

America's Health Care Providers

February 18, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services (CMS)
Hubert Humphrey Building
Suite 314 G
200 Independence Ave., SW
Washington, DC 20201

RE: HHS OIG Report on Alternative Medicare Payment Methodologies for the Costs of Training Medical Residents in Nonhospital Settings

Dear Administrator McClellan:

On December 8, 2004 the Office of Inspector General (OIG) released the above-referenced report. The report contains a comprehensive analysis of resident training in nonhospital sites, focusing on volunteer supervisory physicians. On behalf of the undersigned organizations, we write to urge that, like the OIG, CMS recognize volunteer supervisory physicians in nonhospital sites for purposes of direct graduate medical education (DGME) and indirect medical education (IME) payment policy. We ask the Agency to immediately undertake regulatory actions that acknowledge volunteerism and permit hospitals and nonhospital sites to determine jointly the amount of supervisory costs, if any, that must be paid by the hospital.

Background

Section 713 of the Medicare Modernization Act (MMA) mandated the OIG's report, largely because of confusion and ambiguity regarding when hospitals may count resident training time in nonhospital sites for purposes of DGME and IME payments.

The undersigned strongly support nonhospital ambulatory training for medical residents. These sites--including physician offices, nursing homes, and community health centers--are cornerstones of ambulatory training for graduate medical education programs and provide access to healthcare in areas where it might not otherwise be available. These sites provide an important educational experience because of the broad range of patients and conditions treated. Such training also is critical to residents' education, ensuring they will be exposed to settings where they may ultimately practice. It is particularly

important for primary care programs that include a great deal of ambulatory training in their educational programs.

The Medicare statute permits teaching hospitals to claim resident time spent at nonhospital sites if the hospital incurs “all or substantially all” of the training costs at that site. Under the CMS regulations in effect through 1998, this requirement was met if the hospital paid the residents’ stipends and benefits. Effective January 1, 1999 CMS, on its own authority, changed its regulatory definition of “all or substantially all” to require hospitals to also incur “the portion of the cost of teaching physicians’ salaries and fringe benefits attributable to direct graduate medical education.” 42 C.F.R. §413.75(b) and 42 C.F.R. §413.78(e).

The vast majority of resident supervision is done by volunteer physicians. Consequently, to comply with the new regulatory requirements, hospitals have modified their written agreements to specify there are no supervisory costs because the supervising physician is volunteering. CMS has recognized the use of volunteer supervisory physicians in two regulation preambles and a program memorandum. See 63 Fed. Reg. at 40996 (July 31, 1998), 64 Fed. Reg. at 41518 (July 30, 1999), and Medicare Program Memorandum A-98-44 (December, 1998). However, Medicare fiscal intermediaries are disallowing nonhospital resident counts for the hospital’s failure to incur supervisory costs, even though the agreements between the hospital and nonhospital site state that the supervising physician is volunteering.

To better understand the use of volunteer supervising physicians at nonhospital sites, Congress requested the OIG to conduct a study as part of the MMA legislation. Section 713 of the MMA also imposed a one-year moratorium (that expired on December 31, 2004) on CMS’ disallowances associated with family practice residents’ training at nonhospital sites by allowing hospitals to count these residents without regard to the financial arrangement between the hospital and the supervisory physician.

OIG Report Findings

The OIG’s report is a comprehensive study of resident training in nonhospital sites, with emphasis on whether physician supervisory costs exist.

Teaching hospitals work with an extraordinary number of nonhospital sites to provide ambulatory educational experiences for medical residents. The report estimates that approximately 18,000 nonhospital settings received residents from about 840 teaching hospitals--an average of 21 sites per hospital--representing 51 different specialty programs. Moreover, the OIG found that 80 percent of the supervising physicians were volunteers and that they were “not coerced into volunteering their time to supervise residents.” OIG Report at 6.

The OIG also estimated that approximately 37,100 residents rotate to nonhospital settings part time, equaling about 6,800 resident full time equivalents (FTEs). While this amount

is less than 10 percent of the total resident FTE count associated with Medicare support for teaching hospitals, the associated Medicare payments represent critical financial support for teaching hospitals and their ambulatory graduate medical education programs. This also is critical training for all specialties that practice in settings that are predominantly ambulatory or nonhospital in nature, such as primary care specialties.

