AAMC
Tomorrow's Doctors, Tomorrow's Cures

OPPS Proposed Rule Teleconference: Medicare DGME and IME Provisions

Learn
Serve
Lead

Karen Fisher, J.D.
Senior Policy Counsel
kfisher@aamc.org

Lori K. Mihalich-Levin, J.D.
Senior Policy Analyst
lmlevin@aamc.org

Association of
American Medical Colleges

Sec. 5504, Counting Resident Time in Nonhospital Sites

(Proposed Rule Display Copy Pages 629-644)

AAMC

Counting Resident Time in Nonhospital Sites (§ 5504)

Hospital may count time residents spend training in nonhospital sites if the hospital:

Currently: Incurs 90% of the sum of resident stipends & benefits & supervisory physician costs

Affordable Care Act (ACA): Incurs resident stipends & benefits while residents are at nonhospital sites

Effective Dates:

DGME:	Cost reporting periods beginning on or after July 1, 2010
IME:	Discharges occurring on or after July 1, 2010

New regulation section at 42 CFR 413.78(g) (DGME) and modification to 412.105(f) (IME)

Counting Resident Time in Nonhospital Sites (§ 5504), Cont.

If Multiple Hospitals Incur These Costs?

- Each counts proportionate share of the time
- Must have written agreement that explains the proportionate distribution which must have a "reasonable basis"
- Must be able to document the amount the hospitals are paying collectively
- New paragraph (g)(2) under § 413.78 (IME regs will have conforming reference)
- Proposed rule display copy at pages 636-641

AAMC

Counting Resident Time in Nonhospital Sites (§ 5504), Cont.

Global Agreements (e.g., with a medical school)

- Lump sum payment amounts not sufficient
- Where residents on payroll of medical school and the hospital reimburses the school for the entire salary and fringe benefit costs “the hospitals could easily document that they have incurred the requisite costs of training in nonhospital sites.” ----IS THIS TRUE?

Counting Resident Time in Nonhospital Sites (§ 5504), Cont.

New Recordkeeping Requirements

- Legislation requires hospitals to maintain records of time residents spend in non provider settings and compare to a base year
- Proposed rule would establish July 1, 2009 to June 30, 2010 as base year
- Source of info would be rotation schedules and only need to keep track of total unweighted DGME counts
  - Information would need to be provided for EACH primary care program but only in aggregate for nonprimary care programs
- New cost report lines will be created to track this information
- Proposed rule display copy at pages 641-644

AAMC

Counting Resident Time in Nonhospital Sites (§ 5504), Cont.

Questions Regarding New Recordkeeping Requirements:

- Do rotation schedules show which rotations are in non-hospital ambulatory sites? If so, can the time be quantified from the schedules?
- Can you distinguish primary care nonhospital rotations from nonprimary care rotations? How difficult is this?
- Are you able to quantify time spent in hospital-based outpatient clinics? How difficult is this?
- Others?

Sec. 5505, Counting Resident Time for Didactic & Research Activities

(Proposed Rule Display Copy Pages 644-654)

AAMC

Counting Resident Time for Didactic and Research Activities (§ 5505)

IME:

Pre-ACA: No didactic in hospital counted

ACA: Didactic in hospital counted (eff January 1, 1983)

ACA: Ratifies October 1, 2001, regulation that excludes research time for IME payments

DGME:

Pre-ACA: No didactic in nonhospital site counted

ACA: Didactic in nonhospital site counted (eff July 1, 2009)

Counting Didactic Time in the Hospital for IME Payments

Can now count didactic time in hospital for IME payments

- NOT research that is “not associated with the treatment or diagnosis of a particular patient” (this was effective October 1, 2001)
- Effective January 1, 1983; legislation says hospitals can modify past cost reports if there is a “pending jurisdictionally proper appeal on direct GME or IME payments”
  - Since this is IME provision, CMS proposes to only allow IME appeals, not DGME appeals

Counting Didactic Time in nonhospital sites for DGME (NOT IME) Payments (§ 5505)

Can now count didactic time in nonhospital sites for DGME payments

- Training must be in a "nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary"
- Proposed rule will continue to use "patient care" definition at § 413.75(b): "the care and treatment of particular patients, including services for which a physician or other practitioner may bill, and orientation activities as defined in this section"
- Effective date: cost reporting periods beginning on or after July 1, 2009

Counting Didactic Time in nonhospital sites for DGME (NOT IME) Payments (§ 5505), cont.

