

## **Redistribution of Graduate Medical Education Slots**

The Patient Protection and Affordable Care Act (ACA) calls for a redistribution of unused residency slots and allocates 65 percent of the slots for primary care and general surgery positions. The law also authorizes teaching hospitals to receive Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments associated with the time residents training in ambulatory settings, such as clinics or physicians' offices, if they incur "all or substantially all" of the training costs so long as the hospital incurs the costs of the residents stipends and benefits for the time the residents spend in that setting. This provision allows hospitals to avoid the administrative burden of calculating physician supervisory costs at the ambulatory site. The law also clarifies that sick leave and vacation time can be counted for IME and DGME. It also ratifies the October 1, 2001 regulation that time spent in research not involving the care of patients cannot be counted for IME.

### **What is the difference between DGME and IME?**

DGME payments partially compensate teaching programs for residency education costs; whereas IME payments compensate hospitals for higher patient care costs due to the presence of teaching programs.

### **Redistribution of Unused Residency Slots (DGME and IME)**

The law requires the Centers for Medicare and Medicaid Services (CMS) to take 65 percent of the DGME and IME residency slots that have gone unused by a hospital for the past three years and to redistribute them according to certain criteria. The DGME and IME resident caps of hospitals with three years of unused residency slots were permanently reduced beginning July 1, 2011. To determine whether and by how many residents a particular hospital's resident cap will be reduced, CMS looked back at the hospital's last three settled or submitted cost reports for cost reporting periods ending and submitted before March 23, 2010. CMS clarified the method that will be used to determine this look-back period and other details in a final rule on November 2, 2010, which went into effect on January 1, 2011.

### **Were any hospitals exempt from the reduction in resident limits?**

Yes, resident limits were not reduced for rural hospitals with fewer than 250 acute care inpatient beds; hospitals that participated in a voluntary residency reduction plan and that have a plan in place to fill the unused positions by March 23, 2012; and the replacement facility for the former Martin Luther King, Jr. - Harbor Hospital (Los Angeles).

### **How many residency slots were redistributed?**

In 2011, CMS announced that it has redistributed roughly 1,354 Medicare residency positions. The 628 indirect medical education and 726 direct graduate medical education positions were allocated to 58 qualifying hospitals from 267 hospitals that were not training up to their residency caps. In accordance with the ACA redistribution formula, 70 percent of the positions were allocated to 39 hospitals in states with resident-to-population ratios in the lowest quartile, and 30 percent were allocated to 19 hospitals in rural or health professional shortage areas.

### **Once a hospital has been awarded slots, when can it expect to start getting paid for those redistributed slots?**

Hospitals awarded slots under the redistribution program may be paid for those redistributed slots beginning July 1, 2011. The per-resident amounts used to calculate DGME payments for the redistributed slots will be

equal to the per-resident amount otherwise in effect for the hospital for primary care and non-primary care. The IME adjustment factor for the redistributed slots is also set at the current 5.5 percent.

### **How many slots may a hospital request?**

Hospitals may apply to receive up to 75 slots under this redistribution program.

### **What considerations were given in awarding the redistributed slots?**

CMS was required to consider factors including: (1) the hospital's likelihood of filling the additional slots within the first 3 cost reporting periods beginning on or after July 1, 2011; and (2) whether the hospital has an accredited rural training track. CMS is also required to allocate 70 percent of the redistributed slots to hospitals in states with resident-to-population ratios in the lowest quartile (CMS determined these states to be: Montana, Idaho, Alaska, Wyoming, South Dakota, Nevada, North Dakota, Mississippi, Indiana, Puerto Rico, Florida, Georgia, and Arizona) and 30 percent of the redistributed slots to hospitals located in (a) the 10 states with the highest proportion of their populations living in a health professional shortage area (HPSA); (CMS determined these states to be Louisiana, Mississippi, Puerto Rico, New Mexico, South Dakota, the District of Columbia, Montana, North Dakota, Wyoming, and Alabama), and (b) rural areas.

### **Were the redistributed slots subject to any restrictions?**

Yes, for five years (beginning on the date the hospital's limit was increased). The hospital may not reduce its pre-redistribution number of primary care residents below the average number of primary care residents training in the hospital during the three most recent cost reporting periods ending and submitted before March 23, 2010. Additionally, at least 75 percent of the additional slots a hospital receives through the redistribution program must be used for primary care or general surgery. If a hospital fails to comply with these requirements, all of the additional slots it gained through the redistribution program will be taken away and redistributed to other hospitals.

### **What is the deadline for hospitals to apply for redistributed slots?**

The deadline for hospitals to apply for redistributed slots was January 21, 2011.

### **Additional Resources**

- *Presentation by AAMC on the CMS regulation:*

<http://www.im.org/AcademicAffairs/PolicyIssues/Education/Funding/Documents/AAMC%20slides%20GME%20reg%20post%20ACA.pdf>

### **PAYMENTS TO TEACHING HEALTH CENTERS**

The ACA also establishes a new Title III program that provides \$230 million from FY 2011-2015 to reimburse qualified teaching health centers (THC) for their direct and indirect costs. Teaching health centers are newly created under the ACA and are defined as community-based, ambulatory patient care centers that operate a primary care residency program. They can include federally qualified health centers, community mental health centers, rural health clinics, and health centers operated by the Indian Health Service. Unlike the requirement for THC grants, it does not appear that a "new or expanded" residency program is required to be a primary care program for its expenses to be covered under this section. However payment is only for expansion—funding

for residents above a base level—or establishment of newly accredited programs. In addition, funding is only for programs where the teaching health center is the institutional sponsor of the residency program.

**Do these payments replace existing payments currently being received for DGME and IME by a teaching health center?**

No, the teaching health center payments are in addition to payments made to hospitals for DGME payments.

**What expenses are defined as “direct expenses” or “indirect expenses”?**

The law does not define what expenses are to be included in either category. Regulations will be required to clarify these terms.

**Do THC residents count toward the current Medicare limits on GME funded resident positions?**

No.

**Can a resident’s time be “double counted” by a THC and a hospital?**

No.

**Additional Resources**

- *HRSA Teaching Health Centers Grant and Technical Information.*  
<http://bhpr.hrsa.gov/grants/teachinghealthcenters/index.html>