



ACA's Impact on GME and Podiatric Residency Training

Podiatric Medicine continues to face shortages of hospitals to sponsor residency training programs. Our profession is working toward a resolution of this issue. Significant advances have been made in the recent past; however we are not yet at the level that the American Association of Colleges of Podiatric Medicine and its Council of Teaching Hospitals (COTH) has set as a target for the number of available residency positions in relation the number of graduating DPM's.

Sponsoring a Podiatric Medicine and Surgery Residency (PMSR) training program advances the mission of most hospitals to provide quality foot health care. However in today's fiscal climate, many facilities are hesitant to take on new programs that may affect their fiscal position. As opposed to sponsoring residency training in many other health care disciplines, several issues make it financially more advantageous for hospitals to sponsor Podiatric Medicine and Surgery Residency training programs. Recent changes in Federal regulations continue to make sponsoring PMSR programs fiscally valuable to sponsoring institutions.

Medicare Graduate Medical Education (GME) funding partially reimburses teaching hospitals for costs associated with training physicians. Payments based on the number of residents training at the hospital, and the number of residents for which a hospital can be reimbursed was capped under a provision in the Balanced Budget Act (BBA) in 1997 (Attachment A). However, podiatry (and dental) residents are exempt from this cap. Since podiatry residents are exempt from the cap, a hospital is generally permitted to increase its number of podiatry residents in training and will receive increased Medicare Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) reimbursement for such an increase.

Under Medicare GME payment policy, hospitals had been permitted to count resident time at non-hospital settings, provided that the hospital incurred "all or substantially all of the costs associated for the training program in the non-hospital setting." Prior to the Affordable Care Act (ACA), CMS defined "all or substantially all" as generally including resident salary, benefits, and supervising physician salary. The ACA modified this requirement to specify that a hospital was generally eligible to count resident time spent in a non-hospital setting if the hospital incurred just the resident salary and fringe benefits. The Affordable Care Act amended section 1886(h)(4)(E) of the Act for direct GME purposes (and section 1886(d)(5)(B)(iv) of the Act for

IME purposes), effective July 1, 2010, (Attachment B) allows a hospital to count residents training in non-provider settings if the residents are engaged in patient care activities and if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time the residents spend in that setting.

In addition, for direct GME purposes only, the time residents spend in certain nonpatient care activities that occur in a nonprovider setting that is primarily engaged in furnishing patient care may also be counted. For IME purposes, residents training in nonprovider settings must spend their time in patient care activities in order to be counted. The implementing regulations at §413.78(g) for direct GME and at §412.105(f)(1)(ii)(E) for IME (Attachment C) require that the hospital must either have a written agreement with the nonprovider setting, or the hospital must pay for the costs of the stipends and fringe benefits of the residents concurrently during the time the residents spends in that setting.

Podiatry residents frequently receive a portion of their training in free standing surgery centers that are typically counted as non-hospital settings. These training sites may be useful in expanding or developing new programs, as the surgical procedures performed in these facilities are allowable by the Council on Podiatric Medical Education (CPME) as educational material counted toward residents minimum activity volumes (MAV's). The changes in the Affordable Care Act should make it easier for sponsor hospitals to bill CMS for GME funds for time the residents are training at these sites.

Sponsor hospitals, however, must be aware of the Community Support Principle. Several years ago, CMS noted that it had become aware of situations by which dental residents training in non-hospital settings had been added to teaching hospital Medicare cost reports such that the Medicare program was now being expected to support a portion of the dental residents' costs. It has been a longstanding policy that Medicare payment is based on the intention that if the "community" has undertaken to support specific costs (not limited to GME), these costs cannot be shifted onto the Medicare program. According to CMS, the intent of Congress in supporting GME costs through Medicare payment is to occur "only in situations where the community has not stepped in to incur them." This concept is referred to as the "community support and redistribution of costs" principle. Thus, in this context, where residents in podiatric medicine and surgery training programs have already been training at free standing surgery centers, and the costs have been historically undertaken by the community, a subsequent redistribution of these costs to a hospital and the Medicare program would **not** be allowable.

