CHMEA

Community Hospital Medical Education Alliance
5550 Friendship Boulevard, Suite 300
Chevy Chase, MD 20815-7201
Phone: 301-968-2642 Fax: 301-9684195

Fax Transmission Cover Sheet

DATE: May 20,2002

TO: John Morrall
Office of Information and Regulatory Affairs
Office of Management and Budget

FAX: *202-395-6974*

FROM: David Kushner, CMP, CAE
President and CEO

SUBJECT: Comments on Draft *OMB* Report to Congress on Costs and Benefits of Federal Regulations

---

You should receive 7 pages, including this cover sheet. If you do not receive all the pages, please call my assistant Becky Merritt at 301-968-4108.

Hard **copy** *to* be mailed.

CHMEA

COMMUNITY HOSPITAL MEDICAL EDUCATION ALLIANCE

May 22, 2002

John Morrall
Office of Information and Regulatory Affairs
Office of Management and Budget
NEOB, Room 10235
725 17" Street, NW
Washington, DC 20503

Via Facsimile: 202/395-6974; email: jmorrall@omb.eop.gov

Subject: **CHMEA** Comments on Draft OMB Report to Congress on the Costs and Benefits of Federal Regulations

Dear Mr. Morrall:

The Community Hospital Medical Education Alliance (CHMEA) represents the nation's community teaching hospitals and physician education programs. These hospitals *are* the backbone of their communities, providing medical education to physicians in training and high quality cafe to local residents, They *are* major employers and valuable community resources, delivering primary and specialized patient care in an atmosphere that promotes active learning. Because research shows that physicians tend to practice in close proximity to the area where they train, community hospital-based training yields lasting value for patients and their communities. Although they share many of the same challenges as academic medical centers, community teaching hospitals generally are smaller in size, are located in less populace areas, and often are faced with additional staffing, financial, and resource constrainrs. They constitute about two-thirds (2/3) of the nation's hospitals with medical education programs.

On behalf of our members, the CHMEA welcomes this opportunity to provide comments on the Draft OMB Report on the Costs and Benefits of Federal Regulations (67 *Fed. Reg.* 15014 *et. seq.*, March 28, 2002.) Our comments focus on Medicare regulations on indirect medical education (IME) and direct graduate medical education (DGME) payment, issued by the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS). These regulations interpret Subsections (d)(5)(B)(v) (IME) and (h)(4)(F)(DGME) of §1886 of the Social Security Act (42 U.S.C§1395ww) and are found at 42 CFR §§412.105 and 413.86, respectively. While, in some cases, the problems we spotlight originate in an overly derailed and prescriptive sratute, amending these regulations to make them more flexible and less burdensome and confusing would assist community teaching hospitals in achieving their mission of excellence in medical education and patient care.

5550 Friendship Boulevard. Suite 300 - Chevy Chase, MD 20815-7201 • 301.968.2642 main number • 301.968.4195 fax • www.chmea.org

GRADUATE MEDICAL EDUCATION

Graduate medical education (GME) is the process whereby physicians obtain academic and clinical education in hospitals and other healthcare settings after graduation from medical school. According to current data, more than 100,000 residents were engaged in training in 2001. Depending on specialty, these residents will spend the next three to eight years receiving advanced training as clinicians and providing care to patients under the supervision of teaching physicians. The Medicare program explicitly recognizes the valuable services of teaching hospitals in providing medical education by funding a portion of their direct and indirect physician training expenses. Besides training physicians and other healthcare professionals, reaching hospitals provide primary and specialized patient care, serve a disproportionate share of the nation's most vulnerable patients, including the poor, the elderly, and the uninsured, and engage in medical research.

Resident Limit Requirements arc Overly Restrictive and Prevent Teaching Hospitals from Responding to Community Needs

Under the Balanced Budget Act of 1997, Pub. L. 105-33, (BBA), the number of interns and residents for which a hospital may receive Medicare paymenr is "capped" and may not exceed the number reported on its most recent cost report ending on or before December 31, 1996. This cap applies to both IME and DGME payment. See 42 U.S.C. §1395ww(d)(5)(B)(v) and (h)(4)(F), respectively. This limit restrains community reaching hospitals' ability ro begin residency programs in new medical specialties, expand existing programs, or alrer the type and mix of medical specialty training offered to medical residents. Although the BBA granted the Secretary of HHS authority to provide exceptions to the resident limit under certain condidons (see, for example, 42 U.S.C. §1395ww(h)(4)(H)(ii)), this authority has been exercised narrowly, hampering change and adaptation in medical education programs. Providing greater flexibility in CMS regulations would ease barriers that prevent these programs from responding to their communities and the changing healthcare environment. Because data suggest that, presently, the number of residents is less than when the cap was established, additional exceptions also could be developed, further tempering program constraints.

The following paragraphs suggest specific instances where resident limit exceptions should be provided or expanded.

