Medicare GME Funding Update for Rural Residencies

Status Update

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AAFP

Topics we will discuss today...

CAA 2021 – three provisions affecting Medicare GME

1. Section 126 New GME slots
2. Section 127 Rural residency provisions
3. Section 131 PRA/cap reset option

Topics for reference...

1. **Application details for section 126 slots**
2. **More Rural Training Program details and rural reclassifications**

3b. Details on Per Residents Amounts for Medicare Direct GME payments: PRA setting and cap clocks

4 **The Rural Residency Program Development grant program**

5 **THC updates**

7 **VA funding of residencies - update**

8. **The Graduate Medical Education Initiative (GMEI)**
9. **The Rural Physician Workforce production Act**
10. **"Community Support"** issues – what are the rules to avoid losing future Medicare GME $?
11. **The Primary Care Exception** potential pitfalls
12. **Closing hospitals and moving programs**
13. **Critical Access Hospitals. Sole Community Hospitals, RCHDP hospitals**
14. **Direct claims by FQHCs** for Medicare GME funding (pre-THC)
15. **Rural places and rural hospitals**
16. **Medicare Dependent Hospitals**
17. **Hospitals sharing caps** = "Medicare GME affiliation agreements"
18. **Moonlighting**

The CAA: Consolidated Appropriations Act 2021
(Public Law No: 116-226)
Three provisions affecting Medicare GME system
Final rules published 12/17/21:

1. Section 126. **1000 new GME slots** to be granted nationwide (200 per year x 5 years)
2. Section 127. **Rural** residency provisions
3. Section 131. **PRA/cap reset option** for hospitals with cap <3.0 (<1.0 if old teaching hospital before 1997)

1K Authorizes 200 New Cap Slots per year for 5 Years (Sec. 126)

- Begins fiscal year 2023 with 200 cap slots per year for 5 years. No more than 25 for one hospital. (1000 new slots).
  - For 2022 allocation a hospital can only get up to the number of slots corresponding to the residency length – e.g. 3 slots for FM, 5 slots for General Surgery
- Must create new positions with these. So FTE claims in subsequent years must be >= prior claims plus new positions.
- Secretary takes into account "likelihood of filling" these within 1st 5 years based entirely on ACGME application/accreditation status. There is no predicted recruitment success factor.
- Not less than 10% in following categories:
  a) rural hospital or urban hospital that is reclassified to rural area
  b) hospitals over cap
  c) in states with new medical school
  d) hospitals that serve area designated as primary care HPSA

  …remainder-about 60% no priority, and no primary care mandate

1K Section 126 slot bottom lines:

- Evidence of some ACGME recognition for new or expanded program needed to apply.
- Overall HPSA score for place and population to be served by new/expanded residency matters **the most** in awarding slots. No "institutional" HPSA scores considered.
- These are not a lot of slots each year.
- Next deadline March 31, 2023
- We'll know more about how slots were awarded after the first 200 are awarded in early 2023
- Details of section 126 application process in appendix
- This may matter more as setting precedent for new slot awards if the bills proposing another 4,000-14,000 slots ever pass

2. Section 127 background: New program vs program expansions ?

To be considered a **New Program** and eligible for new Medicare GME funding must pass 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" and not eligible for new Medicare GME funding… ***except* hospitals (urban and rural) who start RTPs (sec 127) or are granted new sec 126 slots**

Note that MEDICAID has different rules in different states

2LM CAA Sec. 127. Promoting Rural Hospital GME Funding Opportunity

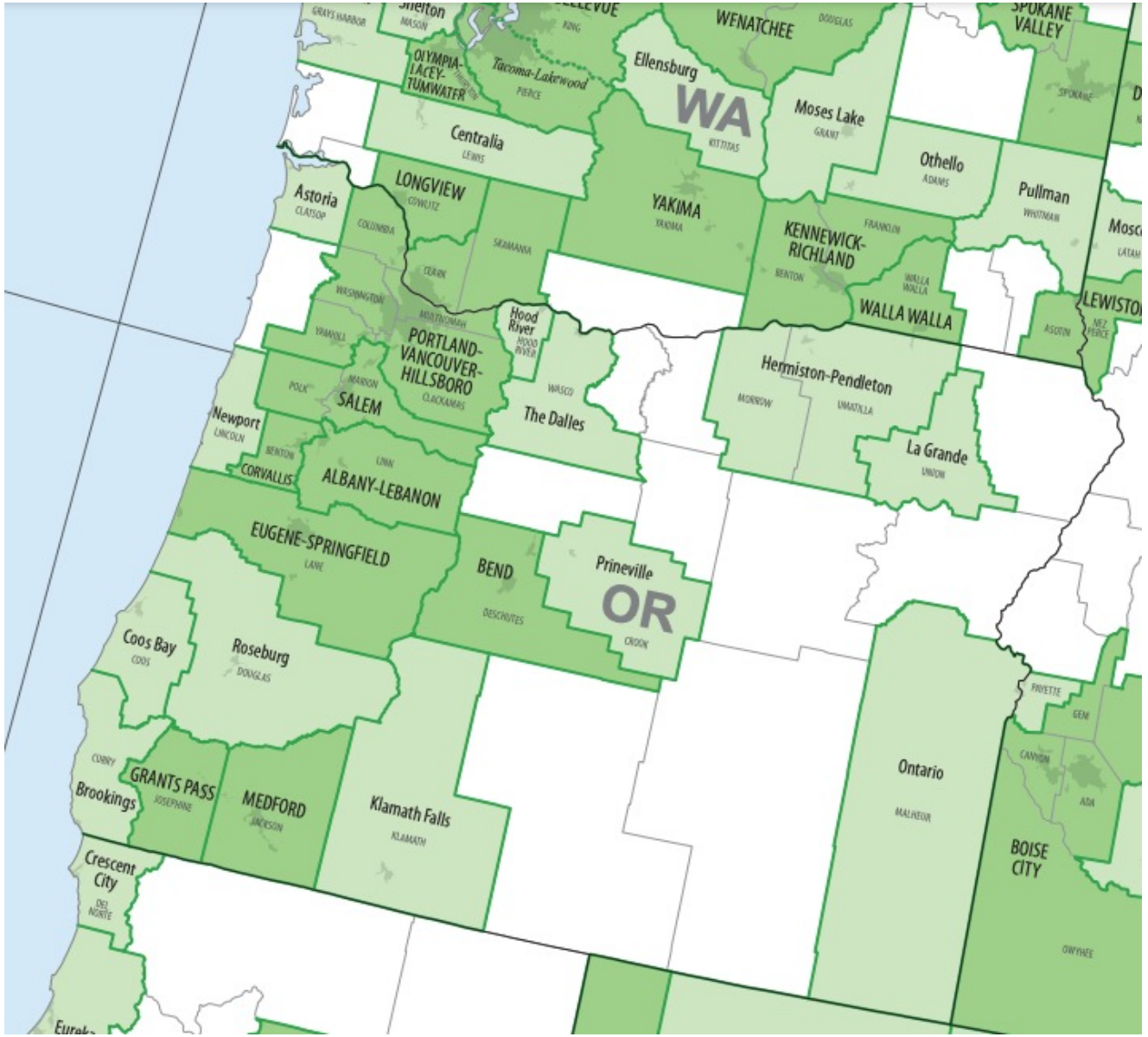
- Effective for cost reporting periods beginning on or after October 1, 2022
- Removes the phrase “separately accredited,” for RTTs and defines a new term Rural Track Program (RTP) that can either be a separately accredited RTT (now old term) or not separately accredited.
- RTP residents must still spend greater than 50% of duration of entire program in rural area (outside a metro-CBSA)

Oregon (and some neighbors) CBSA map Feb 2013

- Dark green = metropolitan CBSA
- Light green = micropolitan CBSA
- White = not in a CBSA

CMS qualifying RTP “rural” locations are light green or white

Map from https://www.census.gov/geographies/reference-maps/2020/geo/cbsa.html



CAA Sec. 127. Promoting Rural Hospital GME Funding Opportunity

continued

- Allows for FTE cap increase to ***both*** urban and rural hospital participating in RTP, even if RTP does not meet Medicare's definition of "new" program
- Starting with FYs starting after October 1, 2022 there will be no application of the "3-year rolling average" during 5-year growth period of RTP. Hospitals will be paid for ***all*** new RTP program residents each year.
  - Before the CAA new RTTs did not have this exception so ended up losing ~1 year's worth of Medicare GME funding.

2. Section 127 additional RTPs now allowed for urban hospital partners

- Now allows urban hospitals with established RTPs to add new RTPs:
  - In a ***different specialty*** in the ***same*** rural community
  - in the ***same specialty*** in ***additional (different)*** rural communities.
- "…in a cost reporting period beginning on or after October 1, 2022, an urban hospital with an existing RTP ("hub") adds an additional RTP ("spoke") to the existing urban core program of the same specialty, the urban and rural hospitals may receive adjustments to their rural track FTE limitation."

2. Section 127 additional RTPs now allowed for urban hospital partners

- Not entirely clear what defines a “different rural community” for adding a same-specialty RTP.
  - For FM we understand that having a **clinic in a different community** as the prime continuity site would qualify and allow the new RTP to use current urban ***and*** rural hospitals for rotations.

”Type” of hospital matters

- “Inpatient Prospective Payment Hospitals” (IPPS) are most common and paid via the DRG system for medical care and are eligible for Medicare GME funding via DGME and IME payments
  - Two important subtypes of IPPS hospitals in New Mexico
    - Sole Community Hospitals
    - Rural Referral Centers
- Critical Access Hospitals are NOT IPPS hospitals. They are paid on a “cost basis” for care and don’t directly participate in the Medicare DGME/IME funding system

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: <= 25 beds, <96 hr average LOS, >35 mi from next hospital. *Exception LOS during COVID-19 can be higher*
- Time residents spend in a CAH can ***either*** be
  - claimed directly with residency expenses claimed as part of the cost of care (rarely used – see appendix)
  - **CAH time can be claimed by an IPPS hospital if that IPPS hospital pays the residents' salary and benefits for that time. This is much more financially advantageous.**

~45 Oregon Critical Access Hospitals (CAH)

- From https://npidb.org/organizations/hospitals/critical-access_282nc0060x/or/

Sole Community Hospitals

- These are IPPS hospitals – with some certification rules similar to CAH
  https://www.calhospital.org/general-information/medicare-reference-guide-sole-community-hospitals
- 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.
  - As of 2015 a SCH 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 direct-claims predicament) unless mostly Medicare Advantage**
- Many advocate that this rule should change

Rural referral centers (RRCs)

- A booming industry where many large urban hospitals have become RRCs while still maintaining urban wage indexes!
  - CMS lost a lawsuit about this so urban hospitals can now convert to RRCs but then partially convert back to “urban” for wage-rate purposes only.
- GME Advantages of becoming an RRC:
  - eligible to participate in the 340B Drug Pricing Program at a lower DSH threshold. This has been VERY profitable for hospitals that qualify
  - 30% IME cap bump (even if in urban place)
  - Can start new residencies in new (to hospital) specialties and build IME cap further.
    - Note: If location still urban then won’t get DGME cap bump for most new residency programs but can be the “urban” partner in a new RTP and get DGME cap adjustment.

