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Centers for Medicare and Medicaid Services Issues Proposed Changes to Medicare Graduate Medical Education Payments

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On July 2, 2010, the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) released the proposed changes to the Medicare Outpatient Hospital Prospective Payment System (OPPS) for Calendar Year (CY) 2011. Included in these proposed regulations are several proposed changes to Medicare Graduate Medical Education (GME) payments related to provisions of the Patient Protection and Affordable Care Act (ACA). These proposed changes address treatment of time spent by residents training in nonhospital settings, time spent undertaking didactic and scholarly activities, implementation of reductions and increases in GME residency caps, and reallocation of residency slots associated with closed hospitals.

Although many of the proposed changes directly reflect the language of the ACA, CMS has used its discretionary authority to propose some changes that are outside of changes mandated by ACA. Hospitals with existing GME programs, those that are contemplating new or expanded GME programs in the future, and those considering "closure" (including acquisitions of teaching hospitals without assignment of the provider number) should carefully review the proposed regulations to evaluate the effect of the proposed changes on the calculation of full-time equivalent (FTE) resident counts, potential reductions in GME cap and opportunities to increase the cap. Such hospitals may wish to submit comments to CMS regarding the proposed rules. CMS is accepting comments until August 31, 2010.

I. Counting Resident Time in Nonhospital Settings

Prior to the passage of the ACA, hospitals were permitted to count resident time spent training in nonhospital settings in those cases where the hospital incurred at least 90 percent of the costs of training at the nonhospital sites, including resident salary, benefits and teaching supervisory costs. Effective for direct GME (DGME) payments associated with cost reporting periods beginning on or after July 1, 2010, and for indirect GME (IME) payments associated with discharges occurring on or after July 1, 2010, Section 5504 of the ACA revised the statutory requirements for counting resident time in nonhospital settings to allow hospitals to count the time so long as the hospital incurs 100 percent of the cost of the residents' salaries and benefits during the time spent at the nonhospital site. In addition, the ACA permits more than one hospital to count a proportional share of the training time spent by residents at a nonhospital site if multiple hospitals incur the residency training costs at the nonhospital site. These provisions of the ACA are to be implemented in a manner that does not require the reopening of settled cost reports except where the hospital has a jurisdictionally proper appeal pending on the issue of DGME or IME payments as of March 23, 2010 (the date of enactment of the ACA).

Consistent with the ACA provisions, CMS proposes to permit hospitals to count resident training time in nonhospital settings for both DGME and IME purposes when the hospitals incur the costs of the salaries and fringe benefits of the resident during the time spent at the nonhospital site and to allow more than one hospital to count resident time spent in nonhospital settings if more than one hospital incurs the resident salary and benefits. The proposed rule would also permit allocation of resident training time if the costs of training at the nonhospital site were funded indirectly through a third party, such as a medical or dental school, on behalf of the hospitals. CMS is proposing to require that resident time allocated among multiple hospitals be divided based on a "reasonable basis," that the hospitals record the proportion of resident time spent training at the nonhospital site that will be counted by each hospital for purposes of DGME and IME payments, and that the hospitals be able to document the amount they are paying collectively for the resident training. CMS proposes that the basis of allocation and proportion of resident time spent at the nonhospital site to be counted by each hospital must be contained in a written agreement between the hospitals.

II. Resident Time for Didactic and Scholarly Activities and Approved Leave Time

Historically, hospitals could not count time spent by residents in didactic and scholarly activities outside of the hospital complex for purposes of calculating the FTE resident count, for DGME purposes, and could not count time spent on any didactic or scholarly activities, for purposes of IME payments, regardless of the setting. Effective for cost reporting periods beginning on or after July 1, 2009, Section 5505 of the ACA permits hospitals to count time spent by residents engaged in didactic and scholarly activities at nonhospital settings, for DGME purposes, so long as the nonhospital setting is "primarily engaged in furnishing patient care." Similarly, for cost reporting periods beginning on or after January 1, 1983, the ACA permits hospitals to count time spent on didactic and scholarly activities, excluding research not associated with the treatment or diagnosis of a particular patient, at hospitals paid under the inpatient prospective payment system (IPPS), hospitals in Maryland, or provider-based hospital outpatient departments, for IME purposes. This section of the ACA also addresses treatment of time spent by residents on vacation, sick leave or other approved leave time. Effective for cost reporting periods beginning on or after January 1, 1983, the statute now permits hospitals to count such time for both DGME and IME purposes as long as the leave does not prolong the total

time the resident participates in the approved residency program. As with the changes applicable to counting resident training time at nonhospital settings, the section 5505 ACA changes are not to be applied in a manner that would require reopening of settled cost reports not pending appeal prior to March 23, 2010.

