

Medicare GME 101: A Refresher and Hot Topics

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GME @ Dentons team



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GME @ Dentons newsletter

- Monthly news and insights related to GME funding issues
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Objectives

At the conclusion of the presentation, participants will be able to:

- Contrast Medicare direct graduate medical education (DGME) funding from indirect medical education (IME) funding
- Discuss limits (“caps”) on Medicare funded training positions and exceptions to the caps
- Understand initial residency period (IRP) and location-of-training issues
- Comprehend community support and redistribution of cost principles (and how they relate to dental programs)
- Identify publicly-available GME funding data and knowledgeable parties within an institution

Funding landscape

- Federal/State funding for graduate medical education goes to over 1,000 hospitals for 115,000 resident positions (100,000 capped number).
- Overall support for GME in 2012
 - Medicare: \$9.35 billion
 - DGME – just under \$2.7 billion
 - IME – just under \$6.7 billion
 - Medicaid: \$785 million
 - Children’s Hospitals GME: \$265 million
 - Teaching Health Centers GME: \$17 million
 - VA Hospitals: \$643 million
 - DOD Programs: \$16 million (administrative costs only)

SOURCE: GAO-13-709R Health Care Workforce Training Programs

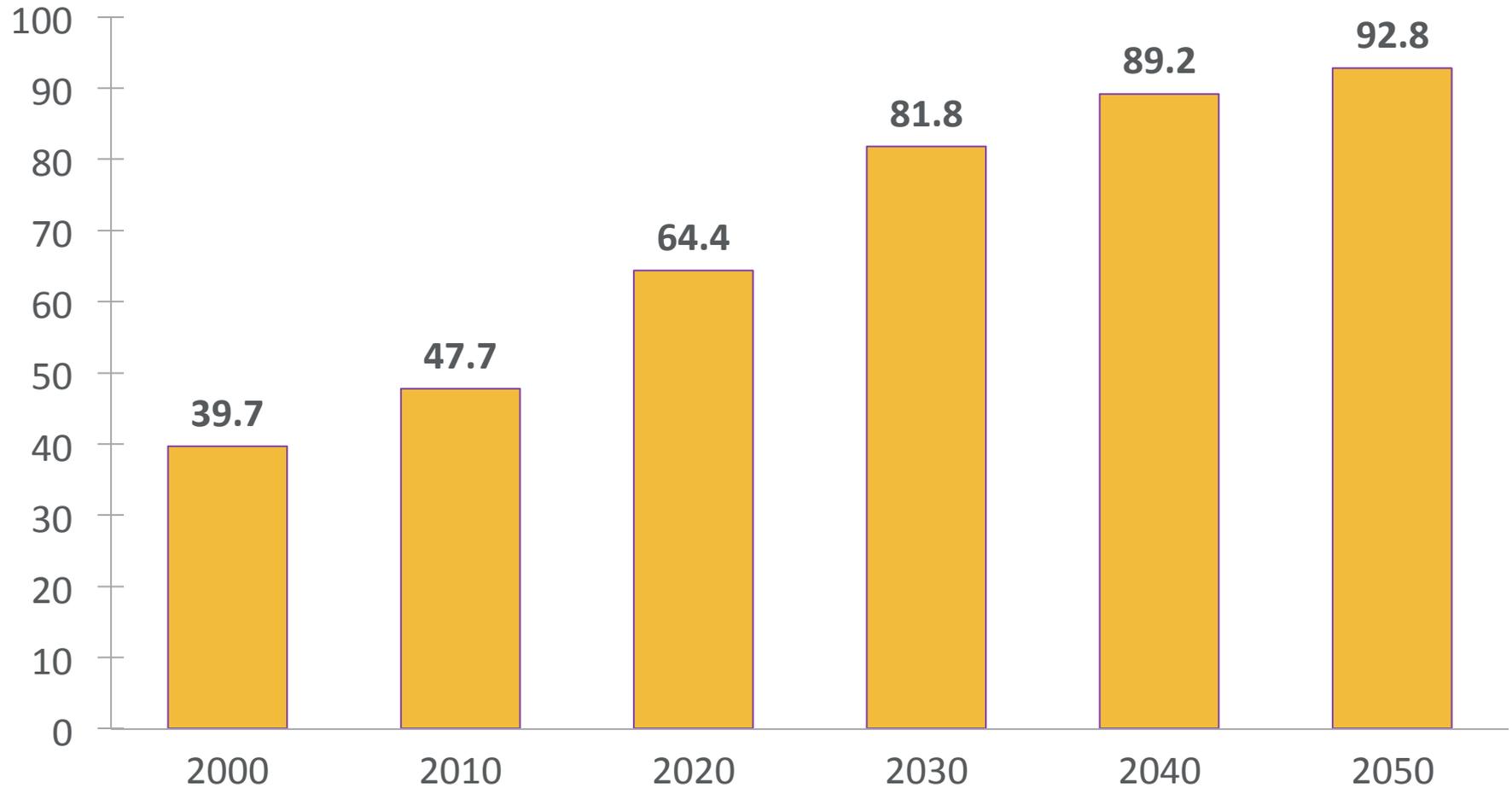
The Medicare program: 50+ years old

- Signed into law by President Johnson in 1965
 - At the time, 50% of all seniors lacked health insurance
- What does Medicare pay for?
 - Individuals 65 years old and older
 - Individuals < 65 years old with permanent disabilities
 - Individuals with end stage renal disease
 - **Physician training through GME funding to hospitals**



Financing care for an aging population

Number of Medicare beneficiaries (in millions)



How are Medicare GME payments calculated?

Type of provider determines type of payment

- **IPPS Hospital:** DGME and IME payments
 - The focus of this presentation
 - Note: GME payments go directly to the hospitals; NOT to the residency programs (so pediatric dentistry program must negotiate with hospital for share of payments)
- **Children's Hospital:** CHGME payments
- **IRF/IPF:** DGME and Teaching Status Adjustment payments
- **CAH:** 101% of direct costs of training residents
- **FQHC or RHC:** Medicare's share of direct costs the FQHC/RHC incurs itself, OR payment to IPPS hospital with FQHC as a non-provider site; THC payments
- **SCH:** DGME only if paid based on hospital-specific rate; DGME and IME if paid on federal rate

No education-related payments to certain entities

