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Section 127 of the Consolidated Appropriations Act: Graduate Medical Education (GME) Payment for Rural Track Programs (RTPs)

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Related Change Request (CR) Number: 12709
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Effective Date: October 1, 2022
Related CR Transmittal Number: R11366OTN
Implementation Date: October 1, 2022 (see note below)

Provider Types Affected

This MLN Matters Article is for providers at rural and urban teaching hospitals billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Note: MACs will follow regular interim rate adjustment schedule after October 1, 2022.

Provider Action Needed

Make sure your billing staff knows about these changes:

- A new definition for Rural Track Programs
- Changes in Section 127 of the Consolidated Appropriations Act (CAA), 2021
- Documentation requirements for hospitals requesting indirect and direct GME rate increases

Background

On December 27, 2021, CMS published a final rule with comment period (CMS-1752-FC3) that implements changes to Medicare GME payments for teaching hospitals. The rule implements legislative changes to direct GME and Indirect Medical Education (IME) payments to teaching hospitals.

Section 127 made several changes affecting urban and rural hospitals that train residents in Rural Training Programs, formerly known as Rural Training Tracks. The changes mean that for cost reporting periods beginning on or after October 1, 2022, hospitals that have an RTP may get an adjustment to their full-time equivalent (FTE) resident limit if the hospital establishes an accredited residency program where more than 50% of the training time occurs in a rural area (86 Federal Register (FR) 73416).

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We modified 42 CFR 413.75(b) to add a new definition for RTPs that states "Rural Track Program means, effective for cost reporting periods beginning on or after October 1, 2022, an ACGME-accredited program in which residents/fellows gain both urban and rural experience with more than half of the education and training for a resident/fellow taking place in a rural area as defined at 42 CFR 412.62(f)(iii)."

Calculations for Interim Rates and RTP FTE Limitations

Hospitals wishing to get increases to their IME and direct GME interim rates for participating in new RTPs or adding clinical participating sites and FTE residents may contact their MACs and provide the appropriate documentation. MACs may adjust the hospital's interim rates so that effective for a cost report starting on or after October 1, 2022, the hospital could get increased IME and direct GME payment, as appropriate.

Final Rule 86 FR 73450 specifies that a hospital seeking the rate increase must provide certain required documentation. Your MAC will verify that the documentation includes:

- The Accreditation Council for Graduate Medical Education (ACGME) accreditation for the program (both urban and rural training components), and documents showing whether the urban and rural participating sites are starting the RTP for the first time in this specialty, or whether the urban and rural hospital already have an RTP in this specialty but are adding additional participating sites to the RTP.
- A list of all urban and rural hospital and non-provider training sites in the RTP. If more than 1 RTP, the hospital should separately list the training sites for each and include the start dates for each RTP.
- The state, county name, and the geographic Core Based Statistical Area (CBSA) where each site is located next to each hospital or non-provider training site name where each site is located.
- Any reclassification under section 1886(d) of the Social Security Act that any participating hospital may have, and the effective date of that reclassification.
- Resident rotation schedules (or similar documentation) showing that residents in the specified RTP spend more than 50% of their training in a geographically rural area in the program to get IME and direct GME rural track FTE limitations. When only a subset of residents in the particular program are participating in the RTP, and the training time of these RTP residents is included in the main rotation schedule for the entire program, the hospital must specifically highlight the names of the residents and their urban and rural training locations on the main rotation schedule. This lets your MAC easily identify which residents are training in the RTP, where they're training. The MAC will verify that more than 50% of their training time is spent in a rural area.

During the 5-year cap-building window for the RTP, we pay hospitals based on the actual FTE count, not to exceed the accredited number of positions. Effective for cost reporting periods

beginning on or after October 1, 2022, we won't apply the 3-year rolling average (42 CFR 413.79(d)(7)) and the IME intern-and-resident-to-bed (IRB) ratio (42 CFR 412.105(a)(1)(i)).

MACs will review your documentation and, if appropriate, adjust the interim IME and direct GME rates according to normal interim rate timeframes.

Requirements for RTP FTE Limitation Calculations:

- Under 42 CFR 413.79(K)(1)(ii) and (k)(2), once the 5-year cap building window ends, the hospital would calculate the IME and direct GME RTP FTE limitations and report them on the first cost report on which the RTP FTE limitations would be effective (that's, the cost reporting period coinciding with or following the start of the 6th program year of the RTP). When MACs review that cost report, each participating hospital must provide to the MAC. Read CR 12709 for documentation requirements at the end of the 5-year cap building period.

Other Information – Effective Date of Exemption from Rolling Averages & IME Intern-and-Resident to Bed (IRB) Ratio Cap

(Federal Register / Vol. 86, No. 245 / Monday, December 27, 2021 / Rules and Regulations 73457

CMS modified the regulations at 42 CFR 412.105(f)(1)(v)(F)(2) for IME and 413.79(d)(7)(ii) for direct GME as follows:

"(ii) Subject to provisions found under paragraph (k) of this section, effective for rural track programs started in a cost reporting period beginning on or after October 1, 2022, FTE residents in a rural track program at an urban hospital or rural hospital are excluded from the rolling average calculation described in this paragraph (d) during the cost reporting periods prior to the beginning of the applicable hospital's cost reporting period that coincides with or follows the start of the 6th year of each rural track."

This means that even for RTPs started prior to October 1, 2022, so long as the urban hospital and rural hospital are within the 5-year growth window for FTE residents participating in the RTP, a hospital can first benefit from the rolling average exemption in its first cost reporting period beginning on or after October 1, 2022. We can't allow hospitals to prorate and exclude FTEs from the rolling average for the portion of a cost reporting period that occurs after October 1, 2022, because the law doesn't say ''for portions of cost reporting periods on or after October 1, 2022.'' Only effective with a hospital's cost reporting period starting on or after October 1, 2022, would exemption from the rolling average apply for IME and direct GME. We'll modify cost reporting instructions to show this.

With regard to the IME IRB ratio cap, as specified at 42 CFR 412.105(a)(1)(i), effective for cost reporting periods beginning on or after October 1, 2022, urban and rural hospitals within a 5-year cap building period for an RTP wouldn't apply the IME IRB ratio cap during the cost reporting periods prior to the beginning of the applicable hospital's cost reporting period that

coincides with or follows the start of the 6th program year of each RTP.

We'll modify CMS Form-2552-10, Worksheet E, Part A, Line 20 instructions to show this exemption from the IRB ratio cap.

More Information

We issued CR 12709 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
April 28, 2022	Initial article released.