BECOMING A NEW MEDICARE TEACHING HOSPITAL

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The timeline included in this article indicates the steps for a non-teaching hospital to become a Medicare Teaching Hospital. On one level, it is pretty simple: A Medicare Teaching Hospital is a hospital that trains residents in accredited GME programs, and a non-teaching hospital becomes a teaching hospital when it starts training residents. When a non-teaching hospital allows residents to train in its facilities, it likely becomes a teaching hospital, whether that status is wanted or not. In turn, when the hospital incurs the related costs, participates in the training of residents in its hospital facilities and other non-hospital sites, and receives (hopefully) medical GME reimbursement from Medicare, the picture of being a ***Teaching Hospital*** becomes more complete.

However, becoming a new Teaching Hospital is triggered simply by having residents training in approved GME programs working and learning in the hospital's facilities, and what matters is the presence of the residents and not the intent of the hospital. Becoming a new Teaching Hospital and achieving sustainable Medicare reimbursement is a long and arduous process. However, due to current and worsening expected physician shortages, the creation of many new U.S. medical schools, and a number of other factors, many traditionally non-teaching hospitals and health systems are looking to start new graduate medical education (GME) programs. This article initially addresses the need to determine whether any ***legacy issues*** may be present that could create bumps in the planning and implementation process for starting new GME programs, and to the right this article lays out a potential future timeline to assess the milestones that can be expected along the way to becoming a Teaching Hospital paid by Medicare.

By ***legacy issues***, we mean the possible presence of past facts that medical residents may have been present in the hospital, even informally, that nonetheless could have triggered determinations that are fundamental to Medicare GME reimbursement. For example, if over the last 10 or more years, medical residents training in approved GME programs were present in the hospital as part of the resident's training, even for incidental rotations, then facts important to setting key Medicare factors may have already occurred. And as we all know, the past cannot be changed. Prior to starting the long, forward-looking task of creating new residency programs, hospitals and systems should explore and understand whether any legacy issues are present, or anticipated Medicare funding may not in fact be available as planned.

YEAR I

- Decide to become a Teaching Hospital
- Leadership establishes commitment to GME and Governing Board adopts Resolution to become a teaching hospital and support specific teaching programs
- Establish Consortium relationship (if applicable)
- Self-assessment to determine any legacy issues – any past "informal" resident rotations to hospital?
- Establish five- to seven-year budget; preliminary work on PRA, FTE cap plan and number of programs
- Establish institutional affiliations

Self-Assessment: Evaluate ability to support proposed new programs, assess whether hospital truly has no FTE cap and no PRA. If residents were previously present in the hospital since 1995, risk assessment is needed

Consortium: Participation with Consortium or other consolidated GME administrative entity structures may reduce common overhead costs and facilitate program operations

Budget: While costs begin right away, Medicare payment usually does not begin for two to four years, starting with the first or second quarter after the new program residents begin training at the hospital

Institutional Affiliations: Affiliated Medical School and Consortium will play important roles in creation of educational infrastructure. Affiliation agreements must meet ACGME requirements

YEAR II

- Hire Program Director(s)
- Identify physician champions who will participate in teaching and encourage others establish/credential faculty to meet accreditation standards
- Establish GMEC or coordinate GMEC with Medical School/Consortium affiliate
- File Program Information Form (PIF) with Accreditation Council for Graduate Medical Education (ACGME); separate PIF needed for each program
- For Family Medicine programs, establish work plan for Family Medicine Center/sites
- Decide on Rotation Schedule process
- Prepare Resident Contract form

Program Director: Key person to act on program development steps. Could be hired in Year I

PIF: The PIF is generally filed 18 to 36 months before the first resident enters the hospital

Program Faculty: Early and ongoing recruitment of paid and volunteer faculty, credentialing of faculty to assure meeting accreditation standards and verification of sufficient coverage/capacity

ACGME/AOA Merger: The ACGME and AOA GME accreditation systems are in the process of merging into a single accreditation system for medical education, to be completed in July 2020

YEAR III

- Receive ACGME approval
- Participate in the MATCH program and start first residents July 1 of the initial MATCH year
- Open Family Medicine Center Clinic (for FM program)
- Start program(s)
- Establish interim Medicare payments for the first residents by working with the Fiscal Intermediary/MAC
- Put program Letter Agreements in place for non-hospital rotations

