TRANS-LETTER, MED-GUIDE ¶154,101, **Changes to the FY 2004 Graduate Medical Education Payments**, (March 12, 2004)

Changes to the FY 2004 Graduate Medical Education Payments

One-Time Notification Manual, Pub. No. 100-20, Transmittal No. 61, March 12, 2004.

Unrelated Text Omitted

Attachment - One-Time Notification

Pub.	Transmittal:		Change Request
100-20	61	Date: March 12, 2004	3071

SUBJECT: Changes to the FY 2004 Graduate Medical Education (GME) Payments as Required by the Medicare Modernization Act of 2003 (MMA), P.L. 108-173

I. GENERAL INFORMATION

A. Background: This One-Time Notification (OTN) implements several provisions related to FY 2004 graduate medical education (GME) payments as required by the Medicare Modernization Act of 2003 (MMA), P.L. 108-173. This OTN notifies you of some of these provisions and the actions you are to take to implement them. As specified, all changes are effective either for cost reporting periods beginning on or after October 1, 2003, or for services furnished on or after January 1, 2004, or on or after April 1, 2004.

B. Policy

INDIRECT MEDICAL EDUCATION

Section 502 of the MMA of 2003 modified the formula multipliers[1] to be used in the calculation of the indirect medical education (IME) adjustment. Prior to passage of the MMA, the formula multiplier for the IME adjustment was fixed at 1.35 for FY 2003 and thereafter. The new legislation modifies the formula multiplier mid-way through FY 2004 and provides for a new schedule of formula multipliers for FYs 2005 and thereafter, as follows:

For discharges occurring on or after April 1, 2004, and before October 1, 2004 —1.47;

For discharges occurring during FY 2005 —1.42;

For discharges occurring during FY 2006 —1.37;

For discharges occurring during FY 2007 —1.32; and

For discharges occurring on or after October 1, 2007 —1.35.

The new schedule is effective for discharges occurring on or after April 1, 2004, and will be incorporated into the IPPS PRICER.

DIRECT GRADUATE MEDICAL EDUCATION

1. New Legislation: Exception to Initial Residency Period for Geriatric Residency or Fellowship Programs

Under Medicare direct GME payment rules, the initial residency period is generally defined as the minimum number of years of training required for a resident to become board eligible in a specialty (not to exceed five years) and is established at the time the resident enters his or her first training program. For purposes of direct GME payments, a resident's full-time equivalent (FTE) training time is weighted at 1.0 during the initial residency period and 0.5 for training that continues beyond the initial residency period. Section 1886(h)(5)(F) of the Social Security Act ("the Act") generally limits a resident's initial residency period to no longer than five years. That section also provides an exception that allows FTE training time spent by residents in an approved geriatric residency program to be treated as part of the resident's initial residency period, i.e., weighted at 1.0, for up to an additional two years after conclusion of the otherwise applicable initial residency period.

We understand, based upon information provided by the American Geriatric Society ("AGS"), that in 1998, the American Board of Internal Medicine and the American Board of Family Physicians (hereinafter "the Boards") reduced the minimum number of years of formal training required for residents to become board eligible in geriatrics from two years to one year. As a result, the initial residency period, and full direct GME funding for residents in geriatric training programs, would be limited to one year.

However, we understand that many teaching hospitals continue to run geriatric fellowships of at least two years in length (some are even three years). We also understand that, despite the decrease in the minimum requirements for board eligibility, the Accreditation Council for Graduate Medical Education ("ACGME") continues to accredit some geriatric training programs for the full duration of the programs. For example, if a hospital's geriatric fellowship is three years in length, the program may continue to be accredited by the ACGME for the full 3 years, but the FTE time spent by a resident training in the geriatrics program would be weighted at 1.0 for the first year of the resident's training for purposes of direct GME payments, and at 0.5 for training in the second and third year of the fellowship. (We note, however, that FTE resident time is not weighted for purposes of IME payments.)