Some examples of newer RRCs (now >700 RRCs)

	became RRC	old IME cap	new IME cap	additional IME per year at least
New York-Presbyterian Hospital	FYB17	1168	1515	$33,000,000
Massachusetts General Hospital	FYB18	495	642	$21,000,000
Cedars-Sinai	FYB17	243	310	$12,000,000
U of Wisconsin	FYB19	287	345	$11,000,000
U of Colorado	FYB19	229	297	$8,000,000

- Just became RRCs since 2019 so IME cap increase is coming: U of Utah Hospital, OHSU, UCSF, Stanford, Parkland, ? Others
- Also interesting what hospitals AREN'T (yet?) RRCs: U of Michigan, U of Seattle, Emory,

Oregon RRCs and Sole Community Hospitals (SCHs)

- 5 RRCs, 3 SCHs
- Plus 4 that are both RRCs and SCHs

Data from FY 2022 IPPS FR and CA Impact File

Provider Number	State	Name	URGEO	URSPA	LUGAR	Section 401 Hospital	Resident to Bed Ratio	Average Daily Census	provider type text
380009	Oregon	Ohsu Hospital And Clinics	LURBAN	RURAL		Y	0.5217	464	RRC
380051	Oregon	Salem Hospital	OURBAN	RURAL		Y	0	279	SCH
380018	Oregon	Asante Rogue Regional Medical Center	OURBAN	RURAL		Y	0	201	RRC
380047	Oregon	St Charles Bend	OURBAN	OURBAN			0.0021	155	RRC
380014	Oregon	Good Samaritan Regional Medical Center	OURBAN	RURAL		Y	0.5029	93	RRC
380027	Oregon	Mercy Medical Center	RURAL	RURAL			0	70	SCH/RRC
380075	Oregon	Providence Medford Medical Center	OURBAN	RURAL		Y	0	70	RRC
380090	Oregon	Bay Area Hospital	RURAL	RURAL			0.0168	64	SCH/RRC
380050	Oregon	Sky Lakes Medical Center	RURAL	RURAL			0.1739	54	SCH/RRC
380040	Oregon	St Charles Redmond	OURBAN	RURAL		Y	0	20	SCH
380001	Oregon	Mid-Columbia Medical Center	RURAL	RURAL			0	19	SCH/RRC
380052	Oregon	Saint Alphonsus Medical Center - Ontario, Inc	RURAL	RURAL			0	13	SCH

“Rural” hospitals in urban places and vice versa

PLACE drives DGME cap change rules for already capped hospitals

- Urban vs rural PLACE here means metro-CBSA vs not-in-a metro-CBSA
- So if hospital is in a **rural place** it can start new programs (new ACGME number, meet other ”new program” rules) and get a DGME only cap bump each time it does so
- If hospital now in **urban place** then no DGME cap bump for new residency
- Exception in new program separately accredited RTP allows urban hospital to get “RTT cap bump” for DGME if >50% training in a rural place. ALSO gets IME cap increase as a “new program”.

CATAGORY of hospital (rural vs other) drives IME cap change rules for already capped hospitals

- So if an already capped hospital gets reclassified rural (including RRC) they can get up to a 30% IME-only cap bump without starting any new residencies
- A RRC in an urban place can start a new residency and build an IME cap bump (clock restart) for a new program each time it adds a new program.

2L Section 127 If an RRC is your urban partner in an RTP

- If the RTP is NOT separately accredited then the RRC (or other "section 401" hospital) only gets a RTP cap adjustment for DGME (for being in an urban place)
- Best to separately accredit this RTP and have it meet all "new program" criteria then the RRC/401 hospital can get both a DGME and IME cap increase:
  - They get a DGME "RTP cap adjustment" as a hospital in an urban place.
  - They get an IME cap increase because the RTP is a new program and rural classified hospitals can start new programs and increase IME cap.
- Remember >50% rural time means in an actual rural ***location-*** a different hospital in a rural place and/or clinic(s) in rural place(s)

Section 131 background: What a "Per Resident Amount" (PRA) is and isn't

- It IS
  - A CMS defined term. Caution because it is used with very different meaning in other contexts (e.g. the THC program, the IOM report)
  - A set figure for a given hospital. Can vary widely depending on local/regional comparisons and windfalls or errors made in base year cost reports (or "zero PRA" errors).
  - The figure that sort-of approximates the direct costs of a residency if Medicare paid for ALL care in a hospital.
  - On average underestimates the direct cost of a residency
  - Is always DISCOUNTED to Medicare's share of care in calculating the DGME payment
- It is NOT what hospitals get paid per resident FTE!

Section 131 background:

What a “Cap”is and isn’t

- It IS
  - A CMS defined term.
  - A set figure for a given hospital determined after the 5th year when a hospital starts claiming residents from a new residency(ies).
  - Can’t be increased for urban hospitals unless they participate in an RTP or get slots from a closed hospital or section 126.
  - Can be increased when a rural hospital starts a new residency
- It is NOT a limit on how many residents a hospital can train. Just a limit on how many Medicare will ***pay*** for via the DGME/IME system.
- Some states ***Medicaid*** GME payments are not capped

CAA section 131 reset process why?

- Many GME-naïve (“virgin”) hospitals - often rural - allowed a few residents to rotate from a distant residency and never claimed them or claimed them but the FTE numbers were small.
- So these hospitals were assigned low PRAs (sometimes zero!) and/or very low caps which made starting their own residencyin the future difficult or impossible financially.
- Many “never claimer” hospitals have been at jeopardy of getting a zero PRA assigned when they start claiming residents due to the discovery of past resident rotations
- Section 131 was written to provide relief for these issues.

CAA section 131 reset process

OLD TEACHING HOSPITALS (Category A)- For IPPS hospitals that became teaching hospitals before Oct 1997

- hospital can reset PRA if:
  - PRA was based on <1.0 FTE
  - If the hospital then trains >=1.0 FTE residents (from ***established and/or new programs***) in a year at some point in the five years following sec 131 enactment (12/27/2020).
- IPPS hospitals can add additional caps if:
  - Their cap is <1.0 FTE
  - If the hospital then ***begins*** training >=1.0 FTE residents from ***new*** **program(s)** in a year in the five years following sec 131 enactment (12/27/2020).

* This opportunity window ***closes*** after 12/27/2025

CAA section 131 reset process

NEWER TEACHING HOSPITALS (Category B)- For IPPS hospitals that became teaching hospitals after Oct 1997 through Jan 2021

- hospital can reset PRA if:
  - PRA was based on <=3.0 FTE
  - If the hospital then trains >3.0 FTE residents (from ***established or new programs***) in a year at some point in the five years following sec 131 enactment (12/27/2020). *
- IPPS hospitals can add additional caps if:
  - Their cap is <=3.0 FTE
  - If the hospital then ***begins*** training >3.0 FTE residents from **new program(s)** in a year in the five years following sec 131 enactment (12/27/2020). *

* This opportunity window ***closes*** after 12/27/2025

Section 131 and hospitals that train <1.0 FTE residents in a year

- For currently "virgin" hospitals no PRA will be triggered (or cap clock started) until a year when resident FTEs claimed >= 1.0.
- No claim need be made if hospital always trains <1.0 residents in a year. Hospital remains "virgin"
  - Going forward, a hospital ***is*** required to fill out IME and DGME cost report worksheets if it trains at least >=1.0 FTE… or the zero-PRA risk continues!

- If a virgin hospital voluntarily enters into a **Medicare GME affiliation agreement** (cap sharing from other hospital) then it ***will trigger*** a PRA even if claims <1.0 FTE in a year.

The plight of the ”never claimers”

- We believe there are many hospitals that have had unpaid resident rotators in the past where the hospital was (and probably still is) unaware that they should have been claiming the residents.
- So lots of ***risk*** for getting a “zero PRA” and low cap out there that may come to light when a hospital decides to start a new residency… or not.

The salvation of the ”never claimers”?

- Section 131 rules provides a process that limits the MAC investigation about past years.
  - It involves the use of a HCRIS file mainly to look for the absence of data for a hospital going back to 1995.
  - **If The HCRIS file for all years shows NO ENTRIES for PRA or FTEs than the MAC will not investigate further. If you are a “never claimer” and are not currently training >=1 FTE resident a year than you need do nothing until you start training >=1 FTE per year. No need now to contact the MAC.**
  - If there are HCRIS entries and a hospital disagrees with the HCRIS data then this can be appealed and the status of past cost reports matters:
    - cost reports that are no longer reopenable,
    - cost reports that have been settled but are still open or reopenable, and
    - cost reports that have not yet been settled.

Other issues for ”never claimers”?

- If you are training >= 1 FTE residents now or in the future (after 2022) and don’t claim the residents then you still are at risk for getting a zero PRA.
- When you anticipate setting a PRA (or resetting one) be sure to claim sufficient GME costs in that FY to get the maximum PRA.
- There is audit risk for another hospital that may have been claiming resident time that was actually spent at your “never claimer” hospital. That is a rule violation. A hospital can’t claim time residents spend at another IPPS hospital or its provider-based clinics.

Section 131 implementation issues

- The hospital that is resetting a PRA this year can then **choose to use either FY22 or FY23** cost report as a basis for resetting their PRA.
- The resident(s) claimed in a “PRA resetting year” don’t have to start rotations at the hospital in the first month of their FY.

Available files

- in the ruralgme.org toolbox:

Featured Financial Planning | Specialty: Not Specialty Specific | Type: Resource Collection Or Website

HCRIS data tool

Tool used to determine whether a hospital potentially qualifies for a PRA reset.

- This summarizes all HCRIS data for a ***single hospital*** to research possible PRA/cap reset. You can also see RRC cap bumps! Instructions and samples included.

Financial Planning | Specialty: Not Specialty Specific | Type: Resource Collection Or Website

Hospital data for Section 131 Analysis

Hospital data for Section 131 Analysis _ updated on April 11th

- This is the HCRIS list" * for ***each state*** that shows potential section 131 reset qualification and "never claimer" hospitals.

