Click here to access session audio.

Reimbursement and Operational Issues Associated with Residency Programs

Nancy C. LeGros
King & Spalding LLP

Andrew D. Ruskin
Morgan, Lewis & Bockius LLP

Karen S. Fisher
Association of American Medical Colleges

Covered Issues

- Fundamentals of Medicare IME/GME reimbursement to hospitals
- PPACA provisions affecting reimbursement
- Establishment of new training programs
- Moonlighting
- New resident duty hour limitations
- Unapproved programs
- Supreme Court decision on FICA
- What's ahead - MEDPAC recommendations

Basic Tenets of Medicare GME Reimbursement

- Medicare regulates payment, not operations
- GME payments have been available since beginning of program in 1965, and used to be cost-based
- Medicare views residents to be more like nurses than like doctors
  - Therefore, reimbursement is under Medicare Part A (for hospitals) instead of under Medicare Part B (for physicians)
  - Teaching physicians can include resident services in their own billing in some circumstances

Basic Tenets of Medicare GME Reimbursement (cont.)

- Now payment is prospective and includes direct GME and indirect medical education (IME)
  - Direct GME reflects direct costs, and is paid through the Medicare cost report
  - IME is a payment for higher case mix of teaching hospitals, and is paid on a per-claim basis

Components of Direct GME formula

- The products of FTE count x per resident amount ("PRA") x Medicare patient load
- FTEs
  - Can be training anywhere in the hospital complex, including provider-based clinics
  - Can include some non-hospital sites (but not other hospitals)
  - Can include time spent in the hospital in research and didactic activities

Components of Direct GME formula (cont.)

- PRA
  - Calculated using a "base year"
  - Includes all direct and indirect costs of training, divided by FTE count
  - Trended forward after first year and not recalibrated
- Medicare patient load
  - Medicare utilization
  - Includes Medicare managed care

Components of IME Formula

- Key numbers include the “interns and residents to bed ratio” and the “multiplier”
- Available bed count
  - Acute care part of the hospital
  - Does not include beds that are never used
  - The lower the bed count, the higher the reimbursement

Components of IME Formula (cont.)

- FTE count
  - Only include time spent in the acute care part of the hospital and the outpatient department (not excluded units such as psych, rehab, etc.)
  - Non-hospital site time may be allowable
  - Exclude research time
- Multiplier
  - Set by Congress
  - MedPAC has for years recommended reducing this number

Rules Applicable to FTE Counts

- Capped at the FTE count for the cost reporting period ending on or before December 31, 1996
  - Separate caps for IME and direct GME
- Separate IME cap on interns and residents to bed ratio
- Three year "rolling average"
- Hospitals that did not have residents in 1996 have a cap of "zero"

Exceptions Applicable to New Teaching Hospitals

- Affiliation Agreements
  - Must be in an affiliated group
    - same or contiguous CBSA;
    - joint listing as sponsors, primary clinical site, or major participating institution in the Green Book;
    - *or*
    - listing under "affiliations and outside rotations" for AOA;
    - *or*
    - common ownership

Exceptions Applicable to New Teaching Hospitals (cont.)

- Must have shared rotations
- Must enter into a Medicare GME Affiliation Agreement prior to July 1 of a given academic year, indicating how much of the cap is to be shared
- Members of an affiliated group can transfer their caps among themselves through the agreement
- **New hospitals create a PRA as early as their first year!**

Exceptions Applicable to New Teaching Hospitals (cont.)

- New Teaching Hospital Exception
  - Applies to hospitals that did not have a medical residency training program in 1996, but establish one thereafter
  - Requires initial accreditation
- **PRA can be established even if no new program created.**

Exceptions Applicable to New Teaching Hospitals (cont.)

- Must be "new", which is a facts and circumstances test:
  - Is program director new
  - Is teaching staff new
  - Are there new residents
  - The relationship between hospitals (for example, common ownership or a shared medical school or teaching relationship)
  - The degree to which the hospital with the original program continues to operate its own program in the same specialty
  - Whether the program has been relocated from a hospital that closed
  - Has there been a program in the past but it has been closed for several years

Exceptions Applicable to New Teaching Hospitals (cont.)

- FTE cap for new programs
  - Not applicable for first 3 years
  - Set at the end of the third year
  - Is never subject to change thereafter
- New teaching hospitals *cannot* shift their caps through affiliation agreements (but can receive portions of others' caps)

Operational Challenges for New Teaching Hospitals

- Need commitment from hospital administration and medical staff
  - Teaching hospitals perceived as furnishing higher quality of care
- How cohesive is the medical staff?
  - Are all members supportive of teaching culture?
  - What about non-faculty physicians?
  - What are the strongest clinical departments?

Operational Challenges for New Teaching Hospitals

- If multi-campus hospital, will all campuses participate?
- Significant resources needed for compliance with ACGME requirements
- 2-3 year timeframe to obtain approval for program(s)

DGME/IME Changes in the Affordable Care Act (ACA)

Final Regulations in the CY 2011 OPPS final rule (released Nov. 2, 2010):

- Unused resident cap slot redistribution program
- Closed hospital cap slot redistribution program
- Counting time in nonhospital sites
- Counting time for didactic, research, approved leave

Note: Final rule was published in the *Federal Register* on November 24, 2010 (75 *Fed. Reg.* 71800, 72133)

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 and submitted as of March 23, 2010

Resident Limit Redistribution Program (§ 5503), Cont.

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 January 21, 2011, a plan to fill the slots by March 23, 2012, and MLK replacement facility
2. Are you at or over your cap in all 3 years? – if yes, no reduction
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.

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)?

- Addressed in Medicare and Medicaid Extenders Act of 2010
  - Look *first* to affiliated group as a whole
  - If group is under its cap, CMS will look at each hospital and look at year with smallest cap-count difference
  - Waiting for regulations

Resident Limit Redistribution Program (§ 5503), Cont.

Where Will Redistributed Slots Go?

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

Maximum of 75 slots per hospital

Resident Limit Redistribution Program (§ 5503), Cont.

