

# Medicare GME Hot Topics

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## Residency Program Solutions March 2016



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## Topics...

1. New teaching hospitals – when/how does it happen? (focus on triggering a PRA and Cap)
2. Cap sharing agreements
3. New residencies vs. program expansions – what are the rules?
4. Rural hospitals, RTTs, what defines rural? What happens when an area is reclassified as not-rural?
5. Critical Access Hospitals
6. Sole Community Hospitals
7. Direct claims by CHCs for Medicare GME funding (pre-THC)
8. “Community Support” issues – what are the rules to avoid losing future Medicare GME \$ ?
9. Closing hospitals and moving residency programs. Orphan residents.
10. THCs
11. How long after a fiscal year can the MAC go back and investigate a prior year?

### **12. Reform efforts !**

## New Teaching Hospitals ("Virgin" GME Hospitals)

- When does the "clock start ticking" for PRA and Caps in New Teaching Hospitals?
  - The processes are independent.
  - A hospital can get a PRA without ever starting a Cap clock.
  - However when a Cap clock starts the PRA setting process also starts if it hasn't occurred before.

## When is a PRA triggered?

- The PRA setting process starts whenever any resident (old or new program) does an official rotation IN a "virgin" hospital (or its provider based clinic).
  - Dental and Podiatry residents DO set the PRA
- Set during fiscal year when 1st resident does rotation (if in first FY month) or following FY if starts later in year

## “Zero-PRA” risk

Example. Virgin hospital on July-June FY.

- 1st resident rotation Oct 2013. PRA set for claims in July 2014-June 2015 FY.
- If 1st resident rotation was July 2013 then PRA set for claims in July 2013-June 2014 FY.
- PRA will be ZERO (forever) if hospital could (should!) have made claim but didn't claim costs
- Flag raised by core residency hospital leaving that resident's time off their IRIS report.
- “Official rotation in hospital or provider based clinic?” – if yes then should have claimed
- Unclear if rotation was in outpatient (non-provider based) setting but resident did some time in hospital. Best to describe official rotation duties so as to not include work in the hospital. Hospital work should be “totally spontaneous and sporadic, and not planned or expected”. Giving residents hospital privileges or hospital specific EHR log-ins (and write progress notes) may be used as evidence of residency training.

## Strategies to avoid Zero PRA

- “Virgin” hospitals need to be careful when “trying out GME” by having residents do rotations in their hospital, ER or provider-based clinic so as not to get a ZERO PRA!
- Can avoid this risk by:
  - Doing no GME until new residency (boo!)
  - Limiting rotations to outpatient only in non-provider based clinics
  - Paying resident salaries and benefits for first 1-2 years any time outside residents do ANY rotations at your hospital or provider-based clinic
    - That “PRA setting” year will set your PRA “forever”
    - then not necessarily paying anything again until actually starting a new residency.
  - Changing the law! (or the interpretation)

## When does the “clock start ticking” for Caps?

- A new residency program in first 5 years will start a cap clock in ANY “virgin” hospital where the residents do an official rotation.
- An old residency program (over 5 years old) will NOT start a cap clock in a “virgin” hospital.
  - CMS presumes that if an old residency rotates residents somewhere the hospitals “cap share” based on IRIS claims for those residents. The hospitals, however, don’t have to cap share (usually do not for new teaching hospitals).

## How is new PRA calculated?

- Set at LOWER of claimed GME costs per FTE resident OR FTE weighted average PRA of teaching hospitals in same CBSA.
- If new hospital is in metro-CBSA with <3 established teaching hospitals in the CBSA then use census region average PRA (1998 data updated by inflation using CPI-U)
- If new hospital not in a metro-CBSA and <3 hospitals “not in metro-CBSA” statewide then use census region average PRA.
- New PRA weighed separately for Primary Care and Non-primary care residents (by FTE) but new hospital gets ONE PRA.

## Sources of PRA data

- Sources of PRAs for established teaching hospitals
  - Graham center (last update 2010)
  - Hospitals themselves
  - Often state hospital associations buy this data from CMS
- Census region PRAs published for 1998 need to be updated for inflation (CPI-U)

## Census region PRAs

	states	FY 1998	Dec 2013
New England	CT, ME, MA, NH, RI, VT	\$ 69,696	\$ 99,874
Mid Atlantic	NJ NY PA PR	\$ 92,567	\$ 132,649
S Atlantic	DE, DC, FL, GA, MD, NC, SC, VA, WV	\$ 62,513	\$ 89,581
EN Central	IL, IN, MI, OH, WI	\$ 67,120	\$ 96,183
ES Central	AL, KY, MS, TN	\$ 59,619	\$ 85,434
WN Central	IA, KS, MN, MO, NE, ND, SD	\$ 70,212	\$ 100,614
WS Central	AR, LA, OK, TX	\$ 55,240	\$ 79,159
Mountain	AZ, CO, ID, MT, NV, NM, UT, WY	\$ 60,697	\$ 86,979
Pacific	AK, CA, HI, OR, WA	\$ 68,652	\$ 98,378