Can modify past cost reports if there is a jurisdictionally proper appeal

Training must be in a "nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary"

Proposed rule will continue to use "patient care" definition at § 413.75(b): "the care and treatment of particular patients, including services for which a physician or other practitioner may bill, . . ." NOT medical schools

Counting Research Time for IME and DGME Payments

Can count any type of research time that occurs in hospital for DGME payments

For IME payments in both hospital and nonhospital sites and for DGME payments in nonhospital sites, can only count research that is "associated with the treatment or diagnosis of a particular patient"

Counting Research Time for IME and DGME Payments, cont.

More on research time that is "not associated with a particular patient":

- "usually comprises activities that are focused on developing new medical treatment, evaluating medical treatments for efficacy or safety, or elaborating upon knowledge that will contribute to the development and evaluation of new medical treatments in the future, rather than on establishing a diagnosis or furnishing therapeutic services for a particular patient." (display copy at page 652)
- Issue: Quality-related "research" / didactic activities

Counting Vacation and other Approved Leaves of Absence

ACA clarified that hospitals can count vacation, sick leave and other approve leave so long as the leave "does not prolong the total time the residents participates in his or her approved program"

Effective: January 1, 1983

Proposed Rule: Regardless of who pays stipends, hospital where resident is assigned when vacation occurs is hospital that would claim the time. . If rotation schedules unclear, "the hospitals to which the resident rotates over the course of the academic year would divide and count the resident's vacation time proportionately . . .(page 654)

- Is there a better way to do this??

Sec. 5503, Unused Residency Slot Redistributon Program

(Proposed Rule Display Copy pages 655-756)

AAMC

Resident Limit Redistribution Program (§ 5503)

Cap Reductions:

- 65% of FTE slots unused for past 3 years
- Look back at last 3 settled or submitted cost reports for cost reporting periods ending before March 23, 2010
  - Cost report "submitted"…by when? By the time the FI makes determination about any reductions

Resident Limit Redistribution Program (§ 5503)

Steps to determine if CMS will reduce your cap:

1. Do you meet an exception? – if yes, no reduction
   - Rural hospital with < 250 beds
   - Voluntary reduction plan participants (National VRRP, NY Medicare GME Demo, and Utah Medicare GME Demo), who submit by Dec. 1, 2010, a plan to fill the slots by March 23, 2012
     - Note: need not have completed the demo
   - MLK replacement facility

2. Are you at or over your cap in all 3 years? – if yes, no reduction

Resident Limit Redistribution Program (§ 5503)

Steps to determine if CMS will reduce your cap, cont.:

3. If no exception and not at/over cap in all 3 years: look at year with "highest" resident count.

   CMS will reduce your cap by 65% of the difference between your cap and your count in the year with the "highest" count.

   - If 2 years have "highest" count, use year with least difference between cap and count
   - If cap has changed, "highest" count may not be in year with smallest difference between cap and count…

Note: One opportunity to review for technical errors

Resident Limit Redistribution Program (§ 5503), Cont.

Example:

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

"Highest" Count is in both FY 2007 & FY 2008 – use FY 2008, because smallest difference between cap & count

- DGME Cap reduced by 65% of 1 slot (or 0.65 slots)

*Perform same analysis for IME slots.

AAMC

Resident Limit Redistribution Program (§ 5503), Cont.

What if your hospital is part of a GME affiliation agreement or emergency affiliation agreement (where hospitals share cap slots)?

- Look to year with highest count
- CMS will compare hospital's count to individual hospital's *affiliated* cap for that year
- CMS will not first look to group as a whole (as in Sec. 422) to see if entire group is over its aggregate cap
- See pages 674 – 676 of display copy

AAMC

Resident Limit Redistribution Program (§ 5503), Cont.

What if your hospital merged after 3/23/10?

- CMS will combine caps & counts for 3 year look-back
- See pages 676-677 of display copy

Resident Limit Redistribution Program (§ 5503)

CMS will ESTIMATE the number of slots available for redistribution

- Estimate to be complete by May 1, 2011
- Contractors may continue to audit counts after that date – will affect actual reduction for hospital, but won't change number in the redistribution pool
- See pages 665-667 of display copy

Resident Limit Redistribution Program (§ 5503)

Other Cap Reduction Issues:

- Didactic time that now counts under Section 5505 of health care reform law can be included if you have an open cost report
- CMS will *not* take into account unused slots you may have gained through the Sec. 422 redistribution program
- Cap adjustments made from July – December 2011 will be retroactive to July 1, 2011

Resident Limit Redistribution Program (§ 5503), Cont.

Where Will Redistributed Slots Go?

- **70% of slots:**
  - To states with resident-to-population ratios in lowest quartile
- **30% of slots:**
  - To states that are in top 10 in terms of population in HPSAs
  - Rural hospitals

Resident Limit Redistribution Program (§ 5503), Cont.

