Memorandum

Date: September 15, 2017

Re: Legal Authority of the Centers for Medicare & Medicaid Services (CMS) to Establish Rules for Calculating Graduate Medical Education (GME) Caps on Teaching Hospitals Training Residents in New Programs

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Issue

A recently published whitepaper entitled "Cap Flexibility: The Case for a Strategic and Targeted Policy to Provide New Teaching Hospitals in Underserved *Areas of Need* with Additional Time to Establish Medicare Funded GME Caps"[1] makes the case for CMS to implement a policy of "cap flexibility." Under this policy, new teaching hospitals would be permitted to apply for and receive a cap-building window extension of an additional one to five years above the current five-year window (which applies universally to all new teaching hospitals). The whitepaper argues that CMS has broad authority to establish Medicare-funded Graduate Medical Education (GME) caps at new teaching hospitals and that this authority extends to CMS' ability to establish rules that allow new teaching institutions to apply for and receive a cap extension beyond the current five year cap-building window.

Furthermore, the paper proposes that CMS tailor the policy to provide cap extensions to so-called "*Areas of Need.*" The whitepaper broadly defines *Areas of Need* as those areas that are rural, underserved, under-resourced, lack existing medical training infrastructure, or are struggling to expand or keep GME programs.[2] Finally, the paper suggests that CMS may structure cap flexibility in a variety of ways, for example, by designing eligibility to directly address particular disparities in the physician workforce or region, approving applications for whole programs or just specific needs within a program, approving applications while limiting the number of residency positions, and/or limiting the number of years that can be added within the cap extension.

This memorandum will explore the legal authority of the Centers for Medicare & Medicaid Services (CMS) to establish rules for calculating direct and indirect GME caps for teaching hospitals training residents in new programs. Specifically, this memorandum will analyze whether CMS has the requisite authority to supplement the current GME cap-building window by establishing rules that allow particular new teaching hospitals to apply for and receive an extension to the cap-building window, and, if so, whether that authority allows CMS the ability to tailor cap extensions to particular programs.

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[1] The whitepaper may be downloaded at www.capflex.org.

[2] The whitepaper does not provide a specific definition of *Areas of Need* but rather provides broad criteria by which CMS can use to define such an area. The paper also provides various examples of criteria by which CMS can use to define a particular *Area of Need*, such as rural areas, Medically Underserved Areas (MUAs) (as designated by HRSA), areas with shortages of physicians, institutions located in states with the lowest resident-to-population rations, residency slots, or Medicare GME funding, etc.

Findings[3]

Congress delegated significant - indeed, nearly unlimited - authority to the Secretary to establish GME caps for new programs, and explicitly provided the Secretary with flexibility in determining the proper time frame by which new programs can establish permanent caps. Through CMS, the Secretary has exercised its authority to establish first a three year window, and subsequently a five year window, and also to grant one particular, if narrow, type of cap relief to rural hospitals. Although the Secretary has not yet exercised the authority to tailor cap windows to the particular needs of individual teaching institutions, the statutory framework setting caps at the facility levels and Congressional intent supports the Secretary's ability to do so. Consequently, there is ample statutory authority for CMS to explore instituting a cap-flexibility policy as proposed in the whitepaper entitled: Cap Flexibility: The Case for a Strategic and Targeted Policy to Provide New Teaching Hospitals in Underserved Areas of Need with Additional Time to Establish Medicare Funded GME Caps.

Discussion

(a) Authority to Establish GME Caps for New Teaching Hospitals

In 1997, Congress passed the Balanced Budget Act of 1997 (BBA)[4] which placed a cap on the number of Full Time Equivalent (FTE) allopathic or osteopathic residents a hospital may claim for Direct GME (DGME) and Indirect Medical Education (IME) payments through Medicare.[5] The BBA also introduced a three-year rolling average[6] for the purpose of paying for the number of FTE residents in a program.[7] At the time the BBA was enacted, Congress was heeding concerns of a rapidly expanding physician workforce, which many thought would lead to an oversupply of physicians and an ensuing increase in Medicare expenditures.[8] In response, Congress capped the number of Medicare-funded allopathic and osteopathic training positions based on each hospital's resident count as of December 31, 1996.[9]