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
South Dakota	South Dakota
Nevada	District of Columbia
North Dakota	Montana
Mississippi	North Dakota
Indiana	Wyoming
Puerto Rico	Alabama
Florida	
Georgia	
Arizona	

Resident Limit Redistribution Program (§ 5503), Cont.

How will CMS distribute to hospitals in these states?

- Demonstrate likelihood of using within 3 years
- CMS will distribute from top to bottom of each list
- Elaborate point system (*e.g.*, 5 points if you will use all new slots for new primary care or general surgery program, 2 points if located in Primary Care HPSA)

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 # of primary care residents cannot be less than average for 3 most recent cost reports submitted by March 23, 2010
- Must use 75% of additional slots for primary care or general surgery
- Auditor can look at average performance over cumulative years (p. 72199) (& no judicial review)
- Lose slots permanently if requirements not met (and slots then redistributed)

Preserving Cap Slots from Closed Hospitals (§ 5506)

Permanently redistributes resident caps from hospitals that close

- Currently, only temporary redistribution until residents complete training
- Hospitals that close on or after March 23, 2008
- No limit on number of slots hospital may apply for

First application deadline (hospitals closed between 3/23/08 and 8/3/10): April 1, 2011 (p. 72231)

Later applications: due 4 months after notice provided

Preserving Cap Slots from Closed Hospitals (§ 5506)

CMS 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

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

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

Priority for distribution?

1) Same or Contiguous Core Based Statistical Area (CBSA)
2) Same state (including PR and DC)
3) Same region (Census Region)
4) General redistribution program criteria as last resort

Must demonstrate likelihood of filling in 3 years…

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

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

(1)Seamlessly assumes entire program (= ≥ 90% of residents)

(2)Received slots from closed hospital under affiliated group & training same # as under affiliation

(3)Seamlessly assumes displaced residents but not entire program

(4)Not (1) – (3) and new or expanded geriatrics program

(5)Not (1) – (3), in HPSA, use all slots for new or expanded primary care or general surgery program

(6)Not (1) – (3), not in HPSA, and use all slots for new or expanded primary care or general surgery program

(7)Purpose not described above

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

Which teaching hospitals have closed?

- List on p. 72230 of *Federal Register*
- 14 hospitals (3 in NY, 2 in NJ, 2 in PA, and 1 each in AL, AZ, IL, IN, LA, MO, and SC)
- Total of > 700 slots

Counting Resident Time in Nonhospital Sites (§ 5504)

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

Pre-ACA: Incurred 90% of the sum of resident stipends & benefits AND supervisory physician costs

Under ACA: Incurs resident stipends & benefits while residents are at nonhospital sites

Effective Dates:

DGME: Cost reporting periods beginning on or after 7/1/10

IME: Discharges occurring on or after 7/1/10

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

New Recordkeeping Requirements

- Compare time residents spend in non-hospital settings to a base year – 7/1/09 – 6/30/10
- Information required for EACH primary care program but only in aggregate for nonprimary care programs
- New cost report lines will be created to track this information

Resident Time Counted and Not Counted for Medicare DGME and IME Payments (§ 5505)

DGME

Hospital	Non-Hospital
Patient Care	Patient Care
Vacation/Sick	Vacation/Sick
Didactic	*Didactic (July 1, 2009+)*
Research	NOT Research

IME

Hospital	Non-Hospital
Patient Care	Patient Care
Vacation/Sick	Vacation/Sick
Didactic (Jan. 1, 1983+)	NOT Didactic
*NOT Research (Oct. 1, 2001+)**	NOT Research

Note: Text in italics indicates language in the ACA.

* The ACA clarifies that IME research time does not count after October 1, 2001. It does not answer the question of whether IME research time counted prior to this date (the section 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").

Resident Time Counted and Not Counted for Medicare DGME and IME Payments (§ 5505)

- "Research not associated with the treatment or diagnosis of a particular patient" – (p. 72144)
- CMS elaborates that it "usually comprises activities that are focused on developing new medical treatments, 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."
- Issue: Quality/safety projects

Additional Resources:

AAMC Health Reform Website:
www.aamc.org/reform

Distinguishing Residents from Physicians

- A trainee is either a resident or a physician.
- A "resident" must be participating in an "approved medical residency training program." Requirements are either:
  - Actual approval by one of the organizations recognized in regulation by CMS, including ACGME or AOA (plus an exception for programs that choose not to teach abortions); or

Distinguishing Residents from Physicians (cont.)

- **If no actual approval, then:**
  - The training may count to certification in a specialty or subspecialty recognized by ACGME or ABMS; and
  - The program must be formally organized, which considers such facts and circumstances as whether:
    - the curriculum is locally determined or national;
    - there is a formal application, acceptance, and enrollment process;
    - there are standardized evaluations; and
    - the training results in a standardized outcome.

Distinguishing Residents from Physicians (cont.)

- The connection between the resident and the program must meet certain requirements:

  a. The resident must be formally accepted, enrolled, and participating in the program.

  b. The resident must actually need the training for certification in the area for which the resident has been training.

Distinguishing Residents from Physicians (cont.)

- There is also reimbursement available for residents formally training in unapproved programs.

- If a trainee is not a resident, then billing under Medicare Part B is allowable, but only if the physician requirements have been met.

Unapproved Fellowship Programs

- ACGME: approves 8888 programs in 130 specialties/ subspecialties at 680 sponsoring institutions involving 110,000 residents
- Unapproved Fellowships - no central registry
- Most academic institutions offer both
- Ex. - University of Massachusetts Medical School
  - 27 accredited fellowships
  - 23 non-accredited fellowships
    - Hospital Medicine Fellowship
    - Minimally Invasive Surgery

Status of Fellows in Unapproved Programs

- Medical Staff membership typically requires Board certification or eligibility in specialty
- Residents not eligible for Medical Staff membership
  - Followed by GME Committee
- Should fellow in unapproved program be treated like a trainee, or be eligible for Medical Staff appointment/independent clinical privileges?

