CMS Manual System

Pub. 100-20 One-Time Notification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 77 **Date: APRIL 30, 2004**

CHANGE REQUEST 3247

I. SUMMARY OF CHANGES: This One-Time Notification (OTN) provides instructions for implementation of a provision related to graduate medical education (GME) payments as required by the Medicare Modernization Act (MMA), P.L. 108-173. This OTN is effective for a hospital no later than June 4, 2004.

NEW/REVISED MATERIAL - EFFECTIVE DATE: June 4, 2004
IMPLEMENTATION DATE: June 4, 2004

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING: Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	**One-Time Notification**
	Recurring Update Notification

Attachment - One-Time Notification

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SUBJECT: Instructions Related to "Redistribution of Unused Resident Positions," Section 422 of the Medicare Modernization Act of 2003 (MMA), P.L. 108-173, for Purposes of Graduate Medical Education (GME) Payments

I. GENERAL INFORMATION

A. Background: This One-Time Notification (OTN) provides instructions related to the Medicare Modernization Act of 2003 (MMA), P.L. 108-173, Section 422, "Redistribution of Unused Residency Positions." While section 422 is applicable to direct graduate medical education (GME) payments and indirect medical education (IME) payments effective July 1, 2005, this OTN notifies you of certain actions you are to take prior to July 1, 2005 in preparation for implementation of section 422.

B. Policy--Section 422 of the MMA, "Redistribution of Unused Residency Positions"

1. Background

The Social Security Act (the Act) under sections 1886(d)(5)(B)(v) for IME and section 1886(h)(4)(F) for direct GME establishes a cap on the number of allopathic and osteopathic residents that a hospital may count for purposes of IME and direct GME payments, respectively. Generally, each hospital's caps, often referred to as the "1996" FTE caps, are based on the number of allopathic and osteopathic residents that the hospital trained in its most recent cost reporting period ending on or before December 31, 1996. The Act also provides for an increase to an urban hospital's FTE cap in limited circumstances for new residency programs, while hospitals in rural areas may receive an increase to their FTE caps for any newly approved programs, in addition to receiving a 130 percent increase to their "1996" FTE caps. Further, under certain conditions, hospitals that have shared residency rotational relationships may elect to combine their hospital-specific FTE resident caps into an aggregate FTE cap by entering into a Medicare GME affiliated group agreement.

While Medicare only makes direct GME and IME payments for the number of FTE residents up to a hospital's FTE caps, some hospitals have trained allopathic and osteopathic residents in excess of their FTE caps. However, there are a number of hospitals that have reduced their resident counts to a level below their caps. Section 422 of the P. L. 108-173 redistributes the "unused" resident positions. Generally, under section 422, CMS is to remove 75 percent of the unused resident slots from the FTE caps of hospitals that were below their resident caps in a specified period. Rural hospitals with less than 250 beds are exempt from reductions to their FTE caps. CMS is to redistribute the estimated number of reduced resident slots in the following priority order: first to rural hospitals, second to urban hospitals not located in large urban areas, and third to hospitals that are the only ones with a particular specialty residency training program in that state. No hospital would be allowed more than 25 new FTEs. The provision is effective for portions of cost reporting periods beginning on or after July 1, 2005.

In the Fiscal Year (FY) 2005 Hospital Inpatient Prospective Payment System (PPS) proposed rule, we will be proposing procedures for determining the number of "unused" residency positions, as well as an application process for hospitals that seek additional residency slots, and specific criteria that we will use in determining which hospitals will receive the additional residency positions. However, since the procedures would not be finalized before publication of the FY 2005 Hospital Inpatient PPS final rule (by August 1, 2004), and the provisions of that final rule would not become effective until October 1, 2004 (at least 60 days after publication of the final rule), we are notifying you and your providers in this OTN of certain information that we will need in order to determine in a timely fashion the number of unused resident positions available for redistribution.