The OIG report set forth five alternative methodologies for Medicare to make payments associated with resident training at nonhospital sites. Alternative three would:

allow the teaching hospital and nonhospital setting to determine which costs at the nonhospital setting the teaching hospital would pay in addition to the residents' salaries and fringe benefits. As long as the teaching hospital reimbursed the nonhospital setting for the costs stipulated in the written agreement between the teaching hospital and the nonhospital setting, Medicare would make both DGME and IME payments to the teaching hospital for the FTEs that rotate to the nonhospital setting.

OIG Report at 11.

We strongly support this alternative. By virtue of its inclusion in the report, the OIG recognizes that this methodology is reasonable and complies with the Medicare statute. We all agree with the OIG's assessment that the two parties are in the best position to determine what, if any, supervisory costs exist that should be paid by the hospital to the nonhospital site.

Request for CMS Action

We respectfully suggest that CMS implement the following actions as soon as possible:

- Adopt alternative three in the OIG report and clarify that where supervising physicians freely agree to forego compensation as faculty at a nonhospital site and the teaching hospital pays the residents' stipends and benefits and other training costs, if any, as agreed to by the parties, the hospital has incurred "all or substantially all" of the costs of the program and is entitled to count the residents for DGME and IME purposes.
- Until the clarification is implemented, extend, through regulatory action, the moratorium established by Section 713 of the MMA and expand its coverage to all residency programs regardless of specialty. While the initial moratorium was mandated legislatively, we believe strongly that CMS can implement a moratorium on its current authority. See Attachment (letter from Thomas Coons, J.D., Ober/Kaler).

In addition, we ask CMS to reaffirm that the level of payment, if any, should be determined by the parties. CMS established this policy in 1998:

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These agreements and amounts paid by the hospital to the nonhospital site may be the product of negotiation between the hospital and the nonhospital site. The hospital does not have to report the nonhospital site's GME costs. We anticipate that in the course of any negotiation between the hospital and nonhospital site, the nonhospital site may need to identify its training costs. However, *this is a matter between the hospital and the nonhospital.* (emphasis added).

63 Fed. Reg. at 40993 (July 31, 1998)

We believe this policy needs to be reconfirmed because recent statements by CMS seem to mandate a payment formula for determining these costs. For example, a letter from CMS to the OIG on December 7, 2004 states that if a salaried teaching physician spends 10 percent of his or her time supervising residents then the hospital "must pay the non-hospital site 10 percent of the supervisory physician's salary." December 7 Letter from Administrator McClellan to Deputy Inspector General for Audit Services Vengrin. See also, OIG Report at 2.

In those cases where the parties agree that supervisory costs exist, the parties should have the flexibility to decide how this amount should be determined. If using physicians' salaries is the only option allowed by CMS, there could be a significant chilling effect on ambulatory training because many physicians believe their salary arrangements and determinations are, and should be, a private matter. Rather than reveal this information as a prerequisite to being a supervisor some physicians might simply choose not to take on this important role.

Summary

The Medicare program has a long history of supporting residency training in ambulatory sites. This training is critical because residents need to be educated in settings in which many of them will ultimately practice. Medicare also has a long history of implementing payment policies that are intended to encourage educational experiences for residents, rather than imposing barriers.

Recent actions associated with Medicare's nonhospital site policies are having a detrimental impact on residency training in these settings. We believe the situation will deteriorate unless CMS clarifies and modifies, where necessary, its policies. The actions we are advocating are reasonable and represent sound policy. We urge CMS to act upon them immediately.