Affiliated Groups. Under certain conditions, currenr regulations allow teaching hospitals that are part of an affiliated group to elect to apply their resident caps on an aggregate basis. See 42 CFR §413.86(b). Such arrangements permit hospitals that share residents an added measure of flexibility in structuring resident rotations. Although these arrangements enhance educational quality, affiliation criteria are restrictive, requiring that hospitals are (1) located in the same *or* a contiguous urban or rural area, (2) listed as sponsors, primary clinical sites or major participating institutions of one or more of the programs in an official listing of approved training programs, or (3) under common ownership. These and other affiliation requirements are unduly narrow and impede cooperative educational efforts. For example -

- Because they train osteopathic residents, many of our members participate in an Osteopathic Postdoctoral Training Institution (OPTI) as a condition of program accreditation. OPTIs are community-based healthcare consortia made up of one or more hospitals accredited by the American Osteopathic Association, one or more colleges of osteopathic medicine, and other healthcare facilities. OPTIs were developed to ensure the provision of high quality, cost-effective medical residency programs and to directly link teaching hospitals with their counterparts, often across state boundaries and regional lines. These teaching hospital networks were established for the same purposes as the provisions for affiliated groups. CMS requirements should be expanded to allow voluntary affiliation by hospitals within an OPTI - or any other educational consortium or network - when these institutions unite for cooperative educational purposes.

- Hospitals that qualify to form an affiliated group must enter into a written agreement specifying the adjustment to each hospital's resident limit within the aggregate cap. HCFA Fiscal Year 1998 Response to Commenrs, Medicare Inpatient PPS Rates (May 12, 1998); see *also* FY 1998 PPS, TEFRA Hospital, and orher Bill Processing Changes, Program Memorandum, HCFA Pub. 60A, Transmittal No. A-97-13 (September 1, 1997). Agreements must be of at least one year's duration and be provided to CMS and the fiscal intermediaries of all affiliating hospitals by July 1, a date apparently selected because many residency programs follow a July 1-June 30 academic year. This requirement is unduly prescriptive and creates difficulties in counting residenrs for hospital cost reporting purposes. Selection of this date is arbitrary as well, because not all hospitals follow the July- June academic cycle nor do they share cost reporting periods. To ease administrative burdens and accommodate these differences, affiliation requirements should be changed to allow agreements to be executed and filed at any time during the year.

- Urban non-teaching hospitals that initiate teaching programs are not permitted to enter into affiliation agreements with other hospitals. PPS and TEFRA Bill Processing Changes, Program Memorandum (Intermediaries), HCFA Pub. 60A (December 1, 1999). According to CMS, these hospitals might be used by orher reaching institutions as a means to expand existing medical education programs in the other institutions. Given the time, resources, and commitment necessary to initiate a teaching program and satisfy Medicare and accreditation requirements, CMS' rationale is strained and unconvincing. Existing policy should be changed to allow all hospitals with new reaching programs to voluntarily affiliate with other hospitals to share resident training rotations.

Initial Residency Period. For DGME payment purposes, a hospital's resident count is determined based on the "initial residency period" (IRP) of each of its residenrs. Medicare regulations define the IRP as the minimum number of years required for board eligibility in a resident's specialty or subspecialty up to a maximum of five years. 42 CFR §413.86(g)(1). During the IRP, the hospital may count the resident as 1.0 full time equivalent (FTE) for payment purposes and as 0.5 FTE if training continues thereafter. The IRP is determined at the rime the resident "enters the residency training program." 42 U.S.C §1395ww(h)(5)(F). CMS has interpreted *this* phrase to mean the first specialty in which the resident trains, regardless of whether the individual ultimately intends to train in another specialty. *See* Memorandum from

Charles R. Booth, CMS, to ARAs for Financial Management, Regions I-VI, VIII-X and ARA for Beneficiary Services, Region VII (February 3, 1998). This inrerpretation discriminares against hospitals with residents who train in one medical specialty as a prerequisite to training in rheir chosen specialty.

For example, certain specialties, such as radiology, require an initial broad-based clinical training year as a prerequisite to further training. This requiremenr can be satisfied in several ways. If the requirement is met by entering a one-year program that does not lead to board eligibility, such as an osteopathic rotating internship or an allopathic transition year program, CMS will look to the residenr's second year of training (i.e., the radiology program) to determine the IRP.

If the residenr completes rhe requirement, however, by entering an internal medicine program for the first year, that program will determine rhe resident's IRP, despite she fact that the only reason he or she entered the program was to satisfy the prerequisite for radiology. Because the IRP for internal medicine is 3 years and the IRP for radiology 4 years, the hospital will be permitted to count the resident as only 0.5 FTE for the final year of training.

To correct this anomaly, whenever a resident trains in one medical specialty as a prerequisite to another, the hospital should be allowed to count that resident based on the IRP of the medical specialty he or she intends to pursue.

Hospital Closures. If certain conditions are met, a reaching hospital can receive a temporary adjustment to its cap to reflect residents it accepts for training when another hospital closes. ***See*** 42 **CFR** §413.86(g)(8). This adjustment is effective only for the length of rime necessary for she residents to complete rheir training; thereafter, the hospital will return to its original cap. In rhe final FY 2002 Hospital Inpatient PPS update, this policy was expanded to allow a temporary cap adjustment when a hospital accepts residents displaced by closure of another hospital's training program. **66** ***Fed.*** *Reg,* **39828** at **39899-39900** (August **8, 2001).** In an era of wide-spread hospital financial distress, these adjustments are welcome and allow residents to continue rheir training without financially penalizing hospitals that accept them in their programs. Such adjustments do not result in a proliferation of residents nor do they increase the number of residents for which Medicare payment is made. To preserve rhe abiliry of local communities to train and retain physicians in their areas, these provisions should be changed to permanently adjust the resident limits ofhospirals that accept residents displaced by either hospital or GME program closures.

