

Excerpt: FY 2024 IPPS Proposed Rule
GRADUATE MEDICAL EDUCATION PROPOSALS

Calculating Prior Year IME Resident to Bed Ratio When there is a Medicare GME Affiliation Agreement

The AAMC thanks CMS for including detailed clarification for calculating the prior year intern and resident to bed ratio (IRB) for the indirect medical education (IME) adjustment. Specifically, CMS clarifies the determination of the net increase in FTEs in the current year as compared to the prior year when a hospital participates in an affiliated group agreement. (p. 27017). To make this determination, CMS instructs hospitals to isolate fluctuations in year-to-year FTE count for Form CMS-2552-10, Worksheet E. The step-by-step walkthrough should ensure accurate preparation of future cost reports.

Though CMS has not proposed a policy change, we thank CMS for the responsiveness to concerns raised by hospitals participating in affiliation agreements in completing these forms. These requests for clarification by teaching hospitals demonstrate a good faith effort to capture accurate cost report information. We appreciate the clarification in the proposed rule and ask CMS to continue listening to teaching hospitals when specific policies are unclear.

Graduate Medical Education Training in Rural Emergency Hospitals

The AAMC supports the CMS proposal to reimburse graduate medical education training at rural emergency hospitals (REHs); as a non-provider site where a hospital may capture resident's time when it pays for the direct cost of training residents while at the REH, or reimburse the reasonable costs of training when the REH incurs the costs of direct graduate medical education. (p. 27018). Congress, through § 125 of the Consolidated Appropriations Act, 2021, added § 1861(kkk) to the Social Security Act (the Act), creating a new Medicare provider type, the REH.¹ The new designation is meant to provide rural communities with flexibility to maintain access to care in response to the number of rural acute inpatient hospital closures that have impacted rural access to care.²

Effective January 1, 2023, rural hospitals (or hospitals treated as rural for IPPS purposes) with 50 or fewer beds and critical access hospitals (CAHs) that held these designations as of December 27, 2020, may convert to REH status. REHs do not provide acute inpatient hospital services; instead, REHs provide emergency department services and observation care. At the election of the REH, the facility may provide outpatient services and extended care services when furnished in a distinct unit licensed as a skilled nursing facility. (p. 27018). Hospitals that convert to the REH status are eligible for a subsidy payment and an add-on payment for REH services performed on an outpatient basis.³ Because these facilities do not qualify for direct graduate medical education (DGME) reimbursement under section 1886(h) of the Act and do not receive IME as they are not paid under the inpatient prospective payment system, stakeholders have asked CMS to consider reimbursing for training in REHs similar to Medicare's treatment of CAHs for DGME and IME reimbursement purposes. (p. 27018).

Specifically, CMS considers training time residents spend in CAHs as countable time to the hospital for IME and DGME if the hospital incurs all of or substantially all of the costs of training (defined as the costs of the residents' salaries and fringe benefits).⁴ Therefore, when a hospital meets the requirements for counting resident time at non-provider sites, it may include resident FTE time spent at the CAH in its DGME and IME FTE counts. Alternatively, CMS permits CAHs to incur the direct costs of training residents in approved programs and receive reimbursement for 101 percent of the reasonable training costs.⁵ No hospital may claim the time spent at a CAH when the CAH incurs the direct training costs.

CMS proposes to expand DGME and IME payment to hospitals when residents train at an REH on the same basis as it does when the training occurs in a CAH. Under the proposal, an acute care hospital may include resident training time at the REH in the DGME and IME FTE count when it meets the requirements under 42 CFR 412.105(f)(1)(ii)(E) and 413.78(g) (e.g., when the hospital incurs the costs of the residents' salaries and fringe benefits). Alternatively, CMS proposes to reimburse the REH at 100 percent of the reasonable DGME training costs when the REH facility incurs the direct cost of training residents consistent with § 1861(v)(1)(A) of the Act. Like CAHs, no hospital may claim the resident time spent at an REH when the REH incurs the direct cost of training residents.

The AAMC supports CMS' proposal that will allow either the hospital or the REH to receive payment from Medicare for incurring the cost of training occurring at an REH. The REH program

¹ Consolidated Appropriations Act, 2021 (Pub. L. 116-260).

² Medicare Payment Advisory Committee, Report to Congress: Medicare and the Health Care Delivery System (June 2021).

³ 87 Fed. Reg. 71748, 72162 (Nov. 23, 2022).

⁴ 84 Fed. Reg. 42411 (Aug. 16, 2019).

⁵ 84 Fed. Reg. 42044, 42411 (Aug. 16, 2019).

should provide stability in healthcare delivery systems for communities that would otherwise experience the closure of a hospital. The proposal will allow small rural teaching hospitals or CAHs that convert to an REH facility to minimize unnecessary financial burdens when they convert to an REH and choose to continue their educational mission.⁶

The size of REH facilities and training requirements from the Accreditation Council for Graduate Medical Education will likely limit the number of residents that train at these sites. Still, with new opportunities for hospitals to expand graduate medical education training through rural track programs, REH GME has the potential to create training partnerships in rural areas with larger academic medical centers. The learning experience provided to trainees in rural areas is unique and additional resources like REH GME may have positive patient care outcomes in these underserved areas. We believe that REHs can act as valuable training sites for residents and, to that end, appreciate CMS's consideration of REHs as GME-eligible facilities. Ultimately, this proposal helps limit the financial barriers for any REH with the capacity to operate as a rural training site.