- IPPS-exempt cancer hospitals
- SNFs
- Home health agencies
- Hospices
- Outpatient rehabilitation facilities
- Physician offices
- Community health centers
- Dialysis centers

Medicare GME overview: 2 categories of payment

- Direct Graduate Medical Education (DGME)
 - Per-resident payment
 - Paid as a separate pass-through payment, independent of MS-DRG payment
 - Roughly 1/3 of total GME (almost \$2.7B in 2012)
- Indirect Medical Education (IME)
 - Not paid on a per-resident basis
 - Percentage add-on payment to basic Medicare MS-DRG payment
 - Roughly 2/3 of total GME (almost \$6.7B in 2012)

Threshold requirement: approved program

- Approved by:
 - Accreditation Council for Graduate Medical Education (ACGME)
 - American Osteopathic Association (AOA)
 - Commission on Dental Accreditation of the American Dental Association
 - Council on Podiatric Medicine Education of the American Podiatric Medical Association
- Leads to American Board of Medical Specialties (ABMS) specialty or subspecialty certification
- Note: different rules for unapproved fellowships

FTE caps

- In the Balanced Budget Act of 1997, Congress capped the number of residents for which a hospital can claim DGME/IME reimbursement
 - Hospitals are capped at the number of “full-time equivalent” (FTE) residents reported in the hospital’s most recent cost reporting period ending on or before December 31, 1996
 - Newer teaching hospitals establish a cap, over a 5-year period, by training residents participating in “new” medical residency programs
- Teaching hospitals have separate FTE Caps for DGME and IME
- **Dental residents are not subject to the Medicare GME FTE caps**
 - FTE caps are statutorily limited to “allopathic and osteopathic” residents (so exclude dental and podiatry)
 - Would take a legislative change to subject dental residents to the FTE caps

Very few exceptions to the caps

- New teaching hospitals
- Rural teaching hospitals
- Rural training track programs
- Temporary and permanent adjustments associated with closed hospitals and programs
- Medicare GME Affiliated Group Agreements

3-year rolling average

- Also enacted in the Balanced Budget Act of 1997
- Applies for both DGME and IME
- RULE: The hospital's total number of FTE residents for payment purposes is equal to the average of the actual FTE resident counts from the current cost reporting period and the preceding two cost reporting periods
- **Dental residents are subject to the 3-year rolling average**
- Effect is to delay the full realization of additional reimbursement for new residents by “phasing in” FTE increases over 3 years
- It would require a legislative fix to eliminate the 3-year rolling average

Medicare DGME payments

What are DGME payments intended to cover?

