject to clause

(ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).
(I) 50 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

(ii) Exception if positions not redistributed by July 1, 2011 — In the case where the Secretary does not distribute positions to hospitals in accordance with clause (i) by July 1, 2011, the Secretary shall distribute such positions to other hospitals in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D).

(F) Limitation — A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

(G) Application of per resident amounts for primary care and nonprimary care — With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

(H) Definitions — In this paragraph:

(i) Reference resident level — The term “reference resident level” means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(ii) Resident level — The term “resident level” has the meaning given such term in paragraph 7(C)(G).

(iii) Otherwise applicable resident limit — The term “otherwise applicable resident limit” means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).
IME: § 1886(d)(5)(B)

(d)(5)(B) ... 
(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. The provisions of subsection (h)(7) subsections (h)(4)(H)(vi), (h)(7) and (h)(8) shall apply with respect to the first sentence of this clause in the same manner as it applies they apply with respect to subsection (h)(4)(F)(i).

(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.

Sec. 5504. Incurring “All or Substantially All” Costs at Non-Hospital Settings

Summary

The Medicare statute authorizes teaching hospitals to receive DGME and IME payments associated with residents training in nonhospital sites, such as physicians' offices, if they incur "all or substantially all" of the training costs. (Note that hospitals may only count the time a resident spends in a non-hospital setting that is “primarily engaged in patient care activities.”) In 1999, CMS issued a regulation defining "all or substantially all" of the training costs as the residents' stipends and benefits plus physician supervisory costs. In 2005, CMS changed the regulatory definition of "all or substantially all" of the nonhospital site training costs to be 90 percent of the residents' stipends and benefits plus physician supervisory costs at the nonhospital site.

The health care reform law clarifies this requirement to mean that a hospital incurs “all or substantially all” of the required costs for both DGME and IME purposes, so long as the hospital incurs the costs of the resident stipends and benefits for the time the resident spends in that setting. The effective date of this provision for DGME purposes is “cost reporting periods beginning on or after July 1, 2010.” For IME purposes, the provision is effective “for discharges occurring on or after July 1, 2010.” This provision allows hospitals to avoid the administrative burden of calculating physician supervisory costs at the nonhospital site.

The law also clarifies that if more than one hospital incurs these costs, each may count a proportionate share of the time. Such an agreement to allocate the time proportionately must be documented in a written agreement between (or among) the participating hospitals.
Hospital cost reports may not be reopened for purposes of this section, unless a proper DGME or IME appeal was pending as of March 23, 2010. Additionally, this section requires hospitals to maintain and make available to the Secretary records of the time residents spend in nonhospital sites as well as how much time they spend in nonhospital sites compared to a base year (a year to be determined by the Secretary).

Text of Health Reform Law

SEC. 5504. COUNTING RESIDENT TIME IN NONPROVIDER SETTINGS.

(a) GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

(1) by striking “shall be counted and that all the time” and inserting “shall be counted and that—

“(i) effective for cost reporting periods beginning before July 1, 2010, all the time;”;

(2) in clause (i), as inserted by paragraph (1), by striking the period at the end and inserting “; and”;

(3) by inserting after clause (i), as so inserted, the following new clause:

“(ii) effective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.”; and

(4) by adding at the end the following flush sentence:

“Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.”.

(b) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)) is amended—

(1) by striking “(iv) Effective for discharges occurring on or after October 1, 1997” and inserting “(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010”; and

(2) by inserting after clause (I), as inserted by paragraph (1), the following new subparagraph:

“(II) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted towards the determination of full-time equivalency if a hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a
proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.”

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).

Redline Version of Medicare Statute

DGME: § 1886(h)

(h) Payments for Direct Graduate Medical Education Costs.—

…

(4) Determination of full-time-equivalent resident.—

(E) Counting time spent in outpatient settings.—Such rules Subject to paragraphs (J) and (K), such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time shall be counted and that

IME: § 1886(d)(5)(B)

(d)(5)(B) …

(iv) Effective for discharges occurring on or after October 1, 1997. (I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(II) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted towards the determination of full-time equivalency if the hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.
Sec. 5505. Counting Didactic and Research Time for DGME and IME Payments

Summary

Didactic Time

Prior to the passage of the health reform law, the Medicare program paid hospitals for time residents spent in didactic training – i.e. conferences and seminars not related to the care of a particular patient – only when the resident was training in the hospital. Additionally, before health reform, didactic time could only be counted for DGME payments, not for IME payments.