What if you don't fit into either category?

- You are *ineligible* for slots
  - i.e. if you are not a hospital in a state on one of the two lists on the next slide, and you're not a rural hospital, you will not receive any slots
  - See page 712 of display copy

What if slots are left over?

- New round of applications with same criteria, after July 1, 2011
- See page 725 of display copy

Proposed application available at p. 746

AAMC

Resident Limit Redistribution Program (Sec. 5503), Cont.

CMS's Proposed Lists:

13 States with Lowest Resident-to-Population Ratios	10 States with Highest Proportion of Population Living in a HPSA
Montana	Louisiana
Idaho	Mississippi
Alaska	Puerto Rico
Wyoming	New Mexico
Nevada	South Dakota
South Dakota	District of Columbia
North Dakota	Montana
Mississippi	North Dakota
Florida	Wyoming
Puerto Rico	Alabama
Indiana	
Arizona	
Georgia	

AAMC

Resident Limit Redistribution Program (§ 5503), Cont.

CMS *requires* proof of likelihood of using the slots within first 3 cost reporting periods beginning July 1, 2011. Options for this proof?

- No room under current cap to accommodate planned new program or expansion of existing program, shown through:
  - ACGME/AOA/ABMS-related documentation, institutional review document, etc., **and**
  - 85% fill rate in '07-'09 in other programs or 85% fill rate in that specialty nationally, within state, or within hospital's CBSA
- OR, already over cap, including 422 slots
  - Most recent cost report AND 2010 match info AND most recent accreditation letters

Resident Limit Redistribution Program (§ 5503), Cont.

CMS Priority Categories, once you're in a state on the list and you meet the "demonstrated likelihood" criteria:

(1) On Res-Pop list AND on HPSA list AND rural area

(2) Res-Pop list AND either rural area or urban with rural training track as of 7/1/10

(3) Res-Pop list

(4) HPSA list AND either rural area or urban with rural training track as of 7/1/10

(5) HPSA list or rural area

Resident Limit Redistribution Program (§ 5503), Cont.

How to decide within each priority category?

Answer: Point system

5 Points Each:

- Medicare inpatient utilization > 60% for 2 of 3 cost reporting periods with settled cost report
- Use new slots for new or expanded geriatrics program
- Will use all new slots for new or expanded primary care or general surgery program

Resident Limit Redistribution Program (§ 5503), Cont.

3 Points:

- Use new slots for new or expanded primary care program with focus on training residents to pursue careers in primary care (e.g. hospital has primary care track of internal medicine program)

2 Points:

- Hospital located in Primary Care HPSA

1 Point:

- Rural hospital that is rural track training site by 7/1/11 and is over its cap

Resident Limit Redistribution Program (§ 5503), Cont.

Example:

- Rural hospital in South Dakota with 1 point, gets slots before
- Urban hospital in Idaho with rural training track with 5 points, gets slots before
- Urban hospital in Alaska with rural training track with 5 points, gets slots before
- Rural hospital in South Carolina with 12 points

Note: if not enough slots for all applicants in 70% pool, will distribute to highest scorers first, then prorate remaining amount to hospitals in same priority category that have the same score. (Same for 30% pool.)

Resident Limit Redistribution Program (§ 5503), Cont.

Other issues:

- Max of 75 cap slots per hospital
- New slots effective July 1, 2011
- Can't use new slots for affiliation agreements
- IME payment for redistributed slots = 5.5%
- DGME payment = hospital-specific amount
- **422 IME payment rates only apply to excess of '96 cap + 5503 slots**

Resident Limit Redistribution Program (§ 5503), Cont.

Other Issues, cont.

- Must complete separate application form for each program
- Proposed deadline for applications:
  - December 1, 2010 – if count audit complete by then
  - March 1, 2011 – if count audit not complete by December 1, 2010
- Slots immediately subject to rolling average calculation and cap on IME resident-to-bed ratio

Resident Limit Redistribution Program (§ 5503), Cont.

5 Year Restrictions on Use of Redistributed Cap Slots:

- 5 years begins on July 1, 2011
- Post redistribution, the number of primary care residents cannot be less than the average for 3 most recent cost reporting periods ending March 23, 2010
  - Primary care = family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice (§ 413.75)
  - DGME – use WS E-3, Part IV, line 3.19 and subtract out OB/GYN residents
  - IME – develop primary care counts based on rotation schedules

Resident Limit Redistribution Program (§ 5503), Cont.