- Medicare's share of the costs directly related to educating residents, including:
 - Residents' stipends/fringe benefits
 - Salaries/fringe benefits of supervising faculty
 - Other direct costs (accreditation fees, etc.)
 - Allocated overhead costs

DGME payment formula

$$\text{Total DGME} = \text{Hospital's PRA} \times \text{FTE resident count} \times \text{Hospital's Medicare patient load}$$

- Step 1: Determine the hospital's per-resident amount (PRA):
 - Determine per-resident base year costs (*i.e.*, how much the hospital spent per resident back in 1984)
 - Update (to current year) for inflation; different for primary vs. non-primary care
- Step 2: Multiply the updated PRA by the number of *countable* full-time equivalent (FTE) residents in the current year, subject to:
 - FTE "cap";
 - 3-year rolling average; and
 - "Weighting" rules (see next slide)
- Step 3: Multiply by the hospital's ratio of Medicare inpatient days to total inpatient days (often called the "Medicare share")

"Weighted" FTE count: Initial residency period (IRP) affects payment

- IRP = minimum accredited length for each specialty
- Residents training during their IRP are counted as 1.0 FTE
- Residents training beyond their IRP are counted as 0.5 FTE
- Examples?
 - Fellowships
 - Retraining in a different specialty (depending on which specialty)
 - Repeating a year of training
- IRP is determined during a resident's first year of training and does not change
- Limited exception for preliminary and transitional-year programs, which do not lead to board certification in a specialty or subspecialty

Dental-specific IRP issues

- GPR and AEGD programs are treated as “transitional” programs
 - They do not set the resident's IRP
 - But note—the 1 or 2 years of training in the GPR or AEGD program is/are counted against the resident's IRP

SOURCE: 54 Fed. Reg. 40286, 40294 (Sept. 29, 1989)

- Example:
 - Pediatric dentistry has 2 year IRP
 - Pediatric dental resident completes GPR; resident counted as 1.0 FTE for DGME purposes during GPR year
 - For first year of pediatric dental program, hospital may count resident as 1.0 FTE for DGME purposes (and 1.0 for IME purposes)
 - For the second year of the pediatric dental program, hospital may count resident only as 0.5 FTE for DGME purposes (though still 1.0 for IME purposes)

What about a 3-year pediatric dental program?

- CMS sets IRP at the minimum accredited length for each specialty
- Because there are 2-year pediatric dentistry programs, pediatric dentistry has a 2-year IRP
- Example:
 - Pediatric dental resident did not complete a GPR or AEGD program
 - Resident decides to participate in a CODA-accredited 3-year pediatric dental program
 - For first 2 years of program, hospital may count resident as 1.0 FTE for DGME purposes (and 1.0 for IME purposes)
 - For 3rd year of program, hospital may count resident only as 0.5 FTE for DGME purposes (though still 1.0 for IME purposes)

Medicare pays its “share” of resident “costs”

Medicare share × PRA = Medicare payment per resident

EXAMPLES

- Medicare DGME payment per primary care resident:
 $35\% \times \$100,000 = \$35,000$
- Medicare DGME per-resident payment for all other residents:
 $35\% \times \$90,000 = \$31,500$
- Medicare DGME payment per fellow:
 $(35\% \times \$90,000) \times 0.5 = \$15,750$

Medicare IME payments

What are IME payments intended to cover?

- "Indirect" *patient care costs* associated with having a teaching program
- Higher inpatient operating costs because of the clinical environment where teaching occurs:
 - Unmeasured patient complexity not captured by the MS-DRG system
 - Increased costs of specialized services
 - Other operating costs associated with being a teaching hospital (standby capacity, lower productivity, etc.)

