

April, 2005

Medicare Payments for Resident Training at Nonhospital Sites Specific Observations/Questions on the April 8, 2005 CMS Q and A Document

Note: The AAMC position on nonhospital supervision costs is that the hospital and nonhospital site should determine the amount of supervisory costs, if any. The questions and observations contained in this document should not be construed as a change in this position.

Q 1

- The answer states that “[g]enerally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive.” The answer fails to mention that Medicare DGME and IME payments are not opened-ended, but rather have been capped since 1997, when Medicare imposed limits on the number of residents that hospitals can claim for Medicare DGME and IME payments.

Q 2

- The answer fails to note that teaching hospitals do not receive IME payments associated with nonhospital resident counts that were reported on hospitals’ 1996 cost reports--the year used for determining the Medicare resident limits. This is because the IME resident limit does not include the count of residents training in nonhospital sites in 1996.¹
- CMS’s statement that the 1984 base year DGME per resident amount calculation includes teaching physician supervisory costs fails to acknowledge that many teaching hospitals utilized voluntary supervisory medical staff in the base year as well.

Qs 3 and 4

Determination of Supervision Time:

- Much of a physician’s supervision and education of residents occurs during the performance of a patient service. For Medicare payment purposes, physician

¹The IME limit is determined by the number of FTE residents who were training in the inpatient setting only during the base year (1996). This is because in 1996 hospitals could not claim resident time in nonhospital sites for IME payment purposes. Thus, it is not possible for a hospital to increase the number of residents that it can count for IME payments by moving residents to a nonhospital site; it can only alter the share of residents training in the hospital versus nonhospital site. The IME resident cap is set, and no matter how many residents may be in a nonhospital setting, they can only be counted to the extent that they do not exceed the 1996 cap. The intent of the BBA was to avoid penalizing hospitals, by reducing their IME payments, that wished to move their residents from an inpatient to a nonhospital setting.

supervision and education that occurs during a billable service is not to be included in the calculation of supervisory costs. Thus, the amount of “countable” supervision, could be quite small (comprising only the completion of resident evaluation forms, for example). The costs associated with such *de minimus* time are also *de minimus*. Thus, the hospital incurring the resident’s stipends and benefits alone should be sufficient to meet the “substantially all” requirement of the “all or substantially all” statutory language.

- Identifying supervision time “other than the supervision of residents while furnishing billable patient care services” would seemingly require physician time studies--which are onerous and burdensome on physicians and providers alike, further diminishing the enthusiasm for community physicians to participate in this activity.

Pre-Determined Salary Versus Fee-for- Service Compensation:

- Why should there be a distinction between solo practitioners and group practices when in both cases the total amount of payments received is based on the number of patients seen?
- Why should one presume that if a physician receives a pre-determined salary that there *a priori* are supervision costs? What if the salary received is based on factors not related to the physician’s supervisory activities?
- For salary arrangements, how are providers and physicians supposed to identify “implicit” (as stated in the document) compensation for supervisory costs?
- If there are group practices in which the physician members are paid solely based on patients seen, it seems that for audit purposes, the hospital must still obtain financial information from the group practice to document the financial arrangement.

Q 5

- The answer seemingly states that using the supervising physician’s salary is the one and only method for determining supervisory costs. This is completely contrary to CMS’s explicit pronouncement in the July 31, 1998 Federal Register that states:

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

- If the hospital and nonhospital site agree there are supervisory costs, why shouldn't they be able to determine what those costs are, rather than have CMS mandate a formula? For example, if the nonhospital site makes a specified payment to the supervisory physician (or identifies a percentage of the salary that is associated with supervision) why shouldn't that amount be the "supervisory cost"?
- All supervisory physicians, and in particular those who see themselves as volunteers, will surely object to providing the hospital with their salary information.
- In past Federal Registers, CMS has stated that "in kind" compensation could be used to meet the supervisory cost requirement, but this is not mentioned in the Q and A. We presume this is still a valid form of compensation.

Q 6

- How does CMS define an "authorized representative" in group practice arrangements?

Q 7

- The parenthetical statement is at odds with the rest of the answer. The answer states that if the physicians are employees of the hospital, the hospital does not need to pay any supervisory costs. Yet the parenthetical statement says that if the hospital chooses to forego a written agreement (as permitted after October 1, 2004), the hospital must document "that it pays the nonhospital site for the teaching physician costs."

Q 8

- This answer seems to require that a hospital have an agreement with itself--a very unnecessary administrative burden and contrary to ordinary contract principles.
- While not directly related to supervisory cost requirements, we continue to disagree with CMS's position that the written agreement must be in place "before the time the resident begins training in the nonhospital site":
 - First, the issue is not when the resident begins training, but when the hospital is permitted to count the nonhospital site training time.
 - Second, under generally accepted accounting principles (GAAP) and state law on contracts, a hospital can incur costs prior to the actual signature date of the agreement. CMS's view ignores the legal permissibility of hospitals and nonhospital sites entering into agreements with a stipulated effective date that is prior to the signature date. At a practical level, often

because of the number of nonhospital sites that hospitals are dealing with, and resident rotation schedule changes, it is very difficult to have a signed agreement in place before the resident begins training.

- Third, the date requirement is an imposition of a new rule, rather than a clarification of an existing regulation. Providers would assume that CMS policy is following GAAP and state law unless the Agency explicitly states otherwise through regulatory language, which it has not done.

Q 9

- Statements in this answer seem at odds with one another. The first sentence states that if the medical school owns the nonhospital clinics, the hospital need only have one agreement with the medical school that encompasses all of the clinics. Yet the second sentence states “if the residents are training in various medical school clinics, the hospital must have written agreement(s) reflecting the compensation arrangements for each clinic.”
- If the school of medicine pays the supervisory costs associated with a community nonhospital site (not owned by the school or hospital), is the supervisory cost requirement met if the hospital pays the medical school an amount that includes payment for physician supervision at nonhospital sites?

Examples of situations where there are no physician supervisory costs

- Example c) makes a distinction between a physician who sees patients in a “freestanding nursing home” versus seeing patients in a “Medicare-certified skilled nursing facility”-- why make this distinction?

Examples of situations where CMS believes there could be physician supervisory costs

- The use of the phrase “could be” physician supervisory costs suggests that in the examples described there could also be no supervisory costs. Given CMS’s answers to previous questions, it would be helpful if, using these examples, CMS could clarify when there would be no supervisory costs.
- Does CMS’s use of the term “group practice” in these examples, and throughout the document, suggest that the Agency believes no physician that is a member of a group practice can be a volunteer supervisor?
- As discussed above, how does the mere fact that the physician is receiving a predetermined salary equate to the nonhospital site incurring supervisory costs?
- If the compensation structure of a group practice does not provide for a base salary, does CMS presume there are still “implicit” supervisory costs?

- Under example c), if the group practice delineates the “other duties” for which the physician receives additional compensation and these duties do not include resident supervision, how is the group practice (i.e. nonhospital site) incurring supervisory costs?
- Under example d), given state financial accounting policies, it will be very difficult for a hospital to identify the appropriate state entity that will accept a supervisory payment.