



DEC 8 2004

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Acting Inspector General

SUBJECT: Alternative Medicare Payment Methodologies for the Costs of Training
Medical Residents in Nonhospital Settings (A-02-04-01012)

Section 713 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 mandated that we conduct a study and report to Congress on alternative Medicare payment methodologies for the costs of training medical residents in nonhospital settings. The attached final report to Congress provides the results of our study.

The Balanced Budget Act of 1997 allowed teaching hospitals to claim Medicare reimbursement for direct and indirect graduate medical education for the time residents spend in nonhospital settings in connection with approved training programs as long as the hospitals paid all or substantially all of the training costs. Determining the actual costs of the training programs has been difficult because supervisory physicians in nonhospital settings often volunteer their time; that is, they do not bill for the time spent supervising residents. During calendar year 2004, a moratorium under MMA has prohibited fiscal intermediaries from disallowing medical education payments to teaching hospitals based on the fact that the hospitals did not incur the costs related to the physicians' time spent supervising residents in nonhospital settings. The moratorium applies only to osteopathic and allopathic family practice residents.

We identified five alternative methodologies for paying the costs of training residents in nonhospital settings:

1. The Centers for Medicare & Medicaid Services (CMS) would maintain the present regulations and ensure that teaching hospitals pay all or substantially all of the teaching costs. CMS would need to clarify its definition of direct teaching costs, including the treatment of volunteer time.
2. CMS would determine a percentage of each teaching hospital's per resident amount that would be a proxy for the nonhospital setting's teaching and overhead

costs. The hospital would be required to pay this amount to the nonhospital setting and to continue to pay the residents' salaries and fringe benefits.

3. CMS would redefine in regulation “all or substantially all” of the training costs at nonhospital settings as the residents' salaries and fringe benefits and other costs as determined by each teaching hospital and nonhospital setting.
4. CMS would make direct Medicare payments to nonhospital settings rather than to teaching hospitals.
5. CMS would make direct Medicare payments to supervisory physicians at nonhospital settings rather than to teaching hospitals.

Each of the five payment options has both positive and negative aspects. Before implementing any option, we recommend that CMS work with Congress to:

- further analyze the current financial arrangements and incentives among teaching hospitals, nonhospital settings, and supervisory physicians in nonhospital settings;
- study the potential impact of any revisions to the current policy; and
- clarify the definition of “all or substantially all” of the costs associated with training residents in nonhospital settings.

In the interim, we recommend that CMS work with Congress to extend the moratorium, so that teaching hospitals may claim Medicare reimbursement for osteopathic and allopathic family practice residents who train in nonhospital settings without regard to the financial arrangements between the hospitals and the supervisory physicians who practice at those settings.

CMS provided informal comments on a draft of this report, and we incorporated the comments as appropriate.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104. Please refer to report number A-02-04-01012.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ALTERNATIVE MEDICARE
PAYMENT METHODOLOGIES
FOR THE COSTS OF TRAINING
MEDICAL RESIDENTS
IN NONHOSPITAL SETTINGS**

REPORT TO CONGRESS



DECEMBER 2004

A-02-04-01012

EXECUTIVE SUMMARY

Section 713 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 mandated that the Office of Inspector General (OIG) conduct a study and report to Congress on the appropriateness of alternative Medicare payment methodologies for the costs of training residents in nonhospital settings. At the request of congressional staff, OIG also examined several issues associated with training residents in nonhospital settings. Those issues were raised in the Conference Agreement accompanying the MMA.

BACKGROUND

Since its inception, Medicare has shared in the costs of training medical residents in approved training programs. Medicare reimburses teaching hospitals for the costs of direct graduate medical education (DGME) and indirect medical education (IME) based on the number of resident full-time equivalents (FTEs). The DGME payments are Medicare's share of the direct costs of training, such as salaries and fringe benefits of residents and faculty, and hospital overhead expenses. The IME payments cover the additional operating costs that teaching hospitals incur in inpatient care, such as the costs associated with offering a broader range of services, using more intensive treatments, treating sicker patients, and ordering more tests for patients.

The Balanced Budget Act (BBA) of 1997 allowed teaching hospitals to claim both Medicare DGME and IME reimbursement for the time residents spend in nonhospital settings in connection with approved programs as long as the hospitals paid all or substantially all of the training costs. Nonhospital entities include freestanding clinics, nursing homes, and physician offices. The purpose of this BBA provision was to encourage the placement of residents in nonhospital settings, especially in rural and underserved areas. Determining the actual costs of the training programs has been difficult because supervisory physicians in nonhospital settings often volunteer their time; that is, they do not bill for the time spent supervising residents.

The MMA provided a moratorium during calendar year 2004 allowing teaching hospitals to claim Medicare reimbursement for residents participating in osteopathic and allopathic family practice programs at nonhospital settings regardless of the financial arrangements between the hospitals and the supervisory physicians. Under this moratorium, fiscal intermediaries have been prohibited from disallowing DGME and IME payments to teaching hospitals based on the fact that the hospitals did not incur the costs related to the physicians' time spent supervising residents in nonhospital settings.

