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Fiscal Year 2022 IPPS Proposals Related to GME Payments

Authors: Allison M. Cohen
May 2021

The FY 2022 Inpatient Prospective Payment System (IPPS) Proposed Rule implements the three noteworthy Graduate Medical Education (GME) provisions included in the Consolidated Appropriations Act, 2021 (CAA). As explained in Baker Donelson's previous Payment Matters article on the CAA, this legislation included several long-awaited GME policy changes. Notably, the CAA: 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 a rural training track (RTT) program (Sec. 127), and 3) made statutory 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). CMS's proposals in the FY 2022 IPPS proposed rule to implement each of these policies are explained in further detail below. Comments are due June 28, 2021.

A few key take-aways about CMS's implementation of the CAA are:

1. CMS is proposing to limit 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, which is far below the statutory requirement that a hospital would not be able to receive more than 25 additional FTE residency positions in aggregate during the distribution. This limitation is not operationally helpful for hospitals trying to start new programs using slots from the new distribution.

2. After applying the prioritization categories called for in the statute, CMS proposes to further prioritize the qualifying residency programs that serve underserved populations in geographic health professional shortage areas (HPSAs) or population HPSAs such that programs serving higher HPSA scores will receive higher prioritization. CMS notes that the outcome will be that 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). This further prioritization is not specifically mandated by statute.

Distribution of Additional GME FTE Cap Slots

The Proposed 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). The new GME Cap Slots will be made available for FY 2023 and each succeeding fiscal year until the aggregate number of slots are distributed to hospitals that apply for them through the application process. Up to 200 GME Cap Slots will be awarded each fiscal year starting in FY 2023. CMS proposes an application deadline of January 31 of the fiscal year before the cap increase will apply. The cap increase will take effect July 1 of the year following the application deadline. For the additional positions that will be effective July 1, 2023, CMS proposes an application deadline of January 31, 2022.

When distributing the new GME Cap Slots, the following must be considered:

1. **The demonstrated likelihood of the hospital filling the new positions within the first five training years beginning after the date that the increase would be effective.**

In order to demonstrate that the hospital does not have sufficient room under its current FTE caps to accommodate a planned new program or expansion of an existing program, CMS proposes that the hospital must submit copies of its most recently submitted Worksheets E, Part A and E-4 from the Medicare cost report as part of its application.

CMS proposes that hospitals demonstrate with supporting documentation and attest to a planned new program (Demonstrated Likelihood Criterion 1- New Residency Program), or expansion of an existing program (Demonstrated Likelihood Criterion 2- Expansion of an Existing Program).

2. **The requirement that at least ten percent of the aggregate number of slots must be distributed to each of the following categories of hospitals:**

Category 1: Hospitals located in a rural area or that are treated as being located in a rural area

CMS proposes to define rural area for these purposes in a manner that is consistent with its policy concerning designation or rural areas for wage index purposes. Under the proposal, a hospital with its main campus located in an area outside of an urban CBSA would be a rural hospital. Additionally, hospitals that meet the regulatory criteria set forth at 42 C.F.R. § 412.103 and that are reclassified as a rural area for purposes of IPPS payment will be eligible to apply under Category 1.

Category 2: Hospitals training over their GME caps as determined by whether their "reference resident level" is above their "otherwise applicable resident limit"

CMS proposes that the "reference resident level" is the hospital's allopathic and osteopathic FTE resident count for the most recent cost report that is settled or under audit as of the date of enactment of the CAA (December 27, 2020). "Otherwise applicable resident limit" is proposed to be defined as the hospital's 1996 cap during its reference year adjusted for the following: new programs, participation in a GME affiliation agreement or Emergency Medicare GME affiliation agreement, participation in a hospital merger, whether an urban hospital has a separately accredited rural training track program, applicable decreases or increases under Sec. 422 of the MMA, applicable decreases or increases under Sec. 5503 of the ACA, and applicable increases under Sec. 5506 of the ACA.

Category 3: Hospitals in states with –

1. new medical schools that received "Candidate School" status from the Liaison Committee on Medical Education (LCME) or that received "Pre-Accreditation Status" from the American Osteopathic Association Commission on Osteopathic College Accreditation on or after January 1, 2000 (AOA Commission on Osteopathic College Accreditation), and that have achieved or continue to progress toward "Full Accreditation Status" (as defined by the LCME) or toward "Accreditation Status" (as defined by the AOA Commission on Osteopathic College Accreditation (COCA)), and

2. additional locations and branch campuses established on or after January 1, 2000, by medical schools with "Full Accreditation Status" or "Accreditation Status" as defined above.

