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Special Bulletin

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AHA Summary of CMS Final Rule Implementing Policies on Graduate Medical Education, Organ Acquisition and Section 1115 Waiver Days

As urged by the AHA, CMS modifies several policies; agency will accept comments

The Centers for Medicare & Medicaid Services (CMS) Dec. 17 issued a final rule with comment period related to certain policies for the fiscal year (FY) 2022 inpatient prospective payment system (IPPS). The rule modifies and finalizes provisions to implement policies related to graduate medical education (GME), payment for organ acquisition and the treatment of section 1115 waiver days for the purposes of Medicare disproportionate share hospital (DSH) payments. Comments are due 60 days after the rule is published in the Federal Register.

AHA Take: We appreciate CMS listening to our concerns by delaying finalization of proposed changes pertaining to Medicare's share of organ acquisition costs. We also are pleased that the agency modified several proposals related to the distribution of GME slots, including an increased adjustment on the number of slots available for each hospital each year. Lastly, while we are disappointed that CMS finalized its policy to use health professional shortage area (HPSA) scores to prioritize slot distributions, we appreciate that CMS recognizes the challenges involved in using such a method and is seeking comments on feasible alternatives for potential future rulemaking. We look forward to working with the agency to develop workable policies.

Highlights of the final rule follow.

INDIRECT AND DIRECT MEDICARE GRADUATE MEDICAL EDUCATION (GME)

In the 2022 IPPS proposed rule, CMS proposed to implement several provisions of the Consolidated Appropriations Act, including its requirement for 1,000 new Medicare-funded medical residency positions; the Promoting Rural Hospital GME Funding Opportunity, which would allow certain rural training hospitals to receive a GME cap increase; and the determination of direct GME per-resident amounts and certain full-time equivalent (FTE) resident limits for hospitals that host a small number of residents for a short duration.

New Medicare-funded Medical Residency Positions. In this rule, CMS finalized its policy related to the number of residency positions made available each year. Specifically, the agency will make 200 positions available for FY 2023 and each subsequent year until 1,000 have been distributed. The agency also finalized its

policy to prioritize applications from qualifying hospitals operating residency programs serving underserved populations by using the Health Resources and Services Administration's HPSA score in allocating FTEs.

CMS is modifying its proposal that limited the number of residency positions to each hospital to no more than one FTE each year. Instead, CMS will allow up to five FTEs per year, with the maximum award amount contingent on the length of the program for which the hospital is applying.

In addition, CMS is modifying its proposal that a hospital's main campus or provider-based facility must be physically located in a primary care or mental health HPSA and that at least 50% of residents' training time over the duration of the program must occur at those locations in the HPSA. Instead, CMS has finalized that as long as the hospital participates in training residents in a program where at least 50% of the training time occurs at sites that are physically located in a geographic HPSA, that hospital is considered to be eligible. The agency is seeking additional comments on appropriate measures of where HPSA residents seek medical care as a feasible alternative for potential use in future rulemaking.

CMS also finalized a modified proposal to include psychiatric subspecialty residency programs in addition to psychiatric residency programs within its mental health geographic HPSA category.

Promoting Rural Hospital GME Funding Opportunity. CMS finalized its proposed policies to implement the Promoting Rural Hospital GME Funding Opportunity, which would allow certain rural training hospitals to receive a GME cap increase. Specifically, the agency will provide an adjustment to IME and direct GME FTE resident caps each time an urban and rural hospital establish a Rural Training Track (RTT) program for the first time, even if the RTT program does not meet the newness criteria for Medicare payment purposes. CMS also will adjust resident caps for an urban hospital creating additional RTTs after establishing its first RTT.

Adjustment of Low Per Resident Amount (PRA) and Low FTE Resident Caps. CMS proposed to implement changes to the determination of direct GME per-resident amounts and certain FTE resident limits for hospitals that host a small number of residents for a short duration. The agency finalized its proposals to allow qualifying hospitals that previously had low FTE caps to recalculate the PRA and FTE cap. CMS also is soliciting comments on a review process to determine eligibility for PRA or FTE cap resets in certain situations.

ORGAN ACQUISITION PAYMENT

CMS did not finalize its proposed policy for counting organs for purposes of determining Medicare's share of organ acquisition costs for organs transplanted into Medicare beneficiaries. The agency acknowledged the need to conduct

additional analyses of the impacts before it considers revising the policy for future rulemaking.

However, the agency finalized its proposals to codify into Medicare regulations some longstanding Medicare organ acquisition payment policies, as well as some new policies, including clarifying definitions of “transplant hospital” and “transplant program.” Lastly, the agency also finalized several proposals related to standard acquisition costs and reporting and billing of organ acquisition costs.

Counting Days Associated with Section 1115 Demo Projects in the Medicaid Fraction of the Medicare DSH Calculation

CMS proposed revisions to the regulation relating to the treatment of section 1115 wavier days for the purposes of DSH adjustments. Specifically, CMS proposed to modify its regulation to only count section 1115 waiver days in the numerator of the Medicaid fraction if the waiver directly provided inpatient hospital insurance coverage to that patient on that day. The agency did not finalize its proposed policy and stated that it expects to revisit the issue of section 1115 waiver days in future rulemaking.

Next Steps

The final rule will be published in the Dec. 27 Federal Register. Comments are due 60 days after publication in the Federal Register.

If you have further questions, please contact Shannon Wu, AHA senior associate director of policy, at 202-626-2963 or swu@aha.org.