FY 2022 IPPS FINAL RULE:

MEDICARE GME-RELATED PROVISIONS

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AGENDA

- Background
- Distribution of Medicare-Funded Residency Slots
- Addressing Low FTE Caps and PRAs
- Rural Training Track Program Updates
- Take-Aways
- Q&A

BACKGROUND

- Medicare subsidizes a portion of residency training costs incurred by teaching hospitals.
  - Direct Graduate Medical Education (DGME)
    - Covers Medicare's share of the direct cost of residency programs.
    - Calculated by multiplying the teaching hospital's per resident amount (PRA) by the weighted number of full-time equivalent (FTE) residents and the hospital's Medicare share of total inpatient days.
  - Indirect Medical Education (IME)
    - Covers costs of residency programs resulting from higher patient care costs at teaching hospitals.
    - Calculated using hospital's ratio of FTE residents to beds and a multiplier that is set by Congress.

BACKGROUND

- Medicare limits the number of residents that hospitals may count in calculating DGME and IME payments.
  - No significant increase in caps since 1996
- Results in hospitals training residents far in excess of the number funded by Medicare.
- GME reimbursement is also tied to the hospital's per resident amount (PRA).

BACKGROUND

- For years, teaching hospitals have advocated for increasing Medicare funding for residency training.
- Lawmakers have resisted these efforts and instead pursued other funding models to support medical education.
- The strain on healthcare providers caused by COVID-19 has highlighted the need to invest in the healthcare workforce.
  - Particularly in rural and other underserved communities.

RECENT UPDATES

- The Consolidated Appropriations Act, 2021 (CAA) was the first significant increase in Medicare funding for residency training in almost 25 years.
  1. Created 1,000 new Medicare-funded residency slots.
  2. Allowed eligible hospitals to “reset” FTE cap and/or PRA calculations.
  3. Changed rules for Rural Training Track (RRT) programs.

- December 2021, CMS issued the second part of its FY 2022 Inpatient Prospective Payment System Final Rule (Final Rule).
  - Implemented the specifics of the CAA provisions on GME.

DISTRIBUTING MEDICARE-FUNDED RESIDENCY SLOTS

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- The CAA requires CMS to distribute 1,000 new FTE resident cap slots over a five-year period beginning in FY 2023.

- Under the Final Rule, CMS will:
  1. Make 200 residency slots available per year, capped at 1,000 total slots.
  2. Award between 1 and 5 FTE slots per eligible hospital per year.

HOSPITAL ELIGIBILITY

- An eligible hospital must fall into 1 of 4 categories:
  - Category 1: located in rural areas or treated as being in a rural area.
  - Category 2: training residents over their Medicare GME cap.
  - Category 3: located in states with new medical schools or branch campuses on or after 01/01/2000.
  - Category 4: serve areas designated as HPSAs.

“DEMONSTRATED LIKELIHOOD”

- Hospitals will need to show a “demonstrated likelihood” that any awarded positions will be filled.
  - To show this, a hospital must:
    1. Be training residents in excess of its FTE cap; and
    2. Show that it has obtained or is working toward obtaining accrediting body approval to establish a new residency program or expand an existing one.
  - Hospitals already operating in excess of their caps are not able to receive awarded positions.

APPLICATION PROCESS

- Hospitals must apply to be eligible to receive FTE slots.
  - Separate applications are required each of the 5 years.
- Priority will be given to hospitals operating residency programs serving certain geographic areas and underserved populations.
  - The HPSAs score will be the metric used.
- Application deadline will be March 31 of the year preceding the award year.
  - Notification of any award by January 31 of the award year.
  - Effective date for program is July 1 of the award year.

ADDRESSING LOW FTE CAPS AND PRAS

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- Historically, some hospitals accepted rotating residents from established training programs.
- This resulted in low or zero PRAs or FTE caps.
- The CAA and Final Rule rectifies this result by allowing PRAs or FTE cap resets.

TWO TYPES OF ELIGIBLE HOSPITALS

- Category A Hospitals
  - Have a PRA or FTE cap based on training less than 1 FTE resident in a cost-reporting period prior to October 1, 1997.

- Category B Hospitals
  - Have a PRA or FTE cap based on training 3 or fewer FTEs in a cost-reporting period from October 1,1997 to December 27, 2020.

ELIGIBILITY FOR FTE/PRA RESTS

- Hospital is eligible for a reset if it established an FTE cap or PRA in a cost-reporting year prior to December 27, 2020.

- Category B Hospitals:
  - Can disagree with the PRA or FTE cap reported in the applicable base year and initiate a one-time request for reconsideration.
    - Base year must be within the three-year reopening window or not yet be settled.
  - This relief is not available to Category A Hospitals.

ELIGIBILITY FOR FTE/PRA RESTS

- Resets will be triggered based on the number of FTEs trained.
  - Category A Hospital
    - Must train at least 1 FTE in a cost-reporting year beginning after December 27, 2020 and but before December 26, 2025.
  - Category B Hospital
    - Must train more than 3 FTEs in a cost-reporting year beginning after December 27, 2020 but before December 26, 2025.

- Only residents training in new programs will trigger an FTE cap reset.
- However, a new program is not a requirement for a PRA reset.

CALCULATING NEW FTE CAPS AND PRAS

- Beyond these changes, new FTE caps and PRAs will generally be calculated in the same manner that FTE caps and PRAs are currently calculated.

- New FTE caps will be added to the hospital's existing FTE cap.

- No FTE cap or PRA will be set for a hospital that trains less than one FTE during a cost-reporting year.

RURAL TRAINING TRACK PROGRAM UPDATES

RURAL TRAINING TRACK PROGRAMS

- Residency programs based at urban hospitals that involve training more than 50% of the time in a geographically rural area
- Intended to expose residents to rural practice environments, which has shown to result in more physicians choosing to practice in rural areas
- Historical restrictions on new FTE cap slots associated with Rural Training Track Programs (“RTTs” or “RTPs”) has limited the number of RTT/RTP programs

RURAL TRAINING TRACK FLEXIBILITY

- FTE cap increases for both urban and rural hospitals that participate in a new RTT program
  - Previously, FTE cap increases were only available to rural hospitals when the RTT was established as an entirely new residency program

- Urban and rural hospitals are eligible for adjusted IME and DGME FTE caps when additional RTT training sites are established
  - But, must be a new training site, not just additional FTEs training at an existing site

RURAL TRAINING TRACK FLEXIBILITY

- An RTT does not need to be separately accredited if:
  1. The whole program is accredited by the Accreditation Council for Graduate Medical Education; and
  2. Residents spend more than 50% of their training in a rural area.

- RTT programs can be in any specialty
  - Subject to the criteria above

- RTT residents are exempt from the three-year rolling average during the five-year cap growth window for RTTs.

CMS ONLINE RESOURCES

- CMS Resource Page
  - Read more about the Final Rule.
  - FTE Distribution
    - Application website and submission portal
    - Instructions and Questions
  - PRA and FTE Cap Reset
    - HCRIS Cost Report Data Files

TAKE-AWAYS

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- These policy changes are viewed overall as positive relief among the teaching-hospital community.
- CMS estimates that the additional funding to hospitals will total approximately $1.8 billion from FY 2023 through FY 2031.
- CMS described the provisions as “…advance[ing] key priorities to close health care equity gaps and enhance the health care workforce in rural and underserved communities.”

TAKE-AWAYS

- CMS also views allowing rural teaching hospitals participating in an accredited RTT to receive increases to their FTE caps as making "additional strides to close the health equity gap in rural communities, which tend to experience health care workforce shortages."

QUESTIONS?