OBJECTIVES

Our objectives were to (1) provide information about training residents in nonhospital settings and (2) identify alternative payment methodologies for the costs of training residents in those settings.

To accomplish our first objective, which responds to the issues raised in the Conference Agreement that accompanied the MMA, we determined:

- the extent to which residents train in nonhospital settings;
- the extent to which teaching hospital officials believe the BBA has increased the number of residents who train in nonhospital settings, especially in rural and underserved areas;
- the extent to which supervisory physicians in nonhospital settings volunteer their time to train residents;
- the types of incentives that teaching hospitals offer to supervisory physicians who volunteer to train residents in nonhospital settings; and
- teaching hospitals' compliance with regulations when claiming Medicare payments for training residents in nonhospital settings.

SUMMARY OF RESULTS

Teaching hospitals rotate a small percentage of their resident FTEs to nonhospital settings. Although one of the goals of the BBA was to increase the number of residents who train in nonhospital settings, especially in rural and underserved areas, teaching hospital officials believe that the BBA has not fully achieved that goal. For teaching hospitals that do rotate residents to nonhospital settings, the supervisory physicians in the nonhospital settings often volunteer their time to teach residents. Some teaching hospitals stated that they offered various incentives to encourage such volunteerism. We noted some noncompliance by teaching hospitals with Medicare regulations regarding reimbursement for residents in nonhospital settings.

We identified five alternative methodologies for paying the costs of training residents in nonhospital settings:

1. The Centers for Medicare & Medicaid Services (CMS) would maintain the present regulations and ensure that teaching hospitals pay all or substantially all of the teaching costs. CMS would need to clarify its definition of direct teaching costs, including the treatment of volunteer time.
2. CMS would determine a percentage of each teaching hospital's per resident amount that would be a proxy for the nonhospital setting's teaching and overhead costs. The hospital would be required to pay this amount to the nonhospital setting and to continue to pay the residents' salaries and fringe benefits.
3. CMS would redefine in regulation "all or substantially all" of the training costs at nonhospital settings as the residents' salaries and fringe benefits and other costs as determined by each teaching hospital and nonhospital setting.

4. CMS would make direct Medicare payments to nonhospital settings rather than to teaching hospitals.
5. CMS would make direct Medicare payments to supervisory physicians at nonhospital settings rather than to teaching hospitals.

RECOMMENDATIONS

Each of the five payment options has both positive and negative aspects. Before implementing any option, we recommend that CMS work with Congress to:

- further analyze the current financial arrangements and incentives among teaching hospitals, nonhospital settings, and supervisory physicians in nonhospital settings;
- study the potential impact of any revisions to the current policy; and
- clarify the definition of “all or substantially all” of the costs associated with training residents in nonhospital settings.

In the interim, we recommend that CMS work with Congress to extend the moratorium, so that teaching hospitals may claim Medicare reimbursement for osteopathic and allopathic family practice residents who train in nonhospital settings without regard to the financial arrangements between the hospitals and the supervisory physicians who practice at those settings.

CMS provided informal comments on a draft of this report, and we incorporated the comments as appropriate.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Graduate Medical Education Payments	1
Reimbursement for Training Residents in Nonhospital Settings.....	1
All or Substantially All of the Costs of the Training Program	2
The Medicare Prescription Drug, Improvement, and Modernization Act of 2003....	2
OBJECTIVES, SCOPE, AND METHODOLOGY	3
Objectives.....	3
Scope and Methodology.....	3
RESULTS OF STUDY	5
INFORMATION ON RESIDENTS WHO TRAIN IN NONHOSPITAL SETTINGS ..	5
Extent to Which Residents Train in Nonhospital Settings.....	5
Effect of BBA on Number of Residents Who Train in Nonhospital Settings	6
Extent to Which Supervisory Physicians Volunteer To Teach Residents in Nonhospital Settings.....	6
Incentives Offered to Physicians Who Volunteer Their Time as Supervisory Physicians.....	7
Compliance With Medicare Regulations	7
ALTERNATIVE PAYMENT METHODOLOGIES	8
Enforce Current Regulations To Ensure That Hospitals Are Incurring Teaching Costs at Nonhospital Settings	9
Determine a Percentage of the Per Resident Amount for Supervisory Physicians’ Costs at Nonhospital Settings	10
Modify the Definition of “All or Substantially All”	11
Make Direct Payments to Nonhospital Settings as Permitted by BBA	12
Make Direct Payments to Supervisory Physicians at Nonhospital Settings	13
RECOMMENDATIONS	14
APPENDIXES	
A – STATISTICAL SAMPLING INFORMATION	
B – TYPES OF ACCREDITED PROGRAMS WITH RESIDENTS WHO ROTATE TO NONHOSPITAL SETTINGS	

INTRODUCTION

BACKGROUND

Graduate Medical Education Payments

Since its inception, Medicare has shared in the costs of training residents in approved training programs by making DGME and IME payments to teaching hospitals. Medicare reimburses hospitals for the costs of DGME and IME based on the number of resident FTEs. The DGME payments are Medicare's share of the direct costs of training, such as salaries and fringe benefits of residents and faculty, and hospital overhead expenses. The IME payments cover the additional operating costs that teaching hospitals incur in inpatient care, such as the costs associated with offering a broader range of services, using more intensive treatments, treating sicker patients, and ordering more tests for patients. According to CMS officials, in fiscal year 2004, Medicare made an estimated \$2.7 billion in DGME payments and \$5.8 billion in IME payments to teaching hospitals.

