PUBLICATION

CMS Releases Final Rule Implementing New GME Policies and Finalizing the Methodology to Distribute 1,000 Medicare GME Slots

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The long-awaited FY 2022 Inpatient Prospective Payment System (IPPS) Final Rule with Comment Period (Final Rule) addressing changes to Medicare Graduate Medical Education (GME) Payments for Teaching Hospitals was placed on display in the Federal Register on December 17, 2021. Comments on the Final Rule are due February 25, 2022.

This rule finalizes policies to implement the three noteworthy Graduate Medical Education (GME) provisions included in the Consolidated Appropriations Act, 2021 (CAA) by building on proposals in the FY 2022 IPPS Proposed Rule. As explained in Baker Donelson's previous Payment Matters article on the CAA and our article on the FY 2022 IPPS Proposed Rule, the CAA included provisions that:

1. Authorized the distribution of 1,000 new Medicare-funded GME positions (Sec. 126);

2. Made statutory changes to modify the way that GME caps are determined for urban and rural hospitals training residents in rural training track programs (Sec. 127); and

3. Made statutory changes to the determination of per resident amounts (PRAs) and direct and indirect GME caps of hospitals that have hosted a small number of resident rotators for a short duration (Sec. 131).

A few key take-aways about CMS's final policies to implement the CAA are below.

The distribution of 1,000 new Medicare-funded GME positions (Sec. 126)

The Final Rule implements Section 126(a) of the CAA, which requires the distribution of an additional 1,000 FTE GME residency cap slots (GME Cap Slots). Up to 200 GME Cap Slots will be awarded for FY 2023 and each succeeding fiscal year until the aggregate number of slots are distributed.

Noteworthy policies finalized to implement this provision of the CAA include the following:

- CMS modified its proposal, which originally limited the increase in the number of residency positions made available to each individual hospital to no more than 1.0 full-time equivalent (FTE) each year. Under the final policy, hospitals will be allowed to receive **up to 5.0 FTEs per year**, with the maximum award amount contingent on the length of the program for which the hospital is applying (up to 1.0 FTE being will be awarded per program year, not to exceed a program length of 5 years, or 5.0 FTEs).

- While hospitals qualify to apply for the new slots by falling into one of the four prioritization categories called for in the statute, the CAA Section 126 residency positions will be awarded to qualifying hospitals based on the HPSA score of the HPSA served by the residency program for which each hospital is applying. Residency programs serving higher HPSA scores will receive higher

prioritization. The outcome will be that qualifying hospitals applying for residency positions for programs that do not serve HPSAs will be the lowest priority (even if they fall into other categories prioritized by the CAA). CMS expects that a hospital would choose to apply for a program that serves the HPSA with the highest score among its programs, but there is not a requirement to do so.

- Qualifying hospitals must submit an application by March 31 of the fiscal year before they would be awarded (e.g., for awarded residency positions that will be effective July 1, 2023 (FY 2023), the completed application must be submitted by **March 31, 2022**). The first-round award of 200 residency slots will be announced by January 31, 2023 and will become effective July 1, 2023.

- A link to the online application system as well as instructions for accessing the system and completing the online application process will be made available on the CMS Direct GME website.

Increasing GME Caps for Urban and Rural Hospitals Participating in Rural Training (Sec. 127)

Under Section 127 of the CAA, for cost reporting periods beginning on or after October 1, 2022, CMS is authorized to establish new rules expanding the GME FTE caps of urban and rural hospitals that partner to create rural training track (RTT) programs. To implement Section 127, CMS finalized the following new rules for rural training programs.

- CMS finalized that each time an urban teaching hospital and rural hospital establish a RTT program for the first time, **both** the urban and rural hospitals may receive a rural track FTE limitation irrespective of whether the program meets "newness" criteria generally used for Medicare payment purposes.

- CMS finalized that if, in a cost reporting period beginning on or after October 1, 2022, an urban hospital with an existing RTT (a hub) adds an additional RTT (a spoke) to the existing urban core program of the same specialty, the urban and rural hospitals may receive upward adjustments to their rural track FTE limitation. CMS has clarified that it will not allow increases in instances where the urban and rural hospital simply add additional FTE residents to an existing rural RTT spoke.

- CMS will provide additional slots to any program in **any specialty** as long as the program in its entirety is accredited by the ACGME (it does not have to be separately accredited as a RTT program), and **the residents spend more than 50 percent of the entire program in a rural area**.

- During the five-year cap growth window for rural training programs, the FTE residents participating in the RTT either at the urban hospital or a rural hospital would not be included in a hospital's three-year rolling average calculation during the cost reporting periods prior to the beginning of the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of each rural track. This exemption also applies to the IRB ratio cap.

Changes to the determination of per resident amounts (PRAs) and GME caps of hospitals that have hosted a small number of resident rotators for a short duration (Sec. 131*)*

Hospitals Qualifying to Reset Their Per Resident Amounts (PRAs)

Section 131 of the CAA includes provisions to allow hospitals without teaching programs that have previously hosted rotators without a GME affiliation agreement and inadvertently triggered the establishment of extremely low PRAs (which are used to establish DGME payments) to establish new PRAs. Under the CAA, any hospital that already established a PRA of (1) less than 1.0 FTE in a cost reporting period ending on or **before December 31, 1996 (these are called Category A Hospitals)**, or (2) up to 3.0 FTEs **for any cost reporting**

period between October 1, 1997, and the date of enactment of the CAA (December 27, 2020) (these are called Category B Hospitals), will be able to establish a new PRA. CMS finalized that this new PRA will not be reset until a Category A Hospital trains at least 1.0 FTE, or a Category B Hospital trains more than 3.0 FTEs in a cost reporting period beginning on or after December 27, 2020, and before December 26, 2025. CMS will only consider "continuous training" so it will not count if the hospital trained at least 1.0 FTE or more than 3.0 FTEs in a cost reporting period or periods prior to December 27, 2020.