Status of Fellows in Unapproved Programs

- Sample bylaws provision:

  Fellows in non-ACGME accredited fellowships may apply for medical staff membership and privileges within their board certified or eligible specialty. Fellows in a non-ACGME fellowship program at the Hospital shall require supervision for those patient care activities that are within the scope of the fellowship program. Such fellows shall not be credentialed to perform these activities independently

Status of Fellows in Unapproved Programs

- How to ensure supervision of services that are part of training program?
- Joint Commission standard on graduate education programs (MS 04.01.01) applies to approved and unapproved programs.
  - Requires defined process for supervision by teaching physician
- Need to confirm program is bona fide with formal curriculum

Status of Fellows in Unapproved Programs

- Need commitment from fellow and faculty physicians that supervision policies will be followed
  - May need faculty physician to confirm in writing responsibility for acts of fellow
- Hospital staff need to be aware of scope of training program
  - No scheduling concurrent procedures for teaching physician and fellow

Status of Fellows in Unapproved Programs

- McGaw Medical Center of Northwestern University
  - Establishes new GMEC subcommittee on non-accredited fellowships
  - Two types of programs for nonapproved fellowships
    - Advanced Specialty Training Program
      - Fellows assume junior faculty status
      - Administrative services agreement with McGaw required for oversight of program
      - Billing for services if fellow qualified to perform independently
    - Non-Accredited McGaw Fellowship
      - Trainees treated as housestaff

Recent Developments -Resident Duty Hours

- December 2008 - IOM Report: *Resident Duty Hours: Enhancing Sleep, Supervision and Safety*
- June 2010 - ACGME proposes new duty hours/supervision standards
- September 2, 2010 - Public Citizen/Committee of Interns and Residents petition OSHA to adopt and enforce resident duty hour regulations
- September 28, 2010 - ACGME approves new standards, to be effective July 1, 2011

ACGME Standards: Duty Hours

Standard	Current	Effective July 2011
Maximum hours per week	80 hours, averaged over 4 weeks, including in-house call & internal moonlighting	Same, but must also include: external moonlighting time spent in hospital committee service & interviewing residency candidates

ACGME Standards: Duty Hours

Standard	Current	Effective July 2011
Maximum duty period length	Continuous on-site duty limited to 24 consecutive hours, with up to 6 additional hours for continuity of care and outpatient clinics	Limit of 16 hours for PGY-1 residents No new clinical responsibilities after 24 hours (no outpatient clinics) OK to remain for 4 hours for transition of care

ACGME Standards: Duty Hours

Standard	Current	Effective July 2011
Time off between scheduled duty periods	10 hours between daily duty periods & after in-house call	PGY-1 and intermediate level residents should have 10 hours/must have 8 hours free 14 hours free after 24 hour duty periods Senior residents may have less than 8 hours free

Resident Duty Hours

- Practical effects of reduced work hours
  - Less moonlighting
  - Development of non-teaching services at academic medical institutions
  - Increased use of hospitalists and mid-levels
  - Calls for reducing nonclinical chores, redesigning workflow and increasing focus on teamwork

Moonlighting - Operational Issues

- Voluntary medical services outside scope of training program
  - Some institutions count non-patient care activities on behalf of the hospital
- ACGME requires institutional policy
  - Must have approval from program director
- Resident generally responsible for obtaining
  - Full license and hospital privileges
  - Liability insurance
  - DEA certificate
- Restrictions for J-1 visa holders

Moonlighting - Operational Issues

- For internal moonlighting, institution needs to consider
  - Which units in hospital involved?
  - Should a separate class of employees be created for moonlighting residents?
  - Who makes decisions about whether services of a moonlighting resident are billable?
    - Patient care services must meet coverage requirements for physician services

Moonlighting

- Generally, all activities of a resident are presumed to be part of the approved medical residency program.

- ***Other Hospital***. If performing services at a hospital different from where the resident is training, then the services can be billed under Medicare Part B if the services are separately identifiable from the services performed as part of the resident's training program.

Moonlighting (cont.)

- Same Hospital. If performing services at a hospital where the resident is also training, Medicare Part B billing is available if:
  - Services are performed in either the outpatient department or the emergency department;
  - The services otherwise meet the physician billing requirements;
  - The resident has the requisite licensure; and
  - The services performed can be separately identified from those services that are required as part of the approved GME program.

Moonlighting (cont.)

- CMS has not explained how to satisfy the requirement that the services be separately identifiable from the resident's training. *E.g.*, cardiology resident working as an internist?

- If a resident is engaged in moonlighting in the inpatient unit, then there is no reimbursement available under either Medicare Part A or Medicare Part B.

FICA and Residents

Issue: Should residents pay FICA? (ie, are residents "students" or "employees" for purposes of the tax code)

Prior to April 1, 2005, IRS made "administrative determination" to accept position that residents were students and exempt from FICA

April 1, 2005 IRS regulation became effective—excluded residents from student exception ("worked" 40 hours)

Mayo and Univ of Minn contested regulation

Supreme Court ruled in favor of the IRS

Teaching Health Center Grants

ACA establishes a new Title VII grant program to develop "teaching health centers" (THCs).

Secretary may award 3-year grants of up to $500,000 for establishing new accredited or expanded "primary care residency programs"

A THC is defined as an entity that:

- Is a community-based, ambulatory patient care center; and
- Operates a primary care residency program.
- Potential grantees include FQHCs, community mental health centers, rural health clinics, Indian Health Service health centers, and Title X family planning programs

The Senate proposed $10 million for this program in its failed FY 2011 omnibus. No funding is available yet for this program.

Teaching Health Center Payments (§ 5508(c))

The law also establishes a program under Title III of the Public Health Service Act to provide payments to qualified "teaching health centers" for expansion or establishment of new approved graduate medical residency training programs.

The legislation *appropriates* such sums as necessary up to $230 million for the period of FYs 2011-2015. Applications for the first round of awards were due to HRSA Dec. 30, 2010.

Payments to THCs (§ 5508(c)), Cont.

