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AAMC Summary of FY 2015 IPPS Provisions Affecting New Residency Training Programs

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This document summarizes the proposals the Centers for Medicare and Medicaid Services (CMS) included in the fiscal year (FY) 2015 inpatient prospective payment system (IPPS) proposed rule that relate to new residency programs. Comments on these proposed regulations are due to CMS by **June 30, 2014**. Please contact Lori Mihalich-Levin at lmlevin@aamc.org if you have any concerns regarding CMS' proposals that you would encourage the AAMC to consider including in the Association's comment letter.

For additional information on CMS' rules on how a hospital can become a teaching hospital by beginning "new" residency training programs, please see the AAMC's publication, "Becoming a New Teaching Hospital: A Guide to the Medicare Requirements," available through www.aamc.org/publications.

Proposed Changes in the Effective Date of the FTE Resident Cap, 3-Year Rolling Average, and Intern- and Resident-to-Bed (IRB) Ratio Cap for New Programs

Summary of Current Rules

CMS permits hospitals that do not have direct graduate medical education (DGME) or indirect medical education (IME) full time equivalent (FTE) caps, because they were not training residents when the caps were established in 1997, to start new programs and establish Medicare DGME and IME FTE caps during a five-year cap-building window. Rural hospitals are also permitted to increase their existing DGME and IME FTE caps at any time by starting *new* programs (though not by expanding existing programs).

The resident FTE counts CMS uses to make DGME and IME payments to teaching hospitals are not based on current year counts but rather on the 3-year rolling average of the DGME and IME FTE counts. Additionally, the intern- and resident-to-bed-ratio used to determine IME payments is not paid based on the current year's ratio, but rather is capped at the lower of the current or the prior year's ratio. (This is the so-called "IRB ratio cap".) Until now, the 3-year rolling average and the IRB ratio-cap have not gone into effect for a new program until the number of years equal to the minimum accredited length of each new program has passed.

For example, if a new teaching hospital began a family medicine residency program (with a minimum accredited length of 3 years) in its first year of training residents, the 3-year rolling average and IRB ratio caps both go into effect at the beginning of the fourth year the hospital trains residents. If the same hospital began a psychiatry residency program (with a minimum accredited length of 4 years) in the third year of training residents, the 3-year rolling average and IRB ratio caps go into effect at the beginning of the seventh year of training residents (four years after the psychiatry program starts).

CMS currently calculates a new urban teaching hospital's DGME and IME FTE caps (or the cap increases of a rural teaching hospital building a new program) based on the number of residents training in the fifth year of the cap-building window, and the caps take effect beginning the sixth year after the start of the first program at a new urban teaching hospital

Summary of Proposed Changes

In this year's IPPS rule, CMS proposes to "synchronize" the effective date of the FTE resident caps with the effective dates and application of the 3-year rolling average and the IRB ratio cap. This proposal would apply to any urban hospital that first began training residents in its first new residency training program on or after October 1, 2012 and would apply to any new program at a rural hospital that was started on or after October 1, 2012. The chart below summarizes these changes:

	Current Rule	**Proposed Rule**
Cap Is Determined	At the end of the 5th year after the first program starts	At the end of the 5th year after the first program starts
Cap Takes Effect	At the end of the 5th year after the first program starts	At start of hospital cost reporting period that precedes the start of the 6th program year after the start of the first program
3-Year Rolling Average Takes Effect	Different date for each program – after the number of years equal to the minimum accredited length of each new program	At start of hospital cost reporting period that precedes the start of the 6th program year after the start of the first program
IRB-Ratio Cap Takes Effect	Different date for each program – after the number of years equal to the minimum accredited length of each new program	At start of hospital cost reporting period that precedes the start of the 6th program year after the start of the first program

Example:

Continuing the example from above, a new teaching hospital with a fiscal year that runs from October 1 – September 30 begins its first residency training program, a family medicine program, on July 1, 2014. It subsequently begins a psychiatry program on July 1, 2016.

