

2023 RESIDENCY TOWNHALL Q & A

CMS

Q. CMS audit – direct control – audit indicated not eligible for pass-through funding due to having faculty involved in the program. Showed all policies and branding and paying 33% of salary. CMS said that the requirement is that faculty need to have W2 forms to demonstrate where pay is coming from. Do you have any guidance?

CMS – resident travel to another site raises red flags and questions from auditors. Can ASHP follow up on this?

ASHP continues to advocate for transparency around guidelines for residency audits. A toolkit designed to assist sites with audits will be released by ASHP in 2024. It will contain compliance tips, FAQs, communications with CMS, and a revised compliance webinar. If you have received notification of an audit please contact Jillanne Schulte Wall at jschulte@ashp.org for assistance. Please see “Tips Document” at the end of Q&A.

PharmAcademic

Q. Can you do an “other section” in the learning experience sections?

Presently, there is not an “other” section in the learning experience description. This will be taken under consideration at an upcoming advisory group meeting. There is a concern that information required to be in identified sections within the LED would be placed in the “other” section.

Q. Can there be PharmAcademic updates pushed out?

PharmAcademic sends out a communication to all RPDs and Designees when any new functionality is released, for surveys (available and reminders), and a general “what’s new” at the beginning and end of each residency year. Updates are also published in Communique biannually.

Q. Educational process in PharmAcademic – midpoint may be the most valuable feedback for our learners. Summative evaluations celebrate the successes of our residents. What would be helpful is a “copy forward” editable midpoint evaluation?

Per the current Standards, summative evaluations are scheduled every 12 weeks. They are evenly spaced depending based on the duration of rotations > 12 weeks. Programs/RPD/Preceptors can also schedule custom evaluations at any time during a rotation at their discretion. The advisory group will discuss “copy forward” suggestion at an upcoming meeting.

Annual Survey

Q. Can the annual survey come out earlier to enable better coordination among multiple programs at a site?

We will be assessing the timing and content of the annual survey in 2024.

Q. Can ASHP look more closely at PGY2 graduates getting jobs in the area they are trained?

ASHP will be looking into trends associated with residency completion and job placement.

Q. Publications and board certification – advice to have an extended timeline at the annual survey questions being asked (e.g., capture resident graduates over the past few years).

ASHP will be reviewing the questions being asked to ensure timing is considered for publications.

Q. Publication – maybe ask “did resident submit manuscript for publication in annual survey?”

ASHP will be reviewing the questions being asked to ensure timing is considered for publications.

Q. Reasons why residents are leaving programs – would it be helpful to know what the specific “personal” reasons are while protecting privacy of individuals?

ASHP will be reviewing abilities to obtain more information on residents not completing programs.

Q. Residents withdraw for personal reasons – should we drill down to what the personal reasons are? Pharmacy School “Reddit” – how are programs treating their residents. Are the residents employees or trainees?

ASHP will be reviewing abilities to obtain more information on residents not completing programs.

CAGOs

Q. CAGOs – changes released in early February – what do programs tell candidates interviewing for positions?

A draft of CAGOs are [here](#). Final Board approved CAGOs will be posted in February 2024.

Q. Elective CAGOs – what is the future of PGY1 elective CAGOs?

Currently being reviewed by Commission on Credentialing subcommittees. More information to follow in first quarter of 2024.

Q. PGY1 CAGOs – can PharmAcademic help programs to lessen the workload of preceptors updating CAGOs in 2024 (considering those who just updated rotation descriptions in 2023)?

There is a help center that will be uploaded in January to learn how to copy/edit/paste new PGY1 CAGOs.

Q. CAGOs – Can you address concern with deadline of July 2024 that is adding a lot of work for preceptors/RPDs.

The Commission understands the work that needs to be done to complete this task. The draft CAGOs are currently posted on ASHP website and PharmAcademic has provided tools to assist with the administrative burden.

Colleges of Pharmacy

Q. Decreasing enrollments – has there been a discussion of how much expansion we can afford moving forward if we continue to see this downward trend?

The Accreditation Services Office will be looking at dates to assist programs in the decision-making process of expanding programs/positions.

Q. Financial burden on students – what is ASHP doing to create equity among students for equity in pursuing residency training?

ASHP hosted a virtual residency showcase the week after the MCM. Any student was able to participate regardless of MCM registration. Program participation is limited to those that participated in the live MCM Residency Showcase. Every effort is made to minimize costs and pass on to applicants only those costs associated with administering the application and Match process.

Q. Consideration for moving residency start dates back a month?

Moving start dates for residency would add to the financial student burden and would not align with current graduation dates, national matching service dates (including the couples match with other disciplines), and currently scheduled national meetings

Q. Can there be a discussion about a standardized start date for residency programs (i.e., September)? Can we solicit interest in this?