Framework, but many details missing – will need regulations

Payments are for any new or expanded program at THC (not necessarily primary care)

- Payments only for # of residents above "base level of primary care positions" (to be defined)

Payments to THCs (§ 5508(c)), Cont.

Payments are for:

- Direct expenses
  - Wage-adjusted national PRA x Average # of full time residents at THC
- Indirect expenses
  - Definition not clear, includes expenses "associated with the additional costs of teaching residents for a fiscal year" calculated by taking into account indirect costs "relative to supporting a primary care residency program" in a THC
  - *Not* the same as IME

What's Potentially Ahead - MedPAC Recommendations

- Report: "Aligning Incentives In Medicare"
  - Need greater accountability and transparency for IME/GME payments
  - Analyze/compare costs of programs in various specialties
  - Reduce IME payments and use for performance-based GME funding
    - Increase diversity of healthcare workforce
    - Incentivize programs to focus on teamwork, quality measurement and cost of care
    - Increase opportunities for community-based, ambulatory rotations

MEDICARE GRADUATE MEDICAL EDUCATION REIMBURSEMENT ISSUES

January, 2010

Andrew Ruskin[1]
Morgan, Lewis & Bockius LLP

I. BACKGROUND

A. Medicare graduate medical education payments are comprised of both direct graduate medical education ("GME") and indirect medical education ("IME") payments.

1. GME payments reflect the costs teaching hospitals incur in connection with the graduate training of physicians. These costs include the residents' salaries and fringe benefits, the salaries and fringe benefits of faculty who supervise the residents, other direct costs (such as costs of GME clerical personnel) and allocated overhead costs.

2. IME payments reflect an add-on payment that is made for each Medicare case to address the greater per-case costs associated with the patients treated in teaching hospitals. 42 U.S.C. § 1395ww(d)(5)(B). These costs are due, in part, to patient severity of illness that are not fully captured by the Medicare patient classification systems, and other items related to providing care in an educational environment, such as lower staff productivity. Separate IME payment methodologies apply to inpatient acute care hospitals, rehabilitation facilities/units, and psychiatric facilities/units.

B. GME regulations can be found at 42 C.F.R. §§413.75-88; IME regulations are at 42 C.F.R. §§412.105. Updates are made almost annually to these regulations as part of the inpatient rulemaking cycle.

II. DIRECT GRADUATE MEDICAL EDUCATION

A. Calculation.

1. GME payments are calculated by multiplying the hospital-specific per-resident amount ("PRA") by the number of the hospital's full-time equivalent residents ("FTEs") and by the hospital's Medicare inpatient utilization (referred to as the Medicare "patient load").

B. Per Resident Amount.

1. In general, the PRA is calculated by dividing allowable GME costs accrued during the GME base year (the cost reporting period beginning

[1] The author wishes to thank Karen Fisher. This Outline is based on an outline previously compiled by the author and Ms. Fisher for a similar session in 2006. Ms. Fisher has allowed the author to use materials contained in that prior outline in compiling this Outline.

between 10/1/83 and 9/30/84) by the base year FTE count. 42 C.F.R. § 413.77(a). Allowable GME costs generally include:

a. Residents' stipends/fringe benefits;

b. Salaries/fringe benefits of physician faculty who supervise the residents;

c. Other direct costs associated with resident training costs (such as the cost of clerical personnel that work in the graduate medical education (GME) administrative office); and

d. Allocated overhead costs (such as building, utilities, etc.).

2. The PRA is generally updated annually by some portion of the consumer price index.

3. For new teaching hospitals, the PRA is determined by the LOWER of their actual GME costs per resident or the average of the PRAs of surrounding teaching hospitals. The PRA is determined either in the first year of the program, if there are residents on-site during the first month of the cost reporting period, or otherwise in the second year of the program. 42 C.F.R. § 413.77(e)(1).

4. For merged hospitals, the PRA represents the weighted average of the PRAs for each of the constituent hospitals, as determined using the most recently settled hospital cost reports. 42 C.F.R. § 413.77(h).

5. Primary Care and Nonprimary Care PRAs. PRAs differ for primary care residents (family medicine, general internal medicine, general pediatrics, preventive and geriatric medicine, osteopathic general practice, and OB/GYN) and non-primary care residents because payment rate increases were frozen for non-primary care residents in FYs 1994 and 1995. 42 C.F.R. § 413.77(c).

C. Counting FTE Residents.

1. Residents in an approved program are countable, so long as they are working somewhere in the "hospital complex". 42 C.F.R. § 413.78(a).

a. "Hospital complex" is any area that meets CMS' provider-based criteria, including areas where research is exclusively performed.

b. An "approved medical residency program" is one that meets one of the following criteria:

i. The program is approved by one of the national organizations specified by CMS in its regulation, including ACGME and AOA;

ii. The training in the program *may* count towards certification in a specialty or subspecialty recognized by the ACGME or the ABMS (even if certification is not ultimately sought by

iii. The training is in a geriatrics fellowship program approved by the ACGME; or

iv. The program would be accredited, but for an accreditation requirement that abortion training be offered.

42 C.F.R. § 413.75(b).

2. Non-hospital sites.

a. An exception to the rule that residents must be training within the hospital complex applies to training in non-hospital sites, such as freestanding clinics and physicians' offices, provided certain conditions are met. 42 C.F.R. § 413.78(e).

D. FTE Caps.

1. In general, the BBA limits the number of allopathic and osteopathic residents that hospitals may claim for GME (and IME) payments to the number of residents counted on a hospital's most recent cost report ending on or before December 31, 1996. Separate limits apply for GME and for IME. 42 C.F.R. § 413.79(c)(2)(i).

a. The GME resident limit is based on unweighted resident counts (i.e. regardless of initial residency periods).

b. Rural teaching hospitals are limited to 130 percent of their FTE counts reported on their most recent cost report ending on or before December 31, 1996.

c. Effective with hospital cost reporting periods beginning on or after October 1, 1997, GME and IME payments are based on a three year rolling average of resident weighted counts (two years in FY 1998), subject to the FTE caps. That is, if a hospital's resident count is over the limit in a given year, the count for purposes of the rolling average will be the resident limit. 42 C.F.R. § 413.79(d)(3).

i. While the resident limit applies to allopathic and osteopathic residents only, the rolling average calculation includes dental and podiatry residents.