Requirements for Resident Rotations to Nonhospital Sites Should be Clarified

Teaching hospitals may count the time residents spend on patient care in nonhospital settings, such as fieestanding clinics, nursing homes, or physician offices, if they incur "all, or subsrantially all" of the rraining program costs in these settings. 42 CFR §413.86(f)(3). According to CMS, this requirement is satisfied if the hospital enters into a written agreement with the nonhospital sire whereby it agrees to incur rhe cost of resident salaries and fringe benefits for training at rhe site and to provide "reasonable compensation" to the site for teaching physician supervisory costs. FY 1999 PPS, TEFRA Hospital, and Other Bill Processing Changes, Program Memorandum (Intermediaries), HCFA Pub. 60A, Transmittal No. A-98-44

(December 1, 1998) (Transmittal No. ***A-98-44).*** The agreement must **specify** the amount of compensation the hospital will **pay** to the nonhospital site KO defray these expenses.

In the **event** the supervising physicians are volunteers who receive no payment for training, CMS has stated that a hospital may receive payment for nonhospital supervisory physician costs even though the hospital may not incur any **costs** for supervisory physician activities. **64** *Fed. Reg.* 41518 (July **30,** 1999); see ***also*** Transmittal No. **A-98-44.** In practice, however, the agency's interpretation of this policy has proved ambiguous and confusing. To lay this confusion to rest, **CMS** should issue **an** interpretarion of program **policy** clearly staring that **a** hospital may receive Medicare payment for residents Training in nonhospital settings when **all** other payment criteria are mer **and** the written agreement indicates that the supervisory physician and nonhospital site agree that supervisory activities **will** be provided on a volunteer basis.

SUMMARY OF RECOMMENDATIONS

Name of Regulations:

- **Special** Treatment: Hospitals that incur indirect costs for graduate medical education programs **(42 CFR 5412.105).**
- Direct graduate medical educarion payments **(42** CFR $413.86).

Regulating agency:

Centers for Medicare **and** Medicaid Services, Department of Health and Human Services.

Citations:

- Resident Limir: 42 CFR §412.105(f)(1)(iv) **and** §413.86(g)(4)(i).
- Affiliated Groups: 42 CFR § 413.86(b).
- Initial Residency Period: **42 CFR** § 413.86(g)(1).
- Hospital Closures: 42 CFR § 413.86(g)(8).
- Nonhospital Sires: **42 CFR** § 413.86(f)(3).

Authority:

Secuon 1886(d)(5)(B)(v) and (h)(4)(F) of the Social Security **Act** (42 **U.S.C.** §1395ww(d)(5)(B)(v) and (h)(4)(F).

General Description of Problem:

These regulations are unduly narrow, restricting community teaching hospitals from responding to **their** communities and the changing healthcare environment. **Although** the Secretary has been granted authority to provide exceptions KO the resident limit, this authority **has** been exercised narrowly, harming Medicare beneficiaries and other community residents, medical residents, community reaching hospitals, and community hospital-based medical education programs.

Proposed Solution:

The regulations should be amended to increase flexibility and provide additional exceptions to the resident limit. Specifically -

Affiliated groups. Affiliation criteria should be modified to

- remove restrictive **geographical** limitations, allowing voluntary affiliation by hospitals that participate in educational consortia or nerworks when they unite for cooperative educational purposes;
- allow affiliation agreemenrs to be executed and filed at any time during rhe year;
- permit all reaching hospitals, urban and rural, which establish new teaching programs to voluntarily affiliate with other hospitals to share resident rotations.

Initial Residency Period. Criteria for counting residenrs should be modified to allow hospitals to count a residenr training in one medical specialty as a prerequisite to another specialty based on the initial residency period of the medical specially rhe residenr plans to pursue.

Hospital Closures, The regulations should be mended to allow hospitals that accept residents displaced by closure of another hospital or graduate medical education program to permanently adjusr their residenr limits by the number of residenrs it accepted for training.

Resident Rotations to Nonhospital Sites. CMS' interpretation of the regulations and Medicare program policy should be clarified to stare unambiguously that a hospital may receive Medicare payment for residenrs training in nonhospital settings when all other paymenr crireria are met and the written agreement with the supervisory physician and nonhospiral sire indicates that supervisory activities will be provided on a volunteer basis.

CONCLUSION

The CHMEA appreciates this opportunity to provide these recommendations for changes to rhe Medicare graduate medical education regulations. If you have questions about our comments, please contact me at 301/968-4109 or Margaret Hardy ar 301/968-4110.

Sincerely,

David Kushner

David Kushner, CMP, CAE
President **and** CEO

cc: CHMEA Board of Directors