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Noteworthy GME Payment Policy Takeaways from the CMS FY 2025 IPPS Proposed Rule

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CMS's FY 2025 Inpatient Prospective Payment System (IPPS) Proposed Rule (Proposed Rule) includes several noteworthy proposals and requests for information related to graduate medical education (GME) payment policies. Below are the takeaways from the Proposed Rule related to GME payment opportunities and a summary of the key GME provisions in the Proposed Rule. Comments on the Proposed Rule are due June 10, 2024.

Takeaways from the Proposed Rule

- Hospitals planning residency programs in psychiatry or psychiatric subspecialties should consider applying for the newest distribution of Medicare-funded GME residency positions (GME Cap Slots) authorized by Section 4122 of the Consolidated Appropriations Act (CAA), 2023. The proposed application deadline for the distribution is March 31, 2025.
- Hospitals planning residency programs for which at least 50 percent of the training would occur in a training site physically located in a primary care or mental health geographic Health Professional Shortage Area (HPSA) are better positioned to apply for the next rounds of Section 126 GME Cap Slot awards based on CMS's proposed modifications to the distribution methodology. Applications for the next round of Section 126 Cap Slot awards are due March 31, 2025.
- Rural hospitals, hospitals that have been reclassified as rural, and new teaching hospitals should take note of CMS's proposals and requests for information (RFIs) related to the criteria residency programs must satisfy, to be considered "new" for cap-building purposes.
- Hospitals in the same geographic region as teaching hospitals that closed in Maumee, Ohio, and St. Louis, Missouri, should consider applying for GME Cap Slots that will be redistributed through the process authorized by Section 5506 of the Affordable Care Act (ACA). Applications are due July 9, 2024.

Summary of Key GME Payment Provisions

1. Proposed Distribution of 200 Residency Slots Under Section 4122 of the Consolidated Appropriations Act, 2023 (CAA 2023) in FY 2026.

Under Section 4122 of the CAA 2023, CMS must distribute 200 Medicare-funded physician residency slots in FY 2026, with at least half of these slots (100 positions) going to psychiatry or psychiatry subspecialty residencies. The phrase "psychiatry or psychiatry subspecialty residency" is defined at section 1886(h)(10)(F)(ii) of the Social Security Act to mean "a residency in psychiatry as accredited by the Accreditation Council for Graduate Medical Education (ACGME) for the purpose of preventing, diagnosing, and treating mental health disorders."

Eligibility to Apply. For a hospital to be eligible to apply for the Section 4122 slots, CMS proposes that it would have to fall within one of four categories of hospitals:

- located in rural areas or treated as being in a rural area;
- training residents over their Medicare GME cap;
- located in states with new medical schools or branch campuses on or after January 1, 2000; or
- training in geographic HPSAs.

CMS also proposes that a hospital would need to show a "demonstrated likelihood" that any awarded slots will be used for a new residency program that the hospital will establish or for an expansion of an existing program that will occur after the date the increase would be effective. The new GME Cap Slots awarded would have to be filled within the first five training years after July 1, 2026. The Proposed Rule includes additional information on "Demonstrated Likelihood" Criteria that hospitals have to satisfy, which include but are not limited to, sending an application to the ACGME or ABMS for a new residency program and receiving an approval or acknowledgment of receipt before the application deadline. If the new program already has been approved, the hospital must have unfilled positions that it can attest will be filled using the Section 4122 GME Cap Slots.

Requirement for Rural Hospitals to Expand Programs. To prevent rural hospitals and hospitals reclassified as rural from being able to receive duplicative cap increases for new programs and Section 4122 awards, CMS proposes that rural hospitals and hospitals that have been reclassified as rural under 42 CFR 412.103 only would be permitted to apply for Section 4122 slots to expand existing programs (not to begin new programs).