2. GME Affiliation Agreements.

a. Under certain conditions, hospitals may enter into an agreement to combine their resident limits into an aggregate limit. In accordance with the terms of such an agreement, one or more hospitals can shift all or some portion of their IME and GME FTE caps to another hospital. The affiliation agreement must specify the resident count increase or decrease from each hospital's

b. The hospitals also must have a "shared rotational arrangement", pursuant to which one or more residents split their training between the hospitals party to the agreement. 42 C.F.R. §413.75(b).

c. Upon termination, the caps must revert to their original BBA limits.

d. Affiliation agreements must be submitted to each hospital's fiscal intermediary and CMS by July 1 of each year.

42 C.F.R. § 413.75(b); 42 C.F.R. § 413.79(f).

III. INDIRECT MEDICAL EDUCATION

A. Calculation.

1. For every Medicare case paid under the inpatient operating PPS, a percentage add-on is applied to the base DRG payment.

2. The amount of the IME adjustment depends on a hospital's teaching intensity as measured by the ratio of the number of interns and residents to beds (IRB).

a. Pursuant to the BBA, a hospital's IRB ratio in any given year is limited to its computed value in the prior year (after accounting for the limit on the allopathic and osteopathic residents). This is known as the IRB cap.

3. The IRB ratio is incorporated into a formula determined by statute (42 U.S.C. § 1395ww(d)(5)(B)(ii)) as follows:

$$\text{Multiplier} \times ((1+\text{IRB})^{0.405} - 1)$$

B. Multiplier.

1. Historically, the multiplier has been determined by Congress.

2. A multiplier of 1.35 means that for every 10 residents per 100 beds, the hospitals receives about a 5.5 percent add-on payment to its basic DRG payment. Thus, for example, a hospital with 5 residents for every 100 beds (IRB = 0.05) would receive an add-on payment of about 2.7 percent. A hospital with 40 residents for every 100 beds (IRB = 0.40) would have its DRG payment increased by slightly more than 20 percent.

3. The current multiplier is 1.35, resulting in a 5.5% IME percentage add-on.

C. Determining the Bed Count.

1. The bed count used in the IRB ratio is based on available beds. Excluded from this count are the following:

a. Unoccupied beds. Beds in a unit that has had no patients reimbursed under the inpatient prospective payment system for the prior 3 months are presumed to be excluded from the bed count beginning in the 4th month. Beds that could not be used for inpatient prospective payment purposes within 24 hours for a 30 day period are also deemed to be excluded.

b. Beds in an excluded distinct part unit.

c. Observation services and swing-beds.

d. Beds or bassinets in a healthy newborn nursery.

e. Custodial care beds.

D. Counting FTEs.

1. In general, the method for counting FTEs for IME purposes is consistent with the method for counting FTEs for GME purposes.

2. However, unlike GME, residents can only be counted for IME if they are in the part of the hospital subject to prospective payment, or they are in the outpatient department.

3. Resident time spent in research not related to the treatment or diagnosis of a particular patient is not countable for IME. 42 C.F.R. §§ 412.105(f)(1)(iii)(B).

IV. Options for New Medical Residency Training Programs

A. Because of the FTE caps implemented by the BBA, reimbursement for increases in a hospital's FTE counts is available only under limited circumstances. One such case is the initiation of new medical residency training programs if certain conditions are met. The conditions vary, depending upon the type and location of hospital seeking the increase.

1. Urban Teaching Hospitals. Urban hospitals that were teaching hospitals in 1996 are able to receive an increase in their caps for new programs under certain very limited circumstances. If a hospital received initial accreditation for a new program between January 1, 1995 and August 4, 1997, then the FTEs training in such a program could be added to the FTE cap.

2. Rural Teaching Hospitals. Resident limits for rural teaching hospitals are adjusted upward to reflect new residency programs, regardless of when they begin.

3. New Teaching Hospitals. For hospitals that did not have a teaching program in 1996, it is possible to subsequently receive GME reimbursement. To do so, the hospital must develop both an FTE cap and a PRA.

a. FTE cap. New teaching hospitals start with an FTE cap of "zero" because they were not training any residents in 1996. The FTE cap

b. PRA. **Hospitals can set the PRA, even if they have not taken on new teaching programs, which can significantly reduce their GME reimbursement if they do later start new teaching programs.** As stated above, the PRA is the amount of direct and indirect cost per resident that it costs a hospital to train a resident. The PRA is a critical element of the direct GME payment calculation. CMS has taken the position that a hospital can set its PRA even in situations where the hospital is not seeking GME reimbursement. For instance, a hospital may have an FTE cap of zero because it did not train any residents in 1996, meaning that it cannot receive any GME payments for residency training. However, if such a hospital participates in training residents from another hospital's program, it could, in CMS' view, inadvertently have become a teaching hospital. As the costs involved in such participation could be negligible, it is possible that PRA would also be close to zero. If such a hospital later establishes new teaching programs, it would receive virtually no direct GME payments for all periods going forward.

B. Calculation of increase in cap. The increase in the FTE cap is equal to the product of the highest number of residents in any program year during the third year of the new program and the minimum number of years the residents in the program need to complete the program. For hospitals that first become teaching hospitals after 1996, programs can be added at any time during the first three years of becoming a teaching hospital. An aggregate cap is determined at the end of the third year of becoming a teaching hospital that applies to all programs. There are no additions to the FTE cap permitted after the third year, even if additional programs are subsequently initiated.