While there may be interest in residency sites pursuing this option, moving start dates for residency would add to the financial student burden and would not align with current graduation dates, national matching service dates, and currently scheduled national meetings.

Q. Is ASHP monitoring the tuition that pharmacy students are paying across the country as this may be another reason that residency interest is declining?

ASHP is aware however we do not intervene in college tuition costs.

Licensing

Q. Licensing – brainstorm a prescribed path with residents who are not licensed within 120 days?

This topic will be discussed at the March 2024 Commission on Credentialing meeting.

Q. Resident failing MPJE – can ASHP work with NABP to make a standard law exam across the country or eliminate it all together?

ASHP will continue to partner with pharmacy organizations and NABP on the future of the MPJE.

Recruitment

Q. Recruitment – virtual vs. non-virtual recruitment and interviews – American Medical Association has provided guidance for recruitment – is ASHP considering publishing guidance for programs?

ASHP will defer to individual programs to make recruitment decisions.

Q. Virtual showcases – is there a centralized place (by state or region) that programs can put information about virtual open houses?

Not at this time.

Q. DEI – cost of applying – can anything be done addressing the cost of phase I and phase II since those fees are required?

Every effort is made to minimize costs and pass on to applicants only those costs associated with administering the application and Match process.

Early Commitment

Q. Should there be guidance on how often a program can early commit?

This will be the first year of the expansion for early commitment within health systems. We will be reviewing the use of this and will discuss at future Commission meeting if needed.

Accreditation of New Programs

Q. Is there an opportunity to prioritize new programs for accreditation approval and notification (e.g., a program will have 3rd residency class under candidate status this year)?

We make every effort to get all programs reviewed within the first year of operation, if you do not hear from a lead surveyor for scheduling of your program for your accreditation survey by March 30th of your candidate class year, please contact Lisa Lifshin at llifshin@ashp.org

Residency Program Directors and RPD Connect

Q. RPD Connect – is there consideration of granting residency coordinators and other administrative personnel access to RPD Connect?

RPD connect group has been opened to all members needing this information.

Q. Can we track the tenure of an RPD?

The Accreditation Services Office will review the potential of gathering this information.

Q. Can we have a focus group for RPDs who are no longer working as they can add value to discussion?

A focus group will be created with a diverse membership to gain insight on the residency process

Development Plan

Q. Development plan on website with only one example. Could we have a positive example for candidates to read to positively influence their decision to pursue residency?

A more positive example will also be added to ASHP's web site in the future. The initial example represents a resident with more challenges than a typical resident to provide RPD's and their designees with multiple examples of possible program changes based on a resident's strengths, opportunities for improvement, career plans, and practice interests as this is an area commonly cited when programs are surveyed.

Letters of Recommendation

Q. How are we making sure that we are getting residents who will succeed in the program that they are matched to. Is there a possibility that important candidate information is now taken away from references that could have impacts?

The PhORCAS focus group will take this under advisement. A review of the changes will be conducted as well as an external survey after current cycle is complete.

Beginning in 2019, the Centers for Medicare & Medicaid Services (CMS) overhauled its audit process for allied health residencies, including postgraduate year 1 (PGY1) programs. Unfortunately, CMS's directive to its auditors has resulted in significant cost disallowances, some over a number of years. Many of these cases involve arbitrary and inconsistent application of cost-reporting requirements as well as substandard and poorly organized audit processes. Based on their own interpretation of the "direct control" requirement (42 C.F.R. §413.85), Medicare Administrative Contractors (MACs) have disallowed costs on the basis of everything from off-site rotations (a staple of residency programs) to the name on a program's diploma or certificate. Pharmacy residency programs in hospitals that are part of larger health systems and those affiliated with schools of pharmacy have been at particular risk of findings regarding a lack of direct control.

ASHP has repeatedly reached out to CMS to request the agency provide PGY1 programs with technical assistance focused on compliance. However, to date, CMS has failed to provide meaningful guidance, so ASHP advocacy continues with federal policymakers. In the interim, ASHP has developed the following list of best practices based on CMS audit findings reported to us by ASHP members. Utilizing these suggestions is not a guarantee that a CMS auditor will consider a program compliant, but they represent our current best understanding of how auditors assess compliance with the direct control requirement. Please note that we have seen wide variation in auditor interpretations, so operationalizing this advice does not guarantee that your program will be considered compliant under CMS audit standards.