Reimbursement for Training Residents in Nonhospital Settings

Since July 1, 1987, section 1886(h)(4)(E) of the Social Security Act has allowed teaching hospitals to receive DGME payments for training residents in nonhospital settings, such as freestanding clinics, physician offices, and nursing homes, if (1) the time was spent in activities relating to patient care, (2) the time was spent under an approved medical residency program, and (3) the hospitals incurred all, or substantially all, of the training costs in the nonhospital settings. Under Medicare rules and regulations, DGME costs in a nonhospital setting include time spent in teaching of a general nature and time spent in developing resident schedules and evaluating or rating residents. The DGME costs do not include time spent caring for individual patients that results in billable services.

Section 4621 of the BBA allowed teaching hospitals to receive IME payments, in addition to DGME payments, for training residents in nonhospital settings if the same three DGME criteria were met. Section 4625 of the BBA permitted DGME payments to be made directly to qualified nonhospital settings. The purpose of these provisions was twofold: to increase access to care by increasing the number of residents who train in nonhospital settings and to increase the likelihood that physicians would practice in rural and underserved areas and in ambulatory sites that are more in alignment with the types of practices the physicians would have upon completing their training.

In addition, regulations (42 CFR § 413.86(f)(4)) specify that for a teaching hospital to receive Medicare payments for a resident in a nonhospital setting, the hospital and the nonhospital setting must have a written agreement stating that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training at the nonhospital setting and that the hospital will provide reasonable compensation to the nonhospital setting for supervisory teaching activities. The written agreement must specify the compensation amount that the hospital will pay the nonhospital setting.

All or Substantially All of the Costs of the Training Program

As stated above, to receive Medicare payments for residents who train at a nonhospital setting, the teaching hospital must actually incur all or substantially all of the costs of the training program. Regulations (42 CFR § 413.86(b)) define “all or substantially all” of the costs as:

- the residents’ salaries and fringe benefits (including travel and lodging where applicable) and
- the portion of the costs of supervisory physicians’ salaries and fringe benefits attributable to graduate medical education.

Determining the actual costs of the training programs has been difficult for CMS and other involved parties because supervisory physicians in nonhospital settings often volunteer their time; that is, they do not bill for the time spent supervising residents. Many hospitals have claimed that they do not provide any compensation to the nonhospital settings because the supervisory physicians are volunteering their time at the nonhospital settings.

Regulations (42 CFR § 413.86(f)(4)) state that the teaching hospital must incur all or substantially all of the training costs to receive Medicare payments but do not define what percentage of costs constitutes “substantially all.” In the past, CMS’s interpretation of the regulations has held that the teaching hospital must, in fact, incur (pay) the costs associated with volunteer efforts to claim DGME and IME reimbursement for the resident’s time at the nonhospital setting. Some CMS staff believe that there are costs associated with volunteerism. They believe that the supervisory costs depend on the supervisory physicians’ salaries and the percentage of time that the physicians devote to the residency program at the nonhospital setting. In an August 2004 Federal Register notice, CMS stated that the teaching hospital must incur all costs associated with supervisory physicians, regardless of whether the written agreement stated that the physicians were volunteering.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003

The MMA provided a moratorium during calendar year 2004 allowing teaching hospitals to claim Medicare reimbursement for residents participating in osteopathic and allopathic family practice programs at nonhospital settings regardless of the financial arrangements between the hospitals and the supervisory physicians. Under this moratorium, fiscal intermediaries have been prohibited from disallowing DGME and IME reimbursement to teaching hospitals based on the fact that the hospitals did not incur the costs related to the physicians’ time spent supervising residents in nonhospital settings.

Section 713 of the MMA mandated that OIG conduct a study and report to Congress on the appropriateness of alternative Medicare payment methodologies for the costs of training residents in nonhospital settings. At the request of congressional staff, OIG also examined several issues associated with training residents in nonhospital settings. Those issues were raised in the Conference Agreement accompanying the MMA.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to (1) provide information about training residents in nonhospital settings and (2) identify alternative payment methodologies for the costs of training residents in those settings.

To accomplish our first objective, which responds to the issues raised in the Conference Agreement that accompanied the MMA, we determined:

- the extent to which residents train in nonhospital settings;
- the extent to which teaching hospital officials believe the BBA has increased the number of residents who train in nonhospital settings, especially in rural and underserved areas;
- the extent to which supervisory physicians in nonhospital settings volunteer their time to train residents;
- the types of incentives that teaching hospitals offer to supervisory physicians who volunteer to train residents in nonhospital settings; and
- teaching hospitals' compliance with regulations when claiming Medicare payments for training residents in nonhospital settings.