Another available tool

- "Hospital type lookup tool" will likely appear in the ruralgme toolbox or can be obtained during this conference
- See prior slide:

Provider Number	State	Name	URGEO	URSPA	LUGAR	Section 401 Hospital	Resident to Bed Ratio	Average Daily Census	provider type text
380009	Oregon	Ohsu Hospital And Clinics	LURBAN	RURAL		Y	0.5217	464	RRC
380051	Oregon	Salem Hospital	OURBAN	RURAL		Y	0	279	SCH
380018	Oregon	Asante Rogue Regional Medical Center	OURBAN	RURAL		Y	0	201	RRC
380047	Oregon	St Charles Bend	OURBAN	OURBAN			0.0021	155	RRC
380014	Oregon	Good Samaritan Regional Medical Center	OURBAN	RURAL		Y	0.5029	93	RRC
380027	Oregon	Mercy Medical Center	RURAL	RURAL			0	70	SCH/RRC
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380090	Oregon	Bay Area Hospital	RURAL	RURAL			0.0168	64	SCH/RRC
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380040	Oregon	St Charles Redmond	OURBAN	RURAL		Y	0	20	SCH
380001	Oregon	Mid-Columbia Medical Center	RURAL	RURAL			0	19	SCH/RRC
380052	Oregon	Saint Alphonsus Medical Center - Ontario, Inc	RURAL	RURAL			0	13	SCH

Oregon section 131 HCRIS file analysis

Provi	Name (square brackets indicate provider of services used)	City	Sta	Status
380018	ASANTE ROGUE REGIONAL MEDICAL CENTER	MEDFORD	OR	Likely Cat A
380047	ST CHARLES MEDICAL CENTER - BEND	BEND	OR	Likely Cat A
380060	ADVENTIST HEALTH PORTLAND	PORTLAND	OR	Likely Cat A
380002	ASANTE THREE RIVERS MEDICAL CENTER	GRANTS PASS	OR	Likely Cat B
380021	TUALITY COMMUNITY HOSPITAL	HILLSBORO	OR	Likely Cat B
380029	LEGACY SILVERTON MEDICAL CENTER	SILVERTON	OR	Likely Cat B
380082	PROVIDENCE MILWAUKIE HOSPITAL	MILWAUKIE	OR	Likely Cat B
380090	BAY AREA HOSPITAL	COOS BAY	OR	Likely Cat B
380103	KAISER FOUNDATION HOSPITAL - WESTSIDE	HILLSBORO	OR	Likely Cat B
384008	OREGON STATE HOSPITAL DISTINCT PART	SALEM	OR	Likely Cat B
380001	MID-COLUMBIA MEDICAL CENTER	THE DALLES	OR	Never Claimer
380005	ASANTE ASHLAND COMMUNITY HOSPITAL	ASHLAND	OR	Never Claimer
380020	MCKENZIE-WILLAMETTE MEDICAL CENTER	SPRINGFIELD	OR	Never Claimer
380025	LEGACY MOUNT HOOD MEDICAL CENTER	GRESHAM	OR	Never Claimer
380027	MERCY MEDICAL CENTER	ROSEBURG	OR	Never Claimer
380033	SACRED HEART UNIVERSITY DISTRICT	EUGENE	OR	Never Claimer
380037	PROVIDENCE NEWBERG MEDICAL CENTER	NEWBERG	OR	Never Claimer
380038	PROVIDENCE WILLAMETTE FALLS MEDICAL CENTER	OREGON CITY	OR	Never Claimer
380040	ST CHARLES REDMOND	REDMOND	OR	Never Claimer
380051	SALEM HOSPITAL	SALEM	OR	Never Claimer
380052	SAINT ALPHONSUS MEDICAL CENTER - ONTARIO, INC	ONTARIO	OR	Never Claimer
380056	SANTIAM HOSPITAL	STAYTON	OR	Never Claimer
380071	WILLAMETTE VALLEY MEDICAL CENTER	MCMINNVILLE	OR	Never Claimer
380075	PROVIDENCE MEDFORD MEDICAL CENTER	MEDFORD	OR	Never Claimer
380089	LEGACY MERIDIAN PARK MEDICAL CENTER	TUALATIN	OR	Never Claimer
380102	SACRED HEART MEDICAL CENTER - RIVERBEND	SPRINGFIELD	OR	Never Claimer
382004	VIBRA SPECIALTY HOSPITAL OF PORTLAND	PORTLAND	OR	Never Claimer
383300	SHRINERS HOSPITAL FOR CHILDREN-PORTLAND	PORTLAND	OR	Never Claimer
384011	BLUE MOUNTAIN RECOVERY CENTER	PENDLETON	OR	Never Claimer
384012	CEDAR HILLS HOSPITAL	PORTLAND	OR	Never Claimer

3. In summary… All hospitals should review their HCRIS data

Look at your HCRIS data:

- If no entries and you are not currently training >=1 FTE then do nothing now.
- If no entries and you ARE training >=1 FTE then start claiming that (and set PRA and possibly start cap clock if new residency) ***NOW***.
- If your HCRIS entries show you ARE eligible for a PRA reset do this:
  - if you are **now training** >=1 FTE (Cat A) or >3 FTE (Cat B) then apply with MAC for PRA reset if current PRA is low.
  - If these are residents from a NEW program then you are likely eligible for a cap reset as well.
  - If you are not currently training sufficient residents then wait until you are doing so with a plan then to apply for a reset. Window closes 12/25/2025
- If the HCRIS entries show you are not eligible for a reset then do nothing unless…
- You disagree with HCRIS data and believe you are truly eligible for a reset, then you must electronically submit complete and unambiguous documentation to your MAC **no later than July 1, 2022**.

CAA GME provision focus slides
Will this effect YOU?

Next 3 slides

1 Will this affect YOU? Section 126 new slots

- **Consider applying for new slots if (all of these factors):**
  - your hospital is an overcapped IPPS hospital
  - you want to start a new residency (urban hospitals) or expand a current residency (urban and rural hospitals)
    - you are either ACGME/ABMS approved for this or well on the way to approval
  - you fit at least one priority category
  - ***you have a high HPSA score***
- We predict there will be **many applications for these few spots** and at most you might get 3-5 slots in a year (enough to add ONE resident depending on the specialty) if your HPSA score is very high.
- This whole process may be more of a **dry run** in case more slots are authorized in the future (e.g. the "14,000 slot bill")
- **Deadlines to apply March 31 of each year**

2. Will this affect YOU? Section 127 Rural relief

- **This matters IF (any):**
  - you are planning an RTP and now consider doing that without separate accreditation
  - you have a current RTT that started before Oct 1, 2022 but are still in cap building 5 years. You will get the rolling average exception advantage
  - your urban hospital(s) has never had an RTP and now may want to start one
    - May be more attractive since RTP no longer needs to fit “new program” criteria and have a separate program director, etc.
  - your urban hospital(s) have an RTT and now wants to expand to a different rural community or involve a different specialty

3. Will this affect YOU? Section 131 PRA/cap reset

- **This matters IF (any):**
  - Your IPPS hospital has a low PRA (<<$100,000, often zero)
    - That PRA was set in base year based on <1 FTE (before 1997) or <3 FTE (after 1997)
  - Your IPPS hospital has never claimed residents on a cost report.
  - Your IPPS hospital has a very low cap (<3) AND is planning to start a NEW residency
- **Relevant dates:**
  - **Review hospital situation well before July 1, 2022**
  - **If applying for PRA reset AND currently training >=1 (Category A) of >=3 (Category B) FTE residents then you MUST apply to MAC for reset by July 1, 2022**
  - **If NOT currently training residents then you have until 12/27/25 to start training >=1 or >=3 FTE and apply for a reset**

Other national resources for new residency planning

- The Rural Residency Program Development grant and technical assistance center. Details in appendix. Look at ruralgme.org for many useful tools available to all!
- Teaching Health Centers (THC). Details in appendix including current legislative proposals to expand/extend the program
- The THC Program Development grant and technical assistance center. Details in appendix. Look at thcgme.org for many useful tools!

The Following Slides are for Reference

1K Applying for section 126 slots

- Deadline is March 31 of each year for next 5 years. E.g. March 31, 2022 application covers 200 slots that if granted can be used starting July 1, 2023. Notification of slots granted may not occur until early 2023. CMS is looking into advancing the annual notification date.
- Applicant MUST meet ***at least one*** of 4 priority areas to apply at all
- **HPSA status will matter the most for ALL applications** (see later slide)

1K Demonstrated likelihood of filling: details for NEW residencies

- Hospital currently overcapped.
- Intends to use new positions starting within 5 years of being granted the new slots.
- At least one of these:
  - ACGME or ABMS new program approved by 3/31/22
  - Hospital has received (by 3/31/22) written correspondence from the ACGME or ABMS “concerning the new program accreditation or approval process (such as notification of site visit)”.

1K Demonstrated likelihood of filling: details for residency EXPANSIONS

- Hospital currently overcapped.
- Intends to use new positions for expanding a current residency program starting within 5 years of being granted the new slots.
- At least one of these:
  - ACGME or ABMS program expansion approved by 3/31/22
  - Hospital has submitted a request by 3/31/22 to the ACGME or ABMS for program expansion
  - Hospital currently has unfilled positions in residency program and now will seek to fill them
- A hospital that is not currently training residents in the program can apply for expansion slots if that hospital will begin training residents from the expanded program within 5 years.

1K Section 126: Category 1 preference Rural

- **the hospital has to be located in a "rural place"** :
  - either outside a metro-CBSA or
  - located in a rural (by Federal Office of Rural Health Policy criteria) Census tract within a metro-CBSA.
- RRCs that are neither in a rural place nor "treated as being located in a rural area" are not eligible for the section 126 rural preference.
- They did not require that a rural hospital getting additional section 126 slots had to actually train the new residents in a rural place.
- What happens if area is reclassified as urban when the **2020 census** is used to reconfigure CBSAs?
  - It looks like they will use the current "Crosswalk" file based on the **most recent** FY IPPS final rule in determining "rural or not" as of each March 31 slot application deadline. So watch out in 2023 or 2024 when the 2020 census causes CBSA changes.

1K Section 126: Category 2 preference Overcapped

- determined based on cost report that ended on or before 12/27/2020.
- If undercapped for DGME and overcapped for IME then the hospital would only get new section 126 IME slots and vice versa.
- If overcapped for both DGME and IME then the hospital would get both IME and DGME slots.
- “Rural hospitals in urban places” generally get new IME slots when they start new programs but no new DGME slots. However these new section 126 slots will be for BOTH DGME and IME for these hospitals.