CMS proposes to adopt regulations implementing these provisions that will provide additional clarification of terms used in the statutory provisions. CMS proposes to define a nonhospital setting "primarily engaged in furnishing patient care" using the existing definition of "patient care activities." Under this definition, didactic and scholarly activities would need to take place at a setting primarily used for "the care and treatment of particular patients, including services for which a patient or other practitioner may bill, and orientation activities." Examples of such locations provided in the preamble text are doctors' offices and community health clinics. Medical schools, dental schools, hotels and conference centers would not fall within the proposed definition.

CMS also provides additional guidance to assist hospitals in distinguishing between those research activities that may be used for resident FTE calculations and those that may not. CMS explains that "research not associated with the treatment or diagnosis of a particular patient" includes research focused on developing new medical treatments, evaluating medical treatments, or elaborating on knowledge that will contribute to development and evaluation of new medical treatments in the future.

For purposes of implementing the provisions regarding counting of approved leave time, CMS proposes to allow only the hospital to which the resident was assigned during the time the leave is taken to count that time for FTE purposes. If the rotation schedule does not clearly indicate where the resident was assigned, CMS proposes that the time be divided among the hospitals based on the proportion of time spent in actual training at the respective hospitals. CMS also proposes a definition of "other approved leave" beyond vacation and sick leave that would include leave "that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program."

III. Reductions and Increase to FTE Resident Caps

Similar to section 422 of the Medicare Modernization Act, section 5503 of the ACA creates a scheme under which CMS is to redistribute unused residency slots. Unlike section 422, section 5503 provides for DGME and IME (as applicable) payments to hospitals for reallocated slots to be made at the full GME payment rates, rather than the reduced rates applicable to slots reallocated under section 422. Section 5503 requires that CMS identify those hospitals that are currently training fewer residents than their DGME or IME FTE resident cap, reduce the cap for these hospitals by 65 percent of the difference between the number of residents trained (the "reference resident level") and the FTE cap (the "otherwise applicable resident limit") and reallocate those residency slots to hospitals that can demonstrate the likelihood of filling the additional positions within the first three cost reporting periods beginning on or after July 1, 2011, and/or have an accredited rural training track program. Seventy percent of the slots are to be allocated to hospitals in states with resident-to-population ratios in the lowest quartile and 30 percent are to be allocated to hospitals among the top 10 states, territories or districts based on the ratio of total population living in a primary care health professional shortage area (HPSA) to total population and to hospitals located in rural areas. The maximum number of slots that any hospital may receive is 75. Rural hospitals with fewer than 250 acute care beds, hospitals participating in a voluntary residency program reduction demonstration project and the replacement hospital for King Hospital in Los Angeles are excluded from the residency slot reductions.

CMS has proposed to implement the section 5503 reallocation in a manner similar to the MMA section 422 reallocation, with some significant differences. As required by the ACA, CMS proposes to define the "reference resident level" as the resident level for the one cost reporting period out of the most recent three cost reporting periods ending before March 23, 2010, with the highest resident level. CMS proposes to calculate the "otherwise applicable resident limit" based on the hospital's 1996 resident cap, adjusted for new residency programs established since that date, participation in a Medicare GME affiliation agreement, participation in an Emergency Medicare GME affiliation agreement, participation in a hospital merger, whether an urban hospital has a separately accredited rural training track, and whether the hospital has additional residency slots allocated under section 422.