## “Medicare GME affiliation agreements”

- A technical CMS term NOT referring to what we usually think of as affiliation agreements
- Refers to **annual** “cap sharing” agreements between hospitals.
- each hospital in the affiliated group must maintain a “shared rotational arrangement” with at least one other hospital in the group. Called a “cross-training” requirement.
- EITHER:
  - Hospitals must be located in the same geographic area (neighbors);
  - jointly listed as the sponsor, primary clinical site, or major participating institution for one or more programs (partners)
  - or under common ownership (siblings).
- New teaching hospitals can “get” but not “give”
  - the intent of the regs was to avoid having old urban teaching hospitals use a new “virgin” hospital to start a residency and then, once cap was set, shift the slots back to the old hospital effectively upping the old hospital’s usable cap.
  - The rules are different for rural vs urban on this issue.

## New program vs program expansions

Three part test (must meet all three):

- New/separate program director (not a listed PD for any other ACGME residency)
- New/separate faculty (e.g. not listed as core faculty for another program)
- New/separate residents (specifically recruited), separate match number.

If criteria not met then you are a “program expansion”

## New program vs program expansion affects if/how hospitals are paid GME \$

- New program (in first 5 years)
  - Triggers cap clock in new teaching hospital
  - If in new specialty then established rural teaching hospital can restart cap clock (add)
- Program expansion
  - No addition to regular cap in any hospital
  - RTT specific FIRST RTT involving urban hospital then the urban hospital can build an “Urban RTT cap” even if RTT not a CMS “new program”

## New Teaching Hospitals – Rural Advantages

- Rural hospitals have advantage in being able to add new residencies (and increase cap then) in future
  - may receive permanent increases to their IME and direct GME FTE resident caps each time they start truly brand new residency programs (that is, new program director, new staff, and new PGY1 residents). They would not get cap increases for merely expanding existing programs, or for serving as a rotation site for a program that already exists elsewhere).
  - New program could be a new specialty or ? a new freestanding FM program (e.g. where there used to be an RTT)
- Non-rural new teaching hospitals have 5 years to set permanent cap (new as of Fiscal Years starting Oct 2012 or later)

## What is a “Rural Hospital”?

- CMS uses Core Based Statistical Areas that CMS then separates into urban and rural designations
- Below is the link to the Inpatient PPS FY 2016 final rule. You can use the FY 2016 NPRM hospital Impact File to look up specific provider numbers and if a 2 digit code is indicated for Geographic Labor Market Area, then you know it's rural. Or you can click on the County to CBSA crosswalk file which lists every single county in every single state and if column E is blank, you know that county is rural.
- <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page-Items/FY2016-IPPS-Final-Rule-Data-Files.html>

## What defines an RTT from the CMS perspective? (Rural Training Track)

- A separately accredited residency program where >50% of training takes place in a rural area. (e.g. in Family Medicine >18 months)
- That 50+% can be at a rural hospital(s) or in rural non-hospital patient care sites or a combination that adds to >50%.
- Some RTTs have NO rural hospital (all rural training is not in a hospital)

## What is the financial advantage of being an RTT?

- Whatever urban hospital(s) claim the residents' time for training in an RTT will get a cap adjustment (an "RTT cap") and thus be paid above their historical cap.
  - "Urban hospital RTT cap" is set after 5 years for hospitals that already have a cap
  - The "RTT cap" for an urban hospital can't be used for other non-RTT residencies – e.g. if the RTT closes,
- Often there is one urban hospital that sponsors the RTT and makes claims for RTT residents for urban rotations and one rural hospital that makes claims for rural rotations.
- Many variants:
  - When no rural hospital than an urban hospital can claim all the time the RTT residents spend in training. Usual rules governing claims (e.g. must pay salary and benefits)
  - Non-hospital rotations in rural area can be claimed by either the rural or urban hospital
  - More than one urban or rural hospital may make claims as long as training is in their hospital or in an affiliated clinic.