The health reform law now permits hospitals to count resident didactic time spent in non-hospital training sites for DGME purposes, beginning July 1, 2009. (Note that didactic training that takes place in non-hospital sites is still not counted for IME payment purposes.) Additionally, the health reform law now permits hospitals to count resident didactic time spent in the hospital for IME payment purposes, beginning January 1, 1983.

Research Time

In the hospital setting, the Medicare program currently allows hospitals to count resident time spent doing research not associated with the treatment or diagnosis of a particular patient for DGME payment purposes only (i.e. not for IME payment purposes). The health reform law clarifies that research time may not be counted for IME payment purposes beginning October 1, 2001. The law does not opine on the status of IME research time prior to October 1, 2001, stating that research provision of the law “shall not give rise to any inference as to how the law in effect prior to such date should be interpreted.”

The health reform law also clarifies that resident time spent conducting research in a non-hospital setting does not count for either DGME or IME payment purposes. This does not represent a change, as the Medicare program does not currently reimburse resident time spent conducting research in non-hospital settings.

Vacation Time, Sick Leave, and Other Approved Leave

The health reform law clarifies that resident time spent on vacation, sick leave, or other approved leave that does not prolong the total time the resident spends in the program beyond the program’s normal duration may be counted for DGME and IME payment purposes. This does not represent a change, as CMS currently permits providers to count this time.

Note: Hospital cost reports may not be reopened for purposes of any provision of Section 5505, unless a proper DGME or IME appeal was pending as of March 23, 2010.
**Summary Chart**

The following chart represents the current state of resident time that is and is not counted for Medicare DGME and IME payment purposes:

<table>
<thead>
<tr>
<th></th>
<th>DGME</th>
<th>IME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td><strong>Non-Hospital</strong></td>
<td><strong>Hospital</strong></td>
</tr>
<tr>
<td>Patient Care</td>
<td>Patient Care</td>
<td>Patient Care</td>
</tr>
<tr>
<td>Vacation/Sick</td>
<td>Vacation/Sick</td>
<td>Vacation/Sick</td>
</tr>
<tr>
<td>Didactic</td>
<td><em>Didactic (July 1, 2009+)</em></td>
<td><em>Didactic (Jan. 1, 1983+)</em></td>
</tr>
<tr>
<td>Research</td>
<td>NOT Research</td>
<td>NOT Research</td>
</tr>
</tbody>
</table>

*Note: Text in italics indicates language in health reform bill.*

*For research time prior to October 1, 2001, the law states that the research provision: "shall not give rise to any inference as to how the law in effect prior to such date should be interpreted."

**Text of Health Reform Law:**

SEC. 5505. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)), as amended by section 5504, is amended—

(1) in paragraph (4)—

(A) in subparagraph (E), by striking “Such rules” and inserting “Subject to subparagraphs (J) and (K), such rules”; and

(B) by adding at the end the following new subparagraphs:

“(J) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.

“(K) TREATMENT OF CERTAIN OTHER ACTIVITIES.—In determining the hospital’s number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the
Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.”; and

(2) in paragraph (5), by adding at the end the following new subparagraph:

“(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term ‘nonprovider setting that is primarily engaged in furnishing patient care’ means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.’’.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

“(x)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

“(II) In determining the hospital’s number of fulltime equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

“(aa) is recognized as a subsection (d) hospital;

“(bb) is recognized as a subsection (d) Puerto Rico hospital;

“(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

“(dd) is a provider-based hospital outpatient department.

“(III) In determining the hospital’s number of fulltime equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.’’.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

(2) GME.—Section 1886(h)(4)(J) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2009.

(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference as to how the law in effect prior to such date should be interpreted.
(d) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h))."

Redline Version of Medicare Statute:

DGME: § 1886(h)

(h) Payments for Direct Graduate Medical Education Costs.—

…

(4) Determination of full-time-equivalent resident.—

(E) Counting time spent in outpatient settings.—Such rules Subject to paragraphs (J) and (K), such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time shall be counted and that

(J) Treatment of certain nonprovider and didactic activities.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.

(K) Treatment of certain other activities.—In determining the hospital’s number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.

(5) Definitions and special rules.—As used in this subsection:

(K) Nonprovider setting that is primarily engaged in furnishing patient care.—The term ‘nonprovider setting that is primarily engaged in furnishing patient care’ means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.
IME: § 1886(d)(5)(B)

(d)(5)(B) …

(x)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

(II) In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital —

(aa) is recognized as a subsection (d) hospital;

(bb) is recognized as a subsection (d) Puerto Rico hospital;

(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

(dd) is a provider-based hospital outpatient department.

(III) In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.