The community support and redistribution of costs principle in application means that a hospital is expected to continuously incur DGME costs of residents training in a particular program at a particular site to count the full time employee (FTE) residents. Therefore, the hospital must have incurred these costs from the time that the residents first began training. However, according to CMS, for situations where a non-hospital (or "the community") has incurred the costs for

training residents in the past, these costs cannot be shifted onto a teaching hospital for the purposes of receiving Medicare GME payment to gain Medicare reimbursement. This concept has particular applicability to podiatry residents due to the fact that certain residency programs had been supported by the community and the exemption for payment of these residents represented a potential opportunity for teaching hospitals to receive additional Medicare reimbursement by newly absorbing those costs onto hospital cost reports.

According to CMS, the intent is not for the Medicare program to take on the cost of training residents who had been previously training at non-hospital sites without hospital funding. Thus, in a situation where a hospital had incurred GME costs at a certain point and then the non-hospital (community) assumed these costs, the hospital cannot newly count these residents for the purposes of Medicare reimbursement. In a situation where additional residents were added to an existing program where the original residents were supported by the community, only the costs associated with additional residents would be eligible to be counted by the hospital on its Medicare cost report. And of course, if the hospital established a new residency program and the residency program specialty was outside the cap, the hospital would be eligible to claim those new residents for Medicare DGME and IME reimbursement.

The changes in GME reimbursement made by the Affordable Care Act present opportunity for hospitals interested in sponsoring podiatric medicine and surgery residency programs. Additionally, existing programs who wish to expand, but may not have the resources to do so, might now have the clinical volume to do so.

The AACPM Residency Facilitation Project is available to answer any questions you may have and to assist you in the development or expansion of podiatric medicine and residency training programs. For further information, please contact Dr. Ed Wolf at ewolf@aacpm.org or (212) 874-0609.

§ 413.86(e)(4), if a hospital did not have residents in the 1984 base period but later participates in teaching activities, the fiscal intermediaries calculate a per resident amount based on a weighted average of all the hospitals in the same geographic wage area. There must be at least three hospitals for this calculation. If there are fewer than three hospitals, the regulations require the fiscal intermediary to contact the HCFA Central Office for a determination of the appropriate amount to use.

We proposed to revise the regulations for determining base year per resident amounts for hospitals that participated in residency training after the 1984 base period. Under the proposed changes to § 413.86(e)(4)(i)(B), we sequentially follow the criteria listed below until we would base the weighted average calculation on a minimum of 3 per resident amounts:

- If there are fewer than three hospitals in the hospital's geographic wage area, we would determine a weighted average based on the per resident amounts for all hospitals in the hospital's own wage area, plus hospitals in geographically contiguous wage areas.

- If there are still fewer than three hospitals in the hospital's own wage area, plus hospitals in contiguous wage areas, the weighted average would be based on the per resident amounts for all hospitals in the State.

- If there are fewer than three hospitals in the entire State, the weighted average would be based on the per resident amounts for all hospitals in that State plus hospitals in contiguous States.

- If there are fewer than three hospitals in that State and contiguous States, the weighted average per resident amount would be based on the national average per resident amount.

Comment: One commenter stated that our proposed policy appears reasonable but we have not indicated how the policy would affect the per resident amounts for hospitals that previously had their payment amounts determined by HCFA Central Office.

Response: The proposed policy simply reflects the methodology in effect prior to this final rule with comment period. As discussed below, we are revising the methodology in this final rule with comment period. However hospitals that previously had a per resident amount determined by HCFA Central Office will be unaffected since policy changes can only be effective prospectively.

Comment: Two commenters suggested that the proposed methodology may negatively affect the expansion of

training sites, particularly in rural areas where there might not be three hospitals with established per resident amounts. One of these commenters suggested that the hospital with the new training program be given the option of establishing a per resident amount based on its "cost, not to exceed the higher of the contiguous area average, or the national average cost per resident, perhaps adjusted by the appropriate wage index." The other commenter suggested that if there are fewer than three hospitals, that we use the lower of the new hospital's cost per resident or the national average cost per resident adjusted by the hospital wage index. The commenter suggested that this approach would be consistent with HCFA initiatives to move from historical local or regional cost based payments to national averages. Another benefit of this approach according to this commenter is that it is simple and would overwhelmingly benefit rural hospitals.