Effective October 1, 2003, section 712 of the MMA clarifies that Congress intended to provide an exception to the initial residency period for purposes of direct GME payments for geriatric residency or fellowship programs, such that, "where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident's initial residency period, but are not counted against any limitation on the initial residency period." Therefore, effective for cost reporting periods beginning on or after October 1, 2003, if residents are training in an accredited geriatric residency or fellowship program of 2 (or more) years in duration, hospitals may treat training time spent during the first two years of the program as part of the resident's initial residency period, and weight the resident's FTE time at 1.0 during that period, regardless of the fact that the minimum number of years of training required for board eligibility in geriatrics is only one year. We note that the statutory language quoted

above does *not* allow a hospital to treat time spent by a resident in a second year of geriatric training as part of the resident's initial residency period in the case where the resident trained in a geriatric residency or fellowship program that is accredited as a one-year program because in that case, the resident could be board eligible after only one year of training. Consistent with the statutory provision at section 712, we will also be issuing regulations to implement this provision.

2. New Legislation: Extension of Update Limitation on High Cost Programs.

The Balanced Budged Refinement Act ("BBRA") of 1999 (P. L. 106-113) amended §1886(h)(2) of the Act to establish a methodology for the use of a national average per resident amount (PRA) in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005. The BBRA established a "floor" for hospital-specific PRAs at 70 percent of the locality-adjusted national average PRA. In addition, the BBRA established a "ceiling" which limited the annual adjustment to a hospital-specific PRA if the PRA exceeded 140 percent of the locality-adjusted national average PRA. Section 511 of the Benefits Improvement and Protection Act (BIPA) of 2000, (P. L. 106-554) increased the floor established by the BBRA to 85 percent of the locality-adjusted national average PRA. For purposes of calculating direct GME payments, each hospital-specific PRA is compared to the floor and ceiling to determine whether the hospital-specific PRA should be revised. For historical reference on calculating the floor and ceiling, please see *Program Memorandum A-01-38* published on March 21, 2001.

Section 711 of the MMA freezes annual CPI-U updates to hospital-specific PRAs for those PRAs that exceed the ceiling for FY 2004 through FY 2013. For cost reporting periods beginning during FY 2004 through FY 2013, calculate a ceiling that is equal to 140 percent of the locality-adjusted national average PRA for each hospital, and compare it to each hospital-specific PRA. If the hospital-specific PRA for the preceding year is greater than 140 percent of the locality-adjusted national average PRA "ceiling" in the current fiscal year, the hospital-specific PRA for the current year is frozen for the current year at the preceding fiscal year's hospital-specific PRA, and is not updated by the CPI-U factor. Note that a hospital may have more than one PRA. Each of a hospital's PRAs must be separately compared to the "ceiling" PRA to determine whether that PRA should be frozen at the level for the previous year or updated by the CPI-U factor.

For example, to determine the applicable PRA for a cost reporting period beginning during FY 2004, compare the hospital-specific PRA from the cost reporting period that began during FY 2003 to the FY 2004 locality-adjusted national average PRA for that hospital. If the FY 2003 hospital-specific PRA exceeds 140 percent of the FY 2004 locality-adjusted national average, then the FY 2004 PRA is frozen at the level of the FY 2003 hospital-specific PRA, and is not updated by the CPI-U factor for FY 2004.

3. New Legislation: Compensation of Supervisory Teaching Activities

Section 713 of the MMA requires that, during the one-year period beginning on January 1, 2004 and ending December 31, 2004, Medicare is to allow all hospitals to count residents in allopathic and osteopathic **family practice** programs training in nonhospital settings, without regard to the financial arrangement between the hospital and the teaching physician practicing in the nonhospital setting to which the resident has been assigned.

Many hospitals have entered into written agreements with teaching physicians that state that the teaching physician is "volunteering" his/her time in the nonhospital site, and therefore, the hospital is not providing any compensation to the teaching physician. Other hospitals have paid only a nominal amount of compensation for the supervisory teaching physicians' time in the nonhospital setting. Because the regulations at §413.86(f)(4) state that the hospital must incur all or substantially all of the direct GME costs, including those associated with the teaching physician, regardless of whether the written agreement states that the teaching physician is "volunteering," we have required that the hospital must pay these costs in order to count FTE residents training in the nonhospital site, as long as such teaching physician costs

exist.