## Important RTT example... where the rural hospital can't get paid (or paid much) for claiming resident rotations

- Sometimes rural hospital won't be paid for claims for RTT residents:
  - It has a "zero PRA" because of prior resident rotations
  - The RTT does not qualify as a "new program" because it has the same program director as the core urban program.
  - The rural hospital is a CAH or a SCH and paid way less
- However since this is a "first RTT" for the urban hospital the urban hospital CAN get a cap adjustment and be paid for:
  - urban rotations (hospital or clinic)
  - and rural non-hospital rotations - including the rural FMP-site if not provider based
- An RTT set up this way ends up getting payment for ~ 2/3 of all rotation time in most cases (if rural FMP-site not provider based). Approaches 100% payment if no rural time is in any hospital.
- Viable funding model if urban hospital DGME+IME collections per resident FTE are high enough.

## So the keys to an RTT qualifying for new CMS GME funding are...

- >50% training time in a rural area (see next slide)
- RTT must be separately accredited (if there is a core FM residency) and be the first RTT in that specialty (e.g. FM) that the hospital has participated in.
- “New program” rules apply for the RURAL (but not urban) hospital to be able to claim:
  - Different program director from urban program
  - Different core faculty
  - Residents specifically recruited to enter the RTT (different match number)

## What is “Rural” area from CMS’s GME perspective?

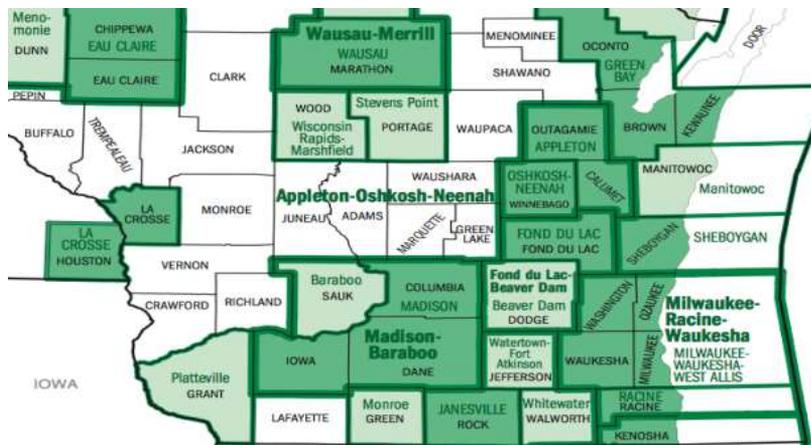
### See CBSA maps:

- [Census.gov > Geography > Maps & Data > Reference Maps > State-based Metropolitan and Micropolitan Statistical Areas Maps](https://www.census.gov/geography/maps/data/reference-maps/state-based-metropolitan-and-micropolitan-statistical-areas-maps)
- Or just google “census CBSA maps”
- Big change (new “delineation”) every 10 years (e.g. 2000 and 2010 and 2020 censuses)
- Interim adjustments made (? Frequency – last was 2013)
- **For CMS “Rural” area means (map colors)**
  - **Not in a metropolitan CBSA (dark green)**
  - **Can be in micropolitan CBSA (light green) or not in a CBSA (white)**

# Core Based Statistical Areas (CBSA)- Colorado Feb 2013



# Core Based Statistical Areas (CBSA)- SE Wisconsin June 2003





What happens if your area is reclassified as “not –rural” in the midst of planning an RTT?

- If you already operate an RTT?
- If you are planning an RTT?
- Rules are complex... ask CMS or RPS consultant.
- This will next become an issue after the 2020 census.

## Critical Access Hospitals (CAH)

- A Critical Access Hospital (CAH) is a hospital certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby reduce hospital closures.
- General rules:  $\leq 25$  beds,  $<96$  hr average LOS,  $>35$  mi from next hospital
- 1,336 CAHs in US as of March 2016.

<http://www.raconline.org/topics/hospitals/cahfaq.php>

## CAH Medicare payments

- It's 1982! Old share-of-costs Medicare system
- Medical education considered part of cost of hospital operation
- CAHs don't participate in DRG/PPS therefore no DGME and IME or Caps.
- Medicare share of costs for GME similar to DGME calculation (plus 1% and no PRA limit and no caps)
- No IME and unlikely patient care costs higher with FM residents involved
- Therefore GME substantially less than for non-CAH hospitals