Congress set strict caps on teaching hospitals with approved programs as of December 31, 1996. However, Congress recognized that "such limits raise complex issues"[10], and also, simultaneously,

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[3] Dentons US LLP reviewed and concurs with the findings and legal analysis set forth in this memorandum.
[4] The Balanced Budget Act of 1997, Section 4623 (Pub.L. 105–33, 111 Stat. 251, enacted August 5, 1997).
[5] Social Security Act, Section 1886(h)(4)(F), (H); 42 U.S.C. §1395ww(h)(4)(F), (H).
[6] DGME and IME payments are subject to a three-year rolling average, whereby the full effect of increasing or decreasing the count of residents in a particular year would not be received until the third year that the additional resident was training at the hospital. If the resident count increases, the hospital would receive one-third in the first year, and two thirds in the second year, of its otherwise applicable additional payment.
[7] Social Security Act, Section 1886(h)(4)(G); 42 U.S.C. §1395ww(h)(4)(G).
[8] Medicare Payment Advisory Commission (MedPAC), March 2003 Report. http://www.medpac.gov/docs/default-source/reports/Mar03_Entire_report.pdf
[9] Social Security Act, Sections 1886(d)(5)(B)(v) and 1886(h)(4)(F)(i) The BBA set out that for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted direct and indirect medical education FTE counts may not exceed the hospital's FTE counts for its most recent cost reporting period ended on or before December 31, 1996.
[10] U.S. House. *Balanced Budget Act of 1997, Conference Report* (to Accompany H.R. 2015), pg. 821.

required the Secretary to promulgate rules establishing GME caps for new programs.[11] Specifically, the BBA instructed CMS to develop rules for new teaching hospitals, as follows:

> (i) New facilities.--The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and subject to paragraphs (7) and (8), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

As this language indicates, Congress gave CMS an immense amount of latitude to promulgate rules for new teaching hospitals as the Agency saw fit, out of concern that enacting the caps would hinder the ability of new teaching hospitals and our national GME system to be able to adapt to changing circumstances.[12] Consequently, in providing the Secretary with extensive discretion to promulgate rules, Congress meant to ensure that there existed "**proper flexibility to respond to such changing needs, including the period of time such programs would be permitted to receive an increase in payments before a cap was applied."**[13] In fact, Congress' mandate to the Secretary is so broad, that the Secretary's discretion is limited only by direction from Congress that any such rules be "consistent" with the principles of (1) establishing a limitation on the number of residents paid for by Medicare, and (2) the three-year rolling average for the purposes of counting residents.[14] The Secretary was also given broad authority to require the submission of information from institutions subject to the cap in order to carry out its rule promulgation authority therein.[15] Congress also directed the Secretary, in crafting rules, to give special consideration to facilities that meet the needs of underserved rural areas.[16]

The CMS has leveraged this broad grant of authority on several occasions to craft rules for setting direct GME caps for new teaching hospitals. In the first instance, CMS implemented the new statutory requirements set forth by the BBA in two sets of rulemakings in 1997 and 1998.[17] At that time, CMS exercised its authority to establish a "period of time such programs would be permitted to receive an increase in payments before a cap was applied"[18] by establishing a three-year timeframe by which new teaching institutions could build up residency programs and establish their permanent cap.[19] In the

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[11] Social Security Act, Section 1886(h)(4)(H); 42 U.S.C. §1395ww(h)(4)(H).
[12] U.S. House. *Balanced Budget Act of 1997, Conference Report* (to Accompany H.R. 2015), pg. 820-822.
[13] *Id.* at 822.
[14] Social Security Act, §1886(h)(4)(H); 42 U.S.C. §1395ww(h)(4)(H).
[15] Social Security Act, Section 1886(h)(4)(H)(iii); 42 U.S.C. §1395ww(h)(4)(H)(iii).
[16] *Id*.
[17] CMS implemented the new statutory requirements through the FY 1998 and FY 1999 Inpatient Prospective Payment System (IPPS) final rules. *See* 62 Fed. Reg. 45966, 46005 (August 29, 1997) ; 63 Fed. Reg. 26318, 26333 (May 12, 1998).
[18] *See* U.S. House. *Balanced Budget Act of 1997, Conference Report* (to Accompany H.R. 2015) at pg.821-822.
[19] *Id.* at note 16; 42 CFR § 413.79(e)(1).