IME payment formula

$$\text{Total IME} = 1.35 \times \left[\left(1 + \text{IRB} \right)^{0.405} - 1 \right] \times \text{MS-DRG Pmts}$$

- IME adjustment is based on statistical analysis
- Critical factor is hospital's ratio of interns-and-residents-to-beds (IRB)
 - Proxy for teaching intensity
 - Capped at lesser of current or previous year's ratio
- Exponent of 0.405 meant to account for effect of teaching activity on inpatient operating costs
- For FFY 2017, Multiplier = 1.35
- Note: There is no IME add-on to Medicare outpatient payments
- **Shorthand for IME: Hospitals get about a 5.5% increase in MS-DRG payments for every 10-resident increase per 100 beds**

Calculating the IME payment

- Step 1: Determine the IRB ratio

Example: 85 resident FTEs / 333 beds = 0.255

(Note: IME resident counts are NOT weighted)

- Step 2: Use statistical formula and IRB to calculate IME add-on

$$1.35 \times [(1 + 0.255)^{0.405} - 1] = \underline{0.13} \text{ (or 13\%)}$$

- Step 3: Calculate the IME payment for each case

EXAMPLE: IME add-on payment for MS-DRG 470 (major joint replacement) =

$$(\$14,213 \times 13\%) = \underline{\$1,847.69}$$

Community support issues

Community support principle: Theory

- Longstanding Medicare policy that IF the "community" has undertaken to support specific costs (not limited to GME), then these costs can't be shifted onto the Medicare program
- Congressional intent re: GME payments was to pay for costs "only in situations where the community has not stepped in to incur them
- If costs have been undertaken historically by the community, a subsequent redistribution of these costs to a hospital and the Medicare program is not allowable

Community support principle: Mechanics

- “Since Inception” Rule

“A hospital must continuously incur costs of direct GME of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents....”

SOURCE: 42 C.F.R. § 413.81(b) (emphasis added); see *also* 68 Fed. Reg. 45346, 45434, et seq. (Aug. 1, 2003)

- For residency programs in nonprovider settings, only those programs funded by a hospital since their inception remain eligible for a hospital to receive DGME and IME funding
- Community support disallowance is forever!

Community support principle: Grant considerations

- A word about grants:
 - “Community support” generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations
 - Community support does not include grants, gifts, and endowments, if a hospital would not be required to offset them against its operating costs on its cost report (CMS has rules about this)
- Take-away: Supporting grants do not necessarily create a community support disallowance if a hospital continuously incurs the required direct program costs, but this is a case-by-case analysis

New programs

- Scenario: There has been a community support disallowance with respect to a particular residency program, and a decision is made to close the program that has become ineligible for GME reimbursement.
- Question: Can the dental school partner with a hospital to establish a different dental residency program in the same specialty that will be GME-eligible?
- Key Consideration: For the hospital to be able to count the new residents for purposes of GME reimbursement, the program must qualify as a “new program,” under CMS guidance.

What is a new program?

- Relocating or "rebranding" an existing program does not count
- The new program must be newly accredited
- CMS also considers factors including, for example:
 - Whether program director is new
 - Whether teaching staff is new
 - Whether residents came from an existing program
 - Whether the hospital operating the program also operates another program in the same specialty
 - Relationships between hospitals operating similar programs

Resource: 74 Fed. Reg. 43754, 43908-17 (Aug. 27, 2009)

Expansions of existing programs

- Scenario: Additional residents are added to an existing program, where the original residents were supported by the community.
- Question: Will the Medicare program support the cost of the additional residents who are added to the program?
- Key Consideration: If the hospital incurs the costs of the additional residents from the time the additional residents begin training, then only the costs associated with the additional residents may be counted by the hospital on its Medicare cost report.

Tips for negotiating with hospitals

- When a new teaching hospital first begins training residents, the hospital is chiefly worried about two things:
 1. Establishing its DGME and IME FTE Caps by training residents in "new programs"; and
 2. Setting its PRA
- Once these two processes are "triggered," they cannot be curtailed
- Some background rules to keep in mind:
 - Dental residents training in "new programs" cannot trigger an FTE Cap
 - Dental residents will trigger a new teaching hospital's PRA, whether they are in a "new program" or a long-established one
 - While medical (allopathic and osteopathic) residents participating in "new programs" are exempt from the 3-year rolling average and the IME ratio cap during the FTE cap-building period, dental residents are not exempt