2. Determining the Estimated Number of FTE Resident Slots Available for Redistribution

Section 422 provides that if a hospital's "reference resident level" is less than its "otherwise applicable resident limit," then its "otherwise applicable resident limit" will be reduced by 75 percent of the difference between its "otherwise applicable resident limit" and its "reference resident level." The "resident level" in section 422 generally refers to the number of unweighted allopathic and osteopathic FTE residents that are training at a hospital in a given cost reporting period. (Generally, the direct GME unweighted allopathic and osteopathic FTE count would be the number on worksheet E-3 Part IV of the Medicare cost report, CMS-2552-96, line 3.05, and the IME allopathic and osteopathic FTE count would be the number on worksheet E Part A of the Medicare cost report, CMS-2552-96, line 3.08[1]). The "otherwise applicable resident limit" in section 422 generally refers to a hospital's FTE resident cap, which is the 1996 FTE cap, as adjusted in a particular period by any other applicable FTE cap adjustments, such as a new program adjustment or an adjustment under a Medicare GME affiliation agreement. (The direct GME FTE cap would be the number on worksheet E-3 Part IV of the Medicare cost report, CMS-2552-96, line 3.04, and the IME FTE cap would be the number on worksheet E Part A of the Medicare cost report, CMS-2552-96, line 3.07). Because hospitals paid under the Inpatient PPS have two FTE caps, one for direct GME and one for IME, a separate determination will be made for direct GME and IME to determine whether one, or both of a hospital's FTE caps, should be reduced. (We note that teaching hospitals that are excluded from the Inpatient Prospective Payment System would only have a direct GME FTE resident cap).

Note: As mentioned above, rural hospitals (as defined at 42 CFR §413.62(f)(iii)) with less than 250 beds are exempt from reductions to their FTE caps. The fiscal intermediary will determine whether a rural hospital has less than 250 beds by using the number of available beds on the rural hospital's most recent cost report ending on or before September 30, 2002. (Use worksheet S-3, Part I of the Medicare cost report, CMS-2552-96, column 2, the sum of lines 1 and 6 through 10, divided by the number of days in the cost reporting period).

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[1] We note that line 3.05 for direct GME and line 3.08 for IME may not reflect the *total* number of FTE residents that are "training at a hospital in a given cost reporting period" for all hospitals (for example, for a hospital that never trained residents before January 1, 1995, and, under 42 CFR §413.86(g)(6)(i), started a new program). In such an instance, the fiscal intermediary should contact CMS for instructions on how to determine the total number of unweighted allopathic and osteopathic FTE residents.

CMS is directed by section 422 to use a hospital's most recent cost reporting period ending on or before September 30, 2002, for which a cost report has been settled (or if not, submitted (subject to audit)) to determine if a hospital's direct GME FTE cap or IME FTE cap, or both, should be reduced[2], unless the hospital submits a timely request to utilize the cost report that includes July 1, 2003, due to an expansion of an existing residency training program that is not reflected on the most recent settled cost report. A hospital should refer to its most recently settled cost report as of the issuance of this OTN (April 30, 2004), to determine whether the hospital believes it has expanded an existing program in a cost reporting period subsequent to the one for that most recently settled cost report. If the hospital submits such a timely request, after audit and subject to the discretion of CMS, the resident level for such a hospital will be the unweighted count of allopathic and osteopathic FTE residents for the cost reporting period that includes July 1, 2003.

Timely Request--To be considered timely and proper, a hospital's request to use its cost reporting period that includes July 1, 2003 must be signed and dated by the hospital's Chief Financial Officer (or equivalent), and submitted to its fiscal intermediary on or before June 4, 2004. In its timely request, the hospital must include the following:

1) The FTE resident caps for direct GME and IME, and the number of unweighted allopathic and osteopathic FTE residents for direct GME and IME in its most recent settled cost report (i.e., its cost report that is most recently settled as of April 30, 2004).

2) FTE resident caps for direct GME and IME, and the unweighted allopathic and osteopathic FTE residents for direct GME and IME from each cost report after its most recently settled cost report, up to and including its cost report including July 1, 2003. If the cost reporting period that includes July 1, 2003 has not ended as of June 4, 2004, the hospital shall report the estimated number of unweighted allopathic and osteopathic residents for that cost reporting period.