Agency's 1997 rulemaking, CMS also determined that the Agency would abide by Congress' mandate to give special consideration to the needs of hospitals in "rural and underserved areas," by adopting a regulation that permits rural hospitals to adjust their GME caps for additional new programs.[20] Then in 2012, CMS again exercised its statutory authority and extended the initial cap-building period from three years to five years.[21] CMS found that three years was inadequate because of ACGME accreditation rules, which often require accreditation prerequisites prior to starting certain new programs.

(b) CMS Authority to Adopt Cap Flexibility

As discussed above, the statutory text and legislative history makes clear that CMS (through delegation by the Secretary) has substantial authority and discretion in establishing a timeframe for new teaching institutions to establish GME caps. If CMS has the authority to change the cap-building window from three years to five years, and can grant flexibility to hospitals in rural areas to increase their caps anytime they establish new programs, surely the agency's authority extends to establishing a cap flexibility policy that could supplement the current five-year window with a targeted policy, allowing specific new teaching hospitals additional time to set permanent GME caps. Such a cap flexibility policy would also be consistent with the principles of (1) establishing a limitation on the number of residents paid for by Medicare, and (2) the three-year rolling average for the purposes of counting residents.

Moreover, and importantly, providing new teaching institutions in *Areas of Need* with additional time to establish their caps through a cap-flexibility policy is in line with Congressional intent in providing the Secretary with broad rulemaking authority and requiring that CMS aid underserved areas. As noted in the whitepaper, the current flexibility CMS provides to rural hospitals to expand their caps to accommodate new programs does not go far enough in providing the flexibility new teaching hospitals need to meet workforce needs. Under the proposed cap flexibility policy, economically and medically underserved areas would be permitted to request additional time to grow much-needed residency programs, and rural hospital could be eligible for more than five years to grow initial programs. Allowing new teaching institutions to apply for a cap extension and targeted additional federal investment dollars to the areas of greatest need is exactly the type of flexibility Congress intended to provide the Secretary, to ensure the cap-building policy for new teaching hospitals could adapt to changing circumstances and national physician workforce needs.

CMS also has the wide latitude and authority to structure cap extensions to particular needs of individual hospitals, through an application and evaluation process. For instance, Congress explicitly gave the Secretary authority to require programs falling under the cap to submit any information

[20] 62 Fed. Reg. at 46006; 42 C.F.R. § 413.79(e)(3).
[21] 77 Fed. Reg. 53258, 53416 (August 31, 2012); *see* 42 CFR 413.79(e)(1).

required to administer the caps.[22] Such authority complements the Secretary's discretion to set caps with an ability to collect information from hospitals that would benefit from this policy.

In developing cap flexibility, the Secretary should, however, consider the Conferee's concern that caps be set "on the facility level rather than providing direction on payment according to specialty of physicians in training." Congress' intent, as explained through the Conference Report, was to ensure that the Secretary would not and could not dictate decisions as to what residency training specialties individual institutions would pursue.[23] As proposed in the whitepaper, cap flexibility does not run afoul of Congressional intent for two important reasons. First, cap-flexibility is neutral as to specialties of the physicians being trained, but rather aims to provide the Secretary with a framework by which to exercise the discretion provided by and encouraged to be exercised by Congress. The focus of cap flexibility is on the needs of the institution and the area where the hospital is located, not on the specialty of the physicians being trained. Second, cap flexibility leaves the training decisions up to the individual institutions, as intended by Congress.

In summary, the broad and nearly unlimited authority granted to the Secretary to establish GME caps for new programs provides the Secretary with ample statutory authority for CMS to explore instituting a cap-flexibility policy as proposed in the aforementioned white paper. Although the Secretary has not yet exercised the authority to tailor cap windows to the particular needs of individual teaching institutions, the statutory framework setting caps at the facility levels and Congressional intent supports the Secretary's ability to do so.

[22] U.S. House. *Balanced Budget Act of 1997, Conference Report* (to Accompany H.R. 2015).
[23] *Id* at 822.