Section 5503 does not include language specifically addressing treatment of hospitals participating in affiliation agreements. For hospitals participating in an affiliation agreement, CMS proposes to apply the hospital's FTE cap, as adjusted by the affiliation agreement, regardless of whether the affiliated group as a whole is training above the aggregate FTE cap. Hospitals that merged on or after March 23, 2010, but were not merged in any or all of their three most recent cost reports, will be treated as if they were merged during those periods for purposes of determining the applicable resident limit. CMS proposes that hospitals that had their

FTE cap increased under section 422 will not have the additional slots attributed to section 422 counted for purposes of determining the applicable resident limit. CMS believes this is appropriate because many of the programs that received these additional slots may not have had sufficient time to fill their new slots. Correspondingly, CMS proposes to permit hospitals that received section 422 slots and later receive section 5503 slots to determine if their total resident FTE count exceeds the combined total of 1996 FTE and section 5503 slots before requiring that any additional FTE residents be subject to the section 422 payment rates.

In order to determine those programs that will receive the reallocated slots, CMS proposes to establish an application process under which interested hospitals would be required to complete a form application (a proposed version of the application form is provided in the proposed rule) on which they would indicate those statutory requirements that make them eligible for the additional slots. These application forms would be due to CMS by December 1, 2010.

The primary factor CMS proposes to consider in redistributing the slots is the hospital's demonstrated likelihood of filling the slots within three cost reporting periods. CMS would require that hospitals meet at least one of three criteria proposed by CMS, as well as additional sub-criteria and documentation requirements, in order to be considered for the additional slots. A summary of the criteria proposed by CMS is provided as Appendix A.

For those hospitals that are able to demonstrate likelihood of filling additional slots based on the proposed criteria, the applications will next be evaluated based on the required distribution categories (70 percent to low resident-to-population ratio, and the remaining 30 percent to high primary care HPSA to population ratio and rural hospitals) established by the ACA. CMS proposes to implement these distribution requirements through five "priority categories" made up of various combinations of these required categories plus urban hospitals with accredited rural training tracks. A list of the proposed priority categories is provided as Appendix B.

CMS also proposes a methodology for identifying those states in the lowest quartile for resident-to-population ratio and top 10 for Primary Care HPSA to population ratio. Under the proposed method, Montana, Idaho, Alaska, Wyoming, Nevada, South Dakota, North Dakota, Mississippi, Florida, Puerto Rico, Indiana, Arizona and Georgia are listed as the states in the lowest quartile for resident-to-population ratio and Louisiana, Mississippi, Puerto Rico, New Mexico, South Dakota, District of Columbia, Montana, North Dakota, Wyoming and Alabama are the top 10 states for Primary Care HPSA to population ratio. Although the statute explicitly references that only states are to be evaluated for resident-to-population ratio, while states, territories and districts are to be considered for Primary Care HPSA to population ratio, CMS has proposed to include territories and districts in the rankings of resident-to-population ratio. As a result, Puerto Rico receives priority status. Were Puerto Rico not included, hospitals in Oregon would be eligible for redistributed slots.

Although the statute includes both demonstrated likelihood of filling the slots and urban hospitals with accredited rural training tracks as factors the Secretary "shall take into account" in the redistribution process, CMS does not treat these factors equally in the proposed redistribution process. While demonstrated likelihood for filling the slots is a threshold requirement for further consideration of receipt of additional slots, CMS places hospitals with an accredited rural training track in a preferential position, but below some other hospitals that meet other criteria but do not have such programs.

Because CMS anticipates that there will be significant demand for a limited number of slots, CMS has proposed additional evaluation criteria, with varying points assigned to each criterion, to be applied to allocate slots among hospitals that fall within each of the priority categories. Hospitals will be ranked based on their score within each priority category to allocate the available slots. These evaluation criteria are not based on any statutory provision. A list of the proposed evaluation criteria is provided as Appendix C.

CMS proposes to require hospitals to submit a separate application form for each program for which it is requesting additional slots and to demonstrate the likelihood of filling the slots for each program. However, once allocated to the hospital, the slots will not be program-specific and the additional FTEs would be applied generally to the hospital's FTE counts. Although CMS would permit the slots to be used for the general FTE cap, CMS proposes to prohibit hospitals from allocating any redistributed slots to other hospitals through affiliation agreements. CMS believes that permitting hospitals to do so would undermine the intent of the redistribution program to increase residency caps at only those facilities that meet the statutory criteria and have a demonstrated need for the additional slots.

