

## **Congress Introduces Resident Cap Relief Legislation**

The U.S. Senate Finance Committee Members Charles Schumer (D-NY) and Bill Nelson (D-FL), along with Senate Majority Leader Harry Reid (D-NV), introduced landmark legislation to increase the number of residency positions that would be eligible for Medicare direct graduate medical education (DGME) and indirect medical education (IME) support by 15% above the current level. A companion bill was introduced in the House of Representatives by Ways & Means Committee Members Joseph Crowley (D-NY) and Kendrick Meek (D-FL), along with Representative Kathy Castor (D-FL).

The new legislation also includes provisions to redistribute residency positions that were lost due to the closure of a teaching hospital, relieves the administrative burden associated with rotating residents to nonhospital settings, and amends the DGME and IME sections of the Social Security Act to explicitly permit teaching hospitals to count educational activities for Medicare reimbursement.

### **Background on the Medicare Resident Cap**

The Balanced Budget Act (BBA) imposed a cap on the number of residents for which teaching hospitals are eligible to receive both Medicare DGME and IME reimbursement. Except for several limited exceptions, this cap has been in place since the enactment of the BBA. The BBA did permit adjustments for new residency programs that had been approved for accreditation prior to enactment of the BBA, and also permitted adjustment to the cap for purposes of academic affiliations. In 2003, the Medicare Modernization Act (MMA) provided limited cap relief by redistributing 75% of unused resident positions from teaching hospitals training residents below their cap. These positions were redistributed through an application process administered by the Centers for Medicare & Medicaid Services (CMS) and cap relief was provided to other teaching hospitals as of July 1, 2005. As per the specifications of the MMA, the redistributed residency positions were reimbursed for DGME purposes at the locality-adjusted national average per resident amount and for IME purposes at a rate of 2.7%.

### **Resident Physician Shortage Act of 2009**

The new legislation is modeled in part on the redistribution program developed in the MMA. The new program provides resident cap relief to teaching hospitals by reducing resident caps at teaching hospitals with unused positions, supplementing those unused positions with additional new positions, and then making the total pool of positions available for redistribution to interested teaching hospitals through an application process.

### **Positions Available for Distribution**

The legislation would reduce the otherwise applicable resident cap at teaching hospitals that have had unused positions for each of the last five cost reporting periods. The reduction for an individual hospital would be the maximum number of positions that have been unused for all of the last five years. An exception to the reduction process is made for rural hospitals and for teaching hospitals that completed the Medicare GME demonstration project and are below their otherwise applicable resident caps. The unused positions become part of a pool of new resident positions available for distribution that totals 15% of the aggregate current number of approved residency positions.

### **Distribution Methodology**

The new positions available for distribution by CMS would be separated into two categories. One-third of the new positions would be available for teaching hospitals that are currently training residents in excess of their caps. A hospital would be eligible to apply for these slots if the hospital demonstrates that it is training at least 10 residents above its cap and is training at least 25% of its residents in primary care and general surgery. Hospitals eligible for cap relief from this part of the pool would also, however, be eligible to apply for cap relief under the second component of the distribution.

The remaining two-thirds of the additional residency slots would be available for teaching hospitals that seek to expand existing residency programs or begin new residency programs. A hospital would have to demonstrate the likelihood that it would fill the positions within three years after distribution and would be eligible for up to 50 additional positions. For this part of the resident pool, preferences would be given in several areas:

- Hospitals seeking residency slots for primary care and general surgery;
- Hospitals that emphasize "training in community health centers and other community-based clinical settings";
- Hospitals in states that have more medical students than residency positions; and
- Hospitals in states that have low resident-to-population ratios.

In the case of residency positions distributed for primary care and general surgery, the hospital would have to maintain at least the same number of residency positions in those specialties after the increase in resident cap positions is granted.

#### **Reimbursement Level for New Positions**

The redistributed positions would be reimbursed at the hospital's otherwise applicable per resident amounts for DGME purposes and using the usual adjustment factor for IME reimbursement purposes (currently, 5.5%).

#### **Additional Components of the Legislation**

The legislation also addresses several other important concerns of the academic medicine community.

#### **Rotating Residents to Nonhospital Settings**

Teaching hospitals are currently eligible for both Medicare DGME and IME reimbursement for the time residents spend at a nonhospital setting. Under current law, hospitals can claim that time as long as the hospital demonstrates that it has incurred "all or substantially all" of the direct GME costs associated with the training at the nonhospital setting. Beginning in 1999, CMS interpreted this provision as requiring hospitals to determine the teaching physician cost associated with the training in the nonhospital setting and specified that except in very limited circumstances, there is always a cost that must be determined and the hospital must reimburse for that cost. Under new rules established in 2007, CMS permitted the use of certain proxies in determining and reimbursing for the teaching physician cost.

This new legislation specifies that as long as the hospital continues to incur the cost of the resident's salary and fringe benefits, the hospital would be eligible to claim the resident time spent at the nonhospital setting. This modification would return the requirement to that which was in effect prior to 1999 and make it easier to rotate residents to nonhospital settings.

#### **Counting Time Spent in Nonpatient Care Activities**

In 2006, CMS "clarified" in the acute inpatient proposed rule that the time residents spend in nonpatient care activities (e.g., educational or "didactic" activities) is not to be counted for IME purposes in any setting and not to be counted for DGME in nonhospital settings. Despite widespread complaints from the academic medicine community that this was a change in policy, CMS affirmed this clarification in August 2006. CMS did, however, establish a one-workday threshold for documentation purposes as a means to alleviate some of the administrative burdens associated with the "clarification."

The new legislation specifies that nonpatient care activities can be counted for DGME purposes in a clinical nonhospital setting and for IME purposes in the hospital, and that "research activities that are not associated with the treatment or diagnosis of a particular patient" would not be eligible to be counted for IME purposes in any setting.

#### **Preservation of Resident Cap Positions from Closed Hospitals**

Under current law, if a teaching hospital closes (defined as withdrawing participation in the Medicare program), the resident cap positions associated with that hospital disappear, although CMS does permit temporary cap increases to other teaching hospitals to accommodate residents suddenly displaced from the closed hospital.

The legislation would preserve the resident cap positions from teaching hospitals that have closed since the enactment of the BBA. The positions would be made available for redistribution to other hospitals on a permanent basis. Preference for the redistribution would be given first to hospitals located in the same or

contiguous core-based statistical area as the closed hospital, then to hospitals located in the same state, then to other hospitals in the region, and then to other interested hospitals.