Efforts to fix the "resident rotator" problem

- CMS not willing to change regulations
- Legislative fix necessary
- Coalition efforts under way to pass legislative fix: Advancing Medical Resident Training in Community Hospitals Act (S 2671; HR 4732)
 - Retroactive (up to 3.0 FTEs)
 - Prospective (up to 1.0 FTE)
 - Base year cap up to 1.0 FTE
- Reasons to get involved:
 - Rotators inadvertently set the hospital's PRA or cap
 - Considering merging with a hospital that has this problem
 - You'd like to partner with a hospital as a training site, and they won't permit you to rotate residents there, because they don't want to set a PRA or cap

Counting resident time

CMS rules for counting resident time

- Factors affecting how resident time may be counted include:
 - Costs hospitals must bear to count resident time in nonprovider sites
 - Activities in which the resident participates—*e.g.*, patient care, didactic, research, approved leave
 - Documentation and recordkeeping requirements
- Note: all time that is eligible to be counted *must* be counted, even if hospital is over its cap

Counting resident time in clinical nonprovider sites: *Costs the hospital must incur*

- **Pre-Affordable Care Act: “Substantially All”**
Hospital had to incur 90% of sum of resident stipends & benefits AND supervisory teaching costs
- **Post-ACA: Residents’ Stipends and Benefits**
Hospital must incur only the costs of residents’ stipends & benefits during the time the residents spend at nonprovider sites; hospitals are no longer required to pay faculty costs at the nonprovider site
- Congress's goal was to encourage more nonprovider-site training by removing financial disincentives (CMS now tracks on cost report)

Counting resident time in clinical nonprovider sites: *Costs the hospital must incur*

- Impact of hospitals not being required to pay faculty costs:
 - Most teaching hospitals will refuse to pay faculty costs
 - More hospitals better able to afford financing new dental programs in nonprovider sites
- Stipend and Benefit Costs—How much is enough?
 - No express guidance
 - Analogy: "volunteer" faculty under the "substantially all" regime
 - CMS used to accept whatever amount was agreed to by the hospital and the physician
 - Then, CMS switched to a "cost-finding" approach to determine the cost of the physician's time
 - This amounted to a "reasonableness" test
 - Takeaway: CMS likely to require that hospital *actually incur* some [reasonable] cost for residents' salaries and benefits
 - Can the hospital charge tuition? No.
 - Can the residents be paid nothing? Probably not.
 - Does the hospital have to pay top-of-range salaries? No.

Counting resident time in clinical nonprovider sites: *Spending time in multiple hospitals*

- Scenario: Hospital A incurs the stipends and benefits of the pediatric dental residents. The residents spend time training in:
 - Hospital A
 - A dental school clinic not affiliated with any hospital
 - A dental clinic that is "provider-based" to Hospital B
- Question: For what time may Hospital A be reimbursed?
- Considerations: **Medicare rules state that one hospital may never claim the time residents spend in *another* hospital.** In this example, Hospital A may claim and be reimbursed for the time residents spend in Hospital A and the time they spend in the dental school clinic.
 - The dental clinic that is provider-based to Hospital B is considered to be part of Hospital B, and Hospital A may NOT claim the residents time for these rotations.
 - Does not matter that Hospital A paid the stipends and benefits while residents were at Hospital B

Counting resident time in clinical nonprovider sites:

Written agreements

- **From CMS's standpoint**, no written agreement is required between the hospital and nonprovider training site, *as long as* the hospital incurs the costs of residents' stipends & benefits within three months of each nonprovider-site rotation
- But if multiple hospitals share stipend & benefit costs for a nonprovider-site program, then the hospitals must have a written agreement with one another ensuring that each hospital counts its proportional share of time
- **As a practical matter, however:**
 - CODA requires that all training partnership arrangements must be formalized in written agreements that clearly define the parties' roles and responsibilities
 - Most training partners find they have many other compliance and business decisions they want to memorialize in written agreements between some combination of the various participating entities (e.g., hospitals, dental schools, and/or community clinics)

Counting resident time for didactic activities

- Post-ACA, certain didactic time (*i.e.*, lectures, conferences, seminars) can be counted for GME reimbursement purposes:
 - Didactic time occurring in a hospital counts for both DGME and IME
 - Didactic time occurring in a dental or medical school clinic counts towards DGME only
 - Didactic time occurring in a dental or medical school auditorium or other classroom never counts