C. Definition of "New". **The cap exception only applies if the program is truly "new," in accordance with CMS' criteria. It is not sufficient simply to receive initial accreditation from ACGME.** CMS also considers:

- Is the program director new;
- Is the teaching staff new;
- Are there new residents;
- The relationship between hospitals (for example, common ownership or a shared medical school or teaching relationship);
- The degree to which the hospital with the original program continues to operate its own program in the same specialty;

- Whether the program has been relocated from a hospital that closed; and
- Has there been a program in the past but it has been closed for several years.

This is a facts and circumstances test, and CMS has not explained whether some factors are more critical than others.

D. Hospitals that have taken on new programs, but do not qualify for a cap increase can also enter into affiliation agreements (should they find a willing partner), which will allow them to count the time residents spend at their facility, up to the amount of cap transferred by the other hospital.

V. Distinguishing Residents Reimbursed under Medicare Part A from Physicians Reimbursed under Medicare Part B

A. A trainee is either a resident or a physician. Other than permitted moonlighting, a trainee cannot be both a resident and a physician at the same time. Accordingly, excluded from the definition of a "physician" is any individual who qualifies as a resident. To qualify as a resident, there are criteria that apply to the program in which the individual is training, as well as criteria that apply to the manner in which resident is participating in such program.

1. A trainee can meet the definition of a "resident" only if the trainee is participating in an "approved medical residency training program," which must meet one of the following sets of requirements:

   a. The program must be actually approved by one of the organizations recognized in regulation by CMS, including ACGME or AOA. Alternatively, the program would qualify for approval by one of these accrediting bodies, but for the decision by the program not to perform, or teach residents how to perform, abortions.

   b. If not approved by one of the accrediting bodies identified by CMS, then the following must apply:

      i. The training may count to certification in a specialty or subspecialty recognized by ACGME or ABMS. The nexus between the training and certification cannot be merely theoretical. It must be known at the time the training begins that the training qualifies the resident for certification in the specific specialty or subspecialty for which the resident is training; and

      ii. The program must be formally organized. This is a facts and circumstances test, and involves determining if: (a) the curriculum is locally determined or national; (b) there is a formal application, acceptance, and enrollment process; (c) there are standardized evaluations; and (d) the training results in a standardized outcome.

2. The connection between the resident and the program must meet certain requirements:

   a. The resident must be formally accepted, enrolled, and participating in the program.

   b. The resident must actually need the training for certification in the area for which the resident has been training. In other words, it is not acceptable to consider a trainee in the sixth year of a five year program to still be a resident. In most cases, chief residents, therefore, do not count as residents.

B. There is also reimbursement available for residents formally training in unapproved programs. CMS has recognized that certain programs, such as surgical oncology and transplant surgery, are not eligible for ACGME or ABMS certification. When residents are training in these programs, **and the residents have restrictions on their licenses**, reimbursement is available at 80% of reasonable cost of furnishing services (but not including administrative costs).

C. If a trainee is not a resident, then billing under Medicare Part B is allowable, but only if the physician requirements have been met.

1. It is not sufficient that a trainee not be a resident. It must also be true that the trainee have appropriate hospital privileges and an unrestricted license.

2. Additionally, the trainee must be involved in the diagnosis or treatment of a particular patient performing a service customarily furnished by a physician.

VI. Moonlighting

A. Generally, all activities of a resident are presumed to be part of the approved medical residency program. A very limited exception applies for moonlighting that meets all of the requirements in the pertinent regulation.

B. If performing services at a hospital different from where the resident is training, then the services can be billed under Medicare Part B if the services are separately identifiable from the services performed as part of the resident's training program.

C. If performing services at a hospital where the resident is also training, Medicare Part B billing is available if the services are performed in either the outpatient department or the emergency department, and:

1. The services otherwise meet the physician billing requirements.

2. The resident has the requisite licensure.

3. The services performed can be separately identified from those services that are required as part of the approved GME program.

D. CMS has not explained how to satisfy the requirement that the services be separately identifiable from the resident's training. However, some questions that may be relevant include: (a) whether there are likely to be any of the same patients seen during moonlighting activities and training activities; (b) whether

E. If a resident is engaged in moonlighting in the inpatient unit, meaning that the activities are separately identifiable from the resident's training activities, then there is no reimbursement available under either Medicare Part A or Medicare Part B. Reasonable steps should be taken to make sure that no claims are submitted for these services, and that the related costs are properly treated for cost reporting purposes.

SELECTED OPERATIONAL ISSUES ASSOCIATED WITH RESIDENCY PROGRAMS

January 2011

Nancy Collier LeGros
King & Spalding LLP

I. New ACGME Standards: Resident Duty Hours

A. 2003 Standards

In 2003, the Accreditation Council for Graduate Medical Education (ACGME) adopted new resident duty hour standards for all ACGME-approved training programs.[1] The standards include the following requirements:

- an 80-hour limit per week, averaged over four weeks, inclusive of in-house call and internal moonlighting;
- ten hours off between duty periods;
- a 24-hour limit on continuous duty, with up to six additional hours for education activities or for continuity of care/conducting outpatient clinics;
- one day in seven free, averaged over four weeks; and
- in-house call no more than once every three nights, averaged over four weeks.

The 2003 Standards are still in effect, although as discussed below, revised standards will take effect later this year.

B. Institute of Medicine Report

The Institute of Medicine (IOM) issued a report entitled "Resident Duty Hours: Enhancing Sleep, Supervision and Safety" in December 2008.[2] The report was drafted in response to a request by Congress for the IOM to evaluate current evidence and develop strategies to increase patient safety by modifying resident training activities and work schedules. In its report, the IOM concluded that "[a] lack of adherence to current limits on duty hours is common and underreported" and that "[t]he science on sleep and human performance is clear that fatigue makes errors more likely to occur." The IOM recommended that duty shifts for residents not exceed 16 hours unless an uninterrupted five hour sleep period is provided, in which case a shift could last 30 hours. Other recommendations included increased restrictions on moonlighting; 12 hours off following a night shift; no more than four consecutive days of in-hospital night shifts; one day off per week without averaging; and one 48 hour period off per month.