Scope and Methodology

We analyzed the BBA, section 713 of the MMA, relevant Federal regulations, applicable sections of the Federal Register from June 1997 through August 2004, Medicare guidelines, and available literature concerning volunteerism and the rotation of residents to nonhospital settings.

Using CMS's Hospital Cost Reporting Information System database for fiscal years 2001 and 2002 (the most recent data available), we identified 1,333 teaching hospitals that received IME payments. According to CMS staff, virtually all hospitals that received IME payments during that period also received DGME payments. We requested that each of the hospitals provide information on the numbers and types of residents who rotate to nonhospital settings and to rural and underserved areas. We received replies from 1,200 of the 1,333 hospitals.

Our review period covered the graduate medical education academic year ended June 30, 2004.

We selected a simple random sample of 100 of the 1,333 teaching hospitals and contacted each of them by phone to verify that they received IME payments and to determine

whether they claimed IME for residents who rotated to nonhospital settings in the academic year ended June 30, 2004. The 100 selected hospitals were located in 38 States and Puerto Rico. Based on our interviews, we identified 63 hospitals in 26 States¹ and Puerto Rico that met the criteria for our review.²

During visits to each of the 63 hospitals, we performed interviews, obtained and analyzed written agreements, and tested costs relating to the rotating residents' salaries and the supervisory physicians' teaching activities. We also compared the data provided in the hospitals' written responses with actual hospital records. Our comparison found that a large percentage of the responses contained inaccurate or incomplete data. Accordingly, we placed little assurance on the accuracy and completeness of the responses; instead, we relied on actual hospital records and interviews with hospital officials.

For each of the 63 hospitals, we judgmentally selected nonhospital settings to visit. For hospitals that rotated residents to multiple nonhospital settings, we selected two nonhospital settings to visit. To obtain broad coverage of nonhospital settings, we generally selected one family practice program (because those programs are subject to the moratorium) and one other type of program to visit. For the 6 of the 63 hospitals that rotated residents to only 1 nonhospital setting, we visited that setting. In total, we visited 120 nonhospital settings. At those sites, we interviewed officials and supervisory physicians to determine whether the physicians were volunteering their time to train residents in nonhospital settings and whether the teaching hospitals offered compensation or other incentives to those physicians for volunteering their time. We also tested costs relating to the teaching activities of supervisory physicians who did not volunteer and were paid for their work.

Based on the data obtained on the 100 hospitals in our statistical sample, we estimated:

- the total number of teaching hospitals nationwide with residents who train in nonhospital settings,
- the total number of residents who rotated from the teaching hospitals to nonhospital settings,
- the total number of FTEs claimed by the teaching hospitals for residents who rotated to nonhospital settings, and
- the total number of nonhospital settings that received residents from the teaching hospitals.

¹The 26 States were California, Colorado, Connecticut, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Texas, Utah, Washington, and Wisconsin.

²The remaining 37 hospitals did not meet the criteria for this study and were not selected because they did not rotate residents to nonhospital settings; did not have medical residency programs during the academic year ended June 30, 2004; rotated residents to nonhospital settings but did not claim the FTEs for graduate medical education reimbursement; or had closed or merged with another hospital.

Statistical sampling information is presented in Appendix A.

We performed fieldwork at the 63 hospitals, the 120 nonhospital settings, the 10 CMS regional offices, and the 19 Medicare fiscal intermediaries that service the 63 hospitals. We also met with congressional staff and officials from the CMS central office, the Association of American Medical Colleges, the Organizations of Academic Family Medicine, the American Osteopathic Association, the National Rural Health Association, and the Accreditation Council on Graduate Medical Education (ACGME) to discuss issues involving residents who rotate to nonhospital settings and the associated costs. We identified alternative payment methodologies for residents who rotate to nonhospital settings based on our interviews with personnel at the hospitals and nonhospital settings visited, as well as our discussions with the above groups.

We conducted the study in accordance with generally accepted government auditing standards.

RESULTS OF STUDY

Teaching hospitals rotate a small percentage of their resident FTEs to nonhospital settings. Although one of the goals of the BBA was to increase the number of residents who train in nonhospital settings, especially in rural and underserved areas, teaching hospital officials believe that the BBA has not fully achieved that goal. For teaching hospitals that do rotate residents to nonhospital settings, the supervisory physicians in the nonhospital settings often volunteer their time to teach residents. Some teaching hospitals stated that they offered various incentives to encourage such volunteerism. We noted some noncompliance by teaching hospitals with Medicare regulations regarding reimbursement for residents in nonhospital settings.

We identified, for consideration by the Congress and CMS, five alternative methodologies for paying the costs of training residents in nonhospital settings.

