

Excerpt: FY 2023 IPPS Proposed Rule Comment letter **GRADUATE MEDICAL EDUCATION PROPOSALS**

Payment for Direct Graduate Medical Education Costs: Milton S. Hershey Medical Center et al. v. Becerra Litigation

The direct graduate medical education (DGME) payment calculation considers the number of weighted full-time equivalent (FTE) residents that train at a hospital. Statutorily, each resident is counted as a 1.0 full-time equivalent (FTE) trainee while they train within their initial residency period (IRP), not to exceed five years, and 0.5 FTE for additional training in an approved post graduate training program. Prior to 1996, hospitals used the total weighted FTE count to calculate the DGME payment. In response to Congress capping the number of residents for which a hospital can be reimbursed, CMS developed a “proportional reduction methodology” to ensure that a hospital’s adjusted weighted FTE count did not exceed their 1996 cap. In May 2021, the United States District Court for the District of Columbia held that the proportional reduction method inappropriately reduced the statutorily mandated weighting factors for hospitals that had a weighted FTE count higher than their 1996 cap, and trained residents beyond their IRP.¹ In effect, the proportional reduction method reduced the statutorily mandated weighting factors to less than their required weights under the law.

In response to the District Courts holding, CMS has proposed a new methodology to arrive at an adjusted weighted FTE count that would have only one consideration: whether the hospital’s weighted FTE count exceeds the hospital’s 1996 cap. Where a hospital’s weighted FTE count is greater than the 1996 cap, a hospital would adjust the weighted FTE count to their 1996 cap. Hospitals that have a weighted FTE count that does not exceed the 1996 cap would use their weighted FTE count. CMS has also proposed making the change effective for hospitals with open or openable cost reports as of October 1, 2001. The AAMC appreciates the proposed changes to the adjusted weighted FTE count calculation and agrees with the American Hospital Association’s comments regarding retroactive rulemaking.

The proposed methodology preserves the statutorily mandated weighting factors and is equitable to teaching hospitals. Under the proposed change, hospitals that train residents in excess of their 1996 caps would no longer experience a reduction in their FTE count, if the excess is because they train residents beyond their IRP. **The AAMC supports CMS’s proposed changes to the calculation for the adjusted weighted DGME count, and thanks CMS for its thoughtful proposal.**

Proposal to Allow Medicare GME Affiliation Agreements Within Certain Rural Track FTE Limitations

For the first time, CMS is proposing to allow hospitals that established an ACGME separately accredited 1-2 family medicine program prior to October 1, 2022, to create Rural Track Medicare GME Affiliation Agreements. Once hospitals participating in a 1-2 family medicine program have finished their cap-building period, these affiliation agreements would allow them

¹ *Milton S. Hershey Medical Center v. Becerra*, 2021 WL 1966572(D.D.C. May 17, 2021).

to share FTE caps for agreed upon-academic years while providing flexibility to match resident rotation schedules where needed. This would allow training experiences for residents that may be required but not available in certain areas. **The AAMC supports this proposal and encourages CMS to engage in future rulemaking that will allow rural track programs that were established under §127 of the Consolidated Appropriations Act, 2021 to also engage in affiliation agreements to strengthen the training of residents following the conclusion of the cap-building period.**