Sec. 5506. Redistribution of Residency Slots from Closed Hospitals

Summary

Prior to the passage of the health reform law, DGME and IME residency cap slots at hospitals that closed could not permanently be redistributed to other hospitals (note that there is a provision that allows a hospital to receive cap slots temporarily if it takes on residents displaced by a closure; the hospital may retain the cap slot only until the resident(s) complete(s) their training). Under the health reform law, the DGME and IME residency slots from any hospital that closed or closes on or after March 23, 2008, will be redistributed permanently to other hospitals. CMS is required to distribute the slots in the following priority order, with preference given within each category to hospitals in the same GME affiliated group as the closed hospital: (1) hospitals located in the same CBSA as the closed hospital or in a CBSA contiguous to the closed hospital; (2) hospitals located in the same state as the closed hospital; (3) hospitals located in the same region of the country as the closed hospital; and (4) only if none of the above is possible, to other hospitals using the redistribution program criteria described above in Section 5503.
CMS may only redistribute these slots to hospitals that can demonstrate a likelihood of filling them within three years. Additionally, CMS will ensure that there is no duplication of slots between this closed hospital redistribution program and the program currently in place that permits hospitals to receive a temporary cap adjustment to accommodate residents from closed hospitals.

Hospital cost reports may not be reopened for purposes of this section, unless a proper DGME or IME appeal was pending as of March 23, 2010.

Note that nothing in this section affects the slots associated with the former Martin Luther King, Jr. - Harbor Hospital (Los Angeles).

Text of Health Reform Law:

SEC. 5506. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED HOSPITALS.

(a) GME.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

‘‘(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

‘‘(I) IN GENERAL.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program closes on or after a date that is 2 years before the date of enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

‘‘(II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

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

‘‘(bb) Second, to hospitals located in the same State as the hospital that closed.

‘‘(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

‘‘(dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

‘‘(III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise
applicable resident limit of a hospital under such process if the Secretary
determines the hospital has demonstrated a likelihood of filling the positions
made available under this clause within 3 years.

‘‘(IV) LIMITATION.—The aggregate number of increases in the otherwise
applicable resident limits for hospitals under this clause shall be equal to the
number of resident positions in the approved medical residency programs that
closed on or after the date described in subclause (I).

‘‘(V) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not
apply to the implementation of this clause.’’.

(b) IME.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)),
in the second sentence, as amended by section 5503, is amended by striking ‘‘subsections (h)(7)
and (h)(8)’’ and inserting ‘‘subsections (h)(4)(H)(vi), (h)(7), and (h)(8)’’.

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner
that requires reopening of any settled hospital cost reports as to which there is not a
jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of
payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social
Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under
section 1886(h) of such Act (42 U.S.C. Section 1395ww(h)).

(d) EFFECT ON TEMPORARY FTE CAP ADJUSTMENTS.—The Secretary of Health and
Human Services shall give consideration to the effect of the amendments made by this section on
any temporary adjustment to a hospital’s FTE cap under section 413.79(h) of title 42, Code of
Federal Regulations (as in effect on the date of enactment of this Act) in order to ensure that
there is no duplication of FTE slots. Such amendments shall not affect the application of section
1886(h)(4)(H)(v) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(v)).

(e) CONFORMING AMENDMENT.—Section 1886(h)(7)(E) of the Social Security Act (42
U.S.C. 1395ww(h)(7)(E)), as amended by section 5503(a), is amended by striking ‘‘paragraph or
paragraph (8)’’ and inserting ‘‘this paragraph, paragraph (8), or paragraph (4)(H)(vi)’’.

Redline Version of Medicare Statute:

DGME: § 1886(h)

(h) Payments for Direct Graduate Medical Education Costs.—

…

(4) Determination of full-time-equivalent resident.—

(H) Special rules for application of subparagraphs (f) and (g).—
(vi) Redistribution of residency slots after a hospital closes—

(I) In general.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (vi)) with an approved medical residency program closes on or after a date that is 2 years before the date of enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

(II) Priority for hospitals in certain areas.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

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

(bb) Second, to hospitals located in the same State as the hospital that closed.

(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

(dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

(III) Requirement hospital likely to fill position within certain time period.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.

(IV) Limitation.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).
(V) Administration.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this clause.

IME: § 1886(d)(5)(B)

(d)(5)(B) …

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent interns and residents in the hospital with respect to the hospital’s most recent cost reporting period ending on or before December 31, 1996. The provisions of subsection (h)(7) subsections (h)(4)(H)(vi), (h)(7) and (h)(8) shall apply with respect to the first sentence of this clause in the same manner as they apply with respect to subsection (h)(4)(F)(i).