However, as stated above, during the one-year period from January 1, 2004 through December 31, 2004, section 713 of the MMA allows hospitals to count allopathic or osteopathic family practice residents training in nonhospital settings for IME and direct GME purposes, without regard to the financial arrangement between the hospital and the teaching physician practicing in the nonhospital setting to which the resident is assigned. Generally, when settling prior year cost reports during this one-year period, or for family practice residents actually training in nonhospital settings during this one-year period, allow the hospitals to count allopathic and osteopathic family practice residents training in the nonhospital setting for direct GME and IME payment purposes without regard to the financial arrangement between the hospital and nonhospital site pertaining to the teaching physicians' costs associated with the residency program.

a. Cost Reports That Are Settled Between January 1, 2004 and December 31, 2004

When settling cost reports during January 1, 2004 through December 31, 2004 (Calendar Year (CY) 2004), a hospital that seeks to count allopathic or osteopathic family practice FTE residents training in a nonhospital setting(s) is allowed to count those FTEs for IME and direct GME purposes even in instances where the written agreement between the hospital and a teaching physician or a nonhospital site does not mention teaching physician compensation, specifies only a nominal amount of compensation, or states that the teaching physician is “volunteering” his/her time training the residents. For example, when settling a cost report during CY 2004 that has a fiscal year end of June 30, 2001, allow the hospital to count family practice FTE residents that trained in a nonhospital setting during the period covered by the June 30, 2001 cost report, regardless of the financial arrangement in place between the hospital and the teaching physician at the nonhospital site during the period covered by the June 30, 2001 cost report. (We note this moratorium does not apply to cost reporting periods that are *not* settled during January 1 through December 31, 2004, which do not coincide with, or overlap the January 1 —December 31, 2004 period. For example, if the cost report for fiscal year ended December 31, 2003 (or June 30, 2003, etc.) is not settled during the January 1 —December 31, 2004 period, the moratorium does not apply).

b. Family Practice Residents That Are Training in Nonhospital Settings Between January 1, 2004 and December 31, 2004

In addition to allowing family practice residents that trained in nonhospital settings to be counted *in cost reports that you are settling* during the period January 1, 2004 through December 31, 2004, without regard to the financial arrangements between the hospital and the teaching physician at the nonhospital site, you are also to allow family practice residents that *actually are or will be* training in nonhospital settings during January 1, 2004 through December 31, 2004, without regard to the financial arrangements between the hospital and the teaching physician at the nonhospital site. That is, when settling cost reports that cover service periods of January 1, 2004 through December 31, 2004, a hospital that seeks to count allopathic or osteopathic family practice FTE residents training in a nonhospital setting(s) is allowed to count those FTEs even in instances where the written agreement between the hospital and a teaching physician, or a nonhospital site, does not mention teaching physician compensation, specifies only a nominal amount of compensation, or states that the teaching physician is “volunteering” his/her time training the residents. If a hospital has a fiscal year that is other than a calendar year, the hospital is allowed to count the family practice residents training in the hospital during those portions of its fiscal years that fall within the January 1, 2004 —December 31, 2004 period. For example, when you are settling a hospital's June 30, 2004 cost report, allow the hospital to count family practice FTE residents that trained in a nonhospital setting *during the period January 1, 2004 through June 30, 2004*, regardless of the financial arrangement between the hospital and the teaching physician at the nonhospital site from January 1 through June 30, 2004. Similarly, when settling the hospital's June 30, 2005 cost report, allow the hospital to count family practice FTE residents that trained in a nonhospital setting *during the period July 1, 2004 through December 31, 2004*, regardless of the financial arrangement between the hospital and the teaching physician at the nonhospital site from July 1 through December 31, 2004. (However, note that family practice residents that train in nonhospital settings beginning January 1, 2005 and after are not subject to the moratorium provided under section 713).

Regardless of whether you are settling prior period cost reports during CY 2004, or settling cost reports after CY 2004 which cover training during the period January 1, 2004 to December 31, 2004, we emphasize that this moratorium only applies for purposes of counting FTE residents in *allopathic and osteopathic general family practice programs that were in existence (i.e., training residents) as of January 1, 2002* and where the requirement to incur the teaching physician compensation related to direct GME may not have been met. Therefore, for residents training in nonhospital settings, the moratorium *applies only* : 1) to FTE residents in family practice programs (not to dental, podiatric, or other allopathic or osteopathic specialty programs); 2) to family practice programs that were in existence as of January 1, 2002; 3) to residents that spent time in patient care activities; 4) if there was a written agreement in place indicating that residents from the hospital would be training in the nonhospital site; and 5) if the hospital actually incurred the residents' salary cost.

