CMS PROPOSES CHANGES TO GME RULES IN 2013 IPPS PROPOSED RULE

On May 11, 2012, the Centers for Medicare and Medicaid Services ("CMS") issued the 2013 Inpatient Prospective Payment System ("IPPS") Proposed Rule. In the IPPS Proposed Rule, CMS proposed to change the rules for:

- Calculating new teaching hospital full-time equivalent cap ("FTE cap") by moving from a 3-year window to a 5-year window;
- What hospitals that received additional cap under Section 5503 of the Affordable Care Act ("ACA") need to do to keep that cap, including the effective dates and detail during the first 5 years after the award;
- Applications under Section 5506 of the ACA for redistribution of closed hospital cap;
- The treatment of labor and delivery beds in the calculation of the IME payment adjustment; and
- The timely filing requirements relating to shadow billing for Medicare Advantage patients.

NEW PROGRAM GROWTH - 3 YEARS TO 5 YEARS

Under existing regulations, at 42 C.F.R. § 413.79(3)(1), there is a 3-year period in which a new teaching hospital can ***grow*** its residency programs, for the purpose of establishing its FTE resident cap (referred to as the "3-year window"). Under the current regulation, the cap is based on the highest number of resident FTEs training in any program year during the third year of the first new program, multiplied by the minimum accredited length of each program (and subject to a limit based on the maximum number of approved slots). In response to concern from the provider community that 3 years does not provide a sufficient amount of time for a new teaching hospital to grow all of its new residency programs and to establish FTE caps that are properly reflective of the number of FTE residents that the hospital will ultimately train, CMS proposed to expand the 3-year window to 5 years and to set the cap permanently at the end of the fifth year of the first new program. The amended cap calculation would be based on the product of the highest number of resident FTEs training in any program year during the fifth year of the first new program, multiplied by the number of years in the program (and subject to the number of accredited slots for the program). This proposed policy change would apply to the establishment of a hospital's cap for both direct graduate medical education ("direct GME") and indirect medical education ("IME") payment purposes and would be applied to both caps beginning with the sixth academic year of the first new program.

CMS also proposed to amend the regulations at 42 C.F.R. § 413.79(e)(1)(i) and 42 C.F.R. § 412.105(f)(i)(vii) for calculating the direct GME and IME caps, respectively, when residents in a new residency program at a new teaching hospital rotate to more than one hospital during the 5-year window. Specifically, CMS proposed to apportion the potential new FTE cap among the hospitals that train the residents based on the percentage of resident FTEs that each hospital trains ***over the entire 5-year window***. If one of the hospitals that the residents in the new program are rotating to already has a cap established, that hospital would be able to count the FTE residents training there only if it has room under its cap to do so, but the fact that the residents were training at that existing teaching hospital would also proportionally decrease the new teaching hospital's FTE cap. CMS stated that it favors the revised methodology because it more accurately reflects the percentage of FTE residents each hospital trained over the course of the entire 5-year window, rather than the percentage of residents trained only during the fifth year. CMS has proposed that the changes would be effective for a hospital that begins training residents for the first time on or after October 1, 2012.

The proposal to apportion the potential new FTE cap through calculations relating to the rotations to all of the hospitals that participate in training the residents in the new program is the first rulemaking change that puts in writing a position that CMS appears to have taken already under the current rule. While not in the plain language of the current rule, in recent practice, CMS has applied the apportionment idea to the calculation of a new teaching hospital's cap, considering the time the new program residents spend at other hospitals during the FTE cap determination year and, in connection with that, decreasing the calculation of the new teaching hospital's FTE cap. While according to CMS, the idea of apportioning the FTE cap among all of the hospitals that participate in the training of new program residents has a policy base in the current law, the changes proposed and existing practice need to be closely analyzed to ensure the optimal FTE cap for new teaching hospitals is achieved, consistent with current law.