Based on information gathered from LCME and the COCA about new medical schools, additional locations and branch campuses, CMS is proposing that hospitals located in the following 35 states and one territory (referred to as Category 3 states), are Category 3 hospitals: Alabama, Arizona, Arkansas, California, Colorado,

Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

If a hospital is located in a state not on this list, but believes the state in which it is located should be on this list, the hospital may submit a formal comment on the proposed rule to make a change to the list of Category 3 states, or must provide documentation with submission of its application to CMS that the state in which it is located has a medical school or additional location or branch campus of a medical school established on or after January 1, 2000.

Category 4: Hospitals that serve as designated HPSAs under Section 332 (a)(1)A) of the Public Health Services Act.

Section 332(a)(1)(A) of the Public Health Service Act defines a "health professional shortage area" as an area in an urban or rural area, which the Secretary determines lacks sufficient health care providers to meet the health care needs of that area's population. The Health Resources and Services Administration (HRSA) designates HPSAs for primary care, mental health, and dental health. A "geographic HPSA" is designated as such only on the basis of a shortage of services for the entire population within that area.

CMS proposes that primary care geographic HPSAs be considered in determining the hospitals that qualify under Category 4 and that hospitals with main campuses or provider-based facilities in these HPSAs may apply for additional residency positions for *any* specialty. Additionally, CMS proposes that hospitals that only have main campuses or provider-based facilities in mental health only geographic HPSAs may only apply for residency positions of psychiatry residency programs.

A Category 4 hospital must submit an attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, that it has its main campus or a provider-based facility physically located in a primary care or mental health geographic HPSA, and in the program for which the hospital is applying, at least 50 percent of the residents' training time over the duration of the program occurs at those locations in the HPSA.

3. **Number of Residency Positions Made Available to Hospitals**

The CAA limits the aggregate number of total residency programs made available in a single fiscal year across all hospitals to no more than 200, which will be made available for FY 2023 and each subsequent year. Because CMS anticipates that numerous hospitals will qualify under proposed Category 4, in order to make additional residency positions available to more hospitals each year, CMS is proposing to limit the increase in the number of residency positions made available to each individual hospital to no more than 1.0 FTE each year (far below the requirement under the statute, which provides that a hospital may not receive more than 25 additional FTE residency positions in aggregate during the distribution).

4. **Use of Geographic HPSAs and Population HPSAs**

In order to address health inequities for underserved populations more fully, CMS proposes to prioritize the applications from hospitals that serve the specific designated underserved population of a population HPSA. Pursuant to Public Health Service Act section 332(a)(1)(B), "population HPSAs" are designated by HRSA on the basis of a shortage of services for a specific subset of the population rather than the entire population in an area as is the case in geographic HPSAs. These population subsets include, but are not limited to low-income

populations, Medicaid-eligible populations, Native American populations, homeless populations, and migrant farmworker populations.

Similar to the proposal for geographic HPSAs, CMS proposes that a hospital serves a population HPSA if it has a main campus or a provider-based facility physically located in a primary care or mental health population HPSA and any such locations that serve the designated underserved population of the HPSA. Additionally, hospitals that only have main campuses or provider-based facilities in mental health only population HPSAs may only apply for positions for psychiatry residency programs. CMS proposes to prioritize applications from qualifying hospitals (i.e., hospitals that qualify under categories 1 through 4, as previously described), for residency programs that serve underserved populations in geographic HPSAs or population HPSAs.

CMS also proposes to use HPSA scores for prioritization by using HRSA scores of the severity of primary care or mental health provider shortages in a geographic area. Specifically, the additional residency positions under section 126 of the CAA will be distributed to hospitals that qualify under categories 1 through 4 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.

CMS proposes to allocate 1.0 FTE to each hospital with the highest HPSA score, prorating only in the event that the number of hospitals with the highest score exceeds the number of residency positions available. If the number of hospitals with the highest score is less than the number of residency positions available, each hospital with the next highest score would receive 1.0 FTE. The process would occur again if the number of hospitals with the next highest score is less than the number of positions remaining and would continue in this manner moving onto hospitals with the next highest score until all available positions are distributed. This means that hospitals applying for residency positions for programs that do not serve HPSAs are not categorically excluded but would have the lowest priority. As a result, CMS is anticipating that hospitals will choose to apply for a program that serves the HPSA with the highest score among its programs, but this is not required. In preparing its application for an additional residency position for a program, CMS instructs hospitals to refer to HRSA's "HPSA Find Tool" (https://data.hrsa.gov/tools/shortage-area/hpsa-find) to obtain the HPSA score of the HPSA served by the program and include this score in its application.

More on the Application Process

Hospitals that wish to apply must complete an application and submit it via an online application system that is under development. When the FY 2022 IPPS/LTCH PPS final rule goes on display, a link to the online application system and instructions to access it and complete the process will be made available on the CMS Direct Graduate Medical Education (DGME) website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME.