1K Section 126: Category 3 preference states with New Medical Schools or Branch Campuses

- specifically listing 35 states plus Puerto Rico as qualifying under 126 category 3:

  AL, AZ, AR, CA, CO, CT, DE, FL, GA, ID, IL, IN, KS, KY, LA, MA, MI, MS, MO, NV, NJ, NM, NY, NC, OH, OK, PA, PR, SC, TN, TX, UT, VA, WA, WV, WI

- Process left open for additional states to appeal for inclusion in the future.
- Your programs doesn't need to be involved with the new medical schools or branches in your state. You just need to be IN one of the listed states

1K Section 126: Category 4 preference HPSA status

- Hospital “participates in training residents in a program in which residents rotate for at least 50% of their training time to a training site(s) physically located in a primary care or mental health only **geographic** HPSA”.
- For “mental health only” HPSAs only psychiatry programs qualify.
- Entire program (not just expansion) needs to train >=50% in the HPSA
- Only ONE HPSA can be listed.
- See upcoming slide for how HPSA status influences overall prioritization for all applicants
- Link to find your HPSA status:

  https://data.hrsa.gov/tools/shortage-area/hpsa-find

1K section 126 rules
Overarching Priority for HPSA service

- Applications (even those that don't qualify by Category 4 geographic HPSA requirement) will ALL be prioritized based on service to ***geographic*** HPSAs plus ***population*** HPSAs using HPSA score cited in the hospitals application for training using the additional 126 slots.
  - Highest scores will be allocated slots first.
  - Hospitals with <250 beds will have priority within each HPSA score group.

1K More section 126 rules

- A hospital can only apply for one residency to get slots added in a given year
- A hospital is limited to maximum 1 slot per program year – e.g. a FM program could be granted 3.0 slots in for July 2023, a General Surgery program could get up to 5.0.
- A hospital can apply every year for additional 126 slots
- A hospital MUST meet one or more of the four priority categories to apply at all for 126 slots.
- A hospital must meet National CLAS standards CLAS = Culturally and Linguistically Appropriate Services.

2. Section 127 RTP documentation requirements

to <u>submit to MAC</u> when first claiming RTP residents

- **The ACGME accreditation** for the program as a whole (that is, both urban and rural training components)
- documents showing whether the urban and rural participating sites are
  - starting the RTP for the first time in this **particular specialty**, or
  - whether the urban and rural hospital already have an RTP in this specialty but are **adding additional participating sites** to the RTP, or
  - claiming this as a **separate RTP**
- A list of all urban and rural hospital and nonprovider **training sites** in the RTP.

2. Section 127 RTP documentation requirements
continued

- **Resident rotation schedules** (or similar documentation) showing that residents in the specified RTP spend greater than 50 percent of their training in a geographically rural area in the 5-year growth window in order to receive IME and direct GME rural track FTE limitations.
  - "In the instance where only a subset of the residents in the particular program are participating in the RTP, and the training time of the RTP residents is included in the main rotation schedule for the entire program, the hospital must specifically highlight the names of the residents and their urban and rural training locations on the main rotation schedule, so that the MAC can easily identify which residents are training in the RTP, where they are training, and be able to verify that over 50 percent of their training time is spent in a rural area."

2. Section 127 RTP documentation requirements
for cap setting

- ”The number of FTE residents and the amount of time training in all **5 program years** at both the urban and rural settings since establishment of a Rural Track Program (based on the rotation schedules), so that this information is available to the MAC when needed in auditing the accuracy of the RTP FTE cap limitation established by the hospital in the cost reporting period that coincides with or follows the start of the sixth program year o the RTP.”

2 LM CAA Sec. 127. Removal of 3 year rolling average rule for RTPs

- As of October 1, 2022 there will be no application of the 3-year rolling average during 5-year growth period of RTP.
- This applies to BOTH new RTPs starting after 10/1/22 and to RTTs that started before that date but are still as of 10/1/22 in their cap building first 5 years.
- Before the CAA new RTTs did not have this exception so ended up losing ~1 year's worth of Medicare GME funding.

2b

What defines an RTP from the CMS perspective?

- A separately accredited residency program or track* within an accredited program where >50% of training takes place in a rural area – outside a metro-CBSA. (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 RTPs have NO rural hospital (all rural training is outpatient)

* CAA 2021 section 127 removed the requirement for separate accreditation

2b. What is the financial advantage of being an RTP?

- **Whatever urban hospital(s) claim the residents' time for training in an RTP will get a cap adjustment (an "RTP cap") and thus be paid above their historical cap.**
  - "Urban hospital RTP cap" is set after 5 years for hospitals that already have a cap
  - The "RTP cap" for an urban hospital can't be used for other non-RTP residencies – e.g. if the RTP closes
  - The urban hospital "RTP cap" can be increased if the urban hospital participates in a 2nd RTP in a ***different*** specialty.

2b. Who claims resident time in an RTP?

- **Often there is one urban hospital that sponsors the RTP and makes claims for RTP 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 RTP 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 that they are claiming is in their hospital or in an non-provider clinic where the hospital pays resident salaries and benefits.
    - A new RTP then may be starting an "urban RTP cap clock" for more than one urban hospital.

2b. Important RTP 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 RTP residents:
  - It has a "zero PRA" because of prior resident rotations. Now can often reset PRA (sec 131)
  - The RTP does not qualify as a "new program" because it has the same program director as the core urban program. Sec 127 changed this
  - The rural hospital is a SCH or RHDP and paid way less (or no) IME
- However since this is a "first RTP" 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 for the rural hospital
- An RTP 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.

2b. So the keys to an RTP qualifying for new CMS GME funding are…

- >50% training time in a rural area (see next slide)
- RTP must be separately accredited * (if there is a core FM residency) and be the first RTP in that specialty (e.g. FM) that the urban hospital has participated in.
- It appears that "New program" rules no longer apply to RTPs (sec 127)
- What if BOTH the core urban residency and RTP are established at the SAME time?
  - Then it appears they can share a program director since the PD is "new" for both simultaneously.

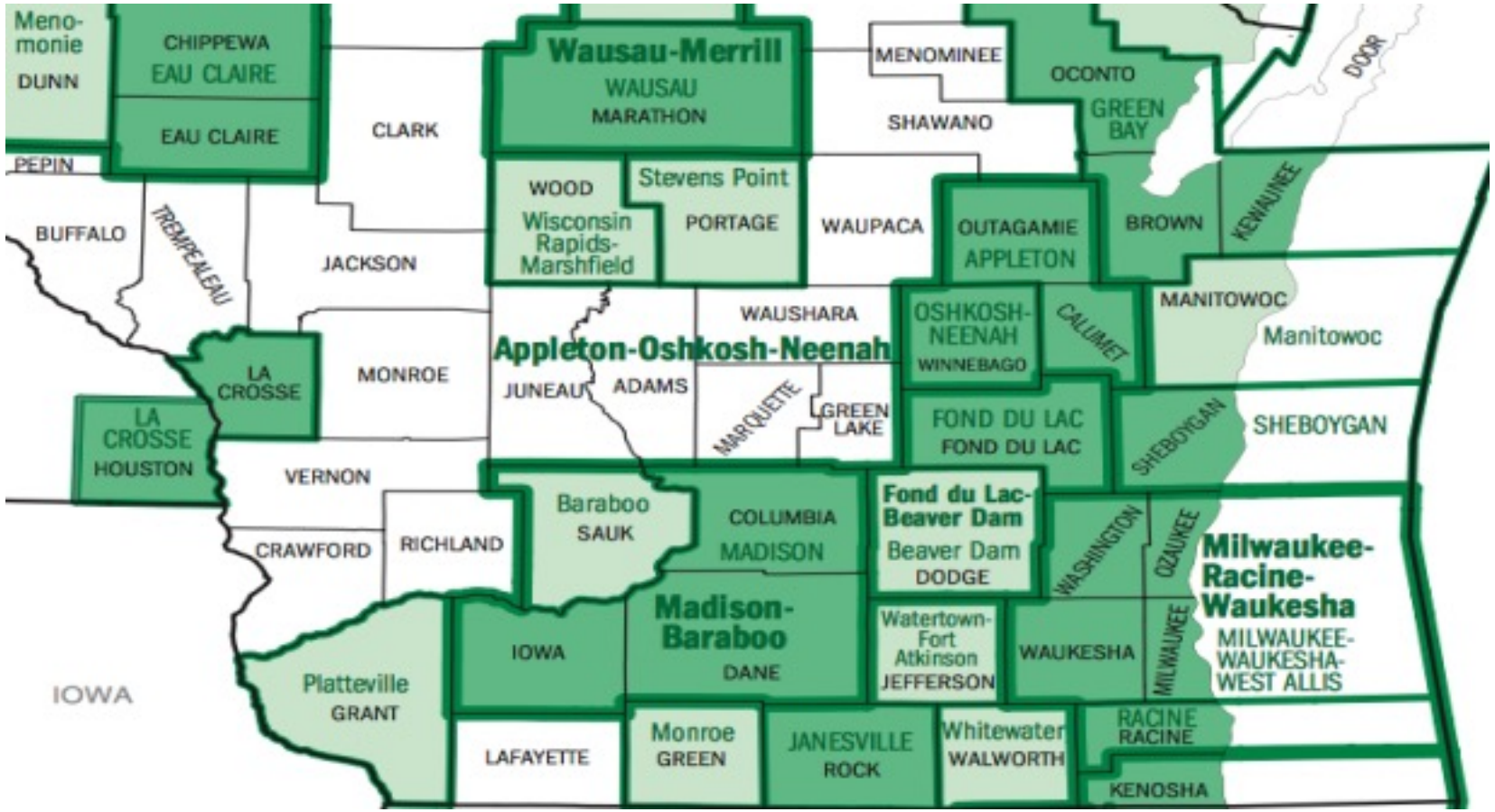
*** CAA 2021 section 127 changed this**

2b. What is "Rural" place from CMS's GME perspective – at least for RTPs? See CBSA maps:

- 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 rural - in a metropolitan CBSA (dark green)**
  - **Rural can be in micropolitan CBSA (light green) and rural can be in the - not in a CBSA (white)**

