PUBLICATION

Proposed 2015 IPPS Rule Contains Many Changes to GME and IME Rules [Ober|Kaler]

May 16, 2014

Each year when CMS publishes its proposed changes to the IPPS Rule, it suggests a number of graduate medical education (GME) and indirect medical education (IME) reforms. This year has been no different. As part of the IPPS proposed rule, CMS has proposed changes that would affect teaching programs at rural hospitals and at urban hospitals with rural track programs; clarified its policies regarding counting time in non-provider settings pursuant to § 5504 of the Affordable Care Act (ACA); would alter the ranking criteria under which CMS awards cap slots redistributed from closed hospitals; and would adjust the effective dates of the FTE caps, the three-year rolling average, and the IRB ratio cap for new programs, all as described below. See 79 Fed. Reg. 27978, 28144-28164 (May 15, 2014).

New Urban and Rural Labor Market Delineations

CMS proposes a number of modifications to its GME and IME policies to address situations in which hospitals are redesignated from rural to urban as a result of new Office of Management and Budget (OMB) labor market area delineations. See 79 Fed. Reg. at 28149-28152. First, focusing on rural hospitals, CMS addresses situations in which a hospital that was rural as of the time it started training residents in a new program is later redesignated as urban during the program's cap-building period. CMS proposes that, in such circumstances, the formerly rural, newly urban hospital be able to continue building its program for the remainder of the cap-building period and receive a permanent FTE resident cap adjustment for that new program as well as retain any increases to its resident cap that it might have earlier received.

Second, CMS addresses situations in which an urban hospital is training residents in a rural track program and the "partner" rural hospital or non-hospital teaching site in the program is redesignated as urban. Generally speaking, once a rural hospital has been redesignated as urban, the newly urban hospital no longer qualifies as "rural." Thus, one might reason, absent an exception, the "original" urban hospital would not be able to continue using the formerly rural, but redesignated as urban, hospital as the rural site for purposes of the rural track limitation. CMS proposes, however, that, during the three-year period used to establish the rural track limitation, the urban hospital's opportunity to receive a rural track FTE limitation would continue.

Under CMS's proposal, there would be a two-year transition period during which the "original" urban hospital would be able to count residents under its rural track FTE limitation. By the end of that two-year transition period, however, the redesignated formerly rural, now urban, hospital must have reclassified back to rural. Otherwise, the "original" urban hospital will need to find a new geographically rural site as its teaching partner for purposes of the rural track program. Notably, if the newly urban hospital reclassifies from urban back to rural, this will continue the rural track's FTE count for IME payment purposes only, and not for GME. If an urban hospital wishes to have a continued rural track program for GME, it will be required to obtain a new rural site partner.

These changes will apply both: (a) when the rural hospital is redesignated as urban after the urban hospital has already established its rural track FTE limit, and (b) when the rural hospital is designated as urban during the three-year period prior to the rural track FTE limitation being established.

Non-Provider Settings

CMS also has clarified its policies regarding the counting of residents in non-provider settings pursuant to § 5504 of the ACA. See 79 Fed. Reg. at 28152-28154. If more than one hospital incurs the residency training costs for rotations to a non-provider setting, § 5504 allows each hospital to count a proportional share of the time that the residents spend training in that setting as determined by a written agreement between the hospitals. This provision is effective for cost reporting periods beginning on or after July 1, 2010. In the clarification, however, CMS addresses the question of whether this provision may be applied to earlier periods, particularly if the hospital had, as of the date of enactment, appealed an IME or GME issue for a settled cost reporting period that occurred prior to July 1, 2010. CMS states that the provisions of § 5504 are not to be applied prior to July 1, 2010, even under circumstances in which the hospital may have had pending, as of the ACA's effective date, a jurisdictionally proper appeal pertaining to an IME or GME issue from a cost reporting period occurring prior to July 1, 2010.

Cap Slots

CMS further proposes several changes to the ranking criteria to be applied in the awarding of cap slots under § 5506 of the ACA. See 79 Fed. Reg. at 28154-28164. First, CMS will modify its policy regarding the effective date of a permanent cap adjustment award when another hospital has received a temporary cap adjustment for training displaced residents. Under the proposed modification of policy, the § 5506 *permanent* cap adjustment granted to one hospital may take effect even though another hospital may be receiving a *temporary* cap adjustment under 42 C.F.R. § 413.79(h) for training displaced residents whose cap numbers might be duplicated in the permanent cap adjustment. Further, CMS is proposing modifications to the ranking criteria to address a prior error (criterion number one) and to include emergency affiliation agreements (criterion number two). Additionally, CMS is proposing to modify ranking criterion 8 so that it will apply only to hospitals seeking FTE slots to establish or expand a non-primary or non-general surgery program. Ranking criterion 8 would no longer be applicable to hospitals seeking FTE cap slots for cap relief.

Caps for New Programs

Finally, CMS is proposing changes to the effective dates of its application of the FTE resident cap, the three-year rolling average, and the IRB ratio for new programs. See 79 Fed. Reg. 28145-28149. Currently, for new programs, a hospital has a cap-building period of five years, with the hospital's new cap applied effective with the beginning of the sixth program year of the first new program's existence. The three-year rolling average for IME and direct GME, and the IRB ratio cap for IME, however, are applied when the minimum accredited length of each new program starts within that five-year window. CMS proposes to simplify and coordinate the timing of these caps. The methodology for calculating the FTE resident caps would continue, with the cap determined at the end of the first new program's fifth year. Instead of the FTE resident cap being effective beginning with the sixth program year of the first new program, however, the FTE resident caps, the rolling average, and the IRB ratio cap would be effective beginning with the applicable hospital's cost reporting period that precedes the start of the sixth program year of the first new program started. In this fashion, the FTE cap, the three-year rolling average, and the IRB ratio cap would begin simultaneously.

Ober|Kaler's Comments

CMS's proposals, in the main, appear to benefit many hospitals, at least in providing greater clarity regarding CMS's rules and expectations. This is particularly true regarding the proposal to coordinate the effective dates for the permanent cap, rolling average, and IRB ratio cap so that they become effective at the same time. On

the negative side, the CMS proposals effectively reduce the amount of time that the new medical residency training programs would be exempt from the FTE resident caps, moving the effective date back by as much as nearly a year. Further, with respect to § 5506 applications, CMS has removed the possibility of hospitals obtaining simple cap relief. Given that CMS makes few awards for cap relief, however, this proposed action by the agency may have little practical affect.

Comments to the regulation are due by June 30, 2014.