Counting resident time for didactic activities

- To count didactic time that occurs outside the hospital, training must occur in a “nonprovider setting that is primarily engaged in furnishing patient care”
 - Hotels and convention centers? Not OK.
 - **Dental and medical schools? Not OK.**
 - CMS’s position: medical and dental schools are primarily engaged in education, not patient care
 - **Dental and medical school clinics? OK!**
 - CMS was persuaded by ADEA’s argument that dental and medical school clinics are primarily engaged in furnishing patient care (CY 2011 Hospital OPPS Final Rule)

CMS rule on research time

- In a hospital setting, research that is “not associated with treatment or diagnosis of a particular patient” can be counted for DGME only
- In a nonprovider setting, however:
 - Such “bench research” activities cannot be counted at all
 - Only patient-specific “research” that is focused on establishing a diagnosis or furnishing therapeutic services for a particular patient can be counted

What resident time counts for Medicare DGME and IME payments?

	Hospital		Nonhospital Clinical Site	
Time	DGME	IME	DGME	IME
Patient Care	Yes	Yes	Yes	Yes
Vacation/Sick	Yes	Yes	Yes	Yes
Didactic	Yes	Yes	Yes	No
Research	Yes	No	No	No

Foreign dental graduates

- Graduates of foreign dental schools that are not accredited by CODA cannot be counted for DGME purposes
 - Why? Because the DGME section of the statute requires that graduates pass the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), and there is no dental equivalent of this exam
 - Graduates of Canadian and Puerto Rican dental schools are not considered foreign
- Graduates of foreign dental schools may be counted fully for IME purposes

Appeals process

What if a hospital disagrees with the amount of Medicare GME reimbursement?

- File appeal with the Provider Reimbursement Review Board (PRRB)
 - Administrator may overturn PRRB decision
 - Provider may then take case to Federal District Court
 - Process can take years
- Accelerated appeal process under special Board rules for CHGME appeals (need to be decided before end of federal fiscal year, based on annual appropriation process)

GME funding data and key stakeholders within hospital

Where to find Medicare GME funding data?

- Sunshine Act list of teaching hospitals (tells you which hospitals have reported resident FTEs on their Medicare cost reports): <https://www.cms.gov/OpenPayments/Downloads/2016-Reporting-Cycle-Teaching-Hospital-List-%5bSeptember-2015%5d.pdf>
- No official website
 - Can order individual hospital cost reports from www.costreportdata.com
 - GME: Worksheets E Part A and E-4
- Graham Center is only public source of aggregated data (somewhat out-of-date but better than nothing): www.graham-center.org

Graduate Medical Education for teaching hospitals in FY2013 (reported FY14)

Hospital Name	DME \$	IME \$	GME \$	Primary Care FTE#	Not-Primary Care FTE #	Primary Care Per Resident Amount \$	# of Beds
ST. LUKE'S Bethlehem	8,267,895	14,808,406	23,076,300	65.5	79.1	111,501	479
TEMPLE UNIVERSITY HOSPITAL	13,613,494	27,830,520	41,444,016	122.5	211.0	116,322	576

<http://www.graham-center.org/rgc/maps-data-tools/data-tables/gme.html>

Key stakeholders within hospital

- Designated Institutional Official (DIO) and GME Office
 - Needs to communicate with reimbursement all relevant details re: residents, including location and duration of rotations, IRP for each individual, accreditation information about each program, etc.
- Chief Financial Officer (CFO) and Reimbursement Manager
 - Upon receiving resident data from DIO and GME Office, must input submit Intern and Resident Information System (IRIS) report to CMS and complete Medicare Hospital Cost Report (HCR) on annual basis

CHGME Highlights

A few notes on CHGME funding

- Impetus: Medicare share is small in freestanding children's hospitals, so IPPS DGME/IME payment mechanism didn't work
- Most funding rules mimic Medicare rules
- Not mandatory funding, like Medicare; instead, uses appropriated funds and requires reauthorization every few years
- Formula-based allocation
- Contributes to support of 5,000+ resident FTEs
- Appeals process is accelerated to ensure decision before end of fiscal year

Hospital eligibility criteria for CHGME funding

Hospital must:

- Participate in an approved GME program
- Have a Medicare Provider Agreement
- Be excluded from the Medicare IPPS under section 1886(d)(1)(B)(iii) of the Social Security Act and its accompanying regulations
- Be a "freestanding" hospital