Sincerely,

Alliance for Academic Internal Medicine
American Academy of Family Physicians

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American Academy of Pediatrics
American Association of Colleges of Osteopathic Medicine
American Hospital Association
American Geriatrics Society
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Osteopathic Family Physicians
American College of Physicians
American College of Surgeons
American Medical Association
American Osteopathic Association
American Pediatric Society
Association of American Medical Colleges
Association of Departments of Family Medicine
Association of Family Medicine Residency Directors
Association of Medical School Pediatric Department Chairs
Association of Osteopathic Directors and Medical Educators
Association of Pediatric Program Directors
Association of Program Directors in Internal Medicine
Association of Professors of Medicine
Federation of American Hospitals
National Association of Children's Hospitals
National Association of Community Health Centers
National Association of Public Hospitals and Health Systems
National Rural Health Association
North American Primary Care Research Group
Society for Pediatric Research
Society of Teachers of Family Medicine

Attachment

cc: Herb Kuhn, Director
Centers for Medicare Management (CMS)

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Margaret J. Hardy, J.D.
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Dear Ms. Fisher and Ms. Hardy:

You have asked for my views regarding whether CMS has the authority to continue the moratorium contained in § 713 of the Medicare Modernization Act (MMA) and to expand it to include other medical specialties. As explained below, I believe that the agency has this authority.

Background

In § 713 of the MMA, Congress directed that, during “the one year period beginning January 1, 2004, ... the Secretary shall allow all hospitals to count [for DGME] residents in osteopathic and allopathic family practice programs in existence as of January 1, 2002, who are training at non-hospital sites without regard to the financial arrangement between the hospital and the teaching physician practicing in the non-hospital site to which the resident has been assigned.” It further directed that the Office of Inspector General (OIG) conduct a study on the appropriateness of alternative payment methodologies for the cost of training residents in non-hospital settings and to submit a report to Congress together with those recommendations that the OIG determined to be appropriate.

The OIG submitted its report on December 8, 2004, and identified five alternative methodologies for paying the costs of training residents in non-hospital settings, noting that each has both positive and negative aspects. The OIG also recommended that the moratorium be extended so that teaching physicians may claim Medicare reimbursement for osteopathic and allopathic family practice residents training in non-hospital settings without regard to the

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financial arrangements between the hospitals and the supervisory physicians who practice at those sites.

CMS, in its December 7, 2004 response to the OIG report, questioned this recommendation, stating that “legislation is necessary to effectuate a moratorium” See CMS’s response at 4.

Discussion

I disagree with CMS’s assertion that legislation is necessary to enable the agency to continue the § 713 moratorium, which in effect suspended enforcement of the supervisory physician cost requirement found in 42 C.F.R. §§ 413.75(b); 413.78(d)-(e). Under similar circumstances in the recent past, CMS has decided not to enforce its own policies. I also believe that CMS may decide not to enforce the supervisory physician cost policy as it might be applied to medical specialties other than family practice medicine.

1. The Statute Provides CMS Considerable Latitude To Set Policy

Initially, it must be stressed that the Medicare statute itself does not include a requirement that hospitals pay supervisory physician costs associated with direct GME activities. Rather, the statute now, as it has for many years, includes only the requirement that time spent by residents in activities related to patient care be counted for GME “without regard to the setting in which the activities are performed, if the hospital incurs all or substantially all of the costs for the training in that setting.” See 42 U.S.C. § 1395ww(h)(4)(E). It is important to note, as well, that CMS long interpreted this very language as requiring only that hospitals pay the residents’ compensation for training spent outside of the hospital. No requirement regarding compensation for supervisory physicians was in effect. Indeed, it was not until CMS published regulations on July 31, 1998, that CMS imposed a requirement that, effective for cost reporting periods occurring on or after January 1, 1999, the written agreement with the non-hospital site reflect that “the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities [and] ... indicate the compensation the hospital is providing the nonhospital site for supervisory teaching activities.” See 42 C.F.R. § 413.86(f)(4) (now 42 C.F.R. § 413.78(d)); 63 Fed. Reg. 40,954, 41,005 (July 31, 1998).

The fact that there is no requirement in the statute that hospitals pay compensation for supervisory physician’s time and that the requirement is contained only in the Medicare regulations is quite important. One can certainly argue that CMS should not ignore clear instructions from Congress, such as those found in statutory language. All should recognize, however, that CMS has far greater latitude to change its own policy interpretations when those policies are not required by statute. Indeed, that is what CMS did on July 1, 1998, when it

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imposed the compensation requirement relating to supervisory physician time, and it is something that CMS can do today in removing that same requirement.