MATCH: The MATCH is the primary way that residents "match" with programs. The MATCH happens in March of each year, and to participate in the MATCH, the program(s) must have been previously approved by ACGME by September of the prior year. Post-MATCH activities, as well as less formal off-cycle resident placements, can occur

Interim Payments: Once residents begin in training, the FI/MAC will calculate and begin to make interim DGME and IME payments. Proactive coordination with FI/MAC required

- **This is Year 1 of the 5 year FTE cap building period!**

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In 1997, Congress imposed hospital–specific caps on the number of full-time equivalent (FTE) resident positions that the Medicare program will fund. While existing Teaching Hospitals at the time had their "FTE caps" determined then, each new teaching hospital is allowed a five-year window in which to establish its own hospital-specific FTE cap, beginning when the hospital first starts to train residents in its first "new" residency program. By ***new*** we mean a truly new program, not just a program new to the hospital. One of the legacy issues relates to whether, since 1995, any residents in newly accredited graduate education programs rotated to the hospital. If they did, the hospital's FTE cap determination may already have been triggered, which would likely be a significant roadblock for the future. While at times the historical FTE cap is known to be present (and once set, it does not change even if it is a very small number), at other times the presence of residents in new programs went unreported. Nonetheless, the current identification of rotations by past new program residents can still lead to new determinations made now by CMS that relate back to these historical facts.

Another important legacy issue relates to a number related to the hospital's residency costs, the hospital's ***per resident amount*** or "PRA." In its early days, Medicare treated GME costs like medical services, reimbursing for the conduct of medical education on a cost basis. Over time, Congress mandated a limit on the cost-based payments, not by setting a standard amount but instead by establishing a hospital-specific cost-based number, referred to as the hospital's PRA. The issue for new Teaching Hospitals is that the PRA base year is triggered by the presence of residents in approved programs training in the hospital, almost irrespective of how far in the past that might have been. So, if residents were present in the hospital in the past, the PRA setting period may have come and gone long ago. Importantly, CMS currently takes the position that if triggered, and no matter if that trigger period occurred 10 or more years ago, the PRA will have been determined, even if the hospital neither had nor submitted any teaching costs at the time. Once the historical base year is identified, CMS will look to those base year facts to set a PRA that will apply for the future. In the extreme, a hospital's PRA amount can be zero dollars, meaning that the new Teaching Hospital might not be eligible for any direct Medicare GME payment.

While the process for assessing and determining whether any legacy issues are present is itself complex and based on a web of CMS regulations that has evolved over the last 30 years, completing that assessment is critical to a realistic determination of what future Medicare GME

YEAR IV

- Operate program
- Plan for expanding additional programs to maximize resident count by and in the fifth ***year after first new program***

Additional Programs: New programs can be added, and all new programs present in the fifth year after first new program will determine FTE cap

Interim Payments: Continue proactive coordination with FI/MAC required. PRA to be determined

YEAR V

- Operate program(s)
- Medicare funding based on actual costs, subject to Medicare percentage. Limited by maximum number of approved slots
- Develop maximum number of programs for year VIII and FTE cap creation
- Determine PRA in discussions with FI/MAC and assess possible need for Medicare appeal (based on the timing of the NPR for the PRA determination year cost report)

Medicare Funding: IME payments, as a formula-driven DRG add-on, will be based on the number of residents trained and the number of available beds, as determined by the IME formula. DGME payments based on actual residents and actual costs in first program year, subject to the PRA limit; once PRA is determined, based on the first or second program year costs, depending on individual facts. Step down to the Medicare percentage occurs. Reimbursed resident time cannot exceed approved/accredited slots and is subject to reduction due to allocation of slots to all training sites

YEAR VI

- Operate program(s)

Additional Programs: New programs can be added, and all new programs present in Year VIII will determine FTE cap

Interim Payments: Once residents begin in training, the FI/MAC will calculate and begin to make interim DGME and IME payments. Coordination with FI/MAC is required. PRA is used instead of actual costs. Step down by the Medicare percentage. Reimbursed resident time cannot exceed approved/accredited slots and is subject to reduction due to allocation of slots to all training sites