Distribution to Eligible Hospitals. Consistent with statutory text, CMS proposes a distribution methodology that would allow ***all*** qualifying hospitals that submit timely applications to receive an award of up to one FTE (which could mean a fraction of an FTE). The maximum number of slots a hospital could receive under the Section 4122 distribution is ten slots. That said, the pro rata share of the 200 FTEs that each hospital could be awarded will depend on the number of qualifying hospitals that apply. If there are over 200 qualifying applicants, each hospital only could be awarded a fraction of an FTE. For example, if there are 350 qualifying applicants (with programs that meet the eligibility and demonstrated likelihood criteria), each hospital's share of the 200 FTEs will be 0.57 FTEs.

CMS Applicant Preferences. If there are slots outstanding after CMS distributes up to 1.00 FTE to each qualifying hospital, CMS proposes to prioritize distributing the outstanding slots to hospitals with the highest HPSA scores. The Health Resources & Services Administration (HRSA) assigns HPSA scores on a scale of 0 to 25 as a measure of the severity of a primary care or mental health provider shortage in a geographic area, with higher scores indicating a more severe health professional shortage. CMS would use the HPSA score of the HPSA served by the residency program to rank applications when making awards. This proposed methodology is the same as the HPSA distribution methodology that CMS finalized for the Section 126 distribution.

Application Process. Under the Proposed Rule, interested hospitals would have to submit applications via the Medicare Electronic Application Request Information System (MEARIS) for slots by March 31, 2025. CMS would notify hospitals of the number of slots distributed to them by January 31, 2026, and the increase would be effective July 1, 2026.

2. Proposed Changes to the Prioritization Methodology That Will Be Used to Award GME Slots for Rounds 4 and 5 of Section 126. Of the CAA, 2021.

CMS proposes to amend the methodology it will use to prioritize awards of GME Slots in the final two rounds (Rounds 4 and 5) of the distribution of 1,000 GME slots authorized under Section 126 of the CAA, 2022. Specifically, CMS is proposing to prioritize hospitals that qualify under Category Four, regardless of HPSA score.

As discussed in the final rule implementing Section 126 of the CAA, 2021, an applicant hospital qualifies under Category Four if it participates in training residents in a program in which the residents rotate for at least 50 percent of their training time to a training site(s) physically located in a primary care or mental-health-only geographic HPSA. Specific to mental-health-only geographic HPSAs, the program must be a psychiatric or a psychiatric subspecialty program (86 FR 73430).

The remaining slots will be distributed using the distribution methodology that applied to the first three rounds (i.e., GME cap slots will be distributed to hospitals qualifying under Category One, Category Two, or Category Three, or hospitals that meet the definitions of more than one of these categories, and awards will be prioritized based on the HPSA score associated with the program for which each hospital is applying).

3. Proposed Modifications to the Criteria for New Residency Programs and Requests for Information.
In regulations, CMS has defined a "new" medical residency program as "a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." *See* 42 CFR 413.79(l). While the regulatory definition is fairly broad, CMS's long-standing policy has been to require residency programs to meet specific criteria to be categorized as "new" for the purpose of determining if a hospital can receive additional direct GME and/or IME cap slots for a new program. *See* 47 Fed. Reg. 43908-43917 (Aug. 27, 2009). In order for a residency program at a new teaching hospital to be considered "new" from CMS's perspective, the program could not simply be transferred from another hospital or be a rebranded version of an existing program. CMS used the following criteria to evaluate whether a residency program is "new" such that a previously non-teaching hospital could receive GME cap slots for training residents in the program:

- The residents are new;
- The program director is new; and
- The teaching staff are new.

  74 Fed. Reg. 43912.

CMS granted some leeway as long as the "overwhelming majority" of residents and teaching staff were new. The fact that CMS has evaluated the "newness" of residency programs based on criteria that have never been codified has been a source of confusion. In the Proposed Rule, CMS also acknowledges the increased importance of clarifying this policy in light of urban to rural classifications under 42 CFR §412.103. This is because hospitals that meet applicable criteria to reclassify as rural under § 412.103 are treated as rural for IME purposes. Therefore, they can build their IME caps by starting new programs. Accordingly, whether or not a program would be considered "new" by CMS could have significant GME payment impact. For these reasons, CMS has decided to establish "newness" criteria through rulemaking. In the Proposed Rule, CMS is soliciting comments and seeking further information through Requests for Information (RFI) related to its proposed "newness" criteria.