- To provide flexibility for hospitals that have a PRA base period that already began at the time of release of the IPPS proposed rule, CMS is finalizing a policy that if a hospital already started training at least 1.0 FTE or more than 3.0 FTEs in a cost reporting period beginning immediately following enactment, the hospital could choose to use either that cost report as the PRA base period, or could wait to see if the first cost reporting period beginning after issuance of the final rule with comment period would result in a more favorable PRA.

- CMS is not requiring that residents be on duty during the first month of the PRA base period for teaching hospitals that receive a PRA reset, **and the guideline applies for all new teaching hospitals** in general (CMS believes this requirement is no longer relevant).

- Effective for a cost reporting period beginning on or after December 27, 2020, if a hospital did **not** enter into a Medicare GME affiliation agreement for training, CMS finalized that it would establish a PRA **only when it trains at least 1.0 FTE.** However, CMS will establish a PRA if a hospital trains less than 1.0 FTE if the hospital has entered into a Medicare GME affiliation agreement for that training.

- CMS finalized that to redetermine the PRA, the training occurring at a Category A or B hospital does not necessarily have to be training residents in a new program. The residents may be in either a program that is "new" for IME and DGME purposes or may be in an existing approved program.

Hospitals Qualifying to Reset Their GME Caps

Section 131(b) of the CAA allows hospitals to establish new FTE caps if, as of December 27, 2020, they: (1) previously established a base year cap below 1.0 FTE in any cost reporting period beginning before October 1, 1997 (Category A Hospitals), or (2) established a cap based on training no more than 3.0 FTEs from a new residency program in any cost reporting period beginning on or after October 1, 1997, and before the date of enactment of the legislation (Category B Hospitals). CMS clarified that this means the 5-year cap building window has to close in a cost reporting period that began before enactment (i.e., only hospitals whose third or fifth-program year **ends** in a cost reporting period that started **prior** to enactment would qualify for a cap reset under section 131 of the CAA).

- Unlike the proposal for establishing new PRAs, in the case of resetting FTE resident caps, CMS finalized that the FTE resident caps would only be reset when a Category A or Category B Hospital **"begins training"** FTE residents in a **new** residency program.

- The relevant factor in determining the timing of resetting their FTE resident caps is if the hospital **first begins training** the requisite amount of FTE residents at some point in a cost reporting period beginning on or after December 27, 2020 (date of enactment) and five years after (December 26, 2025).
- CMS finalized that it will not disqualify a hospital that started a new program prior to enactment of the CAA from being eligible for a cap reset, so long as it starts a new program after enactment. Yet, CMS maintains that it will only give the cap adjustment for new programs started after enactment of the

CAA (not before enactment).

- Eligible hospitals will receive a FTE cap adjustment equal to the sum of the original FTE cap and the new program FTE cap adjustment.

Process for PRA or Cap Review Requests

- CMS finalized policies for per resident amounts (PRA) and cap resets related to cost reports that are open, reopenable, or not yet settled.

- CMS will post a file on its website containing an extract of the HCRIS cost report worksheets on which the FTE counts, caps, and PRAs, if any, would have been reported, starting with cost reports beginning in 1995. This file will be made available here.

- **Hospitals must check the HCRIS posting** to determine reset **eligibility** (MACs will not reach out to hospitals). If no PRA or caps are reported on a settled cost report, or when PRAs or caps are reported without any FTEs for a cost report that is settled but reopenable, the hospital gets the benefit of a reset without further review from the MAC.

- If, for open or reopenable cost reports, there is a PRA and/or FTE caps reported on the HCRIS web posting, and the hospital believes its PRA was in fact established based on not more than 3.0 FTEs, or its IME and/or direct GME FTE caps were based on not more than 3.0 FTEs**, a hospital has a one-time opportunity to request reconsideration by its MAC, which must be submitted electronically and received by the MAC on or before July 1, 2022**. The MAC will make a final determination, which may be appealed to the Provider Reimbursement Review Board if all conditions for appeal are satisfied.

- If a cost report is not in the HCRIS web posting or if the posting does not include a PRA or FTE caps because the cost report has not been settled and/or the MAC has not determined the PRA or FTE caps, the hospital must submit a request to the MAC by July 1, 2022, requesting the MAC issue a determination regarding possible reset eligibility for the PRA and/or FTE caps using cost reports that began before enactment. MACs will reject incomplete or untimely submissions, with no opportunity for later or MAC review.

Topics Still Open for Comment

CMS is still receiving comments on the following topics:

- How to account for health care provided outside of a HPSA to HPSA residents, and feasible alternatives to HPSA scores as a proxy for health disparities in the prioritization of additional FTE cap slots; and

- The review process to determine eligibility for PRA or FTE cap resets in situations where a hospital disagrees with the information on cost reports that are no longer within the three-year reopening period.

Conclusion

Existing and aspiring teaching hospitals should carefully evaluate the implications of CMS's final policies to implement CAA provisions related to the distribution of 1,000 new GME Cap Slots, the modification of the rules

applicable to setting rural track FTE limitations for urban and rural hospitals participating in rural training programs, and the establishment of new rules to allow hospitals to reset low PRAs and GME caps. With comments due by February 25, 2022, it is important to consider how your organization will be affected by these final policies and whether it would be beneficial to offer formal comments.

Please feel free to contact Allison Cohen or any member of the Baker Donelson Reimbursement Team if you have questions regarding commenting on these proposals, or would like further guidance with respect to how they may affect your current or future GME programs.