Response: The per resident amounts vary widely among hospitals nationwide. Given this wide variation, we believe it is difficult to know whether a hospital establishing a new program in any given geographic area will receive a high or low per resident amount using our proposed methodology. Although the first commenter's suggested alternative is similar to the proposed policy, it guarantees a per resident amount for the new hospital that is either equal to or higher than the per resident amount under the proposed methodology if the hospital's own costs exceed the contiguous area average or the national average per resident amount. We find merit in the latter commenter's suggested alternative of using the lower of the hospital's own costs or a national average per resident amount. It has the advantage of being simple and equally as likely to produce an equitable rate as our proposed methodology. We support using the commenter's proposed methodology with a modification.

Thus, effective October 1, 1997 the per resident amount for new teaching hospitals is based on the lower of the hospital's actual per resident costs or:

- The weighted average of the per resident amounts for hospitals located in the same geographic area as that term is used in the prospective payment system under 42 CFR part 412.

- Where there are fewer than three hospitals in a geographic wage area, we will use regional weighted average per resident amounts determined for each of the nine census regions established by the Bureau of Census for statistical and reporting purposes.

2. New Legislative Changes to Direct Graduate Medical Education (Direct GME)

a. Limit on the Count of Residents (§ 413.86(g))

Section 4623 of Public Law 105-33 adds section 1886(h)(4)(F) of the Act to establish a limit on the number of allopathic and osteopathic residents that a hospital can include in its full time equivalent (FTE) count for Direct GME payment. Residents in dentistry and podiatry are exempt from the cap. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted direct medical education FTE count may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996.

Currently, hospitals report their weighted but not their unweighted FTE count on their Medicare cost report. New section 1886(h)(4)(H)(iii) of the Act gives the Secretary authority to collect whatever data are necessary to implement this provision. Hospitals have been required to report resident-specific information to their fiscal intermediaries under longstanding requirements of § 413.86, and we believe it is possible to implement section 1886(h)(4)(F) without mandating significant additional reporting. Since the unweighted direct GME FTE count will be used in calculating direct GME payments, we expect to amend the Medicare cost report to require hospitals to report the unweighted FTE direct GME count for future cost reporting periods. A separate data collection effort will be required to obtain the information for the most recent cost reporting periods ending on or before December 31, 1996.

We believe the hospital's unweighted FTE limit for its most recent cost reporting period ending on or before December 31, 1996 should be based on a 12 month cost reporting period. If the hospital's most recent cost reporting period ending on or before December 31, 1996, is a short period report, the fiscal intermediaries shall make adjustments so that the hospital's unweighted FTE limit corresponds to the equivalent of a 12 month cost reporting period. We are revising § 413.86(g)(4) accordingly.

(1) Counting Residents Based on a 3-Year Average (§ 413.86(g)(5))

Section 1886(h)(4)(C)(iii) of the Act, as added by section 4623 of Public Law 105-33, provides that for the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count for payment

One Hundred Eleventh Congress
of the
United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Tuesday,
the fifth day of January, two thousand and ten

An Act

Entitled The Patient Protection and Affordable Care Act.

Be it enacted by the Senate and House of Representatives of
the United States of America in Congress assembled,

SEC. 5504. COUNTING RESIDENT TIME IN NONPROVIDER SETTINGS.

(a) GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

(1) by striking “shall be counted and that all the time”
and inserting “shall be counted and that—

“(i) effective for cost reporting periods beginning
before July 1, 2010, all the time;”;

(2) in clause (i), as inserted by paragraph (1), by striking
the period at the end and inserting “; and”;

(3) by inserting after clause (i), as so inserted, the following
new clause:

“(ii) effective for cost reporting periods beginning
on or after July 1, 2010, all the time so spent by
a resident shall be counted towards the determination
of full-time equivalency, without regard to the setting
in which the activities are performed, if a hospital
incurs the costs of the stipends and fringe benefits
of the resident during the time the resident spends
in that setting. If more than one hospital incurs these
costs, either directly or through a third party, such
hospitals shall count a proportional share of the time,
as determined by written agreement between the hospitals,
that a resident spends training in that setting.”;



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Direct Graduate Medical Education (DGME)

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99-272) and implemented in regulations at existing §§413.75 through 413.83, establish a methodology for determining payments to hospitals for the costs of approved graduate medical education (GME) programs.