While section 422 did not impose any requirements on hospitals to demonstrate that they actually filled the reallocated slots, section 5503 requires that for the five-year period beginning with the date on which the hospitals are allocated the additional slots,

the hospitals must demonstrate that they have increased or maintained their number of primary care resident FTEs and that at least 75 percent of the reallocated slots awarded to the hospitals are used in a primary care or general surgery residency program. The statute defines "primary care residents" as residents in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice. CMS would use the unweighted FTE residents in these programs, as reflected in the Medicare cost report, for purposes of the calculation. However, for DGME purposes, because the cost report includes ob/gyn residents within primary care, hospitals would be required to subtract such residents from their calculations. For IME purposes, the cost report does not permit calculation of primary care residents only. Therefore, hospitals would be required to develop IME counts to correspond to the appropriate cost reporting years based on rotation schedules. The statute leaves it to the Secretary to determine how the 75 percent primary care and general surgery increase will be evaluated over the five-year period following the award of any additional slots. CMS proposes to require that this 75 percent requirement be met in each of the five years, rather than looking at the entire five-year period in the aggregate. Because the GME funds paid to hospitals that do not meet these requirements are to be recouped by CMS, applying the 75 percent requirement on a yearly basis will permit yearly recoupments. CMS believes that yearly recoupment will be less financially and administratively disruptive to hospitals than one adjustment at the end of the five-year period. Although hospitals that do not meet the required primary care and general surgery training requirements would be subject to yearly financial adjustment, CMS would not reduce the FTE cap for non-compliant hospitals until the end of the five-year period.

IV. Preservation of Resident Cap Positions for Closed Hospitals

Section 5506 of the ACA instructs the Secretary to develop a process to permanently increase FTE residents caps of certain hospitals by reallocating residency slots associated with teaching hospitals that close. Section 5506 requires that the process apply to hospitals closed two years prior to the enactment of the ACA and to all future hospital closures.

CMS proposes to define "closed hospital" as a hospital that terminates its Medicare provider agreement and for which none of the FTE resident cap slots associated with the closed hospital exist as part of any other hospital's FTE resident cap. CMS explains that the proposed definition would exclude hospitals that have declared bankruptcy but are participating under the same Medicare provider agreement, hospitals that remain open but close a residency program, or hospitals that merge. Importantly, the definition would include hospitals that have their Medicare provider agreement retired in association with the sale of the hospital. In addition, CMS would not permit hospitals receiving the reallocated slots to allocate them to other hospitals through a GME affiliation agreement. Thus, for example, in a hospital acquisition structured as an asset deal without assignment of the provider number, any transferred slots would be ineligible to be transferred through affiliation agreements, even to other hospitals acquired as part of that transaction.

CMS proposes to use an application process for reallocating the slots that is similar to the process used for the section 5503 reallocation. A copy of the proposed reallocation application is provided in the proposed rule. As required by section 5506, CMS proposes to first evaluate applicants for the slots based on their demonstrated likelihood of filling the slots within three years. CMS proposes to measure the three years as the first three academic years following the application deadline for the slots. Hospitals would be required to demonstrate such a likelihood based on criteria that are very similar, although not identical, to those required under section 5503. A list of the proposed requirements is provided as Appendix D.

Similar to section 5503, for those hospitals that are able to demonstrate a likelihood of filling the slots, CMS proposes to allocate the slots based on the following priority order, with preference within each category given to hospitals that are members of the same affiliated group:

i) Hospitals located in the same CBSA as, or in a CBSA contiguous to, the hospital that closed. CMS proposes to use the CBSA in which the hospital is physically located, without regard to any reclassifications that may have occurred for payment purposes.

ii) Hospitals located in the same state as the closed hospital.

iii) Hospitals located in the same region as the hospital that closed.

iv) If the slots have not yet been fully distributed, to qualifying hospitals in accordance with the criteria established under section 5503.

As with section 5503, CMS proposes additional ranking criteria to create an objective process for allocation of slots within each priority category. Hospitals that assume the programs of the closed hospital and that operate the programs as they had been

operated before the closure (*i.e.,* same residents and program director and substantially similar faculty) would receive first priority. The proposed ranking criteria are listed as Appendix E.