YEAR VII

- Operate program(s)
- Start additional new programs

Additional Programs: Same as prior year

Interim Payments: Same as prior year

YEAR VIII

- Medicare FTE Caps determined based on this year, separate caps for IME and DGME
- The fifth year after the first new program is the data year that the new Teaching Hospital establishes its FTE cap. Maximum number of programs and maximum number of residents mean a bigger FTE cap.
- Formula also allocates the maximum FTE cap over all locations where residents trained for over five years!
- CAUTION: The 5th year of a new program may trigger the FTE cap of any non-teaching hospital to which the residents rotate in the important 5th year, whether the residents ever trained at the hospital before. This rule may have the effect of shortening the 5 year period for some hospitals.

FTE Caps: If the first residents enter the hospital in Year III, Year VII or VIII (depending on the timing) is the fifth year after the first new program residents are rotated through the hospital; therefore, the cap is calculated and established in Year XI or after, based on Year VII or year VIII data, and will apply to the Year IX Medicare payments

CMS rules published in August 2012 expanded the FTE cap determination period from three to five years. During the initial five-year period, additional new allocation process for spreading accredited slots across all training locations (irrespective of new or old training sites) where residents trained is applied, and out rotations (rotations away from New Teaching Hospital or non-hospital sites supported by New Teaching Hospital) have the effect of reducing the permanent FTE cap.

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payments may be expected. If a hospital's FTE cap has already been set, unless the hospital is located in a rural area, the presence of an FTE cap will place significant limitations on any ability to achieve new Medicare funding: an urban hospital with an FTE cap cannot create new FTE cap, except for new rural track programs or rural reclassifications. The PRA analysis can be equally as troubling, since if a hospital's PRA base year determines a small PRA amount (even including a zero amount determination), that amount cannot be intentionally increased. In certain past years, Congress set a floor on PRA values, which can offer some relief but only for several specific years: 2001-2003. However, if a hospital has a small PRA, that will lead to smaller Medicare direct GME reimbursement than what might have been possible.

The timeline in this article walks through the process for becoming a Teaching Hospital and includes a discussion of some of the important milestones along the way. Actual time periods for the steps mentioned can be longer or shorter (and many other steps and actions are needed), but this outline is intended to highlight the critical milestones and give a sense of the overall time needed to become a Teaching Hospital.

A Note on Medicare GME Payments: The Medicare program makes two types of payments to teaching hospitals: direct graduate medical education (DGME) and indirect medical education (IME) payments. DGME payments are intended to reimburse teaching hospitals for their costs directly related to educating residents, including residents and faculty stipends and fringe benefits as well as institutional overhead costs (subject to the PRA). IME payments compensate teaching hospitals for their increased patient care costs by virtue of their having teaching programs. Medicare distributes DGME payments to teaching hospitals based on a hospital-specific per resident amount (PRA). Each hospital's PRA will be the lower of its actual DGME costs incurred during the base year or the weighted average PRA of all teaching hospitals in the hospital's geographic area. Currently, a Teaching Hospital's PRA is permanent, updated annually only for inflation. IME payments are made in the form of an add-on payment for each Medicare patient DRG discharge. Both DGME and IME payments are subject to the hospital-specific FTE cap, which determines for that hospital the maximum number of residents Medicare will pay for, irrespective of the actual number of residents who train at the hospital.

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YEARS IX & AFTER

- Consider and, as needed, initiate appeals of any disagreements with FI/MAC or CMS relating to FTE Cap, or specific reimbursement amounts
- Monitor required dates for filing of appeals

FTE Caps: Based on the Year VIII and earlier cost report data and rotation information, the FI/MAC will work with CMS and the Hospital to determine the IME and DGME caps for the Hospital. In 2015, CMS made the IRB cap and the three-year rolling average also applicable in the sixth program year of the first new program

PRRB Appeals: The determination of many key factors relating to Medicare DGME and IME reimbursement are established through the cost-reporting process, with final verification from CMS occurring through the PRRB appeals process if the provider disagrees with any prior decisions made. Hospital appeal rights are timed to the cost report NPR, which need to be monitored closely