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CMS Issues FY 2022 IPPS Final Rule. Implements Medicare GME-Related Provisions

Article By:

Emily J. Cook

Drew Elizabeth McCormick

In December 2021, the US Centers for Medicare and Medicaid Services (CMS) issued the second part of its FY 2022 Inpatient Prospective Payment System (IPPS) Final Rule with Comment Period. Among other policies, the Final Rule implements three provisions of the Consolidated Appropriations Act of 2021 (CAA) regarding Medicare graduate medical education (GME). The Final Rule also establishes a comment period regarding potential additional rulemaking, including certain uses of health professional shortage area (HPSA) scores in prioritization of additional full-time equivalent (FTE) cap slots and processes for determining eligibility for FTE and per-resident amount (PRA) cap resets.

On December 17, 2021, the Centers for Medicare and Medicaid Services (CMS) released the second part of the Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) Final Rule with Comment Period (Final Rule), which, among other things, implemented three provisions of the Consolidated Appropriations Act of 2021 (CAA) related to Medicare graduate medical education (GME). Specifically, as to the Medicare GME provisions, the Final Rule outlines parameters governing the distribution of 1,000 new Medicare-funded physician residency slots to qualifying hospitals; provides a process through which teaching hospitals can establish new full-time equivalent (FTE) resident caps or per-resident amounts (PRAs); and details changes to rules for Rural Training Track (RTT) programs.

Distribution of Additional Medicare-Funded Residency Slots

Section 126 of the CAA requires CMS to distribute 1,000 new FTE resident cap slots to qualifying hospitals over five-year period beginning in FY 2023. Under the Final Rule, CMS will make 200 residency slots available per year, beginning in 2023, until all 1,000 slots have been allocated. Although the proposed rule would have limited a hospital's annual award to one FTE residency slot, in response to commentary CMS modified this proposal in the Final Rule to allow for a range of one to five FTE slots to be awarded per hospital per year. The number of slots awarded is determined by the length of the residency program for which the hospital is applying, which is intended to ensure that the hospital is provided with sufficient new FTE cap slots to support the training of residents through the duration of the program.

Hospitals must apply to be eligible to receive FTE slots, and applications from qualifying hospitals operating residency programs that serve certain geographic areas and underserved populations will be prioritized by using the Health Resource and Services Administration's health professional shortage areas (HPSAs) score. Specifically, for a hospital to be eligible, it must fall into one of four categories of hospitals:

- Category 1: located in rural areas or treated as being in a rural area
- Category 2: training residents over their Medicare GME cap
- Category 3: located in states with new medical schools or branch campuses on or after January 1, 2000
- Category 4: that serve areas designated as HPSAs.

Regarding Category 4 hospitals, CMS initially proposed that a hospital must confirm that more than 50% of residential training time is spent training at the hospital locations within the geographic HPSA. However, under the Final Rule, training that occurs at a program training site located in an HPSA and that treats the HPSA's population will count toward meeting the 50% training requirement of the category. In addition, psychiatric subspecialty residency programs and psychiatric residency programs are now included within the mental health HPSA category under the Final Rule.

The application deadline will be March 31 of the year preceding the award year (e.g., applications for 2023 will be due March 31, 2022), instead of the proposed January 31. Hospitals will be notified of any award by January 31 of the award year. The effective date for the additional residency programs will be on July 1 of the award year. Separate applications will be required in each of the five years.

Along with the application, CMS confirmed that hospitals will need to show a "demonstrated likelihood" that any awarded positions will be filled. As clarified in the Final Rule, this means that CMS will require a hospital to be training residents in excess of its FTE cap and show that it is working to obtain approval (or has already obtained approval) from the appropriate accrediting body to either establish a new residency program or expand an existing residency program. In response to comments, CMS expressly clarified that hospitals that are already operating in excess of their caps would not be able to receive awarded positions on that basis.

Addressing Low FTE Caps and PRAs

Historically, some hospitals inadvertently limited their ability to receive Medicare funding for residents in a new training program by accepting residents that rotated to the hospital from established training programs for a short duration, which resulted in the hospital establishing low or zero PRAs or FTE caps. The Final Rule generally confirms CMS's proposed approach to implementing Section 131 of the CAA and outlines the requirements for resetting PRAs and FTE caps for eligible hospitals.

Specifically, CMS has identified two categories of eligible hospitals based on its interpretation of the CAA: (1) Category A, which consists of hospitals that have a PRA or FTE cap based on training less than one FTE resident in a cost-reporting period prior to October 1, 1997; and (2) Category B, which refers to hospitals that have a PRA or FTE cap based on training three or fewer FTEs in a cost-reporting period beginning on or after October 1, 1997, and before enactment of the CAA on December 27, 2020. Under the Final Rule, hospitals that are eligible for resets are those that have

established an FTE cap or PRA in a cost-reporting year that started prior to enactment of the CAA on December 27, 2020. If a hospital in Category B disagrees with the PRA or FTE cap reported in the applicable base year, and the base year is within the three-year reopening window or is not yet settled, the hospital can initiate a one-time request for reconsideration. However, Category A hospitals are not able to avail themselves of this process.