5 Year Restrictions, Cont.:

- Must use 75% of additional slots for primary care or general surgery
- CMS proposes that FI will check *each year* (as early as tentative cost report settlement) to ensure 5-year requirements are met
  - If not training full complement of new residents yet, FI will ensure 75% of added residents are primary care or general surgery
- Failure to comply? CMS will "recover any overpayment after 1 year rather than after the conclusion of the full 5 year monitoring period" and ultimately redistribute the slots to original applicants (but specifics of consequences not clear in proposed rule)

Resident Limit Redistribution Program (§ 5503), Cont.

What if you are over the cap?

- 25% of new slots may be used for over-the-cap specialists
- 75% of new slots, hospital must either
  - Convert over-the-cap specialist positions to primary care or general surgery, or
  - Create new primary care or general surgery positions

Resident Limit Redistribution Program (§ 5503), Cont.

Example:

- Hospital with 100 DGME cap slots; 55 used for primary care in 2007, 65 in 2008, and 60 in 2009
- Hospital receives 4 new slots through redistribution program
- For each year from July 1, 2011 - June 30, 2016, hospital must:
  - Train at least 60 primary care residents ((55+65+60)/3=60) *not including the new slots*
  - Use at least 3 of its 4 new slots for primary care or general surgery
    - If in first year hospital trains only 2 new residents, 75% (i.e. 1.5 FTEs) must be primary care or general surgery

Sec. 5506, Closed Hospital Medicare Cap Permanent Redistribution Program

(Proposed Rule Display Copy pages 756-784)

AAMC

Preserving Cap Slots from Closed Hospitals (§ 5506)

Permanently redistributes resident caps from hospitals that close

- Currently only temporary redistribution until residents complete training
- Applies to hospitals that close on or after March 20, 2008
- Proposed distribution process would apply to slots of all closed hospitals going forward
- No limit on number of slots hospital may apply for

First application deadline: January 1, 2011

Later applications: due 4 months after notice provided

Preserving Cap Slots from Closed Hospitals (§ 5506), Cont.

CMS proposed definition of a "closed hospital":

- Hospital terminates Medicare provider agreement, and
- Cap slots of closed hospital no longer exist as part of any other hospital's permanent FTE resident cap
- See pages 759-761 of display copy

E.g., the following are not closed hospitals:

- Hospital that declared bankruptcy but still participates under same provider agreement
- Hospital that closes a residency program but stays open
- Hospitals that merge, and no provider agreement is retired

AAMC

Preserving Cap Slots from Closed Hospitals (§ 5506), Cont.

Priority for distribution?

(1) Same Core Based Statistical Area (CBSA) (same pre-reclassification CBSA as used for wage index)

(2) Contiguous CBSA

(3) Same state (including PR and DC)

(4) Same region (Census Region)

(5) General redistribution program criteria as last resort

AAMC

Preserving Cap Slots from Closed Hospitals (§ 5506), Cont.

How to decide within each priority category? (assign slots from top to bottom of list)

(1) Hospital assuming entire program & operating program exactly as operated by closed hospital (same residents, same program director, same/many of same teaching staff)

(2) Hospital received slots from closed hospital under most recent affiliation agreement of closed hospital, and will continue training at least same # of FTEs as under agreement

Preserving Cap Slots from Closed Hospitals (§ 5506), Cont.

(3) Hospital took in displaced residents from closed hospital and will use slots to keep training residents in same program as displaced residents, but isn't assuming an entire program

(4) Hospital will use slots to establish new or expand existing geriatrics program

(5) Hospital located in Primary Care HPSA and will use all slots to establish new or expand existing primary care program

Preserving Cap Slots from Closed Hospitals (§ 5506), Cont.

(6) Hospital will use all slots to establish new or expand existing primary care program

(7) Hospital will use all slots to establish new or expand existing general surgery program

(8) Hospital does not fit into categories (1) – (7)

Note: Categories (1), (2), & (3) are assigned *immediately* and *permanently* (i.e. no temporary cap)

AAMC

Preserving Cap Slots from Closed Hospitals (§ 5506), Cont.

Also, hospital must demonstrate likelihood of filling slots within 3 years

- Very similar ways of demonstrating as under Sec. 5503 redistribution program

Proposed application form available at page 775 of display copy.

AAMC

Preserving Cap Slots from Closed Hospitals (§ 5506), Cont.

Other issues:

- No limit on # of slots hospital may apply for
- Can't use new slots for affiliation agreements
- IME payment for redistributed slots = 5.5%
- DGME payment = hospital-specific amount
- Slots immediately subject to rolling average calculation and cap on IME resident-to-bed ratio

Questions?