Other funding opportunities

Teaching Health Centers (THC) GME Program

- HRSA-administered grant program under the Public Health Service Act, established under Affordable Care Act (§ 5508)
 - Provides per-resident payments to “teaching health centers” (THCs) that establish and/or expand primary care residency training programs, including programs in general and pediatric dentistry
 - THCs are community-based, ambulatory patient care centers—including, e.g., FQHCs and RHCs—that operate a primary care residency program
- Initially funded at \$230M over 5 years (FYs 2011 - 2015)
- In April 2015, Congress (through MACRA) extended funding through FY2017 (\$60M for FY 2016 and \$60M for FY 2017)
- But no grant competition is planned for FYs 2016 or 2017
- Funding scheduled to end September 30, 2017

Examples of other potential grants

- **Predoctoral Training in General Dentistry, Pediatric Dentistry, and Dental Public Health and Dental Hygiene**—Funds the planning, development, operation of, and participation in approved professional training programs in general, pediatric, or public health dentistry and dental hygiene.
- **Postdoctoral Training in General, Pediatric and Public Health Dentistry**—Funds the planning, development, operation of, and participation in approved professional training programs in general, pediatric, or public health dentistry for dental residents, practicing dentists, or other approved primary care dental trainees.
- **Faculty Development in General, Pediatric, and Public Health Dentistry and Dental Hygiene**—Funds the planning, operation of, and development in programs for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry or dental hygiene.

SOURCE: <http://bhpr.hrsa.gov/grants/dentistry/index.html>

Policy trends & recent developments

GME funding perennially on the chopping block

- MedPAC June 2010 Report to Congress
 - Recommended cutting IME by \$3.5B + adding accountability
- National Commission on Fiscal Responsibility and Reform—“Simpson-Bowles” Plan (Dec. 2010)
 - Recommended cutting IME by 60% and capping DGME payments at 120% of national average resident salary
- Joint Select Committee on Deficit Reduction (“supercommittee”) proposed GME budget cuts of 50 percent
- President's Budget Request routinely calls for cut in IME and CHGME
- July 2014 IOM Report
 - Would effectively cut total GME payments for existing residency slots by 35% by Year 5
 - Payments would go directly to program sponsors; no link to Medicare
- Medicare IME Pool Act of 2015
 - Would convert IME payments from a percentage add-on to hospitals' inpatient MS-DRG payments to a block grant

Bills to increase GME funding perennially introduced by Congress

- Resident Physician Shortage Reduction Act
 - Would increase funded resident positions by 15%—adding 3,000 new slots/year between 2017 and 2021 for a total of 15,000 new slots
 - Similar legislation introduced in 2011 (by the Senate), in 2012 (by the House), in 2013 (by both chambers), and in 2015 (by both chambers), but never emerged from Committee
- Creating Access to Residency Education Act
 - Would require CMS to award grants or enter into contracts with “eligible entities” to create or expand medical residency training programs in states where there are fewer than 25 medical residents per 100,000 people
- Building a Healthcare Workforce of the Future Act
 - Would require HHS to award matching grants to enable states to implement scholarship programs to ensure an adequate supply of health professionals

Comprehensive Dental Reform Act of 2015

- 114th Congress, Bill Nos. HR1055 and S570
- Would authorize appropriations to expand the Teaching Health Centers program to expand opportunities for community based dental residencies
- Would establish, revise, and extend funding for grant programs for, among other things, providing scholarships and education loans for oral health professional students
- Has been referred to committee; very few sponsors

Upshot: Congressional climate

- A year of uncertainty
- High price tag is a major sticking-point!
- GME as infrastructure?
- Some in Congress believe medical education is a responsibility that is shared with States and that the bill should be allocated accordingly
- There is interest in addressing workforce shortage realities, but proposals must be both creative and limited in scope
- Not much chance of total overhaul of GME funding mechanisms, which would invite too many "food fights"
- But Congressional committees with appropriate jurisdiction have indicated that they intend to consider improvements to GME...

Any upcoming GME regulatory changes?

Upcoming regulatory changes?

- GME-related policy changes typically issued in inpatient prospective payment system (IPPS) annual proposed rule
 - Timing?
 - Proposed Rule = later part of April
 - Final Rule = by August 1
- Topic we might see?
 - CMS does not discuss until published, so really crystal-ball gazing
 - Section 5506 slots from closed hospitals?
 - Any regulatory references to the Single Accreditation System or attempt to address questions arising because of the move to the new system?

Questions

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