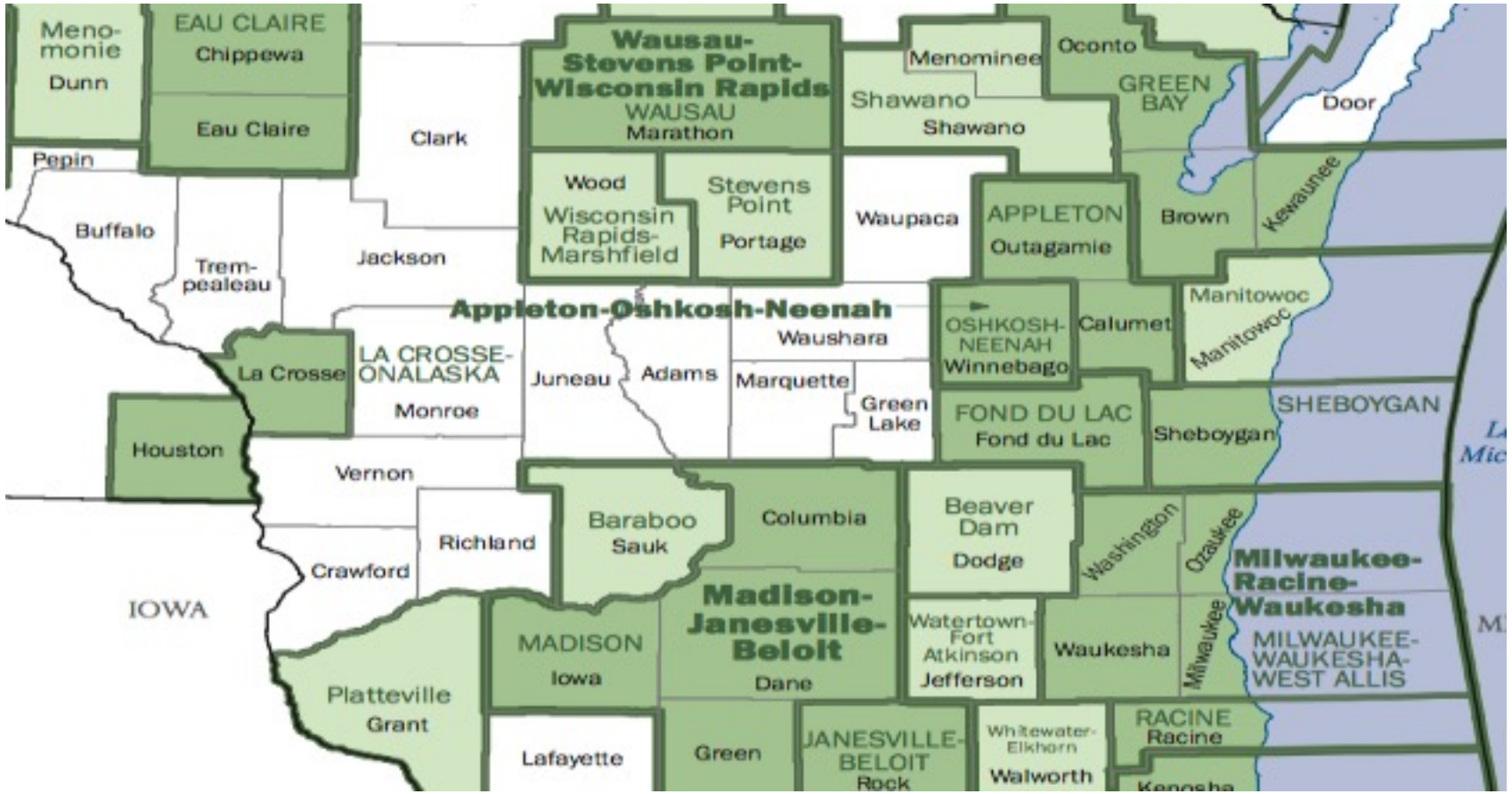
2b. Core Based Statistical Areas (CBSA)-Colorado Feb 2013

2b. Core Based Statistical Areas (CBSA)-SE Wisconsin June 2003



2b Core Based Statistical Areas (CBSA)- SE Wisconsin Feb 2013

(notice what happened to Green County in southern WI)



2b. OMB is proposing to redefine micropolitan CBSA which would reclassify many “urban” communities as “rural”

- Current definition micropolitan requires “urbanized” population <50,000
- Proposed definition would allow population <100,000
- Proposed 1/19/21. Comment period ends 60 days after.

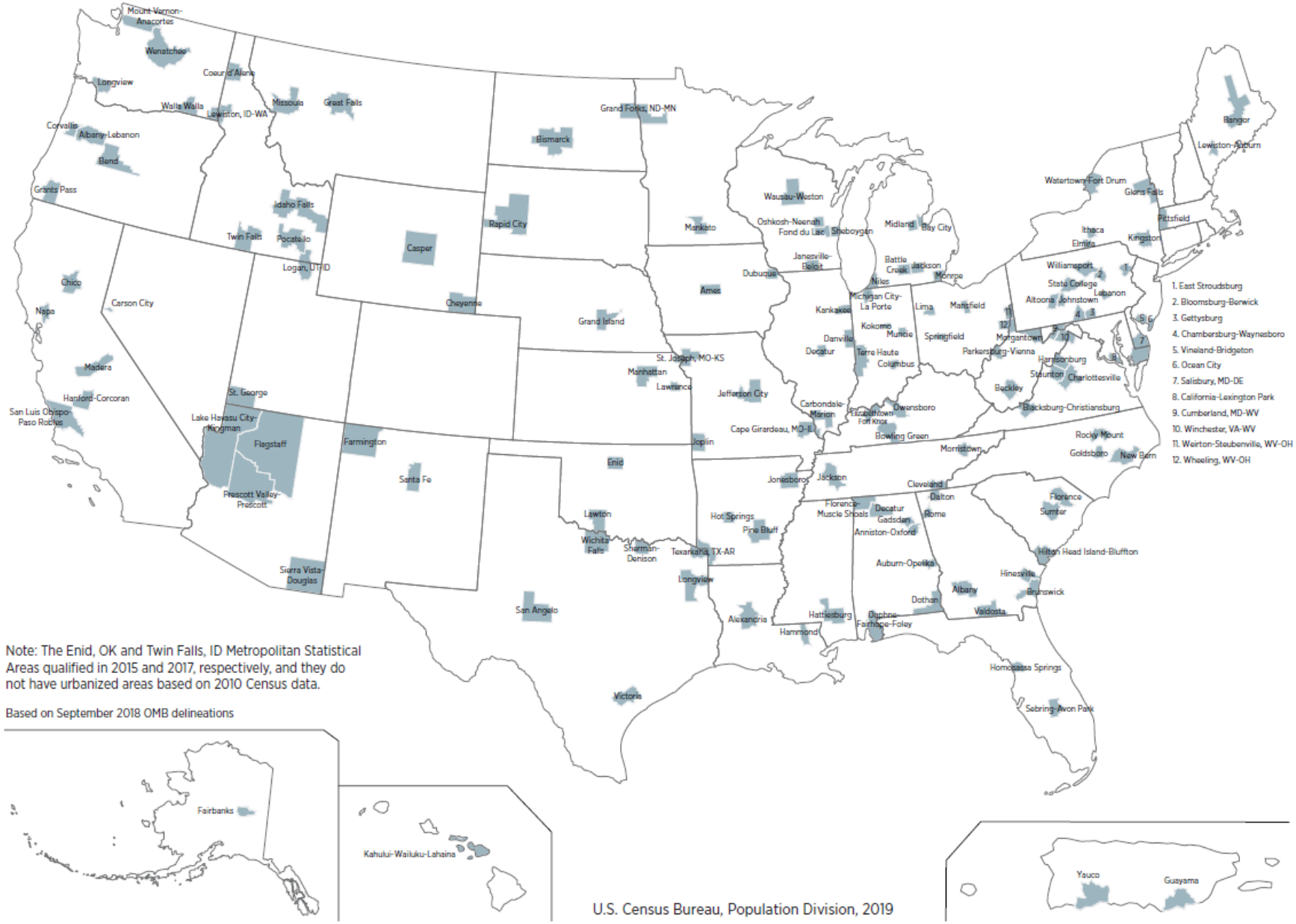
https://www.federalregister.gov/documents/2021/01/19/2021-00988/recommendations-from-the-metropolitan-and-micropolitan-statistical-area-standards-review-committee

Google search “OMB proposed micropolitan CBSA”

This is not in your slides

2b

Metropolitan Statistical Areas With a 2010 Urbanized Area Population Between 50,000 and 99,999



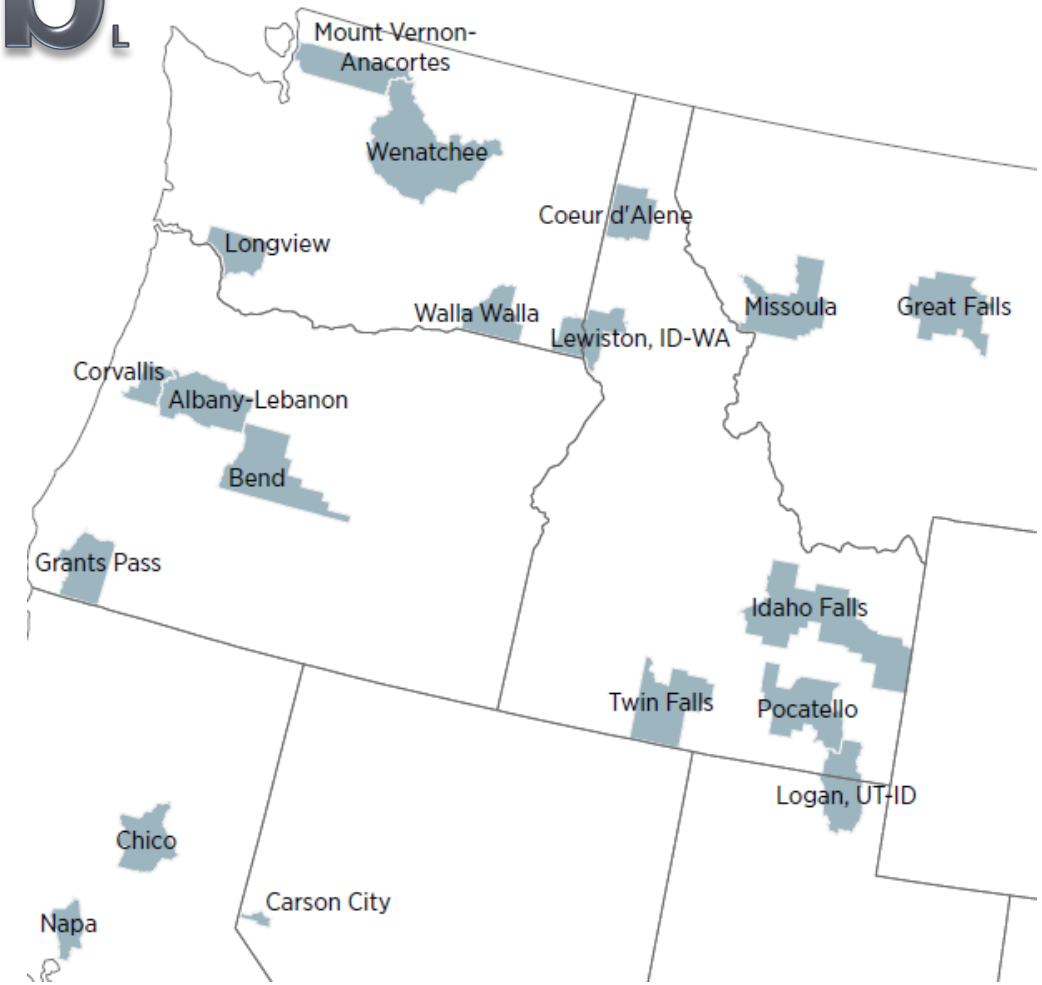
Note: The Enid, OK and Twin Falls, ID Metropolitan Statistical Areas qualified in 2015 and 2017, respectively, and they do not have urbanized areas based on 2010 Census data.