CMS proposes that for a program to be considered "new," the following will be considered:

- At least 90 percent of the individual resident trainees (not FTEs) must not have previous training in the same specialty as the new program;
- The proportion of brand-new residents in a residency program would be determined by the MAC based on all the individuals (not FTEs) that enter the program as a whole at any point during the five-year cap building period, after the end of the five years; and
- Up to 50 percent of teaching staff in a new program may come from a previously existing program in the same specialty, but if so, each of those staff members should come from different previously existing programs.

CMS is soliciting information through RFIs regarding the following:

- What is a reasonable threshold for the relative proportions of experienced and new teaching staff?
- Should there be different thresholds for small (which may include rural) residency programs?
- What variables should be used to examine the newness of teaching staff?
- Should any threshold for determining the newness of teaching staff for a new program consider only the ACGME's definition of "Core Faculty," or count non-core faculty as well?
- In considering whether the presence of a faculty member might jeopardize the newness of a new program, would it be reasonable to consider whether five or ten years or some other amount of time, has passed during which that faculty member has not had experience teaching in a program in the same specialty?
- Would it make sense to define a similar period of time (for example, five or ten years) during which an individual must not have been employed as the program director in a program in the same specialty? Should there be a different criterion for small (which may include rural) residency programs?
- What should be considered a "small" residency program (for example, programs accredited for 16 or fewer positions)?
- What staff threshold or other approach should be applied to small (which may include rural) programs?
- What amount, if any, of commingling is appropriate among residents in an existing program and residents in a program where training is occurring at a hospital that may be eligible for an FTE cap increase for training residents in a new program?
- Why would hospitals want to train residents in separately accredited programs in the same specialty, and how much does this happen in both sparsely populated and more densely populated areas?

4. Notice of Closure of Teaching Hospitals and Opportunity to Apply for Available Residency Slots.
Notice of Closure. Under Section 5506 of the ACA, CMS must redistribute the residency slots of a hospital that closes. In the Proposed Rule, CMS provided public notice that the residency slots from the closure of McLaren St. Luke's Hospital and South City Hospital are available for redistribution. The table below contains the identifying information and IME and direct GME FTE resident caps for the closed hospitals.

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME FTE Resident Cap	Direct GME FTE Resident Cap
360090	McLaren St. Luke's Hospital	Maumee, OH	45780	May 9, 2023	14.93	14.93
260210	South City Hospital	St. Louis, MO	41180	November 18, 2023	67.54	74.0

Application Process for Available Resident Slots. Interested hospitals may access the application through MEARIS. The application period for 5506 slot redistributions is 90 days from the publication of the notice of closure. Therefore, hospitals that wish to apply for and receive slots from the closed hospitals' FTE resident caps must submit applications via MEARIS no later than July 9, 2024.

Application Considerations. A hospital applicant must demonstrate a likelihood of filling requested slots within the three academic years immediately following the application deadline to receive slots after a particular hospital closes. Priority is given to hospitals located in the same geographic region as a closed hospital. Hospitals located in the same or a contiguous Core Based Statistical Area (CBSA) are given the highest

priority, and those in the same state or region receive the next highest. Among other factors, CMS also gives preference to an applicant that:

- Assumed a program from the closed hospital;
- Received slots from the closed hospital under a GME affiliation agreement and would use the slots to continue to train at least the same number of residents the closed hospital had trained under the affiliation agreement;
- Took in the resident physicians displaced by the hospital closure and would continue to train residents in the same programs as the displaced residents, even after the displaced residents completed their training; and
- Will use the slots to establish a new, or expand an existing geriatrics residency program; or
- Is located in an HPSA and will use all the additional slots to establish or expand a primary care or general surgery residency program.

For more information about the Proposed Rule or further analysis regarding Medicare GME payment opportunities and other federal and state funding for graduate medical education programs, please contact Allison M. Cohen, Alex S. Lewis, or any other member of Baker Donelson's Reimbursement Group.