II. Increasing GME Caps for Urban and Rural Hospitals Participating in Rural Training

Under Section 127 of the CAA, starting with cost reporting periods beginning on or after October 1, 2022, HHS will establish new rules to allow urban hospitals to create rural training track programs with rural hospitals without obtaining separate accreditation for these programs. To implement Section 127, CMS proposes the following new rules for RTT programs.

3. **Cap Adjustments for Urban and Rural Hospitals Participating in RTT Programs**

   CMS proposes that each time an urban teaching hospital and rural hospital establish an RTT program for the first time (even if the RTT program does not meet newness criteria for Medicare payment purposes), both the urban and rural hospitals may receive a rural track FTE limitation.

4. **Cap Adjustments When the Urban Hospital Adds Additional RTTs**

   CMS believes that the CAA granted authority to prospectively allow cap adjustments to existing RTTs expanded in a cost reporting period beginning on or after October 1, 2022 (under certain circumstances). Specifically, CMS will adjust the RTT limitations of an urban hospital wishing to create additional RTTs after establishing its first RTT, while also adjusting the resident caps of the additional rural hospital(s) by creating each additional RTT. Using this new authority, CMS proposes 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 adjustments to their rural track FTE limitation. CMS has clarified that it will not allow increases in instances where the urban and rural hospital add additional FTE residents to an existing rural RTT spoke.

5. **Removal of the Requirement That the RTT Must Be "Separately Accredited"**

   CMS proposed that effective for cost reporting periods beginning on or after October 1, 2022, as long as the program in its entirety is accredited by the Accreditation Council for Graduate Medical Education (ACGME), regardless of the specialty, it may qualify as an RTT. Further, urban and/or rural hospitals would receive rural track FTE limitations as long as all other requirements are satisfied.

6. **Requirement That Greater Than 50 Percent of the Program Occurs in a Rural Area**

   CMS believes that under the CAA, an "accredited program where greater than 50 percent of the program occurs in a rural area" is the new statutory authorization for development of rural tracks in specialties other than family medicine (because eligibility for cap adjustments is no longer tied exclusively to "separately accredited" RTT programs).

   Therefore, prospectively for cost reporting periods beginning on or after October 1, 2022, CMS is proposing to provide additional slots to any program in any specialty as long as the program in its entirety is accredited by the ACGME and the residents spend more than 50 percent of the entire program in a rural area. Separately accredited 1-2 family medicine RTTs may continue to maintain their RTT FTE limitations, assuming all applicable requirements are met.

   CMS is also proposing to allow a rural hospital that partnered with the urban hospital in the RTT to similarly include in its FTE count (not to exceed its rural track FTE limitation) the time residents train in the rural hospital if the residents rotate to a rural area for greater than 50 percent of the duration of the particular program.

7. **Exemption from the Three-Year Rolling Average During the Five-Year RTT FTE Limitation Window**

   Under CMS's previous interpretation of the RTT rules, FTE residents in RTT programs at urban hospitals have been immediately subject to the three-year rolling average unless the new RTT programs were started by an urban teaching hospital for the first time.

   Pursuant to authority from Section 127 of the CAA, CMS proposes that during the five-year cap growth window for RTTs, 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.

CMS is also proposing to make appropriate changes to the regulations for indirect medical education (IME) to mirror the following proposed regulatory changes for DGME.

III. Establishment of Per Resident Amounts and GME Caps for Hospitals That Hosted Resident Rotators

Hospitals Qualifying to Reset Their Per Resident Amounts (PRAs)

Section 131 of the CAA includes provisions to prevent hospitals without teaching programs that have previously hosted rotators without a GME affiliation agreement from inadvertently triggering the establishment of extremely low PRAs (which are used to establish DGME payments). Under the CAA, any hospital that already (A) established a PRA of less than 1.0 FTE in any cost reporting period beginning before October 1, 1997, or (B) 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), will be able to establish a new PRA. This new PRA could be established for hospitals in Category A that report training at least 1.0 FTE or for hospitals in Category B that report more than 3.0 FTEs in a cost reporting period within five years of enactment of the CAA. The recalculation period begins on December 27, 2020, and ends five years later (December 26, 2025). CMS proposes to calculate the replacement PRA using the existing regulations currently in place.

CMS proposes 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.

CMS plans to issue instructions to the Medicare Administrative Contractors (MACs) and to hospitals with details on the process of request and review for the purpose of receiving replacement PRAs. The MACs of the Category A and Category B Hospitals will review the Medicare cost reports, GME costs, FTE counts, rotation schedules, etc. to determine the point at which the requisite threshold of FTE residents are trained. As required under 42 C.F.R. §§ 413.20 and 413.24, hospitals must provide sufficient documentation to ensure proper payment (for GME this includes, but is not limited to, rotation schedules and training agreements). Once reset, the PRAs for either a Category A or B Hospital are permanent, subject to annual inflation updates.