INFORMATION ON RESIDENTS WHO TRAIN IN NONHOSPITAL SETTINGS

Extent to Which Residents Train in Nonhospital Settings

Based on a statistical sample of 100 teaching hospitals that received IME reimbursement in fiscal years 2001-02, we estimated the following for the academic year ended June 30, 2004:

- Approximately 37,100 residents rotated, on a part-time basis, from teaching hospitals to nonhospital settings. Hospitals reported approximately 80,000 total resident FTEs in their 2002 cost reports. Rotating residents represented only 9 percent of this total, or about 6,800 FTEs. The remaining 73,200 FTEs practiced in hospital settings only.

- Approximately 840 of the 1,333 teaching hospitals claimed IME costs and rotated residents to nonhospital settings, and approximately 18,000 nonhospital settings received residents from those hospitals.

See Appendix A for additional information on our statistical estimates.

The average number of residents who rotated from teaching hospitals to each of the 18,000 nonhospital settings during the academic year was 2.06. The average number of resident FTEs at each setting was 0.38.

In addition, we found in our sample that:

- Sixty-three teaching hospitals rotated residents to different types of nonhospital settings, the majority of which included physician offices (45 percent), clinics (42 percent), and nursing homes (2 percent).
- Fifty-one types of accredited teaching hospital programs rotated residents to nonhospital settings. The majority of the residents being rotated were from three programs: Family Practice (49 percent), Internal Medicine (15 percent), and Pediatrics (6 percent). See Appendix B for a complete list of the accredited programs.

Effect of BBA on Number of Residents Who Train in Nonhospital Settings

Although one of the goals of the BBA was to increase the number of residents who train in nonhospital settings, especially in rural and underserved areas, teaching hospital officials believe that the BBA has not fully achieved that goal.

At 61 (97 percent) of the 63 hospitals visited, graduate medical education officials indicated that the BBA had not resulted in increasing the number of residents who rotate to nonhospital settings. Many of the officials said that the driving force behind a hospital's rotation of residents to nonhospital settings was the training requirement set by ACGME. Further, at 60 (95 percent) of the 63 hospitals, officials said that the BBA had not resulted in the implementation or expansion of residency training in rural and/or underserved areas.

Extent to Which Supervisory Physicians Volunteer To Teach Residents in Nonhospital Settings

Supervisory physicians often volunteer their time to teach residents in nonhospital settings. Of the 120 nonhospital settings visited, 95 (79 percent) had a physician or physicians who told us that they voluntarily supervised residents in nonhospital settings. Both the nonhospital setting officials and the supervisory physicians indicated that no compensation was involved with the volunteerism. Additionally, supervisory physicians indicated they were not coerced into volunteering their time to supervise residents.

At the remaining 25 nonhospital settings, the nonvolunteer supervisory physicians were financially compensated.

Incentives Offered to Physicians Who Volunteer Their Time as Supervisory Physicians

Teaching hospitals sometimes offer incentives to supervisory physicians who volunteer their time to train residents at nonhospital settings. As shown in the table below, the hospitals stated that they offered various incentives for volunteers at 21 (22 percent) of the 95 nonhospital settings that had volunteer supervisory physicians.

Type of Incentive	Number of Nonhospital Settings³
Continuing Medical Education Credits	10
Academic Appointments	7
Access to Hospital Medical Library	2
Access to Hospital Seminars/Conferences	2
Access to Hospital Web Site/Internet Services	2
Medical Books, Computers, and Software	2
Participation in Hospital Rounds	1
Use of Hospital Laboratory	1

Our review did not extend beyond developing information on the volunteerism of supervisory physicians. We note, however, that a teaching hospital that provides these incentives probably incurs some costs associated with the physicians who volunteer their supervisory time.

Compliance With Medicare Regulations

When visiting the 63 hospitals and 120 nonhospital settings, we found instances of noncompliance with Medicare regulations. The 63 hospitals had 1,577 agreements with nonhospital settings to rotate residents to those settings. Of the 1,577 agreements, 324 (21 percent) were not in writing as required (42 CFR § 413.86(f)(4)).

In other instances, the agreements would have been noncompliant with the regulations had the moratorium not been in effect during calendar year 2004. The moratorium applies only to osteopathic and allopathic family practice programs and only to the financial arrangements between teaching hospitals and supervisory physicians at nonhospital settings. Because assessing compliance with the moratorium was outside the scope of our study, we did not determine whether the following instances of noncompliance with 42 CFR § 413.86(f)(4) were allowable under the moratorium.

³Total exceeds 21 nonhospital settings because some teaching hospitals offered more than 1 type of incentive.

- Of the 1,253 written agreements between teaching hospitals and nonhospital settings, 1,082 (86 percent) made no mention of financial compensation for the supervisory physician costs.
- Supervisory physicians at 95 of the 120 nonhospital settings stated that they were volunteering to train residents, and the hospitals incurred no supervisory physician costs.
- Schools of medicine, rather than teaching hospitals, compensated supervisory physicians at seven nonhospital settings.
- Five supervisory physicians said that they did not volunteer their time to teach residents because teaching residents at nonhospital settings was part of their normal duties. They stated that they did not receive additional compensation for this time.