C. OSHA Petition

Although the ACGME proposed revised duty hour standards in July 2010, the organization did not adopt all of the IOM's recommendations. The advocacy group Public Citizen, joined by the American Medical Students Association and the Committee of Interns and Residents/SEIU Healthcare (a housestaff union), filed a petition for OSHA rulemaking

[1] The 2003 Standards are available at:
http://www.acgme.org/acWebsite/dutyHours/dh_ComProgrRequirmentsDutyHours0707.pdf
[2] See http://iom.edu/Reports/2008/Resident-Duty-Hours-Enhancing-Sleep-Supervision-and-Safety.aspx

on resident duty hours in September 2010.[3] The groups argued that extended duty hours posed a significant health risk to residents, and that ACGME could not be relied upon to enforce duty hour standards.

D. 2010 Standards

Following the IOM's report, the ACGME commenced a previously scheduled review of the 2003 Standards. The review included appointment of a 16-member task force which conducted surveys and consulted with multiple individuals, including the authors of the IOM report.[4] The ACGME finalized the revised duty hour standards on September 28, 2010, less than 30 days following the filing of the petition with OSHA. In a subsequent letter to OSHA, the ACGME argued that focusing on duty hours alone would not provide for adequate protection of residents and patients.[5] Rather, a more comprehensive approach was needed, one that also addressed faculty oversight of residents. ACGME further asserted that it was in a better position than OSHA to enforce training standards, and pledged to conduct unannounced site visits to enforce compliance, something it has not done previously. The 2010 Standards on duty hours are effective July 1, 2011.[6] They significantly expand the standards adopted in 2003 (7 pages v. 2 pages), and address a number of topics in addition to duty hours, including transitions of care, supervision of residents and personal responsibility/patient safety. A table prepared by the ACGME comparing the 2003 Standards to the 2010 Standards is attached. Key changes in the 2010 Standards include counting all moonlighting (internal and external) for purposes of the 80-hour weekly limit, and establishing a 16 hour shift limit for first year residents.

E. Impact of New Standards

The ACGME Institutional Standards already require that all moonlighting be approved in advance by the residency program director.[7] The counting of external as well as internal moonlighting as part of the 80-hour weekly limit under the 2010 Standards likely will decrease the number of hours approved. Tighter restrictions on moonlighting and stricter enforcement of duty hour limits could result in increased use of hospitalists and mid-level practitioners for coverage of inpatient hospital units and emergency departments. Some academic medical centers already have established non-teaching services to decrease the volume of patients assigned to each resident. This results in more time for educational activities, has been reported to result in shorter lengths of stay and lower costs per admission on the non-teaching services.[8] According to the IOM report, however, reduced resident duty hours have resulted in increased patient care responsibilities and less educational time for faculty physicians, which could lead to difficulties with recruitment and retention of faculty.

[3] The petition is available at http://www.citizen.org/documents/1917.pdf
[4] See "An Open Letter to the GME Community," May 4, 2010 at: http://www.acgme.org/acWebsite/home/nascalettercommunity5_4_10.pdf
[5] The letter from Thomas J. Nasca, M.D. to David Michaels, OSHA Assistant Secretary, is posted at http://www.acgme.org/acWebsite/home/OSHAACGMEResponseLetterOSHA.pdf
[6] http://acgme-2010standards.org/pdf/Common_Program_Requirements_07012011.pdf
[7] ACGME Institutional Standards § II.D.4.j.
[8] See *A Nonresident Cardiovascular Inpatient Service Improves Resident Experiences in an Academic Medical Center: A New Model to Meet the Challenges of the New Millennium*, Academic Medicine, Vol. 79, No. 5 (May 2004); see also *Improving Resource Utilization in a Teaching Hospital: Development of a Nonteaching Service for Chest Pain Admissions*, Academic Medicine, Vol. 81, No. 5 (May 2006).

II. Unapproved Training Programs

A. Background

The ACGME approves approximately 8900 training programs at 680 sponsoring institutions around the country.[9] Although there is no central registry for training programs that are not approved by the ACGME or by the American Osteopathic Association, almost all academic institutions now offer unapproved fellowships in a variety of specialties. These programs are designed for physicians who have completed approved residency programs and already are board certified or board eligible in their primary specialty. For example, there are a number of one and two year fellowships in minimally invasive surgery (MIS) at various hospitals and academic institutions around the country. The Fellowship Council, a nonprofit organization that approves standards for such fellowships, has opted not to seek ACGME approval for a certificate of special competence, but simply to offer fully trained general surgeons an opportunity to acquire specialized surgical skills.[10] As discussed further below, unapproved fellowships raise a number of operational issues for hospitals serving as training sites.

B. Medical Staff Appointment

While many hospitals require board certification as a condition of medical staff appointment, a physician who recently completed his or her residency program and is eligible for board certification generally is viewed as meeting this requirement. If a board-eligible physician is participating in an unapproved fellowship program, a hospital must determine whether the physician should be treated like a trainee, or like a member of the medical staff. Many medical staff members believe that a physician participating in any type of training while at the hospital should be treated like a trainee for purposes of all of the physician's activities in that hospital. On the other hand, if a fully-licensed physician would otherwise be eligible for medical staff appointment and clinical privileges commensurate with the physician's training, it seems unfair that the physician's desire for further training should render the physician ineligible for medical staff appointment and those independent clinical privileges for which he or she is qualified. Here are two medical staff bylaws provisions that reflect the different approaches:

> [FELLOWS TREATED LIKE TRAINEES] The Graduate Staff shall consist of Residents and/or Sub-specialty Residents (including fellows) who are currently enrolled in a professional graduate training program which has received required approval or sponsorship from the Graduate Medical Education Committee (GMEC) of the Hospital. Members of the Graduate Staff are excluded from eligibility for Medical Staff membership. Residents may not admit patients and must practice under the supervision of a member of the Medical Staff. These practitioners are governed by teaching affiliations or by job descriptions established by authorized representatives of the Hospital's Education Institute and shall comply with these Bylaws, the Rules and the policies and procedures of the Hospital.