Under the Current Rules:

	Family Medicine Program	Psychiatry Program
Cap is Determined	July 1, 2019	July 1, 2019
Cap Takes Effect	July 1, 2019	July 1, 2019
3-Year Rolling Average Takes Effect	July 1, 2017	July 1, 2020
IRB-Ratio Cap Takes Effect	July 1, 2017	July 1, 2020

Under the Proposed Rules:

	Family Medicine Program	Psychiatry Program
Cap is Determined	July 1, 2019	July 1, 2019
Cap Takes Effect	October 1, 2018	October 1, 2018
3-Year Rolling Average Takes Effect	October 1, 2018	October 1, 2018
IRB-Ratio Cap Takes Effect	October 1, 2018	October 1, 2018

Rationale

CMS explains that the Agency has not been able to integrate the setting of FTE resident caps, the rolling average, and IRB ratio caps in an accurate manner on the Medicare hospital cost report, necessitating review on an individual and manual basis for all new programs. These proposals are intended to "simplify and streamline" the rules for new teaching hospitals.

New Program FTE Cap Adjustments for Rural Hospitals that are Redesignated as Urban

Summary of Current Rules

As mentioned above, a rural hospital may continue to increase its DGME and IME FTE caps to account for residents training in new programs at the rural hospital, even after permanent caps have already been established for that hospital. A hospital only receives the benefit of this exception to the Medicare caps if it is located in an area designated as "rural."

Summary of Proposed Changes

In the FY 2015 IPPS proposed rule, CMS proposes to implement new Office of Management and Budget (OMB) labor market area delineations that are based on the 2010 Census. These new delineations have the effect of changing some areas from being rural to being urban, and vice versa. Teaching hospitals that are redesignated from being located in a rural area to being located in an urban area lose their ability to increase their DGME and IME FTE resident caps when they start new residency training programs.

CMS proposes to permit hospitals that were already actively training residents in a new program at the time they were redesignated as urban to continue to increase their cap for that new program.

Example

A rural hospital begins training residents in a new internal medicine program on July 1, 2013, begins training residents in a new general surgery program on July 1, 2014, is redesignated as urban as of October 1, 2014, and is planning to begin training residents in a new anesthesia program on July 1, 2015.

Under the proposal, the hospital may continue to grow the internal medicine program for five years and receive DGME and IME cap increases for this program. The cap increases would be determined at the conclusion of the fifth year of the internal medicine program, or on July 1, 2018. The hospital also may continue to grow the surgery program for five years and receive DGME and IME cap increases for this program. The cap increases would be determined at the conclusion of the fifth year of the surgery program, or on July 1, 2019.

Because of the redesignation as urban beginning October 1, 2014, the hospital would not be eligible for any DGME or IME cap increases for the anesthesia program they were planning to start on July 1, 2015, because residents were not actively training in the program as of the date the hospital was redesignated as urban.

Urban Hospitals Building a "Rural Training Track Cap" with a Rural Hospital Redesignated as Urban

Summary of Current Rules

If an urban hospital meets certain criteria, it may establish a separate "rural track FTE limitation" or rural training track (RTT) cap. The cap-building window for an RTT program is three years. A hospital only receives the benefit of this separate cap if residents in the accredited rural training track program train for more than half of their time at a rural hospital or at rural non-hospital sites.

Summary of Proposed Changes

Because CMS proposed to implement new OMB labor market area delineations as described above, urban hospitals that already are in the three-year cap-building window for establishing an RTT program with a particular rural hospital may find that their rural hospital partner has been redesignated as urban. In this rule, CMS proposes that in this situation, the urban hospital's opportunity to build an RTT cap would not be affected by this redesignation. The urban hospital may continue to build its RTT cap and have that cap take effect at the end of the three-year cap-building window.

CMS also proposes that the urban hospital will have a two-year transition period to seek a new partner and continue to count residents under its RTT cap after that two-year period ends. At the end of this two-year transition period, the urban hospital may only count its RTT residents if: (1) the newly-redesignated hospital reclassifies back to being rural (in which case the urban hospital may only receive IME payments, not DGME payments, for residents in the RTT program), or (2) it must seek out a new rural hospital partner where residents in the RTT program can train.

One note of caution: a rural hospital that becomes a new partner for an existing rural training track program will not be eligible for DGME and IME cap increases under the new program exception, because CMS does not consider the program to be "new." Residents may be "new" to that rural hospital training site, but because the program itself was already in existence, CMS will not apply the Agency's "new program" rules.