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MEDICARE POLICY CLARIFICATIONS ON GRADUATE MEDICALEDUCATION PAYMENTS FOR RESIDENTS TRAINING IN NON-HOSPITAL SETTINGS

Question 1) How does Medicare support Graduate Medical Education (GME) programs?

Answer 1) Medicare makes both direct GME and indirect GME (IME) payments to hospitals that train residents in approved medical residency training programs. The calculation of both direct GME and IME payments is affected by the number of full-time equivalent (FTE) residents that a hospital is allowed to count. Generally, 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 Medicare statute provides for direct GME payments to hospitals to cover Medicare's share of the **hospital's** direct costs of the residency training taking place at the hospital. The direct GME payment is based on a hospital-specific per resident payment amount that is based on the **hospital's** direct graduate medical education program costs (including teaching physician and resident salaries) incurred in a base year. IME payments to a hospital are paid under the Inpatient Prospective Payment System (IPPS) as a percentage add-on for each Medicare patient discharged from the hospital. IME payments are designed to cover Medicare's share of the higher indirect costs of providing patient care at teaching hospitals relative to non-teaching hospitals. The higher costs are primarily due to increased or inefficient testing of patients by residents and the relatively increased level of patient acuity at teaching hospitals.

Question 2) Does Medicare make both direct GME and IME payments to hospitals for training residents at nonhospital sites?

Answer 2) Prior to October 1, 1997, hospitals could receive only direct GME payments for the time that residents train in nonhospital settings. However, Congress recognized the importance of moving more resident training out of the hospital setting and into settings that more closely reflect the settings where most physicians will practice. Accordingly, beginning with discharges occurring on or after October 1, 1997, the Balanced Budget Act of 1997 (BBA), amended the Medicare statute to allow hospitals to count residents in nonhospital sites for IME payment purposes as well. In making this change Congress intended to encourage hospitals to rotate more residents to nonhospital sites. In implementing this provision, CMS acknowledges the value of training more residents in nonhospital sites and it is our intent to make sure our rules encourage and facilitate this kind of activity.

However, since the per resident direct GME payment is based on all of the costs incurred by the hospital in training residents during a base year (including teaching physician costs), we believe Congress intended to permit hospitals to count time spent by residents training in nonhospital sites for purposes of IME and direct GME payments only if the hospital is actually incurring "all or substantially all the costs" of the residents training at

the nonhospital site. For this reason, our current regulations require a hospital to incur the residents' salaries and fringe benefits, travel and lodging costs where applicable and the cost of teaching physicians' salaries and fringe benefits attributable to supervision of resident training in the nonhospital setting.

Question 3) Are there situations where it's ok for a physician to volunteer his/her time to supervise residents in a nonhospital site?

Answer 3) Under section 1886(d)(5)(B)(iv) of the Social Security Act for IME, and section 1886(h)(4)(E) for direct GME, the time residents spend training in nonhospital settings in connection with approved programs may be included in determining the hospital's number of full time equivalent (FTE) residents, if, in addition to other requirements, the hospital incurs "all or substantially all" of the costs for the training program in the nonhospital setting. Accordingly, the relevant question is *not* whether volunteerism is permissible, but whether *there is a cost* to the nonhospital site for supervising the resident training. If there is a cost, the hospital must reimburse the nonhospital site for those costs. If there are no costs, then no payment for supervisory physician time is required. Typically, there is a cost for teaching physician time if, for example, the physician receives a predetermined compensation amount for his/her time at the nonhospital site that does not vary with the number of patients he/she treats. In contrast, there is typically no cost for teaching physician time if the physician's compensation at the nonhospital site is based solely and directly on the number of patients treated and for which he/she bills. The most obvious example of this situation would be a solo practitioner that serves as a nonhospital training site. With respect to compensation for teaching physicians, the hospital is required to compensate the nonhospital site for the costs of the teaching physician's activities provided in connection with an approved residency program <u>other</u> than the supervision of residents while furnishing billable patient care services. That is, only the costs associated with teaching time spent on activities within the scope of the GME program, but <u>not</u> in billable patient care activities, would be considered direct GME costs that would need to be incurred by the hospital.