In addition, the fiscal intermediaries that serviced the 63 hospitals found instances of noncompliance. Based on discussions with hospital officials and fiscal intermediary personnel, we noted that:

- Disallowances related to nonhospital settings were taken at eight hospitals (generally for the lack of written agreements).
- Disallowances related to supervisory physicians who volunteered to teach residents at nonhospital settings were taken at two hospitals. The fiscal intermediaries determined that the nonhospital settings incurred training costs that were not paid by the teaching hospitals that claimed IME.

ALTERNATIVE PAYMENT METHODOLOGIES

The reimbursement methodology covered by this study involves four parties: the teaching hospital, the nonhospital setting, the supervisory physician, and the resident. Variations in the treatment of the financial arrangements among these four parties could generate numerous methodologies for paying the costs of training residents in nonhospital settings. We have presented five alternatives:

1. CMS would maintain the present regulations and ensure that teaching hospitals pay all or substantially all of the teaching costs. CMS would need to clarify its definition of direct teaching costs, including the treatment of volunteer time.
2. CMS would determine a percentage of each teaching hospital's per resident amount that would be a proxy for the nonhospital setting's teaching and overhead costs. The hospital would be required to pay this amount to the nonhospital setting and to continue to pay the residents' salaries and fringe benefits.

3. CMS would redefine in regulation “all or substantially all” of the training costs at nonhospital settings as the residents’ salaries and fringe benefits and other costs as determined by each teaching hospital and nonhospital setting.
4. CMS would make direct Medicare payments to nonhospital settings rather than to teaching hospitals.
5. CMS would make direct Medicare payments to supervisory physicians at nonhospital settings rather than to teaching hospitals.

We discuss each of these options in more detail below.

Alternative 1: Enforce Current Regulations To Ensure That Hospitals Are Incurring Teaching Costs at Nonhospital Settings

Under this alternative, teaching hospitals would be required to follow current regulations to claim Medicare reimbursement for residents who rotate to nonhospital settings; that is, hospitals would be required to incur all or substantially all of the training costs in nonhospital settings.

Prior to the BBA, hospitals were able to count, for DGME purposes only, the residents who rotated to nonhospital settings without incurring the supervisory costs at the nonhospital settings. The BBA allowed teaching hospitals to count the residents who rotated to nonhospital settings for IME purposes as well if the hospitals paid all or substantially all of the training costs at the nonhospital settings. After the BBA, in a final rule, CMS indicated that it was appropriate to include supervisory costs at the nonhospital settings as part of all or substantially all of the costs that hospitals must incur to count the residents. CMS stated in a July 1998 Federal Register notice that on average, resident salaries and fringe benefits accounted for less than half of total DGME costs in hospital settings. We note, however, that the situation may differ in nonhospital settings. The CMS officials stated that requiring a hospital to incur the costs associated with training at the nonhospital setting was equitable to both the hospital and the nonhospital setting and was consistent with the statutory requirement that the hospital incur all or substantially all of the costs.

However, teaching hospitals’ responses to our requests for information, as well as our site visits, showed that the hospitals may not have been fully aware of Medicare regulations on claiming FTEs for residents who rotate to nonhospital settings. We also noted some noncompliance with existing regulations. Therefore, to successfully implement alternative 1, CMS would need to take the following steps:

- To ensure that hospitals fully understand and comply with Medicare regulations, we believe that CMS should provide additional clarification. There appears to be confusion on the part of teaching hospitals as to when it is appropriate to claim reimbursement for residents who rotate to nonhospital settings and what constitutes a nonhospital setting.

- If a teaching hospital does not directly compensate nonhospital supervisory physicians in salary for performing their supervisory roles, CMS should work with hospitals and nonhospital settings to determine the costs, if any, of the teaching physicians' salaries and fringe benefits while performing their supervisory roles at the nonhospital settings. These costs may be difficult to quantify because some supervisory physicians may not be willing to divulge their salaries and fringe benefits.
- CMS should clarify how to treat nonmonetary incentives that teaching hospitals provide to supervisory physicians at nonhospital settings. Most (79 percent) of the nonhospital supervisory physicians we interviewed indicated that they did not receive wage compensation for their supervisory work. However, many indicated that they received other incentives, such as continuing medical education credits and academic appointments, from the teaching hospital. Therefore, although the teaching hospital is not directly incurring the costs of the nonhospital supervisory physician's salary, there is a value to the supervisory physician for these incentives and a cost incurred by the teaching hospital. If the current methodology continues, CMS needs to clarify how teaching hospitals should quantify and report these nonmonetary incentives.
- As discussed previously, our work has shown some noncompliance with existing Medicare regulations. Even with the policy clarifications recommended above, additional guidance and oversight by fiscal intermediaries will be needed to successfully implement this payment methodology.

Alternative 2: Determine a Percentage of the Per Resident Amount for Supervisory Physicians' Costs at Nonhospital Settings

Under this alternative, teaching hospitals would be required to reimburse nonhospital settings a specified amount as a proxy for the teaching costs associated with residents who rotate to the nonhospital settings. The teaching hospital would continue to receive Medicare reimbursement for residents in nonhospital settings and would continue to pay the residents' salaries and fringe benefits while the residents rotated to the nonhospital settings. The hospital would then be required to pay a portion of the already established per resident amount to the nonhospital setting as a proxy for the setting's supervisory physician and overhead training costs. CMS would need to conduct further analysis to determine the appropriate percentage of the per resident amount currently used in the DGME reimbursement formula that the hospital would be required to pay the nonhospital setting.