NOTE : Scheduling of cost report audit or settlement activities during CY 2004 should be done in accordance with normal procedures. If, since January 1, 2004, but before issuance of this OTN, you have settled cost reports and did not allow hospitals to count family practice residents at nonhospital sites where the hospitals did not pay for all of the teaching physician costs, then review such settlements and, if appropriate, reopen and reverse the disallowance. If, as of issuance of this OTN, you have disallowed such residents in the process of settling a cost report, but have not yet issued the Notice of Program Reimbursement (NPR), then reverse the disallowance of those residents. Cost reports that have already been settled prior to January 1, 2004 should *not* be reopened to allow a hospital to count family practice residents at nonhospital sites where the hospital did not pay for all of the teaching physician costs, even if requested by a hospital.

Residents Training in Nonhospital Settings in Programs Other Than Family Practice

FTE residents in programs other than general family practice may be disallowed from cost reports that are settled during CY 2004, or settled after CY 2004 for training that occurs during the period January 1, 2004 through December 31, 2004, if the hospital did not properly incur the teaching physician compensation associated with direct GME. If a hospital did incur the teaching physician compensation cost, or if it is determined that there was no teaching cost to be incurred, then the hospital may count the FTE residents in accordance with the regulations at 42 CFR §413.86(f)(4).

C. Provider Education: A provider education article related to this instruction will be available at *www.cms.hhs.gov/medlearn/matters* shortly after the CR is released. You will receive notification of the article release via the established “medlearn matters” listserv. FIs shall post this article to their Web site, and include it in a listserv message if applicable, within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

“Shall” denotes a mandatory requirement

“Should” denotes an optional requirement

Requirement #	Requirements	Responsibility
3071.1	Contractors shall receive and install a	SSM

new IPPS PRICER to account for changes to the IME formula, in addition to numerous other expected changes related to MMA (which will be discussed in other CRs). This provision is effective for discharges occurring on or after April 1, 2004.

3071.2	The FI shall allow hospitals to count residents at a full FTE for 2 years for purposes of the initial residency period where residents train in a geriatric program that is accredited by the appropriate accrediting body as at least a 2-year program, regardless of the minimum board eligibility requirements. This provision is effective with cost reporting periods beginning on or after October 1, 2003.	FI
3071.3	The FI shall not update the current year PRA by the CPI-U factor if the hospital's preceding year PRA is greater than 140 percent of the locality-adjusted national average PRA in the current fiscal year. This provision is effective for cost reporting periods beginning in FY 2004 through FY 2013.	FI
3071.4	When settling cost reports during January 1, 2004 through December 31, 2004 that have been submitted by teaching hospitals that seek to count allopathic or osteopathic family practice FTE residents training in nonhospital settings, the FI shall allow the hospital to count family practice FTE residents that trained in nonhospital settings, regardless of the financial arrangement between the hospital and the teaching physician at the nonhospital site. After CY 2004, when settling cost reports that cover service periods of January 1, 2004 through December 31, 2004, the FI shall allow a hospital to count family practice FTE residents that *actually trained* in nonhospital settings during January 1, 2004 through December 31, 2004, without regard to the financial arrangements between the hospital and the teaching physician at the nonhospital site. This provision is effective January 1, 2004.	FI

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date:	These instructions should be
IME --Section 502: discharges on or after April 1, 2004	implemented within your current operating budget.
DGME --	
Section 711: cost reporting periods beginning on or after October 1, 2003	
Section 712: cost reporting periods beginning on or after October 1, 2003	
Section 713: January 1, 2004 through December 31, 2004	

Implementation Date: April 5, 2004 for requirement 3071.1.

Implementation Date: April 12, 2004 for all other requirements they are non-systems changes.

Pre-Implementation Contact(s): Rebecca Hirshorn, (410) 786-3411, and Miechal Lefkowitz, (410) 786-5316

Post-Implementation Contact(s): Rebecca Hirshorn, (410) 786-3411, and Miechal Lefkowitz, (410) 786-5316

[1] The formula multiplier is represented as *c* in the following equation used to calculate the IME adjustment factor: $c \times [(1 + r)405/ - 1]$. The variable *r* represents the hospital's resident-to-bed ratio