[9] ACGME Graduate Medical Education Resource Book 2009-2010, at https://www.acgme.org/acWebsite/dataBook/2009-2010_ACGME_Data_Resource_Book.pdf

[10] Guidelines for Fellowship Council Accredited Fellowships in Surgery at http://fellowshipcouncil.org/finalguidelines.php

[MEDICAL STAFF APPOINTMENT OF FELLOWS PERMITTED] No physician engaged as a resident in an ACGME-accredited training program may be granted Medical Staff membership. Post-residency trainees participating in an ACGME-approved fellowship training program at the Hospital must be followed through the Department of Medical Education and are not credentialed through the regular Medical Staff credentialing program. Physicians participating in an ACGME-approved fellowship who are not rotating through the hospital and are board certified or eligible in another specialty/sub-specialty may apply for Medical Staff membership and privileges in his/her board certified or eligible specialty. Fellows in non-ACGME accredited fellowships may apply for medical staff membership and privileges within their board certified or eligible specialty as outlined in Article Five. Fellows in a non-ACGME fellowship program at the Hospital shall require supervision for those patient care activities that are within the scope of the fellowship program. Such fellows shall not be credentialed to perform these activities independently.

C. Supervision/Billing

A hospital serving as a training site for a non-approved fellowship program needs to ensure that the program is bona fide and that fellows actually receive any needed supervision. The Joint Commission requires a hospital's medical staff to have "a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each member in the [professional graduate education] program carrying out his or her patient care responsibilities."[11] This standard applies to any type of professional graduate program, approved or unapproved. The medical staff's graduate medical education committee is the likely source for oversight of supervision processes, but the committee must have sufficient information about unapproved programs to perform this function. Any clinical privileges granted to the fellow need to be contingent upon the commitment of the fellow and any teaching physician(s) to comply with supervision policies that apply to training activities. If the trainee has been granted independent clinical privileges for certain procedures but not for others, hospital staff responsible for scheduling and staffing surgical procedures also need to be aware of which procedures require supervision.

Some institutions require a fellow who will furnish services in his or her board certified or eligible specialty outside the scope of the training program to have a faculty appointment as an instructor. For example, McGaw Medical Center of Northwestern University has established two different tracks for unapproved programs: an Advanced Specialty Training Program (ASTP) under which participants assume junior faculty status and may provide billable services, and Non-Accredited McGaw Fellowships (AMF) where fellows are treated as housestaff and billing is permitted only in limited circumstances.[12] Both types of programs are overseen by a subcommittee of McGaw's graduate medical education committee.

Billing for services furnished by physicians participating in an unapproved fellowship is another area that needs to be addressed in advance by the responsible institution or physician practice. Any physician furnishing Medicare Part B services needs to be fully

[11] Joint Commission Comprehensive Accreditation Manual for Hospitals MS.04.01.01.

[12] The policy is posted at: http://www.gme.northwestern.edu/pdf/McGawPolicyonOversightofNonACGMENonABMSProgramsFINALAPPROVED.pdf

licensed.[13] In addition, the Medicare reimbursement rules governing Indirect and Direct Graduate Medical Education payments to hospitals must be consulted. These rules treat a fellow in an unapproved program as a resident under certain circumstances, in which case Medicare Part B billing opportunities are limited (see attached outline on Medicare Graduate Medical Education Reimbursement Issues).

III. Moonlighting

As with fellows, a resident who furnishes physician services outside the scope of the resident's training program must have an unrestricted license, as opposed to one which confines his or her practice to training activities. This essentially rules out moonlighting for first year residents, although the ACGME 2010 Standards prohibit moonlighting by first years anyway. PGY-2 residents and above are required to obtain approval from the program director for moonlighting. Moonlighting must be voluntary, and good academic standing usually is a prerequisite. Residents who are J-1 visa holders usually are prohibited from working outside the scope of the residency program. However, if the moonlighting site is a Health Professional Shortage Area, then moonlighting by J-1 visa holders may be permitted.[14]

A moonlighting resident is not eligible for medical staff membership at most hospitals. The resident would need to apply for independent clinical privileges through the process described in the medical staff bylaws, which would require that the resident obtain malpractice insurance coverage for his or her moonlighting activities. A moonlighting resident is subject to the same monitoring and corrective action processes that apply to other physicians without a medical staff appointment, such as locum tenens physicians. If a resident is performing patient care services at his or her teaching institution, certain Medicare coverage limitations may apply (see attached outline). Performance of non-patient care services can also be considered to constitute a form of moonlighting which would entitle the resident to compensation. Some institutions have created a distinct employee status for moonlighting residents in order to simplify the payment process.

IV. Looking Ahead: MEDPAC Report

In June 2010, the Medicare Payment Advisory Commission (MEDPAC) published its bi-annual report to Congress on issues affecting the Medicare program, entitled "Aligning Incentives in Medicare."[15] MEDPAC's report included a chapter on Medicare graduate medical education financing and how to align payments so they are consistent with those health care reforms needed to increase the value of healthcare in the U.S. MECPAC pointed out that Medicare funding of graduate medical education amounts to approximately $100,000 per resident, and that there should be increased transparency and accountability for such payments. The report proposes taking $3.5 billion of the $6.5 billion annual IME payments, and distributing the funds as performance-based payments to educational programs. MEDPAC suggests that programs should be incentivized to foster skills such as teamwork, quality measurement and cost of care, and to maintain strong ambulatory care rotations that focus on care of chronic disease. MEDPAC also suggests that the nation's health care workforce needs to better reflect the diversity of communities in the U.S.

---

[13] 42 C.F.R. § 410.20(b); Medicare Benefit Policy Manual (CMS Pub. 100-02) Chapter 15, § 30.3B

[14] For example, the Louisiana Department of Health and Hospitals' (DHH) Bureau of Primary Care and Rural Health operates a J-1 visa waiver program. See http://www.dhh.state.la.us/faq.asp?ID=1&CID=34#Faq-642

[15] The report is available at: http://www.medpac.gov/documents/Jun10_EntireReport.pdf