Appendix A

PROPOSED CRITERIA TO DEMONSTRATE LIKELIHOOD OF FILLING NEW RESIDENCY SLOTS

(1) Hospital does not have sufficient room under its current FTE cap for a new residency program that it intends to establish on or after July 1, 2011. Hospital must select one of the following:

(a) Hospital will establish a newly approved residency program. Hospital must provide one of the following pieces of documentation:

(i) Application for approval of the new residency program has been submitted to the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), or the American Board of Medical Specialties (ABMS) by December 1, 2010.

(ii) Hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program by December 1, 2010.

(iii) Hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the new program, or other type of communication from the accrediting bodies concerning the new program approval process.

(b) Hospital will likely fill the slots requested. Hospital must provide one of the following pieces of documentation:

(i) Hospital does not have sufficient room under its FTE cap, and the hospital's existing residency program had a combined resident fill rate of at least 85 percent in each of program years 2007-2009.

(ii) Hospital does not have sufficient room under its FTE cap, and the specialty program for which the hospital is applying has a resident fill rate either nationally, within the state, or within the Core Based Statistical Area (CBSA) in which the hospital is located, of at least 85 percent.

(2) Hospital does not have sufficient room under its FTE cap, and the hospital intends to use the additional FTEs to expand an existing residency training program within the hospital's first three cost reporting periods beginning on or after July 1, 2011. Hospital must select one of the following:

(a) Hospital intends to expand an existing program. Hospital must provide one of the following pieces of documentation:

(i) Appropriate accrediting body has approved the hospital's expansion of the number of FTE residents in the program.

(ii) AOA Residency Match Program has accepted or will be accepting the hospital's participation in the match for the existing program that will include additional resident slots in that residency training program.

(iii) Hospital has submitted an institutional review document or program information form for the expansion of the existing residency training program by December 1, 2010.

(b) Hospital will likely fill the slots of the expanded existing residency program. Hospital must provide one of the following pieces of documentation:

(i) Hospital does not have sufficient room under its FTE cap, and the hospital has other previously established residency programs, with a resident fill rate of at least 85 percent in each of program years 2007-2009.

(ii) Hospital does not have sufficient room under its FTE cap, and the hospital is expanding an existing program in a particular specialty with a resident fill rate either nationally, within the state or within the CBSA in which the hospital is located, of at least 85 percent.

(3) Hospital is applying for an increase in its FTE residency cap because the hospital is already training residents in an existing residency training program or programs in excess of its direct DGME FTE cap or IME FTE cap, or both. Hospital must provide all of the following pieces of documentation:

(a) Copies of Medicare cost reports that have been most recently submitted to Medicare by July 1, 2010, documenting FTE resident counts and caps.

(b) Copies of the 2010 resident match information concerning the number of residents at the hospital in its existing programs.

(c) Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for DGME and IME.

Appendix B

PROPOSED PRIORITY CATEGORIES

(1) First Level Priority Category: The hospital is in a state whose resident-to-population ratio is within the lowest quartile, AND the hospital is in a state whose Primary Care HPSA to population ratio is in the top 10 states, AND the hospital is located in a rural area.

(2) Second Level Priority Category: The hospital is in a state whose resident-to-population ratio is within the lowest quartile, AND is either in a state whose Primary Care HPSA to population ratio is in the top 10 states, or it is located in a rural area, or is an urban hospital and has or will have as of July 1, 2010, a rural training track.

(3) Third Level Priority Category: The hospital is in a state whose resident-to-population ratio is within the lowest quartile.

(4) Fourth Level Priority Category: The hospital is in a state whose Primary Care HPSA to population ratio is in the top 10 states, AND either the hospital is located in a rural area or the hospital is an urban hospital and has, or will have as of July 1, 2010, a rural training track.

(5) Fifth Level Priority Category: The hospital is in a state whose Primary Care HPSA to population ratio is in the top 10 states, or the hospital is located in a rural area.

Appendix C

PROPOSED EVALUATION CRITERIA

(1) Evaluation Criterion One. The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report. (5 Points).

(2) Evaluation Criterion Two. The hospital will use the additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program. (5 Points).