## CAH cost accounting to add in residency costs (a reference slide!)

- CAH inpatient payment calc -
  - $(\text{inpatient total costs} / \text{total inpatient days}) = \text{per diem} \times \text{Medicare inpatient days} + 1\%$ . Computed on worksheets D-1, Parts I and II on the Medicare cost report (Form 2552-10). 1% is added to increase to 101 percent on Line 6 on Worksheet E-3, Part V.
  - Residency costs added in as part of "inpatient total costs"
- CAH outpatient payment calc –
  - $(\text{outpatient total costs} / \text{outpatient total charges}) \times \text{outpatient charges associated with Medicare beneficiaries} + 1\%$ .
  - Residency costs added in as part of "outpatient total costs"
- CAHs complete Worksheet D, Part V, of the Medicare cost report (Form 2552-10), columns 3, 4, 6, and 7. The cost to charge ratio for each cost center is in column 1, multiplied by the Medicare charges in either column 3 or 4 to get the Medicare costs in column 6 or 7. 1% is added at Line 21 on Worksheet E, Part B

## How does CAH divide residency costs inpatient vs outpatient?

- Residency salary and benefits paid by CAH can be apportioned depending on how much time residents spend in the inpt vs outpt costs centers.
- Other residency costs paid by CAH (e.g. education coordinator, faculty time, space, supplies, etc.) apportioned inpt vs outpt using a “reasonable estimate” similar to how CAH apportions other global costs (e.g. the CEO) to different cost centers.

## Can urban hospitals claim resident time spent at a CAH?

- No
- Many advocate that this be allowed

## CAH Medicaid payments?

Some states use the same methodology for cost reimbursement of CAHs via the Medicaid program and then "% Medicaid" drives similar formulas and can yield more contribution towards residency costs including for time spent in maternity and newborn care

## Sole Community Hospitals

- Certification rules similar to CAH but up to 50 beds  
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SoleCommHospfctsh508-09.pdf>
- Get paid larger of federal IPPS rate or hospital specific rate (based on past reported costs)
- If paid federal rate then can get both IME and DGME using usual formulas
- If paid hospital specific rate then can get DGME but NO IME.
  - **NEW**: 2015 will get IME for Medicare Part C (Medicare Advantage) even if hospital gets "hospital specific" rate
- Since hospital specific rate almost always > federal rate then no IME is the rule (similar to CAH predicament) **unless** mostly Medicare Advantage
- Many advocate that this rule should change

## FQHCs and RHCs can get direct GME funding

- Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and FQHC “lookalikes”.
- The FTE time claimed can’t be claimed by a hospital (zero sum FTEs).
- Direct GME claims work on a “Medicare share of costs” model similar to CAHs.
- Since most FQHCs and RHCs have <<50% of their visits funded by Medicare, this GME funding option is rarely used

*RPS Consultant opinion not shared by CMS:*

## **CHCs, CAHs and SCHs share a common inability to get adequate GME funding through the traditional Medicare GME program**

- CAHs, CHCs (FQHCs, RHCs, etc) and most SCHs suffer from the same math problem. They get the rough equivalent of DGME (medicare share of costs) but nothing akin to the IME \$ that PPS hospitals get.
- THCs are/were a potential solution for CHC based residencies but not a CAH or SCH solution

## “Community support” residents and CMS rules

- If the total salary and benefits of a specific resident “slot” is being paid for by local/state source of funding **direct to the program** (bypassing the hospital) then there is risk that the hospital will not be paid Medicare GME \$ for claiming that resident “slot” now and in the future
- Funds paid **to a hospital** by local/state funders are considered part of the general funds of the hospital so the hospital can claim – and be paid for - all residents under Medicare GME regs.
  - Why? Because CMS considers that it is paying the hospital only “Medicare’s share” of residency costs and assumes the hospital is getting money some other way to pay the rest.

## Closing Hospitals and Moving Programs

- If you are moving your program from one hospital (that is NOT closing) to another hospital then you need to:
  - Start a new program application with new hospital as sponsor
  - If new hospital is “virgin” for GME purposes and you want the new hospital to receive IME and DGME slots, then the program cannot be transferred “as is” from the previous hospital. Rather, the criteria of a “new” program must be met (tests are: different program director, new faculty, new residents)
  - If new hospital is not “virgin” and already has a cap then the new program could functionally increase the cap IF the old hospital is willing to enter into a cap sharing agreement (renewed annually) with the new hospital for the slots it now won’t be using.

## Closing Hospitals and Moving Programs continued

- If hospital is closing (surrendering its acute care license) then its GME “slots” can be picked up by other local hospitals
  - Priority to hospitals located in the same CBSA as closed hospital AND that take over entire program(s) from closed hospital Application form spells out process and priorities
  - Google: CMS, closed hospitals, GME
  - <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/Section-5506-Application-Form.pdf>

## Orphan residents from programs that close

If a residency program closes then the residents from that program who are accepted for transfer to another residency allow the accepting program’s hospital(s) to temporarily increase their cap(s) to finish training that resident.