PGY1 COMPLIANCE BEST PRACTICES:

I. **Develop and maintain a paper trail documenting direct control of the program.**

Adverse audit findings have largely focused on the "direct control" requirement. Developing a paper trail that demonstrates that the hospital retains full and complete control over all elements of the residency program may help protect against adverse audit findings. This will be particularly beneficial for hospitals that are part of a larger health system, as auditors have raised concerns about health systems, rather than individual hospitals, controlling residency program operations. Specifically, we suggest the following:

- **PGY1 Program Materials:** Ensure that all residency program materials (marketing, agreements, educational materials, residency completion certificates) include only the hospital name, not the health system name.
 - » Auditors have penalized residencies for having marketing materials or completion certificates that include the name of a health system or schools of pharmacy, rather than the sponsoring hospital.
 - » Even in health systems with multiple residencies, we recommend against grouping them under the health system name due to CMS's outsized concern regarding any indication that a health system, rather than a hospital, exercises control over the residency program.
 - » When possible, health system executives' names should not be used on residency completion documents or other materials – reference only those directly employed by the hospital operating the residency program.

- **Rotations:** Rotations can provide a valuable training experience for residents, including by providing exposure to clinical services not available at the sponsoring site. However, the sponsoring hospital must still maintain control of the residency experience, even when the resident is participating in an off-site rotation.
 - » If you opt to have a residency rotation site, even at another site within the same health system, develop a memorandum of understanding or other agreement memorializing the site curricula and documenting that the hospital sponsoring the residency program has *full* control over resident's experience at the rotation site.
 - » Have a hospital-specific Residency Advisory Committee (RAC) that oversees the residency program and develops policies and procedures. Even if other hospitals in your system have residency sites, each site needs its own independent RAC.
 - » Any agreements for the purposes of the residency program, including affiliation agreements, such as those used for rotation sites, should be established directly between individual hospitals, rather than their health systems. This should apply even if the hospitals are part of the same health system.
- **Health System Engagement:** CMS is very focused on situations where a health system versus an individual hospital is controlling a residency program. If the hospital is part of a larger health system, ensure that all documentation related to the program clearly outlines that the hospital retains *sole and full* authority over the program, with no decision-making or involvement of the larger health system.
 - » Some programs have seen success by working with their finance teams to create residency program-specific cost centers and tying all program expenses back to those cost centers. The results of this approach may vary based on auditor familiarity with residency programs and the structure of the residency program itself.
- **Shared Services:** Auditors have raised concerns about shared services between hospitals and their parent health systems. While the regulations specifically allow shared services, the use of the services should be carefully documented, and affiliation agreements with hospital control of the PGY1 program should be clearly outlined.
 - » If your hospital shares payroll services with the health system, document the residency payroll expenses carefully to provide auditors with backup documentation.
 - » This does not mean you shouldn't use shared payroll, just that hours and payroll practice administered by the health system, on behalf of the hospital, should be documented and tracked closely. If your hospital does not directly employ any clinicians (e.g., a separately incorporated but related entity employs everyone), ensure that you have documentation to that effect for your auditors.
- **Pharmacy School Affiliations:** Affiliations with schools of pharmacy can be valuable, but these arrangements can create questions for auditors around program control. CMS is also very focused on whether other community organizations (e.g., pharmacy schools) are providing support that would undermine the need for CMS funding.
 - » Residency preceptors must be employed by the sponsoring hospital, rather than the school of pharmacy.
 - » Any affiliation agreement between a residency program and a school of pharmacy should document that the sponsoring hospital, rather than the school of pharmacy, has *full* control over the resident's training.

II. Plan for how your program will respond to a CMS audit.

Advance preparation for an audit can help protect your program and reduce burden associated with the audit. It is important to note that CMS audit regulations are different from ASHP accreditation standards. While ASHP's standards focus on the clinical aspects of the program, CMS audit standards focus solely on tracking the dollars associated with pass-through funding, without regard for program quality or offerings. To best position your program for a CMS audit, we recommend the following:

- Ensure that documentation for all elements of the residency program clearly delineates the hospital's full and complete control over the residency program operations, curricula, and staffing. Documentation should also clearly indicate that the residency program director maintains authority over the program. Residency programs have encountered challenges when other hospital or health system personnel are engaging in decision-making around, or oversight of, a residency program. Be prepared to provide this documentation to auditors.
- Engage your hospital's finance staff and general counsel early in the audit process, especially if auditors challenge aspects of the program.
- Push auditors to specify how they arrived at a potentially adverse finding. For example:
 - » If an auditor questions an element of the program, request that the auditor cite the program regulations in question. If they cite "direct control" as the issue but are raising questions about something like the use of shared payroll services, ask them to point you to exactly where in the auditor transmittal or regulations the prohibition appears. In many cases, we've encountered auditors who realize they can't adequately cite the regulations supporting a disallowance.
 - » If an auditor requests additional documentation regarding any aspect of the program, challenge them to provide specifics as to exactly what type of documentation they expect to see. If the expectations are unreasonable and the auditor won't change course, consider engaging their supervisor(s).
- Should auditors begin questioning aspects of the program, contact ASHP as early as possible. ASHP does not provide legal advice but can work with programs and their hospital's finance and general counsel colleagues to address these issues, as it is much easier to fight potential disallowances before an auditor submits his/her report.