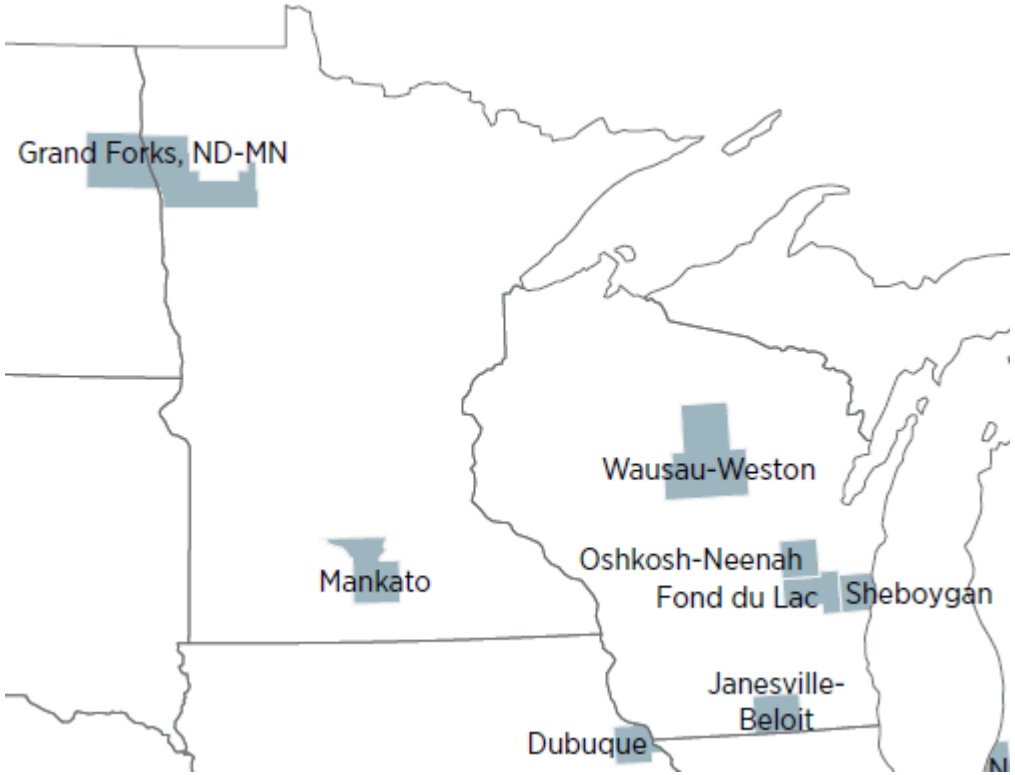
Based on September 2018 OMB delineations

U.S. Census Bureau, Population Division, 2019

2b

Some OMB examples of possible newly "rural" areas





2b

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

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

2L RTP cap allocation issues

- Since the 2016 final rule, caps for RTPs (like other residencies) are being set based on the entire first 5 years of RTP claims by all partner hospitals.
- In the 5th year an RTPs largest PGY year FTE claims (all hospitals) is multiplied by length of program. e.g., an FM RTP had 6 PGY1s, 5 PGY2s, 4.5 PGY-3s. Largest year is PGY-1 so total available cap addition is 6 x 3 = 18.
- Then apportioned to participating hospitals ***based on the first 5 years' worth of claims data***. Yes that includes early years when proportionately more resident time claimed by the urban hospital(s)
- Since a typical RTPs have more resident time spent in the urban place in the PGY-1 year this ends up assigning more cap to the urban hospital(s) than that hospital will use for the mature 6-6-6 program and less to the rural hospital than its future claimed residents.

2L RTP cap allocation issues example

- Example for 4-4-4 RTP
- Year one 4 PGY-1s all at urban hospital
- Year two 4 PGY-1s at urban hospital, 4 PGY-2s at rural hospital
- Year three 4 PGY-1s at urban hospital, 4 PGY-2s and 4 PHY-3s at rural hospital
- Year four and five same as year 3
- Claims by urban hospital over 5 years: 4+4+4+4+4=20
- Claims by rural hospital over 5 years: 0+4+8+8+8=28
- 12 slot Cap allocation:
  - Urban hospital 20/48 * 12 = 5 (but in future will only claim 4)
  - Rural hospital 28/48 * 12 = 7 (but in future will claim 8 but only get paid for 7)

2L RTP cap allocation issues continued

- This was not changed by section 127 of the CAA
- This is the same process used for all new residencies
- Hospitals participating in non-RTP residencies can adjust the use of their caps via Medicare Affiliation Agreements
- However RTP “cap adjustments” are NOT currently eligible to be shared via Medicare Affiliation Agreements
- CMS is looking at solutions for this unintended consequence

3b

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 (but don’t start a cap clock)
  - CAA 131 new: No PRA set until a year when >= 1.0 FTE resident does rotation
  - PRA set during fiscal year when 1st resident does rotation (if in first FY month) or following FY if 1st resident starts later in year.
    - Note this is different from the section 131 PRA ***resetting*** rules where rotation in first FY month not required.

3b

When does the “clock start ticking” for Caps?

- A resident or fellow from a ***new*** residency program in first 5 years will start a cap clock in ANY “virgin” hospital where the residents do an official rotation if >=1 FTE resident rotates in a year in that hospital.
- A resident or fellow from an ***old*** residency program (over 5 years old) will NOT start a cap clock in a “virgin” hospital.

3b

Many hospitals are in a precarious position if they don't claim resident activity but *should* have.

- Old rules: ANY resident rotation in hospital or provider based clinic ***should*** be claimed. If rotation occurred but not claimed AND this is discovered when the hospital first claims residents then the hospital may get assigned a zero PRA because they claimed no costs in a past year when they should have claimed residents.
- The "no claims" year also may have started a cap clock if a resident was from a new program.
- New CAA sec 131 rule does not require claims when less than 1.0 FTE rotate at a virgin hospital in a year.
- See prior sec 131 slides about "never claimers" and PRA/cap reset.

Strategies going forward 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:
  - Limiting rotations to outpatient only in non-provider based clinics
  - Carefully 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 IN the hospital.
  - **Being careful to not train >= 1 FTE resident total in any year (2022 forward) until the hospital plans to start a new residency.**
  - Paying resident salaries and benefits for first 1-2 years any time outside residents do ANY rotations at your hospital or provider-based clinic. If you execute a "Medicare Affiliation Agreement" with a capped hospital you can do this even with <1.0 FTE trained that year. This will lock in your PRA.

3b.

PRA setting details: How is a new PRA calculated?

- GME cost claims made and FTEs claimed during PRA setting year: then calculate DGME cost/FTE
- Compared to a specific local/statewide/regional PRA.
- Hospital gets *smaller* of DGME cost/FTE vs comparison PRA

Sources of PRA data

- Sources of PRAs for established teaching hospitals
  - Graham center (last update 2016)
  - 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)

3b. Census region PRAs updated from 1998 using CPI-U

region	states	Dec-1998	Dec-2021
	CPI-U ->	163.9	278.802
New England	CT, ME, MA, NH, RI, VT	$ 69,696	$ 118,556
Mid Atlantic	NJ, NY, PA, PR	$ 92,567	$ 157,461
S Atlantic	DE, DC, FL, GA, MD, NC, SC, VA, WV	$ 62,513	$ 106,338
EN Central	IL,IN, MI, OH, WI	$ 67,120	$ 114,174
ES Central	AL, KY, MS, TN	$ 59,619	$ 101,415
WN Central	IA, KS, MN, MO, NE, ND, SD	$ 70,212	$ 119,434
WS Central	AR, LA, OK, TX	$ 55,240	$ 93,966
Mountain	AZ, CO, ID, MT, NV, NM, UT, WY	$ 60,697	$ 103,249
Pacific	AK, CA, HI, OR, WA	$ 68,652	$ 116,780

3b

How is new PRA calculated?

Set at LOWER of claimed GME costs per FTE resident vs a specific comparison group/number:

1. If >=3 established teaching hospitals in CBSA then calculate FTE weighted average PRA of teaching hospitals in same CBSA.
2. If new hospital is in **metro-CBSA** with <3 established teaching hospitals in the CBSA then use census region average PRA (data updated by inflation using current CPI-U)
3. If new hospital **not in a metro-CBSA** and <3 hospitals "not in metro-CBSA" ***statewide*** then use census region average PRA (data updated by inflation using current CPI-U)
4. If new hospital **not in a metro-CBSA** and >=3 established teaching hospitals "not in metro-CBSA" ***statewide*** then use FTE weighted average PRA of all non-metro CBSA teaching hospitals in the state.

New PRA calculation weighed separately for Primary Care and Non-primary care residents (by FTE) but new hospital gets ONE PRA (PC = NPC PRA).