(3) Evaluation Criterion Three. The hospital will use additional slots to establish a new or expand an existing primary care program with a demonstrated focus on training residents to pursue careers in primary care, rather than in nonprimary subspecialties of those primary care programs (for example, the hospital has an internal medicine program with a designated primary care track). (3 Points).

(4) Evaluation Criterion Four. The hospital will use all the additional slots to establish a new or expand an existing primary care residency program or general surgery program. (5 Points).

(5) Evaluation Criterion Five. The hospital is located in a Primary Care HPSA. (2 Points.)

(6) Evaluation Criterion Six. The hospital is in a rural area and is or will be on or after July 1, 2011, a training site for a rural track residency program, but is unable to count all of the FTE residents training in the rural track because the rural hospital's FTE cap is lower than its unweighted count of allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011. (1 Point).

Appendix D

PROPOSED CRITERIA TO DEMONSTRATE LIKELIHOOD OF FILLING RESIDENCY SLOTS ASSOCIATED WITH CLOSED HOSPITALS

(1) Hospital will establish this newly approved residency program or will expand an existing residency program. Hospital must provide documentation of one of the following:

(a) Application for approval of the new residency program has been submitted to the ACGME, AOA or the ABMS.

(b) Hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program.

(c) Hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the new or expanded program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit).

(2) Hospital does not have sufficient room under its DGME FTE cap or IME FTE cap, or both, and has or is seeking approval from the relevant accrediting body to take over the closed hospital's residency program(s), or expand its own residency program(s) to reflect a permanent commitment to train additional residents. Hospital must provide documentation of one of the following:

(a) Application for approval of the residency program has been submitted to the ACGME, AOA or the ABMS.

(b) Hospital has submitted an institutional review document or program information form concerning the program in an application for approval of the program.

(c) Hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the program, or other types of communication from the accrediting bodies concerning the program approval process (such as notification of site visit).

(3) Hospital will likely fill the slots requested, as demonstrated by the fact that the hospital does not have sufficient room under its DGME FTE cap or IME FTE cap, or both. Copies of EACH of the following must be attached:

(a) Copies of the Medicare cost reports that have been most recently submitted to Medicare demonstrating resident counts and FTE resident caps for both DGME and IME for the relevant cost reporting periods.

(b) Copies of the most recent residency match information concerning the number of residents at the hospital in its existing programs.

(c) Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

(4) Applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. Copies of EACH of the following must be attached:

(a) Copies of the most recent Medicare GME affiliation agreement of which the applying hospital and the closed hospital were members before the hospital closed.

(b) Copies of the Medicare cost reports that have been most recently submitted to Medicare documenting resident counts and FTE resident caps for both DGME and IME for the relevant cost reporting periods.

(c) Copies of the most recent accreditation letters for all of the hospital's training programs in which the hospital had a shared rotational arrangement.

Appendix E

PROPOSED RANKING CRITERIA FOR REDISTRIBUTION OF RESIDENCY SLOTS ASSOCIATED WITH CLOSED HOSPITALS

(1) Ranking Criterion One. The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as operated by the hospital that closed (that is, same residents, same program director and same (or many of the same) teaching staff).

(2) Ranking Criterion Two. The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement.

(3) Ranking Criterion Three. The applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training (that is, the applying hospital is permanently expanding its own existing programs).

(4) Ranking Criterion Four. The applying hospital does not fit into Ranking Criteria One, Two or Three, and will use additional slots to establish a new or expand an existing geriatrics residency program.

(5) Ranking Criterion Five. The applying hospital does not fit into Ranking Criteria One, Two or Three, is located in a Primary Care HPSA, and will use all the additional slots to establish a new or expand an existing primary care residency program.

(6) Ranking Criterion Six. The applying hospital does not fit into Ranking Criteria One, Two or Three, and will use all the additional slots to establish a new or expand an existing primary care residency program.

(7) Ranking Criterion Seven. The applying hospital does not fit into Ranking Criteria One, Two or Three, and will use all the additional slots to establish a new or expand an existing general surgery residency program.

(8) Ranking Criterion Eight. The applying hospital does not fit into Ranking Criteria One through Seven.

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