GME in the IPPS Final Rule: Medicare GME slots now up for grabs from three closed hospitals

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In the Fiscal Year 2017 inpatient prospective payment system (IPPS) Final Rule published in the *Federal Register* on August 22, 2016, the Centers for Medicare & Medicaid Services (CMS) announced the next open round of GME slots available through the Affordable Care Act's (ACA's) closed hospital slot redistribution program. The agency also finalized several changes to the Medicare GME regulations related to the rural training track (RTT) program. These noteworthy announcements and changes are discussed in turn below.

Resident slot redistribution rounds announced

Section 5506 of the ACA requires CMS to redistribute the Medicare GME residency positions of closed teaching hospitals. Priority is given to applicant hospitals located in the same or contiguous core-based statistical area (CBSA) as the closed hospital. Since the ACA was enacted, there have been seven rounds of applications and slot redistributions. In this IPPS final rule, CMS announced the following eighth, ninth, and tenth rounds of redistribution under the Section 5506 program, as follows:

Round Number	Name of Closed Hospital	City & State	Direct GME Cap Slots Available	Indirect Medical Education Cap Slots Available
8	Pacific Hospital of Long Beach, CA	Long Beach, CA	25.92	20.47
9	Huey P. Long Medical Center	Pineville, LA	11.04	11.04
10	St. Joseph's Hospital	Philadelphia, PA	8.35	8.35

Hospitals interested in applying for the available cap slots must complete an application (one per round). Applications must be submitted in hard copy to CMS such that they arrive by October 31, 2016, and applicants must also e-mail CMS at ACA5506application@cmshhs.gov with specific language articulated in the proposed rule, to inform the agency of the application and to provide the hospital's appropriate points of contact.

Changes to RTT regulations finalized

The IPPS Final Rule also finalized changes to the RTT regulations. First, CMS finalized its proposal to increase from three to five years the period of time urban hospitals are granted to establish rural training track direct and indirect GME caps (RTT caps). For a more detailed analysis on the Medicare payment rules for RTT residency programs, see our previous GME @ Dentons article, "Rural Training Tracks: An opportunity for additional GME slots through a little known exception." Under the final revisions to the RTT regulations, an urban hospital's RTT cap will take effect beginning with the hospital’s cost-reporting period that coincides with or follows the start of the sixth program year of the rural training track’s existence. The revised policy will take effect for any urban hospital that began an RTT

program on or after October 1, 2012.

In the Final Rule, CMS also provided a detailed example of the calculation of urban (and rural, if applicable) FTE resident cap adjustments under the RTT rules, and "clarified" regulatory language regarding how RTT caps are calculated. Referring to some of the changes as "technical corrections," CMS changed the RTT cap-calculation regulations to conform with the cap-building rules applicable to new teaching hospitals, under which cap calculations are "apportioned" among all training sites that participated in resident training during the five-year cap-building period according to each site's proportional amount of training time. Notwithstanding CMS's stated position that this is a mere clarification, Dentons believes this may be a departure from the agency's previous cap calculation methodology. If your institution is affected by this issue, we encourage you to contact the GME @ Dentons team to discuss the policy implications of this change.

Other noteworthy issues: GME and Worksheet S-10

The final GME-related issue in the Final Rule is CMS's ongoing commitment—over commenters' objections ~~not~~ to include GME costs in the numerator of the cost-to-charge ratio on Line 1 of Worksheet S-10, a worksheet CMS states that it will, in the future, propose to use (on a phased-in basis) for purposes of calculating Medicare disproportionate share hospital uncompensated care payments to qualifying hospitals. In response to comments, CMS reiterated, "we believe that the purpose of uncompensated care payments is to provide additional payment to hospitals for treating the uninsured, not for the costs incurred in training residents."

Dentons' Health Care team can help you assess the implications of the Final Rule and can assist in the preparation of Section 5506 slot redistribution applications on behalf of your institution.

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