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

CMS further proposes that *all* hospitals, even if they do not classify as Category A or Category B Hospitals, must enter the FTE counts on Worksheets E, Part A and E-4 of the CMS-Form-2552-10, for cost reporting periods during which the hospital trains at least 1.0 FTE. In addition, hospitals must provide the information required by the Interns and Residents Information System (IRIS) software for cost reports that contains at least 1.0 FTEs on Worksheets E, Part A (IME) and E-4 (direct GME). CMS is proposing this rule regardless of whether a hospital incurs the costs or is the program sponsor. CMS states that the FY 2022 IPPS Proposed Rule puts hospitals on notice that they would establish a PRA when they report FTE residents on their Medicare cost report beginning on or after December 27, 2020.

Hospitals Qualifying to Reset their FTE Resident Caps

Section 131(b) of the CAA allows hospitals to establish new FTE caps if, as of December 27, 2020, they: (A) previously established a base year cap below 1.0 FTE before October 1, 1997, or (B) established a cap based

on training no more than 3.0 FTEs from a new residency program between October 1, 1997 and the date of enactment of the legislation.

CMS will adjust the FTE resident caps if the hospital "*begins training*" at least 1.0 FTE (in the case of Category A) or "*begins training*" more than 3.0 FTE (in the case of Category B) in a program year beginning on or after such date of enactment and before the date that is five years after December 27, 2020. Unlike the proposal for establishing new PRAs, in the case of resetting FTE resident caps, CMS is proposing 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. CMS also proposes that 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 further explains that "in order to qualify for a replacement FTE resident cap, both a Category A Hospital and a Category B Hospital would have to wait to start training residents in a new program in a cost reporting period beginning on or after enactment; if they started training residents in a new program at some point prior to enactment, [CMS is] proposing that they would not qualify to receive replacement resident caps." This clarification from CMS could be read to preclude a hospital from *ever* qualifying for a replacement cap if it did not wait to train residents in a new program until a cost reporting period beginning on or after December 27, 2020. CMS should clarify that interprets the CAA to allow a hospital to reset its cap if it starts a new program that meets the threshold requirement of training 1.0 FTEs (for Category A Hospitals) or 3.0 FTEs for Category B Hospitals at some point during the five-year window between December 27, 2020 and December 26, 2025, irrespective if it started training residents in a separate new program prior to its cost reporting period beginning on or after enactment, but after it originally triggered its cap.

CMS proposes to calculate the replacement FTE resident caps using the existing regulations in place at 42 C.F.R. § 413.79(e)(1). CMS also plans on issuing instructions to MACS and to hospitals to provide details on the process of request and review for the purpose of receiving replacement FTE resident caps.

Finally, consistent with the CAA, CMS proposes that for all hospitals that do not yet have caps triggered, CMS will not establish permanent FTE caps for hospitals training residents in new programs that are begun on or after December 27, 2020, until CMS determines that in a cost reporting period beginning on or after December 27, 2020, the hospital trains at least 1.0 FTE in a new medical residency program. This will prevent permanent FTE caps for new programs from being triggered if the number of FTEs being trained by a hospital in the new program is less than 1.0 FTE.

Proposal for Intern and Resident Information System (IRIS) Data

Section 42 C.F.R. § 413.24(f)(5)(i) requires teaching hospitals to submit the IRIS data along with their Medicare cost reports in order to have an acceptable cost report submission. CMS is in the process of issuing a new Extensible Markup Language (XML)-based IRIS file format that captures FTE resident count data consistent with the manner in which FTEs are reported on the Medicare cost report. CMS is proposing to remove the outdated reference in 42 C.F.R. § 413.24(f)(5)(i) to a diskette and instead reference "Intern and Resident Information System data."

CMS is also proposing to amend 42 CFR 413.24(f)(5)(i) to state that the IRIS data must contain the same total counts of direct GME FTE residents (unweighted and weighted) and of IME FTE residents as the total counts of direct GME FTE and IME FTE residents reported in the hospital's cost report, or the cost report would be rejected for lack of supporting documentation. If finalized, this new policy will be effective for cost reporting periods on or after October 1, 2021.

Providers would be required to use the new XML IRIS format for all cost reports with cost reporting periods beginning on or after October 1, 2021. CMS does not have a free download of the new IRIS XML format and instructs providers to use their vendors' software to file their IRIS report with the MAC.

IV. Conclusion

The FY 2022 IPPS Proposed Rule includes several important proposals that will affect GME payments for years to come. Existing and aspiring teaching hospitals should carefully consider the implications of CMS's proposals 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 RTT programs, and the establishment of new rules to allow hospitals to reset or avoid triggering low PRAs and GME caps. 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.