Section 1886(h)(2) of the Act, as added by COBRA, sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of beginning between October 1, 1983, through September 30, 1984). Medicare direct GME payments are calculated by multiplying the PRA times the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital (and non-hospital sites, when applicable), and the hospital's Medicare share of total inpatient days.

Section 1886(h)(4)(F) of the Act established limits on the number of allopathic and osteopathic residents that hospitals may count for purposes of calculating direct GME payments. For most hospitals, the limits were the number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996.

Prior to July 1, 2010, under section 1886(h)(4)(E) of the Act, a hospital could count residents training in nonprovider settings for direct GME purposes (and under section 1886(d)(5)(B)(iv) of the Act, for IME purposes), if the residents spent their time in patient care activities and if ". . . the hospital incurs all, or substantially all, of the costs for the training program in that setting." The implementing regulations, first at §413.86(f)(3), effective July 1, 1987, and later at §413.86(f)(4) (redesignated as §413.78(d)), effective January 1, 1999, required that, in addition to incurring all or substantially all of the costs of the program at the nonprovider setting, there must have been a written agreement between the hospital and the nonprovider site (in place prior to the time the hospital began to count the residents training in the non-provider site) stating that the hospital would incur all or substantially all of the costs of training in the nonprovider setting. The regulations further specified that the written agreement must have indicated the amount of compensation provided by the hospital to the nonprovider site for supervisory teaching activities. Effective October 1, 2004, the hospital must have either had a written agreement with the nonprovider setting, or, as described in the regulations at §413.78(e), paid for all or substantially all of the costs, concurrent with the training in the nonprovider setting. Effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, "all or substantially all of the costs for the training program" in the nonprovider setting is defined as at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physician's salaries attributable to nonpatient care direct GME activities.

The Affordable Care Act amended section 1886(h)(4)(E) of the Act for direct GME purposes (and section 1886(d)(5)(B)(iv) of the Act for IME purposes), effective July 1, 2010, to allow a hospital to count residents training in nonprovider settings if the residents are engaged in patient care activities and if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time the residents spend in that setting. In addition, effective July 1, 2009, for direct GME purposes only, the time residents spend in certain nonpatient care activities that occur in a nonprovider setting that is primarily engaged in furnishing patient care may also be counted. For IME purposes, residents training in nonprovider settings must spend their time in patient care activities in order to be counted. The implementing regulations at §413.78(g) for direct GME and at §412.105(f)(1)(ii)(E) for IME require that the hospital must either have a written agreement with the nonprovider setting, or the hospital must pay for the costs of the stipends and fringe benefits of the residents concurrently during the time the residents spend in that setting.

Section 5503: Distribution of Additional Residency Positions

Section 5503 of the Affordable Care Act provides for reductions in the direct GME and IME FTE resident caps for certain hospitals, and authorizes a "redistribution" to certain hospitals of the estimated number of FTE resident slots resulting from the reductions. Effective for portions of cost reporting periods occurring on or after July 1, 2011 for direct GME and IME, a hospital's FTE resident caps will be reduced by 65 percent of the "excess" resident slots if its "reference resident level" is less than its "otherwise applicable resident limit." The Secretary is authorized to increase the otherwise applicable FTE resident cap for each qualifying hospital that submits a timely application by a number that the Secretary may approve, effective for portions of cost reporting periods occurring on or after July 1, 2011. Section 5503 specifies that the slots are to be distributed in the following manner: 70 percent of the resident slots are to be distributed to hospitals located in States with resident-to-population ratios in the lowest quartile, and 30 percent of the resident slots are to be distributed to hospitals located in a State, a territory of the United States, or the District of Columbia that are among the top 10 States, territories, or Districts in terms of the ratio of Health Professional Shortage Area (HPSA) population to the total population, and/or to hospitals located in rural areas. Hospitals not located in these states or in a rural area do not qualify for redistributed slots. CMS issued a listing of which hospitals would receive additional slots under section 5503 on August 15, 2011, with the effective date of the slots retroactive to July 1, 2011. To see the list of awardees, see the link below called Section 5503 Cap Decreases and Increases - Posted 8/15/2011 [ZIP, 27KB].