# Teaching Health Center Graduate Medical Education (THCGME) Program

- Authorized by Affordable Care Act of 2010
- 5 Year Pilot with \$230 Million Authorized – Through HRSA
- First Applications December 2010 with funding annually July 1 – June 30, for 5 years
  - During the 2014-2015 academic year, 60 Teaching Health Center Graduate Medical Education programs in 24 states supported more than 550 residents.
  - Pilot extended 2015 – 2016 for existing programs at lower amount (\$70,000 per resident, previously at \$150,000 per resident per year), using left over funding not spent from original \$230 Million

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## Teaching Health Center

- THC is/was a community based ambulatory patient care center that operates a primary care medical or dental residency program
  - Federally Qualified Health Centers (FQHC)
  - Community Mental Health Centers
  - Rural Health Clinics
  - Health Centers operated by Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization
  - Entity receiving funds under title X of Public Health Services Act
    - » OR

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## Teaching Health Center

- (OR – Continued) - Entities can collaborate to form a **GME Consortium** (must include a CHC) that operates an accredited primary care residency program
  - GME Consortium is the institutional sponsor and residency is accredited by ACGME, AOA or CODA
- **Teaching hospitals and academic institutions alone** holding institutional sponsorship not eligible to receive THCGME. Would need to **give up sponsorship** and give control to a consortium
- **75% of THCs** are Federally Qualified Health Centers (**FQHC**) or FQHC Look-Alikes, serving underserved communities.

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## Primary Care Residency Program that can be a THC

- Family Medicine
- Internal Medicine
- Pediatrics
- Med-Peds
- OB-GYN
- Psychiatry
- General Dentistry
- Pediatric Dentistry
- Geriatrics

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## THC vs CMS rules

- There have been discussions between HRSA (administers THC program) and CMS to attempt to clarify how THC-funded residents should be handled on hospital Medicare cost reports and the impact this should have on setting PRAs, cap setting and other Medicare GME issues.
- The resolution... CMS wins (must follow current Medicare GME law) so yes there have been zero PRAs and inadvertent cap clocks started.
- CMS has judged that THC funded positions are not “community support” positions (good!)

## How long after a fiscal year can the MAC go back and audit the possible GME events in a fiscal year?

- Relevance to the possible presence of a resident or two at the “virgin” teaching hospital in the remote past
- Appears to be only about 3 years... not looking past last “settled” cost report.
- However there may be evidence of prior rotations not apparent in a cost report (e.g. the MAC asked and you told them)

## Repeal/replace/repair Obamacare: potential GME impact

Secondary to actual impact on paying for patient care...

GME impact if ALL ACA GME related provisions disappeared:

- Have to again pay volunteer faculty (Lou adds 30 slides...)
- Complex rules about claiming didactic time come back
- Closed programs and closed hospital slot reallocation rules disappear or become muddled.
- THC program disappears
- ? more difficult for hospitals to claim clinic non-hospital rotations in other communities
- Will other “final rule” changes that have happened since ACA passed be revisited?

## Updates of one reform effort

- The “Ribble/Nelson” bill was introduced in 2016 congress. Will need new sponsor and new introduction.
  - 2016 congress: HR4732, S2671
- If passed... would provide relief to hospitals stuck with small caps and low PRAs:
  - If cap <1 (or <3 depending on date issues)
  - Then PRA and cap clock can be reset if/when hospital starts making claims for a “new program”
    - “new program” might be removed as a restriction
- Contact Hope Wittenberg for more information and to help build national support. Hope Wittenberg <hwittenberg@stfm.org>

## Reform efforts

- The **GME Initiative** invites your participation!
  - <http://www.gmeinitiative.org/>
- Current efforts:
  - Comprehensive reform (CONGR meeting 2018 – **Compehensive National GME Reform**) to push forward concepts in the IOM report
  - “Technical fixes” (reform within the current system)
  - THC permanence
  - Rural rotation/residency direct funding via an “alternative payment” process
  - Building partnerships and advocacy
  - State GME funding initiatives

## Poll Question:

Enter your email address to be included in any follow-up communication from the presenter(s).

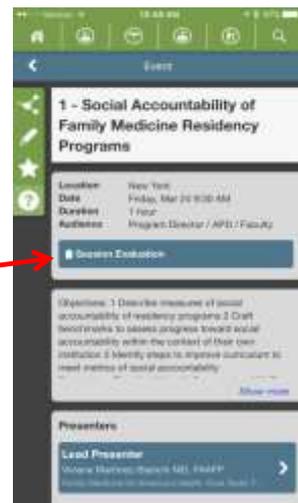


# Social Q & A

Please...

Complete the  
session evaluation.

Thank you.





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