CLARIFICATION RELATED TO SECTION 5503 CAP INCREASE

Section 5503 of the ACA provided for a redistribution of resident cap slots from hospitals that were below their caps to other hospitals that applied to CMS for the slots for use in expanding primary care and general surgery programs. Once the teaching hospitals received new slots under Section 5503, they had to meet certain requirements to keep the slots, referred to as the "Primary Care Average," which requires that the hospital maintain the number of FTE primary care residents the hospital had before the increase at or above the average number of FTE primary care residents during the three most recent cost reporting periods ending before March 23, 2010, and the "75% Threshold," which requires that the hospital ensure that not less than 75% of the positions attributable to the cap increase are in a primary care or general surgery residency. In the IPPS Proposed Rule, CMS clarified that the 75% Threshold applies once the hospital starts using any of its Section 5503 slots, and the Primary Care Average applies immediately on July 1, 2011, regardless of whether the hospital began using its Section 5503 slots at that time or the use of the slots is delayed to a later time. In addition, CMS proposed that to keep the slots, a hospital must fill at least half of its Section 5503 slots within one of the first three 12-month cost reporting periods beginning on or after July 1, 2011. Finally, CMS proposed that hospitals that receive Section 5503 slots must fill ***all*** of the slots they receive by their final cost reporting period beginning during the timeframe of July 1, 2011 through June 30, 2016. If a hospital that received 5503 FTE cap fails to meet all of the applicable requirements, it risks the loss of all of its Section 5503 slots after June 30, 2016. Even if this proposal added certain clarity to questions that were previously unanswered, this is a complex proposed rule and one that should be closely scrutinized to align the application of these limits to the intent of the 5503 redistribution.

PROPOSED CHANGES TO SECTION 5506 CAP INCREASE

On November 24, 2010, CMS issued regulations implementing Section 5506 of the ACA, which directed CMS to redistribute FTE cap slots from closed hospitals. CMS now proposes to shorten the deadline for hospitals to apply for Section 5506 cap slots. Currently, the deadline is four months from the date following CMS' public notice of a hospital's closure and the availability of resident slots from the closed hospital. CMS has proposed to reduce this timeframe to 60 days in response to comments from providers that the four month application period unduly delayed the process. In addition, CMS proposed changes to modify the criteria for ranking applications for cap slots from closed hospitals. CMS currently uses seven criteria ranked in order of priority. CMS has proposed two new criteria to replace existing criterion seven. Criterion seven, which has the lowest priority, is currently a catch-all for hospitals that do not fit within any of the first six criteria. CMS does not propose to alter criteria one through six. However, CMS has proposed to clarify the effective dates of the permanent cap slots awarded under each of the ranking criteria. Finally, CMS has proposed several changes to its evaluation form for Section 5506 applications.

CALCULATION OF IME PAYMENT ADJUSTMENT WITH RESPECT TO LABOR AND DELIVERY BEDS

CMS proposed to remove ancillary labor and delivery services from the types of services currently excluded from payment under the IME payment adjustment and the Disproportionate Share Hospital ("DSH") adjustment. Prior to the 2010 IPPS Final Rule, CMS had excluded labor and delivery patient days associated with beds used for ancillary labor and delivery services from the count of inpatient days for purposes of DSH reimbursement when the patient did not occupy a routine bed prior to occupying an ancillary labor and delivery bed. In the 2010 IPPS Final Rule, CMS revised the regulations to include in the DSH adjustment all patient days associated with patients occupying labor and delivery beds once the patient has been admitted as an inpatient. CMS stated that its rationale for this change was that costs associated with labor and delivery patient days are generally payable under the IPPS; therefore, the bed in which the service is furnished should also be counted. CMS proposed to extend its current approach of including labor and delivery patient days in the DSH payment adjustment to the rules for counting hospital beds for purposes of the IME payment adjustment as well, which are found at 42 C.F.R. § 412.105(b).

TIMELY FILING REQUIREMENTS FOR MEDICARE ADVANTAGE PATIENTS

CMS clarified that it always intended for the timely filing requirements found at 42 C.F.R. § 424.44 to apply to shadow claims, or "no-pay bills," submitted by hospitals that receive IME, direct GME and nursing or allied health education payments. CMS proposed to implement the timely filing requirements for no-pay bills associated with calculating the DSH adjustment as well.

COMMENT PERIOD CLOSES 5:00 P.M. EDT JUNE 25, 2012

Each of the proposed changes summarized above deserves a close analysis and comments to CMS to ensure that these important changes to the Medicare GME reimbursement system achieve the right result for providers.

The IPPS Proposed Rule can be accessed here.

If you would like additional information or assistance with policy/procedure or comment preparation, please contact:

- Scott J. Geboy at sgeboy@hallrender.com or (414) 721-0451;
- Susanne E. Crysler at scrysler@hallrender.com or (248) 457-7843;
- Rachel S. Delaney at rdelaney@hallrender.com or (414) 721-0448; or
- Your regular Hall Render attorney.