3) If not already included in steps 1 or 2, the FTE resident caps for direct GME and IME, and the number of unweighted allopathic and osteopathic FTE residents for direct GME and IME in its most recent cost reporting period ending on or before September 30, 2002.

The cost report worksheets and lines from which the resident caps and number of unweighted allopathic and osteopathic residents for direct GME and IME are to be obtained are identified in the first paragraph of this subsection.

Expansions Under Newly Approved Programs

A hospital may also submit a timely request (in accordance with the instructions above) that its unweighted FTE resident level in either the most recent cost reporting period ending on or before September 30, 2002, or its cost reporting period that includes July 1, 2003, be adjusted to include the number of residents for which a new program was accredited by the appropriate

[2] Section 1886(h)(7)(A) of the Act, as added by section 422 of the MMA, does not apply to a teaching hospital that filed a low utilization (i.e., abbreviated) Medicare cost report for its most recent cost reporting period ending on or before September 30, 2002, since there is no reference resident level for such a hospital.

accrediting body (that is, the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA)) before January 1, 2002, but which was not in operation during the hospital's most recent cost reporting period ending on or before September 30, 2002, or the cost report including July 1, 2003, as explained below.

For example, assume a hospital that has a fiscal year end of June 30 received accreditation in October 2001 to train 10 residents in a new surgery program. The hospital first begins to train residents in the new surgery program on July 1, 2002. The surgery residents are not reflected on the hospital's June 30, 2002 cost report, which is the hospital's most recent cost reporting period ending on or before September 30, 2002. Thus, the hospital may submit a timely request that we increase its unweighted allopathic and osteopathic FTE resident level for its cost reporting period ending June 30, 2002 by 10 to reflect the residents approved for the new surgery program. However, if the hospital's fiscal year end would be September 30, a program accredited in October 2001 and begun on July 1, 2002, would be in operation during the hospital's cost report ending on September 30, 2002, and the hospital would not qualify to have its unweighted allopathic and osteopathic FTE resident level for its cost reporting period ending September 30, 2002, increased to reflect the residents in the new surgery program.

We note that, as directed by section 422, a hospital may only request that its resident level for the cost reporting period that includes July 1, 2003, (rather than its most recent cost reporting period ending on or before September 30, 2002) be adjusted to reflect residents in a new program if (1) the new program was not in operation during the cost reporting period that includes July 1, 2003; and (2) if the hospital also qualifies to use its cost report that includes July 1, 2003, due to an expansion of an existing program that is not reflected on its most recent settled cost report. (This will be explained further in the FY 2005 Hospital Inpatient PPS proposed rule).

To be considered timely and proper, a hospital's request to have the number of unweighted allopathic and osteopathic FTE residents for direct GME and IME adjusted to reflect residents in a newly approved program must be signed and dated by the hospital's Chief Financial Officer (or equivalent), and submitted to its fiscal intermediary on or before June 4, 2004. In addition, the hospital must include a copy of the accreditation letter for the program and (if not included the in the approval letter), information as to the number of approved residency slots for the program, and, if more than one hospital serves as the training site for residents in the new program, an estimate of the number of FTE residents that will train at the requesting hospital. Furthermore, the hospital must indicate the cost reporting period for which it requests an adjustment to the unweighted allopathic and osteopathic FTE resident level to include the residents in the newly approved program. (This cost reporting period must be either the most recent cost reporting period ending on or before September 30, 2002 or, where there was an expansion of an existing residency training program that is not reflected on the most recent settled cost report, the cost reporting period that includes July 1, 2003).

Hospitals that Are Members of a Medicare GME Affiliated Group

In determining whether particular hospitals' FTE resident caps should be reduced, section 1886(h)(7)(A)(iii) of the Act directs CMS to consider hospitals "which are members of the

same affiliated group . . . as of July 1, 2003." Hospitals that are affiliated "as of July 1, 2003" means hospitals that have in effect a Medicare GME affiliation agreement as defined at 42 CFR §413.86(b) for the program year July 1, 2003 through June 30, 2004, and have submitted a Medicare GME affiliation agreement by July 1, 2003 to their fiscal intermediaries with a copy to CMS. These hospitals may have already been affiliated prior to July 1, 2003, or may have affiliated for the first time on July 1, 2003.