3b. "New program" potential vulnerability

"New/separate residents"

- Is it a violation to recruit residents who already have some residency training already in another program?
  - Not if from ***different*** specialty (including transitional year as a different specialty)
  - Potential vulnerability if from ***same*** specialty
    - "overwhelming majority" must be recruited as R1s or transferred from a different specialty.
- Particularly an issue with General Surgery where ~25% of PGY-1s change programs or specialties after 1 year

3b. 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). See Rural Referral Center slides
- Program expansion
  - No addition to ***regular*** cap in any hospital
- Special RTP rules:
  - RTP specific FIRST RTP in a specialty involving urban hospital then the urban hospital can build an "Urban RTP cap" even if RTP not a CMS "new program"
  - Also now (sec 131) the rural hospital CAN get a cap increase for an RTP even if it does not meet "new program" criteria

4. Rural Residency Program Development (RRPD) HRSA funding

- In 2018, HRSA funded a RRPD - Technical Assistance Center (TAC) to support the development of new rural graduate medical education (GME) programs
- Grants are $750,000 over 3 years for each developing program
- Grants already made:
  - In 2019, HRSA funded 26 RRPD Programs, referred to as Cohort 1, with a program start of August 2019.
  - In 2020, HRSA funded 10 RRPD Programs, known as Cohort 2, with a program start of September 2020.
  - Recently, HRSA awarded 10 organizations RRPD funding to participate in Cohort 3 starting August 1, 2021.
  - More programs (cohort 4) will be funded with application deadline Dec 2021.
- ? Future funds might become available (cohort 5, 6…).

4L Rural Residency Program Development (RRPD) Technical Assistance Center (TAC)

- HRSA funded at University of North Carolina
- See https://www.ruralgme.org/ ruralgme.org
- LOTS of Rural residency planning resources available to all – not just RRPD grantees.

Teaching Health Center Updates

- There have been 4 new Notice Of Funding Opportunities for THC funding since 2021
- Now funding has been provided via the **American Rescue Plan appropriated $330 Million for THCGME** to remain available until September 30, 2023 for:
  - planning (the THCPD program)
  - New and expanded THCs.
  - Ongoing THC operations.
- **Teaching Health Center Planning and Development (THCPD):**

  HRSA-22-107
  - To help establish **newly accredited** and sustainable community based residency programs in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, psychiatry, obstetrics and gynecology, general dentistry, pediatric dentistry, or geriatrics to support the expansion of the primary care physician workforce in rural and underserved communities
  - Eligible to Community-based ambulatory patient care settings
  - Estimated total funding: $25 Million Expected Awards: 30
  - Posted: July 14, 2021; Applications Closed: August 30, 2021
  - Getting a THCPD grant ($750,000 over 3 years) does NOT guarantee THC operational funds will be available
- **THCPD technical assistance center funded at University of North Carolina**
  - See https://www.thcgme.org for more information and MANY THC planning resources available to all (not just THCPD grantees)

5K Teaching Health Center New/Expanded Program Funding

- **HRSA-22-105 for new/expanded THCs**
  - Covers two award types: 1. **Expansion** Awards **and** 2. **New** Awards
  - Estimated total funding $45.92 Million Expected Awards 85
  - Posted: June 23, 2021; Applications Closed: September 20, 2021
  - Link: https://www.grants.gov/web/grants/view-opportunity.html?oppId=334336
  - Current Interim Rate is $160,000 per resident FTE per year
- **HRSA-22-139**
  - Covers two award types: 1. **Expansion** Awards **and** 2. **New** Awards
  - Estimated total funding: $19.2 Million Estimated Awards: 30
  - Posted: January 31, 2022; Applications Closed: March 31, 2022
  - Link: https://www.grants.gov/web/grants/view-opportunity.html?oppId=337206
  - Current Interim Rate is $160,000 per resident FTE

- **Other current THC operations are also covered at $160,000 per resident FTE per year**

5K Teaching Health Center New/Expanded Program Funding

- **Total new programs authorized by Congress**
  - **145 new programs**
- **Total amount authorized by Congress**
  - **$330 Million**
- **Amount authorized out of the $330 Million**
  - **$95.12 Million**
- This would suggest that there may still be additional funding for further new THC Awards up until September 30, 2023, unless part of the total funding is to fund existing programs. This is unclear, but hopefully they will still plan on funding additional new programs.
- With Congress authorizing the further expansion of the THC program, the larger that it gets, the more difficult it will be for Congress to defund this program.

Teaching Health Center Bills

- **Doctors of Community (DOC) Act** (*AKA: THC Permanence Bill*)
  HR3671 and S. 1958
- Chairman Frank Pallone (D-NY) and Chairman Patty Murray (D-WA), head the committees of jurisdiction of this program
- $6 Billion over 10 years, create over 100 new centers for total of about 200, and add 1600 resident slots for total of about 3,000 residents
- **Budget Reconciliation Bill**, $6 Billion, but no permanence
- Included in **Build Back Better** as $3.7 Billion, no permanence, and Build Back Better still not approved in the Senate

THC vs CMS rules

- There have been discussions between HRSA (administrates 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!)

7K VA Mission Act Pilot: Program on GME and Residency (PPGMER)

- Comment period opened Feb. 4, 2022, and closed April 5, 2022
- To fund not less than 100 residents or fellows in accredited program. Sunsets 8/7/31, at which time reauthorized or ends
- Training can be outside of VA Hospital, preference for Indian Health Service, FQHC, Rural, HPSA, specialties of higher need in an area. Residency expansion or new – apply to VA. Timing not stated yet.
- Pay for time residents training in the PPGMER. Can see non-VA patients. Pay resident stipend/benefits, some start up costs.
- Federal Register :: VA Pilot Program on Graduate Medical Education and Residency

Reform efforts

- The **GME Initiative** invites your participation!
  - http://www.gmeinitiative.org/
  - Next annual meeting in Washington DC March 31-April 2 2021 (now virtual)
- Current efforts:
  - Comprehensive reform (CONGR meeting 2018 – **Co**mpehensive National **G**ME **R**eform) to push forward concepts in the IOM report
  - LIFT – **L**egislative **I**nitiative **F**ocused **T**askforce
    - "Technical fixes" (regulatory reform and new legislation to "fix" the current system). Also refer to Hope Wittenberg's talk (some done in stimulus bill January, 2021).
    - THC permanence
    - Rural rotation/residency direct funding via an "alternative payment" process within the Medicare GME system = **The Rural Physician Workforce Production Act (RPWP act).** Looking for new sponsors, and at compromises to enhance chance of passing.
  - Building partnerships and advocacy
  - State GME funding initiatives
  - ABFM Conducting study of GME leaders with Delphi process to get consensus of what to do

9K Rural Physician Workforce Production Act of 2021 - summary

- Rather than Medicare IME/DME, payment set at $150,000 per FTE resident, with annual inflation adjustments per CPI-U thereafter, and not discounted by % Medicare a hospital has
- If >50% time in rural, then urban site can qualify for this
- If 8 weeks, such as some specialties, they can be reimbursed at this rate
- Initially Introduced by Senator Corey Gardner (R-CO). After not reelected now picked up by Senator Jon Tester (D-MT)

RAP-GME became RPWP… Key feature: Fixed Per Resident Payment (PRP)

- **Pays a fixed predictable amount** (the "Per Resident Payment" = PRP) annually per resident FTE
- not discounted by Medicare share (e.g. NOT a Medicare "PRA") or contingent on patient care billings (e.g. DRG volume)
- not variable by region
- Rather than Medicare IME/DME, payment set at $150,000 per FTE resident, with annual inflation adjustments per CPI-U thereafter.

9K RPWP Key feature: Pays for rural time with 2 different thresholds

- Resident FTE claims eligible for payment under this program are:
  - **Resident time actually spent in rural areas (from any specialty)** as long as that resident spends **at least 8 weeks** training in rural areas during their entire residency.
  - **The entire residency training time** for a resident (urban and rural time) is eligible for payment if the total **rural time for that resident is >= 50%** of their total residency time.

9K RPWP Key feature: will be built into Medicare GME system

- This payment system will be **reliable (permanent) and predictable** because it is an alternative payment method administered ***within*** **the Medicare GME system** (part of that entitlement system and not subject to the need for grant extension legislation)
  - Requires a modified IRIS system and hospital cost report to separate claims made under this alternative method vs the standard method
  - Payments made to hospitals using the established rules for allowable claims for resident time.
    - E.g. a rural or an urban hospital can make claims for rural time as long as that hospital pays resident salary and benefits.
  - Administration and auditing using the established Medicare contractor (intermediary) system

9K RPWP Key feature: ALL kinds of hospitals eligible. ALL specialties

- **All hospitals**, including Critical Access Hospitals and Sole Community Hospitals, would have the choice to claim payment under this method or the traditional method.
- This payment would apply to all physician residency training occurring in rural areas, **irrespective of specialty**.

9K RPWP Key features: Hospital choice, no caps, no PRA or cap trigger

- A **hospital can choose** to claim resident time under the traditional system or the RPWP system or both on any given cost report. The same resident can have some time claimed under either system as long as there is no overlap for a given week or overlap with another hospital claiming that resident's time that week. Resident time for a given week can't add up to >100% across all hospitals and traditional vs RPWP claims.
- RPWP claims have **no caps** and claims *solely* under the RPWP system **will not trigger a PRA nor a cap clock** for a new teaching hospital

9K RPWP Key feature: Broad rural definition, stable over time

- For the purposes of this program a training location is considered **"rural" if it meets ANY** of the following criteria:
  - Is not in a metropolitan CBSA
  - Is defined as "rural" by HRSA Office of Rural Health Policy (excluding state-based definitions)
  - Is in a community with a Sole Community Hospital
  - Would meet the HRSA or CBSA criteria above based on the current decennial census (as of 2020 census) or the immediately preceding decennial census (e.g. the 2010 census).

9K RPWP Negotiations…

- Ongoing negotiations with the AAMC may result in:
  - AAMC did not like "budget neutral" since could stimulate congress to cut IME to pay for this
  - Reconfigured the bill language and calculations to "leave IME alone" – the major policy priority of the academic medical centers
  - Supposed to result in the AAMC adopting a "neutral" position towards RPWP vs current "opposed" position.
    - May then release AAMC members to make their own local determinations of support
  - Will complicate the explanation of the final bill
  - Likely will increase the projected cost of the bill

RPWP Can this happen??

- Rural training tracks across the country could help to train the rural physician workforce for the country (should be appealing to both sides of the aisle to do good for their state)
- However will have a fiscal note, which in Congress can be a non-starter, even if the return on investment is great for the country – so uphill climb
  - May be difficult to score – as would be rate limited by the number of residents who would choose this, and difficult to calculate.

10 "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.
- Safe harbor: **if the grants go directly to the hospital, and the grant is not the sole source of funding, and the hospital is incurring some cost, then it is not considered community support**

11. The Primary Care Exception (PCE)

- Rule that exempts preceptor in a primary care residency continuity clinic from needing to see patients ***during*** visits by residents (after 1st 6 months) for E&M codes below level 4, Welcome to Medicare visits and Medicare Annual Wellness Visits.
- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners Table of Contents (Rev. 4431, 11-01-19) pages 124-126

11. To qualify for PCE

- services must be furnished in a center located in the outpatient department of a hospital or another **ambulatory care** entity
- in which the **time spent** by residents in patient care activities is included in determining **direct GME payments to a teaching hospital**
- residents providing the billable patient care service without the physical presence of a teaching physician must have **completed at least 6 months** of a GME approved residency program
- Teaching physicians submitting claims under this exception **may not supervise more than four residents** at any given time and must direct the care from such proximity as to constitute **immediate availability**.
- Teaching physicians submitting claims under this exception **must not have other responsibilities** (including the supervision of other personnel)
- **Review the care** provided by the residents **during or immediately after each visit**.