This alternative differs from alternative 1 in that it specifies the amount that the teaching hospital must pay the nonhospital settings. Alternative 1 requires the teaching hospital to reimburse the nonhospital settings' actual costs of training residents in nonhospital settings, rather than a specified amount.

Alternative 3: Modify the Definition of “All or Substantially All”

Another alternative would be for CMS to modify the definition of which costs in nonhospital settings the teaching hospitals would have to incur to claim FTEs for Medicare reimbursement. CMS would define costs as all, or substantially all, of the training costs at a nonhospital setting associated with residents’ salaries and fringe benefits and would set broad parameters, within the limits of law and regulation, on other costs that could be included in the definition. Within those parameters, each hospital and nonhospital setting would determine what other costs, if any, should be included. In November 2003, two Senators introduced this alternative in Senate bill 1897, which is still pending.

This alternative differs from the current definition of “all or substantially all” in that it would allow the teaching hospital and the 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.

Many in the medical community believe that a modification of the definition of “all or substantially all” would encourage hospitals to rotate more residents to nonhospital settings, would be a simpler and less administratively burdensome methodology, would be more equitable toward hospitals, and would encourage volunteerism by supervisory physicians involved in teaching residents at nonhospital settings. Based on our interviews with industry groups, hospital personnel, and nonhospital supervisory physicians, we identified several rationales that support this position:

- For 15 years, the regulation on DGME reimbursement defined “all or substantially all” as the rotating residents’ salaries plus fringe benefits. When the BBA allowed payments for IME, CMS broadened the definition for both DGME and IME to include payments for supervisory physicians’ salaries and fringe benefits at the nonhospital settings. Many in the medical community disagreed with CMS’s decision to expand the definition for a program that was working smoothly.
- Nonhospital settings generally have no cost allocation or time and effort systems in place to effectively break out supervisory teaching costs.
- Industry groups stated that if CMS continues or expands enforcement of the regulations on payment of supervisory teaching costs, supervisory physicians may drop out and hospitals may pull the residents back from communities to their hospital outpatient settings, if available. Per the industry groups, in that event, the number of residents who train in rural and underserved areas would likely decrease. The CMS staff believe that if the enactment of the BBA did not increase the number of residents who rotate to nonhospital settings, hospitals would continue to rotate residents to nonhospital settings mainly to satisfy ACGME training requirements.

Under this alternative, teaching hospitals would continue to receive DGME and IME payments for the time residents spend in nonhospital settings possibly without incurring all teaching costs in the nonhospital settings.

Alternative 4: Make Direct Payments to Nonhospital Settings as Permitted by BBA

Under this alternative, Medicare payments for residents who train in nonhospital settings would be made directly to the nonhospital setting, and the nonhospital setting would be responsible for paying all training costs. The nonhospital setting would pay the resident's salary and fringe benefits, the supervisory teaching costs, and overhead costs for the time the resident rotated to that setting. Medicare would reimburse the nonhospital setting for Medicare's share of the nonhospital setting's actual costs. This alternative differs from alternatives 1, 2, and 3 in that under those alternatives, the teaching hospital would pay the residents' salaries and fringe benefits while the residents rotated to the nonhospital setting, and Medicare would pay the teaching hospital DGME and IME for residents rotating to the nonhospital setting. In alternative 1, the teaching hospital would also pay all or substantially all of the teaching costs at the nonhospital setting; in alternative 2, the teaching hospital would also pay a specified amount to the nonhospital setting; and in alternative 3, the teaching hospital would also pay the nonhospital setting for the costs stipulated in the written agreement.

Current CMS regulations allow DGME payments to be made directly to certain nonhospital settings, including federally qualified health centers, rural health clinics, and Medicare+Choice organizations, if the nonhospital settings incurred all or substantially all of the training costs at those settings (including the residents' salaries and fringe benefits). The CMS officials stated that fewer than 10 nonhospital settings currently receive DGME payments.

For other types of nonhospital settings, such as freestanding clinics, nursing homes, and physicians' offices, CMS has not developed implementing regulations, nor has it accumulated costs, to allow DGME payments to these types of settings.

CMS indicated in the process of rulemaking that one of its major concerns in developing policies for paying nonhospital providers for DGME was the feasibility of determining the amount of direct teaching costs incurred by those providers. CMS did not propose a policy of fixed payments because it had no reliable data on the direct costs of training residents in nonhospital settings.

We agree with CMS's assessment of the difficulty in determining the amount to pay a nonhospital setting for its costs incurred in helping to train residents. Rotations to nonhospital settings are often of very short duration. It would be administratively burdensome for nonhospital settings to pay residents and calculate overhead costs for the short time spent at the settings. However, a benefit that could be derived from this payment methodology is that more nonhospital settings might be interested in participating in the training of residents. Unless legislative changes are enacted, this alternative would eliminate DGME and IME payments to teaching hospitals for residents who rotate to

nonhospital settings because the teaching hospitals would not incur all or substantially all of the costs of the training program. This alternative could discourage teaching hospitals from rotating residents to nonhospital settings.

