



## **GRADUATE MEDICAL EDUCATION VOLUNTEER FACULTY AND COMMUNITY SUPPORT**

### **Objective**

- **Support S. 1897, the “Medicare Education Payment Clarification Act of 2003,”** introduced by Senator Olympia Snowe (R-ME). This legislation provides a clarification of congressional intent regarding the counting of residents in a nonprovider setting for purposes of making payment for medical education under the Medicare program.

### **Issue**

Recent rulemaking and agency interpretations by the Centers for Medicare and Medicaid Services (CMS) are creating significant operational problems for residency training programs in ambulatory settings such as physician offices, nursing homes, community health centers, etc. Such actions go against Congressional intent to expand and enhance residency training beyond the hospital setting and to increase access to essential health care services.

### **Background**

The Balanced Budget Act of 1997 (BBA) contained provisions intended to both encourage training of residents in rural and other underserved areas and in non-hospital settings which are more like the types of medical practices they will work in upon completion of their residencies. Specifically the BBA allowed hospitals to receive Medicare indirect medical education (IME) payments in addition to Direct Graduate Medical Education (DGME) payments they had already been receiving if hospitals financially supported training programs in ambulatory settings.

#### **Volunteer Faculty:**

In the late 1990s, CMS (then HCFA) specified in two notices and in a program memorandum that physician faculty were permitted to volunteer their resident supervisory services in ambulatory settings, as long as certain rules were followed, including that such volunteerism be stated clearly in the written agreement between the hospital and the ambulatory site. For 2002, it was documented that certain CMS fiscal intermediaries denied retroactively through audits, the time residents spend in non-hospital settings where faculty are volunteering their services. This has the effect of reducing, by significant amounts, the IME and DGME reimbursements a hospital receives for residents training in non-hospital settings. This is particularly a cause for concern for primary care and other programs that include a great deal of ambulatory training in their educational programs. For example, in family medicine, data show that 85 percent of faculty in non-hospital settings are volunteers.

#### **Community Support and Redistribution:**

In 2003, CMS finalized rulemaking that put into place a new regulatory standard whereby CMS halted IME and DGME reimbursements for non-hospital training if at any point in the past, that training had been totally supported by non-Medicare funds. There are a number of residency programs, including family practice, where the hospital historically did not financially support training in ambulatory sites; training in these programs were often funded by

community or state entities. Over recent years, due to declining community and state revenues, hospitals have been increasingly willing to support residency training sites, particularly if they could receive IME and DGME reimbursements. However, the 2003 Inpatient Prospective Payment System (PPS) Final Rule prohibits DGME and IME payments to hospitals for these non-hospital training sites if the hospital has not “continuously incurred the costs of the training program from the date the training program first began in that location.”

In the final rule preamble, CMS states that “[I]t is longstanding Medicare policy that if the community has undertaken to bear the cost of medical education, these costs are not to be assumed by the Medicare program. In addition, medical education costs that have been incurred by an education institution may not be redistributed to the Medicare program.” In the final rule, CMS emphasized that the hospital need only incur a portion of the DGME costs for the training program in order to comply with the regulations.

The issues of “community support” and “redistribution of costs” garnered attention by CMS because of recent arrangements between some teaching hospitals and dental clinic residency programs whereby the hospital would assume the costs of the dental program and claim the dental residents for IME and DGME reimbursement. CMS makes clear that the provisions also apply to all other residents and programs including, but not limited to, family practice residency programs.

### **Current Political Environment**

#### **Congress:**

The Medicare Modernization Act of 2003 (MMA) includes a provision in Section 713, which specifies that for one year beginning on January 1, 2004, CMS will not be allowed to continue their new practice of disallowing volunteer preceptors for selected programs. Hospitals are allowed to continue to count osteopathic and allopathic residents in family practice programs in existence as of January 1, 2002, who are training in non-hospital sites, without regard to the financial arrangement between the hospital and the supervisory physician. Report language accompanying the section requires the Inspector General of the Department of Health and Human Services to conduct a study on the appropriateness of “alternative payment methodologies” for the costs of training residents in non-hospital settings and issue a report with any potential recommendations to Congress no later than one year after the law’s December 8, 2003 enactment date. Section 713 represents a short-term fix, and only for the volunteer teaching issue. A permanent solution is still required. Moreover, the report due in December 2004 will not be completed in time to facilitate timely Congressional action for this year.

Senator Olympia Snowe (R-ME) introduced S. 1897, the “Medicare Education Payment Clarification Act of 2003” in November 2003, which would provide a permanent solution for residents training in non-hospital settings. The bill would ensure that the Congressional intent of encouraging training of physicians in non-hospital settings – established in BBA 1997 – would be clarified.

### **Advocacy Message**

The University of California believes that the CMS interpretation of rules relating to the training of residents in non-hospital sites is contrary to Congressional intent to expand and enhance residency training beyond the hospital setting.