Question 4) In the context of GME training in nonhospital sites, what is the difference between a "solo practitioner" and a "member of a group practice"?

Answer 4) A solo practitioner works in his/her own private office and a member of a group practice is typically one of several physicians employed at a particular nonhospital site. The solo practitioner's compensation is based solely and directly on number of patients treated and for which he/she bills. When the solo practitioner is not treating patients, he/she is not receiving payment for any other duties at the nonhospital site. In this instance, there is <u>no</u> cost to the nonhospital site for the teaching physician's time. In the case of the group practice or clinic setting, however, the physician often receives a predetermined payment amount, such as a salary, for his/her work at the nonhospital site. This predetermined payment amount reflects *all* of his/her responsibilities at the nonhospital site, including treating patients, training residents, and other administrative activities (as applicable), and he receives that predetermined payment from the nonhospital site regardless of how many patients he/she actually treats. The

predetermined amount implicitly compensates the physician for supervising residents. A portion of this implicit compensation is the *cost* attributable to teaching activities, and the hospital must pay the nonhospital site this amount.

Question 5) How do we determine the amount of teaching physician costs that the hospital must pay the nonhospital site?

Answer 5) Determination of the teaching physician costs to the nonhospital site is dependent upon the teaching physician's salary and the percentage of time he/she devotes to activities related to non-billable GME activities at the nonhospital site. Assume, for example, that a resident spends 30 hours per week training at the nonhospital site and the teaching physician works 40 hours per week at the nonhospital site. Also assume that 20 out of the resident's 30 hours are spent in billable patient care activities supervised by the teaching physician, leaving 10 hours of the time the teaching physician spends with the resident in non-billable GME teaching activities, such as general clinical didactic training or assessing the resident's performance. Accordingly, 25 percent (10/40) of the teaching physician's time is spent with the resident in non-billable GME activities. Additionally, the teaching physician may take some time beyond the 30 hours spent with the resident to perform some administrative tasks related to the program, such as completing resident evaluation forms. Again, for illustrative purposes, assume the teaching physician spends one hour out of the 40-hour workweek, or 2.5 percent of his/her time, completing evaluation forms. Therefore, in this example, the teaching physician spends 27.5 percent (25 percent plus 2.5 percent) of his/her time in non-billable GME activities. If the teaching physician receives a salary of $100,000 per year, then 27.5 percent, or $27,500 is the direct GME cost of the physician's teaching activities in the nonhospital site for a whole year. In this example, the hospital would need to pay $27,500 to the nonhospital site in order to count the FTE resident time spent in the nonhospital site for direct GME and IME payment purposes. (If residents are not trained at the nonhospital site throughout the whole year, then $27,500 would be prorated based on the number of weeks that residents train at the nonhospital site).

Question 6) Should the written agreement be with the teaching physician or with the nonhospital site where the physician works?

Answer 6) If the physician is self-employed (e.g., a solo practitioner in his/her own private office), then the physician and nonhospital site are one and the same, and the agreement would be with the physician. However, if the physician is an employee, or must report to another official(s) at the nonhospital site, then the written agreement must be between the hospital and an authorized representative of the nonhospital site.

Question 7) What if the physicians supervising the resident training at the nonhospital sites are employees of the hospital?

Answer 7) If the teaching physicians are employees of the hospital, and the physicians do not receive any additional compensation from the nonhospital site, no additional payment from the hospital is needed since the salaries paid by the hospital to the physicians cover

teaching costs inside and outside of the hospital. In such a case, the written agreements should indicate that the teaching physicians are on staff at the hospital, and the hospital is already incurring the teaching physician costs for training time in nonhospital settings (unless, after October 1, 2004, the hospital opts to forego a written agreement and, instead, documents that it pays the nonhospital site for the teaching physician costs concurrently with the training at that site in accordance with 42 CFR §413.78(e)).