Alternative 5: Make Direct Payments to Supervisory Physicians at Nonhospital Settings

Under this alternative, Medicare would make a direct payment to the supervisory physicians who are actually teaching and incurring the direct teaching costs. Such direct payments might encourage additional physicians to become teaching physicians at nonhospital settings.

We spoke to a number of individuals who identified different ways to implement this methodology, as described below:

- One supervisory physician stated that a new Medicare Part B physician payment code should be added. Graduate medical education should be broken into two pools: one pool to reimburse the hospitals for residency program costs and a second reallocation pool to pay supervisory physicians directly. This would reward supervisory physicians and could encourage others to train residents.
- Officials at a fiscal intermediary suggested that the hourly rate that the supervisory physician receives should include an add-on for fringe benefits. Another methodology would be to pay the supervisory physician an add-on through the claims processing system via a code on the claim for the patients seen by the resident and the supervisory physician. This add-on would be determined through a national wage indexed for the service area.
- Officials at a nonhospital setting indicated that doctors should be paid an hourly rate for training residents because costs are difficult to measure. They said that compensation would improve the quality of the training program because some volunteers do not put forth enough effort when training residents. They added that supervisory physicians should receive some compensation, even though out-of-pocket expenses are minimal.
- Officials at another nonhospital setting stated that CMS should pay supervisory physicians an hourly rate for teaching residents to encourage them to reduce the number of patients they see and spend more time teaching residents.

One obstacle in establishing appropriate direct payments to supervisory physicians would be the administrative difficulty of determining an equitable reimbursement amount. CMS would need to gather the cost data because it currently has no reliable data on the direct costs of training residents in nonhospital settings. Unless legislative changes are enacted, this alternative would eliminate DGME and IME payments to teaching hospitals for residents who rotate to nonhospital settings because the teaching hospitals would not incur all or substantially all of the costs of the training program. A significant disadvantage of

this alternative would be the lack of a provision, under current law, for reimbursement of residents' salaries and fringe benefits, as well as overhead costs, while residents rotated to nonhospital settings. This alternative could discourage teaching hospitals from rotating residents to nonhospital settings.

RECOMMENDATIONS

Each of the five payment options has both positive and negative aspects. Before implementing any option, we recommend that CMS work with Congress to:

- further analyze the current financial arrangements and incentives among teaching hospitals, nonhospital settings, and supervisory physicians in nonhospital settings;
- study the potential impact of any revisions to the current policy; and
- clarify the definition of “all or substantially all” of the costs associated with training residents in nonhospital settings.

In the interim, we recommend that CMS work with Congress to extend the moratorium, so that teaching hospitals may claim Medicare reimbursement for osteopathic and allopathic family practice residents who train in nonhospital settings without regard to the financial arrangements between the hospitals and the supervisory physicians who practice at those settings.

CMS provided informal comments on a draft of this report, and we incorporated the comments as appropriate.

APPENDIXES

APPENDIX A

STATISTICAL SAMPLING INFORMATION

	Attribute Appraisal	Variable Appraisals		
	Total Hospitals Rotating Residents	Total Nonhospital Settings	Total Residents Rotating	Total FTEs
Universe Size	1,333	1,333	1,333	1,333
Sample Size	100	100	100	100
Characteristics of Interest in Sample	63	1,354	2,780	509.89
Lower Limit	729	13,883	27,064	4,365
Point Estimate	840	18,049	37,057	6,797
Upper Limit	943	22,215	47,051	9,229
Precision Percentage	N/A	23.08%	26.97%	35.78%

The lower and upper limits are for the 90-percent confidence intervals.

APPENDIX B

**TYPES OF ACCREDITED PROGRAMS WITH RESIDENTS
WHO ROTATE TO NONHOSPITAL SETTINGS**

Accredited Program	Number of Programs in Sample of 63 Hospitals	Percentage
Family Practice	758	49%
Internal Medicine	235	15%
Pediatrics	98	6%
Transitional Year	43	3%
OB/GYN	38	2%
Combined Program–Internal Medicine and Pediatrics	28	2%
General Surgery	27	2%
Sports Medicine	26	2%
Geriatric Medicine	24	2%
Psychiatry	24	2%
Orthopedics	21	1%
Traditional Rotating Osteopathic Internship	20	1%
Emergency Medicine	18	1%
Occupational Medicine	16	1%
Pathology	15	1%
Anesthesiology	12	1%
Child Psychiatry	12	1%
Physical Medicine and Rehabilitation	12	1%
Cardiovascular Medicine	10	1%
Combined Program–Emergency and Internal Medicine	9	1%
Remaining Programs	93	6%
51 Types of Accredited Programs	1,539	100%*

*The sum of the percentages does not total 100 percent due to rounding.