Section 5506: Preservation of Resident Cap Positions from Closed Hospitals

Prior to the passage of the ACA, generally, if a teaching hospital closed, its direct GME and IME FTE resident cap slots would be "lost," because those slots are associated with a specific hospital's Medicare provider agreement that has terminated. Section 5506 of the ACA addresses this situation by instructing the Secretary to establish a process by regulation that would redistribute slots from teaching hospitals that close to hospitals that meet certain criteria, with priority given to hospitals located in the same Core Based Statistical Area (CBSA) or in a contiguous CBSA as the closed hospital.

Section 5506 applies to teaching hospitals that closed on or after March 23, 2008, and to future teaching hospital closures. For teaching hospital closures that occurred on or after March 23, 2008 through August 3, 2010, CMS issued a listing of which hospitals would receive the slots from the various closed teaching hospitals on February 28, 2012 (see link below Section 5506 Cap Increases Related to Applications Due April 1, 2011 - Posted 2/28/12 [ZIP, 112KB]). All teaching hospital closures occurring after August 3, 2010 will be handled as part of a separate notification and application process.

In April 2012, CMS posted Guidelines for Submitting Applications under Section 5506 (see the link in the Downloads section below).

On August 3, 2012, CMS posted a revised Section 5506 Application Form (see the link in the Downloads section below).

On September 13, 2012, CMS posted the link to the FY 2013 IPPS Final Rule, which contains updated policy on section 5503 and contains updated policy on section 5506 and additional information relevant to section 5506 applications (see the link in the Related Links section below).

Downloads

[Section 5506 Cap Increases Round 5 – Applications due August 29, 2013 \[ZIP, 105KB\]](#)

[Section 5506 Cap Increases Round 4 – Applications due July 25, 2013 \[ZIP, 82KB\]](#)

[Section 5506 Cap Increases Round 3 – Applications due Oct 29, 2012 – Posted 01/30/13 \[ZIP, 191KB\]](#)

[Section 5506 Cap Increases Round 2 – Applications due Dec. 1, 2011 – Posted 11/30/12 \[ZIP, 190KB\]](#)

[Section 5506 CMS Application Form – Updated 09/04/13 \[PDF, 245KB\]](#)

[Guidelines for Submitting Applications Under Section 5506 - Posted 04/26/2013 \[PDF, 92KB\]](#)

[Section 5506 Cap Increases Related to Applications Due April 1, 2011 - Posted 2/28/12 \[ZIP, 112KB\]](#)

[Section 5503 Cap Decreases and Increases - Posted 8/15/2011 \[ZIP, 27KB\]](#)

[2009 American Medical Group Association Compensation Survey Data \[PDF, 52KB\]](#)

[2008 American Medical Group Association Compensation Survey Data \[PDF, 51KB\]](#)

[2007 American Medical Group Association Compensation Survey Data \[PDF, 127KB\]](#)

Related Links

[CMS-1588-F \(PDF Version\)](#)

[CMS-1430-IFC: Revisions to the Reductions and Increases to Hospitals' FTE Resident Caps for Graduate Medical Education Payment Purposes](#)

[CMS-1430-IFC: Revisions to the Reductions and Increases to Hospitals' FTE Resident Caps for Graduate Medical Education Payment Purposes - Text Version](#)

[CY 2011 OPPS Final Rule Corrections including Changes to Payments to Hospitals for Graduate Medical Education Costs: Corrections \(Published Version - page 13294\)](#)

[CY 2011 OPPS Final Rule Corrections including Changes to Payments to Hospitals for Graduate Medical Education Costs: Corrections - Text Version](#)

[CY 2011 OPPS Final Rule including Payments to Hospitals for Graduate Medical Education Costs \(Published Version - pages 72133 - 72240 and 72261 - 72264\)](#)

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