Question 8) Must the hospital incur the teaching physician costs and have a written agreement with the nonhospital site if a) the nonhospital site is owned by the hospital, or b) the nonhospital site is owned by the same organization that owns the hospital?

Answer 8) In either scenario, the hospital must incur the teaching physician costs, and there must be a written agreement in place before the time the residents begin training in the nonhospital site (unless 42 CFR §413.78(e) applies, in which case a written agreement is not required). The hospital would need to demonstrate, under either ownership scenario, that it is paying all or substantially all of the costs of the training program by actually paying the nonhospital site through the hospital's accounts payable system. (If the hospital and nonhospital site share a single accounting system, the hospital could demonstrate payment of the nonhospital site training program costs using journal entries that expense these costs in the hospital's GME cost center and credit the nonhospital site.)

Question 9) What if the teaching physician is on the staff of a medical school and supervises residents in the hospital and in clinics owned by the medical school?

Answer 9) In this case, (unless the hospital opts to pay for the training program costs concurrently under 42 CFR §413.78(e)), rather than having a written agreement with each clinic, it would be appropriate for the hospital to have a written agreement with the medical school, since the medical school owns the clinics. If the residents are training in various medical school clinics, the hospital must have written agreement(s) reflecting the compensation arrangements for each clinic.

Following are examples of situations where there is no teaching physician cost associated with resident training in nonhospital sites, and, therefore, the hospital would not be required to pay the nonhospital site for teaching physician time in order to count the residents for direct GME and IME purposes:

a) A physician trains residents in his private practice. He is a solo practitioner; he does not share the office with other physicians. His compensation is based solely and directly on the number of patients treated and for which he bills.
b) A physician that supervises residents in her private practice shares office space with two other physicians. The three physicians share overhead expenses, such as electricity and rent, but otherwise, there is no sharing of revenues from patient care activities, and the physicians are not compensated according to some predetermined arrangement. Despite sharing office space, the physician that supervises the residents essentially operates as an independent practitioner,

receiving her compensation solely and directly from the number of patients she treats and for which she bills.

c) A resident goes along with a *solo practitioner* to see the physician's patients in a freestanding nursing home (not a Medicare-certified skilled nursing facility). The physician does not receive any payment from the nursing home, and bills independently for the patient care services he provides.

Following are examples of situations where there could be a teaching physician cost associated with resident training in nonhospital sites since, in each instance, the physician receives a predetermined compensation amount regardless of the number of patients he/she treats. In these instances, the hospital is required to identify and pay for the costs of supervising resident training at the nonhospital sites in order to count the residents for direct GME and IME purposes:

a) A physician receives a predetermined salary as compensation for working at a nonhospital site.
b) The compensation of a member of a group practice consists of a base salary, plus a percentage of revenues based on productivity (i.e., the number of patients he treats relative to other physicians in the practice), or seniority.
c) A physician that supervises residents is a member of a group practice. His compensation at the practice is based on the number of patients that he sees and for which he bills, plus additional compensation for other duties that he performs at the practice.
d) A physician is employed and paid by the State (or some other third party) to provide services in various state-owned nonhospital settings. The physician does not receive any predetermined compensation from the nonhospital settings themselves, and bills independently for the patients that she treats in these settings. At the request of Hospital A, the physician has agreed to teach several residents when she is working in some of these nonhospital settings. Hospital A would be required to pay the State (i.e., the employer of the physician) for the portion of the physician's salary attributable to GME activities at the applicable nonhospital sites. The written agreement(s) between the hospital and the State would list each clinic and would specify the amount of compensation attributable to each clinic (unless 42 CFR § 413.78(e) is applicable).