Per the Final Rule, a PRA and/or FTE cap reset will be triggered for Category A hospitals when they train at least one FTE, and for Category B hospitals when they train more than three FTEs, in a cost-reporting year beginning after December 27, 2020, but before December 26, 2025. Only training residents in new programs will trigger an FTE cap reset, but training residents in a new program is not a requirement to trigger a PRA reset. Additionally, CMS is no longer requiring that residents be on duty during the first month of the PRA base period for teaching hospitals to receive a PRA reset. This provision also applies to all new teaching hospitals going forward. Otherwise, new FTE caps and PRAs will generally be calculated in the same manner that FTE caps and PRAs are calculated under current rules. (See 42 C.F.R. 413.77(e) (with respect to establishing PRA) and 42 CFR 413.79(e)(1) (with respect to establishing FTE caps).) The Final Rule also provides that the triggering year for the reset will serve as the base year for calculating new PRA determination, although it also provides hospitals the option to instead use the year beginning on or after the issuance of the Final Rule as the base year.

CMS confirmed that new FTE caps will be added to the hospital's existing FTE cap. In response to comments, CMS changed its original proposal to disqualify a hospital from being eligible for the FTE cap reset because it started a new program prior to enactment of the CAA, so long as it also starts training residents in a separate new program after the date of enactment. However, CMS will only calculate the adjustment based on the new program that was started after December 27, 2020.

Going forward, the CAA and Final Rule provide that no FTE cap or PRA will be set for a hospital that trains less than one FTE during a cost-reporting year, which should provide some protection against inadvertently setting low or zero FTE caps and PRAs going forward.

Creating Flexibility for Rural Training Track

Additionally, CMS finalized the Promoting Rural Hospital GME Funding Opportunity, which allows certain teaching hospitals participating in RTT programs to receive indirect medical education (IME) and direct graduate medical education (DGME) payment increases. More specifically, previously, a rural track established from an already-existing rural family medicine program would have been ineligible to receive an FTE cap adjustment unless the program was new for Medicare payment purposes. In contrast, if an urban hospital already had an accredited family medicine residency program, it could establish from that existing family medicine program, for the first time, a rural track, and, assuming all applicable requirements were met, that urban hospital could receive IME and DGME FTE resident cap adjustments.

Under the Final Rule implementing Section 127 of the CAA, CMS allows for FTE cap increases for urban and rural hospitals that participate in a new RTT program, even if the RTT program does not meet the Medicare "newness" criteria. Additionally, the Final Rule describes that urban and rural hospitals will be eligible for adjusted IME and DGME FTE resident caps when additional RTT programs are established after the first program. Previously, an adjustment was only offered for the first RTT program implemented.

CMS also removed the requirement that an RTT must be separately accredited, so long as the

program in its entirety is accredited by the Accreditation Council for Graduate Medical Education and residents in the program, as a whole, spend more than 50% of their training in a rural area. In addition, the Final Rule provides that RTT programs can be in any specialty (whereas previously, only RTT programs specializing in family medicine were permitted).

Lastly, the final rule exempts residents in RTTs from the three-year rolling average during the five-year cap growth window for RTTs.

ANALYSIS

Although CMS received a significant number of comments in response to the 2022 IPPS proposed rule, particularly regarding the distribution of the 1,000 FTE slots under Section 126 of the CAA, these policy changes are overall viewed as positive relief among the teaching-hospital community. CMS described the provisions of the Final Rule implementing Section 126 of the CAA as "…advance[ing] key priorities to close health care equity gaps and enhance the health care workforce in rural and underserved communities" and estimates that the additional funding to hospitals will total approximately $1.8 billion from FY 2023 through FY 2031 (Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) Final Rule with Comment Period (CMS 1752-FC3), December 17, 2021). CMS also views allowing rural teaching hospitals participating in an accredited RTT to receive increases to their FTE caps as making "additional strides to close the health equity gap in rural communities, which tend to experience health care workforce shortages." (*See also* the fact sheet linked above). Finally, CMS noted that the provisions of the Final Rule implementing Section 131 advance health equity by allowing these hospitals, which often provide services to otherwise underserved communities, to receive additional residency FTE cap slots and increased PRAs.

Finally, CMS solicited comments on certain issues to inform potential rulemaking, including:

1. How to account for healthcare provided outside of an HPSA to HPSA residents, and feasible alternatives to HPSA scores as a proxy for health disparities in the prioritization of additional FTE cap slots.
2. 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.

Comments are due by 5 pm EST on February 25, 2022.

McDermott Will & Emery law clerk Sarah Reis also contributed to this article.

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