11. More qualifications for PCE

- **Patients** under this exception should consider the **center to be their primary** location for health care services.
- The residents must be expected to generally provide care to the same **group of established patients** during their residency training.
- The types of services furnished by residents under this exception include acute care, chronic care, coordination of care and **comprehensive care** not limited by organ system or diagnosis.
- Residency programs most likely qualifying for this exception **include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology**. Certain GME programs in **psychiatry** may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients.

11. PCE pitfalls

"…the time spent by residents in patient care activities is included in **determining direct GME payments** to a teaching **hospital**"

- Resident time in some FMP-sites are NOT claimed on any IPPS hospital cost report used to determine DGME:
  - A THC program is being paid directly via HRSA for the residents' time
  - A CAH provider-based clinic is the residency's continuity clinic and – under the "old" rules – an IPPS teaching hospital couldn't claim that time
  - A CAH is paying the residents' salary and benefits for time in the continuity clinic and claiming these costs directly
  - A Community Health Center (FQHC, FQHC look-alike, Rural Health Clinic or IHS clinic) makes direct GME claims
- In all these scenarios the PCE probably doesn't apply

11. PCE pitfalls

"Teaching physicians submitting claims under this exception **must not have other responsibilities** (including the supervision of other personnel)"

- It is likely common that preceptors (especially if few residents) are called upon to answer questions from nurses or provide advice for APPs or cover EHR inbasket tasks or respond to in-office emergencies while precepting.
- Be careful of formally assigning ANY responsibilities to the preceptor.

11. PCE pitfalls

"Review the care provided by the residents **during or immediately after** each visit."

- What does "immediately" mean? - especially if supervising 4 residents necessarily means the preceptor may not be instantly available when supervising another resident.
- There is no CMS rule defining this. Many programs have taken the position that reviewing PCE visits should be done during the same clinic session before the resident or preceptor leave the office.

11 Local Compliance Offices and interpretation of supervision rules

There is a lot of variability in how local organizational compliance offices have interpreted supervision rules:

- Some apply Medicare rules to ALL payers or just Medicare insured patients or Medicare and Medicaid.
- Some specify that preventive visit codes and/or OB visits require the supervising physician to see the patient and some consider these PCE visits
- Some specify the “critical” portion of procedures for supervising physician presence and some don’t. Some consider OMT to require supervisor presence for entire treatment.
- Some are aware of potential issues with DGME claims required for PCE eligibility and some aren’t.

12K 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 (big if) the old hospital is willing to enter into a cap sharing agreement (“Medicare Affiliation Agreement” renewed annually) with the new hospital for the slots it now won’t be using.

12K Closing Hospitals and Moving Programs continued

- If hospital is closing (surrendering it's acute care license) then it's GME "slots" can be picked up by other local hospitals. Current rules per ACA section 5506:
  - 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
- When a hospital announces its closure all current residents become eligible to be treated as "Displaced Residents"

12K

Displaced residents from *programs* that close

- If a residency program closes then the residents from that program who are accepted for transfer to a residency at another hospital ***may*** allow the accepting program's hospital(s) to temporarily increase their cap(s) to finish training that resident.
- This is a temporary cap transfer and ***is at the discretion of the hospital that is closing its program***.
- NEW: The acceptable transfer dates for residents from the program closing to the new program have been liberalized as of the September 2020 final rule 85 FR 58865 § 413.79 (h)(1)(iii)

12K

Displaced residents

from programs or hospitals that close when can the resident transfer?

Any of these situations if the resident

(A) Leaves a program after the hospital or program closure is publicly announced, but before the actual hospital or program closure;

(B) Is assigned to and training at planned rotations at another hospital who will be unable to return to his/her rotation at the closing hospital or program;

(C) Is accepted into a GME program at the closing hospital or program but has not yet started training at the closing hospital or program;

(D) Is physically training in the hospital on the day prior to or day of program or hospital closure; or

(E) Is on approved leave at the time of the announcement of closure or actual closure, and therefore, cannot return to his/her rotation at the closing hospital or program.

13. 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

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

- CAH inpatient payment calc -
  - (inpatient total costs/total inpatient days) = per diem x 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 –
  - (outpatient total costs/outpatient total charges) x 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

13. 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.

13L

Can urban hospitals claim resident time spent at a CAH?

- **YES** NEW 2019 RULE: As of Fiscal Years starting on or after October 1, 2019, a hospital (IPPS hospital) may include in its FTE count time spent by residents training at a CAH, so long as the hospital meets the nonprovider setting requirements (IPPS hospital pays resident salaries and benefits for time in CAH)
- Not applied retroactively – a problem for IPPS teaching hospitals that were partnering with CAHs for rotations or RTPs and have already gotten capped.
- CAHs can still elect to make direct cost claims for residency costs the CAH bears and be paid 101% of Medicare's share.

13L If a CAH makes direct claims for residency costs does it have to deduct any payments it gets from outside entities to help pay the non-Medicare share?

- No. It can claim all residency costs without deducting other outside support (e.g state grants).
- From CMS: “CAHs (and other hospitals, when applicable) don’t have to deduct grants that they directly receive from their revenues for determining net cost.”

13L

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

13. Rural Community Hospital Demonstration Program (RCHDP)

- Fact sheet link https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-Sheet-items/2018-04-18.html
- 30 rural hospitals (13 new in 2018). 5 year demonstration projects actually started 2004 after MMA legislation. New solicitations 2018.
- **NEW: Was reauthorized under 2021 CAA**
- base year (calculated ONCE) inpatient operating costs will be reimbursed on a cost basis and all subsequent fiscal years' operating costs will be limited based on amounts as determined in in that base year.
- Since Indirect Medical Education (IME) reimbursement is considered part of operating costs, there will not be any additional payments allowed for IME should a residency be started at that hospital (e.g. an RTP) after the base year.
- Direct GME payments will be allowed as a separate payment stream in addition to the limit as determined in the base year because GME payments are made outside of IPPS (Inpatient Prospective Payment System) .

14L

FQHCs and RHCs can get direct GME funding

- Federally Qualified Health Centers (FQHCs), Rural Health Clinics (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

14L

RPS Consultant opinion not shared by CMS:

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

- These hospitals 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, SCH or RCHDP solution

15. What is a “Rural” place? What is a “Rural” hospital”?

- CMS uses Core Based Statistical Areas that CMS then separates into urban and rural designations. See topic 4, slide #21.
- Below is the link to the Inpatient PPS FY 2019 final rule and other files. It is the most certain way to see if a specific hospital is “rural” or the place is “rural”.
  - You can use the FY 2022 Final Rule hospital Impact File to look up a specific provider number and if a 2 digit code is indicated for Geographic Labor Market Area, then you know the hospital is “rural”
  - 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.
  - All these files are listed in the 2022 final rule home page:

https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page

16L

Medicare Dependent Hospitals (MDH)

- If hospital has a high % of Medicare patients it can apply to become an MDH
- MDHs have some similarities to Sole Community Hospitals (SCH) in that a hospital-specific rate(HSR) is calculated for DRG payments (always higher than the federal rate)
- MDHs “share savings” with the feds so end up only getting 2/3 of the difference between the federal rate and the HSR. E.g if federal rate would pay $100,000 and HSR $130,000 then the hospital gets $120,000

16L

Medicare Dependent Hospitals (MDH)

This affects GME payments:

- DGME is fully paid like a regular IPPS hospital
- IME is discounted to 1/3 of the usual IME that would otherwise be paid. Basically the MDH gets IME only for the “federal rate” part of the DRG payment.

17. "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**).

17. "Medicare GME affiliation agreements"

- Now ultimately all ***capped*** hospitals can "give" or "get" in a valid Medicare affiliation. NEW rule as of Aug 2018.
  - New teaching hospitals can't "give" until 10 years after starting 1st residency. (See next slide)
    - FY 2019 IPPS final rule, pages 41492--41498
    - https://www.govinfo.gov/content/pkg/FR-2018-08-18/pdf/2018-16766.pdf
  - Prior rule limited cap "giving" to pre-1997 teaching hospitals

17.

"Virgin" Hospital (1997 or later)

1

2

Hospital gets PRA but no cap clock started

2

New teaching hospital has PRA and starts building cap (5 years)

Can share * Cap 1 way

Old Established (before1997) teaching hospital with cap

Can share * Cap 1 way

share * cap both ways

5 Years later

Gets a cap

Can now share with other "new" capped hospitals *

5 Years later

Now can share * cap both ways

Triggers:

1. = 1st resident rotation from ***established*** program
2. = 1st resident rotation from a ***new*** program (<5 years old)

** if partner, sibling or neighbor*

17. …one more thing on "Medicare GME affiliation agreements"

- If one or more hospitals become "**new teaching hospitals**" in the **same year** they can start sharing caps with each other both ways once they get capped. Don't have to wait another five years after getting a cap.
- This helps whole communities with multiple hospitals who start GME programs at once.

CMS Rule Change Regarding Inpatient Moonlighting in Home Training Hospital

- Previously moonlighting by a resident/fellow in home hospital was only allowed in ED or Outpatient, and not Inpatient
- With the COVID-19 Public Health Emergency (PHE), Inpatient Moonlighting and separately billing allowed if the following met
  - Services identifiable physician services and meet conditions for payment of physicians services to beneficiaries by providers
  - Resident is fully licenses to practice medicine, osteopathy, dentistry, or podiatry by the state in which the services are performed
  - Services can be separately identified from those services that are required as part of the approved GME Program
- This policy allowing inpatient moonlighting in home hospital was just recently was made permanent by CMS

18K CMS Rule Change Regarding Inpatient Moonlighting in Home Training Hospital

- To address the concerns about the potential duplication of payment with the IPPS for GME, CMS requires documentation of the arrangement in the patient's medical record
- May want to make a "smart phrase" in the EHR. CMS Example:

"Resident is licensed to practice medicine, osteopathy, dentistry or podiatry in the state in which the service was performed. Document that the service was performed outside of their approved GME program, and include a notation describing the specific physician service that was furnished."

- Resident may need separate malpractice insurance, and be credentialed with the insurance plans

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