2. CMS Has Often Suspended Implementation Or Enforcement Of Its Own Policies.

There is considerable precedent for CMS's suspending enforcement of its supervisory physician cost requirement. CMS has often delayed implementation or enforcement of its own regulatory provisions, and, at times, even of statutes. For example, in recent times, CMS has delayed implementation of the 75 percent rule for qualification as a rehabilitation facility (the "75 percent rule"), found at 42 C.F.R. § 412.23(b)(2). That rule contains criteria that a hospital or unit must satisfy in order to be exempt from PPS for acute care hospitals, and the rule has been in place, in varying forms, since the early 1980s. *See* discussion in 69 Fed. Reg. 25,752-25,754 (May 7, 2004). In 2002, however, CMS became aware that many hospitals were not in compliance with the regulation, in part because of confusion over how the regulation was to be applied. *See* 69 Fed. Reg. at 25,754. Therefore, on June 7, 2002, CMS "suspended enforcement of the regulatory requirements at § 412.23(b)(2) until [CMS] conducted a careful examination of this area and determined whether the regulation, or the operating procedures used to verify compliance with it, should be changed." 69 Fed. Reg. at 25,755.

The position taken by CMS with regard to the 75 percent rule does not stand alone. Another example of CMS delaying enforcement or implementation of both statutory and regulatory provisions can be seen in CMS's actions regarding outpatient prospective payment system (PPS) and related policies. In § 4523 of the Balanced Budget Act of 1997, Congress directed that CMS put into place a prospective payment methodology "with respect to covered ... services furnished during the year beginning with 1999." CMS, however, did not implement that provision until the summer of 2000 despite Congress's clear deadline. *See* 65 Fed. Reg. 18,434 (Apr. 7, 2000). Then, CMS delayed the effective date of outpatient PPS from July 1, 2000—the implementation date that it had originally set out in the April 7, 2000 Federal Register—until August 1, 2000. *See* 65 Fed. Reg. 40,535 (June 30, 2000). Later, the agency also postponed the effective date of the provider-based rules—also contained in the April 7, 2000 Federal Register—from October 10, 2000, until January 10, 2000. *See* 65 Fed. Reg. 58,919 (Oct. 3, 2000). Plainly, therefore, CMS has felt free to delay its application of both statutory requirements and its own regulations, and to do so without Congressional approval.

Actions taken by CMS regarding the 75 percent rule, outpatient PPS, generally, and the provider-based rules, are but three examples of CMS's delays in applying, or declining to enforce, certain provisions contained in its regulations or the statute. Another example, which bears considerable similarity to the situation here, relates to the statutory provisions applicable to outpatient therapy services. In § 4541 of the Balanced Budget Act of 1997, Congress put into place financial limitations—commonly known as the \$1500 cap—on PT, OT and SLP services

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furnished to Medicare beneficiaries. Those caps went into effect in 1999, but in subsequent legislation, Congress placed moratoriums on the application of those caps. First, in § 211 of the Balanced Budget Refinement Act of 1999, Congress placed a two-year moratorium, from 2000 through 2001, on the application of the financial limitation provision. Later, in § 421 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Congress extended the moratorium through December 31, 2002. More recently, in § 624 of the Medicare Modernization Act, Congress extended the moratorium further beginning with the date of enactment, December 8, 2003, through calendar year 2005. What is significant, however, is that none of these provisions directed the Secretary to apply the moratorium for the period between January 1, 2003, and December 8, 2003. Yet, in effect, that is exactly what the Secretary did. In two Transmittals, AB-03-018 (Feb. 7, 2003) and AB-03-097 (July 3, 2003), CMS delayed implementation of the outpatient therapy caps from January 1, 2003, through August 31, 2003, even though Congress had not directed this result and even though there was a statutory provision—one that is far more explicit than the provision at issue here—directing that the caps be applied.

Conclusion

The examples set out above show that CMS has frequently suspended its enforcement of its own regulations. Similarly, here, CMS may suspend enforcement of its supervisory physician cost requirement pending further study. Further, CMS may suspend its enforcement not just to family practice programs but to other medical specialties as well. This is well within the broad latitude that Congress has given CMS to interpret the statute.

Sincerely,



Thomas W. Coons

TWC/mla