Under a Medicare GME affiliation agreement, hospitals form an aggregate cap, and individual hospitals' caps are adjusted within that aggregate cap. Thus, we determine if a hospital's FTE resident cap should be reduced on a hospital-specific basis. In order to determine whether a hospital's FTE cap should be reduced, the fiscal intermediary would measure a hospital's July 1, 2003 "affiliated" FTE caps (based on the Medicare GME affiliation agreement that the hospital submitted to the fiscal intermediary by July 1, 2003) against the unweighted allopathic and osteopathic FTE counts in either the hospital's most recent cost report ending on or before September 30, 2002, or the hospital's cost report that includes July 1, 2003, as appropriate.

Audits of the Reference Cost Reporting Periods

A hospital's unweighted allopathic and osteopathic FTE resident counts that are used for the purposes of determining possible FTE cap reductions may be subject to audit by the fiscal intermediaries. Fiscal intermediaries will perform desk reviews or more detailed audits related to section 422 using instructions that will be issued in a separate document.

In general, if a hospital does not submit a timely request to the fiscal intermediary asking that its cost report that includes July 1, 2003 be used, the fiscal intermediary would use the most recent cost report ending on or before September 30, 2002, to determine if and by how much a hospital's FTE resident caps should be reduced.

We are requiring fiscal intermediaries to post this OTN on their Web sites, and include it in a listserv message by May 7, 2004. The fiscal intermediaries are to include the name and address of the individual at the fiscal intermediary to whom the hospitals should send the timely requests and related information.

C. Provider Education: None

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3247.1	FIs shall post this OTN on their Web sites, and include it in a listserv message by May 7, 2004. FIs shall include the name and address of the individual at the fiscal intermediary to whom	FI

	the hospitals should send the timely requests and related information.	
3247.2	If a hospital requests to use its cost reporting period that includes July 1, 2003, for purposes of determining a possible reduction to the FTE cap, the request must be signed and dated by the Chief Financial Officer (or equivalent), and submitted to the hospital's fiscal intermediary by June 4, 2004. In its timely request, the hospital shall include the FTE resident caps for direct GME and IME and the number of unweighted allopathic and osteopathic FTE residents for direct GME and IME that are included in its most recently settled cost report as of April 30, 2004, and FTE resident caps for direct GME and IME, and the unweighted allopathic and osteopathic FTE residents for direct GME and IME from each cost report after its most recently settled cost report, up to and including its cost report including July 1, 2003. The hospital shall also include the FTE resident caps for direct GME and IME, and the number of unweighted allopathic and osteopathic FTE residents for direct GME and IME in its most recent cost reporting period ending on or before September 30, 2002. If the cost reporting period that includes July 1, 2003 has not ended by June 4, 2004, the hospital shall report the estimated number of unweighted allopathic and osteopathic residents for that cost reporting period.	Hospital
3247.3	If a hospital requests to have the number of unweighted allopathic and osteopathic FTE residents for direct GME and IME adjusted to reflect residents in a newly approved program, the request must be signed and dated by the Chief Financial Officer (or equivalent), and submitted to the fiscal intermediary by June 4, 2004. The hospital shall include a copy of the accreditation letter for the program and (if not included the in the approval letter), information as to the number of approved residency slots for the program and, if more than one hospital serves as the training site for residents in the new program, an estimate of the number of FTE residents that will train at the requesting	Hospital

	hospital. The hospital shall indicate which cost reporting period's unweighted allopathic and osteopathic FTE resident count should be adjusted to include the residents in the newly approved program.	

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: June 4, 2004 **Implementation Date:** June 4, 2004 **Pre-Implementation Contact(s):** Miechal Lefkowitz, (410) 786-5316 **Post-Implementation Contact(s):** Miechal Lefkowitz, (410) 786-5316, and Rebecca Hirshorn, (410) 786-3411	**These instructions should be implemented within your current operating budget.**