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CMS Proposes Changes to GME/IME Payment Rules and Provides Guidelines for § 5506 Application Process

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CMS has been busy addressing GME and IME issues in recent days. First, in late April, the agency issued its proposed Federal Fiscal Year 2013 inpatient prospective payment system (IPPS) update, www.gpo.gov/fdsys/pkg/FR-2012-05-11/pdf/2012-9985.pdf, which contains a number of proposed revisions regarding the GME and IME payment provisions. Second, at the very end of April, it issued guidance regarding applications for additional FTE slots under § 5506 of the Affordable Care Act (ACA). www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/Section-5506-Application-Guidelines.pdf.

The FY 2013 IPPS Proposed Rule

1. In the proposed rule, CMS "clarifies" its policy regarding claiming IME and GME payment for services provided to Medicare Advantage (MA) enrollees. Those payments have been permitted since 1998, and CMS has maintained in litigation that hospitals were required to submit Medicare claims to their Medicare contractors for the MA (previously, M+C) enrollees in UB-92 format in order for days associated with those enrollees to be counted. In the IPPS update, CMS repeats this position, stating that it was "always our intent that the time limits applicable in 42 U.S.C. § 424.44 apply to those claims submissions." Similarly, says CMS, the timely filing limits of § 424.44 apply to claims related to nursing and allied health education program payments for services provided to MA enrollees.
2. CMS proposes, as well, to include labor and delivery bed days in the count of available beds used in both the IME and DSH calculations.
3. Additionally, CMS proposes to alter the cap measuring process for new teaching hospitals in two ways. First, CMS proposes to expand the program growth period for measuring new teaching hospitals' GME and IME caps from

three years to five years. Under the proposal, therefore, hospitals that become new teaching hospitals will not have their caps established until the end of the fifth program year. Second, in instances in which more than one hospital trains the residents, CMS proposes to look at the highest total number of FTE residents training in any program year during the fifth academic year of the first new program's existence at all participating hospitals. Then, CMS would multiply this highest FTE count by the number of years in which residents are expected to complete the program, based on the minimum accredited length of that program. CMS would then take that product and multiply it by each hospital's ratio of the number of FTE residents in the new program training over the course of the five year period at each hospital to the total number of FTE residents training in all participating hospitals over the course of that five year period. CMS states that this approach should more completely reflect the training patterns in years after the fifth academic year.

Both cap proposals mark a substantial departure from current policy. The expansion of the cap measuring period from three to five years will benefit most hospitals. At the same time, the apportionment requirement may adversely affect other hospitals.

4. CMS also clarifies its policies regarding what hospitals must do during the five year period following the redistribution of resident caps under § 5503 of the ACA. Under § 5503, hospitals must satisfy certain requirements in order to obtain, and keep, redistributed FTEs from hospitals that do not close. Included among those requirements are that a hospital that receives an increase in its caps shall ensure that, during the five-year period beginning on the date of the increase (which occurred on July 1, 2011), the pre-enactment "primary care average" and the 75% "primary care/general surgery" threshold be met. CMS proposes that, in satisfying these standards, hospitals be obligated to fill at least half of their § 5503 slots, for both IME and GME, in either their first, second, or their third 12-month cost reporting periods beginning July 1, 2011, and that the 75% threshold apply once the hospitals begin using those slots. CMS also proposes that, should hospitals fail to meet these requirements,

Medicare contractors would, after audit, permanently remove all of the hospital's § 5503 slots from the earliest cost reporting period subject to reopening. Under CMS's proposal, this forfeiture of slots would take place even if the hospitals had used at least half of their § 5503 slots in their fourth or subsequent cost reporting periods. Moreover, CMS proposes that hospitals must fill all of the slots that they received by the time of their final cost reporting period beginning during the timeframe July 1, 2011, through June 30, 2016, or lose all of those slots after June 30, 2016.

5. CMS also proposes changes to the application process under § 5506, which relates to the redistribution of FTE slots from closed hospitals. First, CMS proposes to reduce the time frame within which hospitals must apply for such slots from four months to 60 days following CMS's public notice of the hospital's closure and of the availability of the closed hospital's resident cap slots. Second, CMS proposes to replace current ranking criterion 7 – which currently applies to slots available when hospitals do not fit within ranking criteria 1–6 – into two separate ranking criteria. Under the proposal, hospitals that do not fit within criteria 1-6 might apply under ranking criterion 7 for slots in primary care or a general surgery program. Criterion 8, as proposed, would then apply to hospitals that wish to use the slots for purposes that do not fit within any of the other ranking criteria. Thus, under the proposal, CMS would give a higher ranking (criterion 7) to those hospitals that seek primary care and general surgery FTE cap slots in addition to non-primary care slots, while the last order of ranking (criterion 8) would then be reserved for hospitals that fail to satisfy any of the other criteria and are seeking only non-primary care or non-general surgery slots. Third, CMS proposes clarifications of the effective dates of the cap transfers under the various ranking criteria.

CMS is seeking comments on a number of its effective date policies and alternatives. CMS is also soliciting comments on whether the current rules regarding temporary cap adjustments for displaced residents from closed hospitals are still necessary now that there is a provision in the statute addressing the permanent reassignment of those slots. Finally, CMS has made a number of proposed changes to its § 5506 evaluation/application form.

Guidance Document

At roughly the same time CMS was issuing its proposed regulation, it posted on its website miscellaneous guidelines regarding the § 5506 application process. The guidance document includes a list of items and issues that the hospitals should follow in preparing applications under § 5506, including, for example, what items that should be included in the cover letters, how to apply under different demonstrated likelihood criteria, documentation necessary to support ranking criteria 1, 2 or 3 applications, and the counting rules applicable for slots where the residents are rotating to two or more participating hospitals.

Ober|Kaler's Comments

CMS's proposed changes and clarifications – which potentially affect most current and new teaching hospitals – warrant scrutiny, and hospitals should consider submitting comments. The comment deadline is June 25, 2012. Additionally, hospitals that anticipate that they may wish to seek additional FTEs under § 5506 would be well advised to take CMS's guidance document into account.