June 9, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W. – Room 314-G
Washington, DC 20201

Attention: CMS-1488—P “Resident Time in Patient-Related Activities”

Dear Administrator McClellan:

On behalf of the five family medicine organizations we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS or the Agency) proposed rule entitled “Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates.” 71 Fed. Reg. 23996 (April 25, 2006).

We strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in “patient care activities.” The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Misinterpretation of Legislative History

The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician’s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not “related to patient care”.

This position reverses the Agency’s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include “scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty.” [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. We support the Agency’s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs. Although the proposal states that this 1999 position was incorrect; we believe CMS’s current interpretation is the incorrect one, and we wonder why CMS feels the need to change its position in this matter.
There also is no specific reference to patient care activities in the hospital setting in the IME legislation. CMS’s position refers to unrelated policy that is regulatory in nature (42 CFR 413.9), not statutory. We disagree with the use of this regulation as a basis for this proposal.

If one looks at the legislative history of Medicare, one finds a different interpretation than the one CMS cites. The House Ways and Means and Senate Finance Committee Reports, in March 1983 – state the purpose of the Indirect Graduate Medical Education (IME) as “This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents [emphasis added]...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.[emphasis added]” As such, the language in the federal register proposal defining the “plain meaning” of patient care as related to the care and treatment of a specific patient or to services for which physicians can bill, is patently incorrect.

Congress’s position with respect to the non-hospital setting is just as clear regarding IME payments. The conference agreement language accompanying the legislative language from the BBA states “The conference agreement includes new permission for hospitals to rotate residents through non-hospital settings, which include primarily ambulatory care settings, without reduction in indirect medical education funds.” (emphasis added)

It seems to us that the only piece of this proposal that CMS has any potential standing relates to the question of payment of DGME and IME in the nonhospital setting. On that issue, we believe that CMS’s position is also incorrect, not because they are wrong in citing what the statute states, but because of their interpretation of that position. CMS, in this regard, is relying on artificial dichotomies between didactic and patient care training time to make a false case for carving out didactic training in the nonhospital setting from the DGME and IME payments. Again, we believe the “plain meaning” of patient care activities as defined in this proposal is erroneous.

**Residency Program Activities and Patient Care**

We firmly believe that with the possible exception of extended time for “bench research,” there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician’s educational development into an autonomous practitioner.

Here are several examples from actual residency training programs in family medicine of how training in residency programs relates to patient care – no matter the format of the teaching/learning:
• Each of my residency sites ends the day with an hour-long session in the conference room called "chart rounds." The session is a teaching conference for the residents at the Family Health Center for that afternoon, based on the patient care that was delivered over the past 3-4 hours. It also provides a second opportunity for the preceptor to review the care that was just given; occasionally the group discussion will recommend a different approach, another test, etc. and a resident may call the patient back, etc. First year residents are required to present all cases, PGY-2 and 3 focus on cases that are challenging, illustrative, etc. Sometimes earlier in the afternoon the preceptor will deal with a difficult question about a patient by saying "hold that until chart rounds so we can do it justice." Is this didactic teaching, or patient care?

• We run resident Balint Groups. The discussion is devoted to working through difficult doctor-patient interactions, helping the resident to better understand and approach these relationships. They are based on real cases, and hopefully lead to better care. Didactic teaching, or patient care?

• Almost all residency teaching opens with a patient case. Even if the case does not come from the residency practice, the material in the teaching sessions is applied directly to patient care in that practice, often immediately. Didactic teaching, or patient care?

• Many teaching sessions actually physically include a patient in the presentation. The patient might be interviewed or examined in front of the learners. Didactic teaching or patient care?

• Many teaching sessions involve skills practice, e.g. interviewing skills. Some times patients are even asked to attend the teaching sessions so that faculty (or trainees) can demonstrate physical findings (e.g. neurologic or orthopedic) or procedures (e.g. soft tissue injection) for the attendees. Didactic teaching or patient care?

• Journal clubs often discuss particular patient cases from the practice (de-identified) as examples or illustrations of issues discussed in the journal article. A common mode of speech among physicians both during and after training is "I had this patient once...." and then the educational discussion ensues. Didactic teaching or patient care?

• In most programs I know about current clinical cases in the hospital often form the basis for Grand Rounds and Case Conferences. These conferences frequently come up with expert opinions and well-researched ideas that contribute positively to those patients' care, providing patients in the hospital a real-time benefit from the teaching conferences. Didactic training or patient care?

• Scholarship is required for residency training by the accrediting RRC for family medicine. POEMS/FPIN Clinical inquiries are the basis of many scholarly activities within residency training. They start and end with clinical questions drawn from actual cases/practices, discuss the best evidence in answering them, along with how to integrate that into patient care in practical terms. Didactic training or patient care?
- Interns in our family medicine program attend a series of Friday afternoon "survival skills" presentations for the first 3 months of their intern year. These presentations involve case based learning with the objectives covering essential skills in managing medical emergencies that the interns may well encounter when on call. Topics include such things as acute coronary syndrome, congestive heart failure, renal failure, electrolyte imbalances, intubation and ventilator management protocols. While the interns have certainly encountered all of these topics in their medical school experiences, the consistency of the group's knowledge base, and the level of responsibility they have had in caring for such problems, is not predictable. If, as a program, we failed to address these topics to prepare our interns, we would be ignoring potentially critical patient safety concerns. These presentations are essential additions to the hands-on clinical learning experiences offered to our residents. Didactic training or patient care?

The underlying premise of residency training is that medical students do not graduate with all the skills and knowledge needed to be practicing physicians -- that is why they are required to learn as residents. All of the knowledge and skills for safe patient care cannot be transmitted with hands on learning. There is specific didactic curricular content (as required by each specialty RRC) that prepares the resident physicians for the next stage of patient care responsibility, with less supervision expected and required as the resident progresses through his or her training.

Having this teaching time funded is essential to maintaining patient safety in the learning environment. Learners have to have teaching sessions where they can talk about cases and how to care for patients safely. To use the metaphor of the IOM report on safety and errors in medicine, not funding teaching time would only add to the "jumbo jet worth of patients crashing" each day from medical errors.

**Consistency of Logic**

One additional issue that we would like CMS to consider relates to the lack of logical coherence of its positions. For example, on the one hand CMS argues that in order for hospitals to receive DGME and IME payments for residents training in non hospital settings the hospital must pay supervising physicians the costs associated with the time they spend educating residents in activities not associated with direct hands on patient care. And yet, under this proposal the hospital would not be able to claim any time in the non-hospital setting unless it was time spent "in the care and treatment of specific patients."

As shown above, we believe all teaching time to be related to patient care. Irrespective of your position on whether preceptors can volunteer that teaching time, it is clear to us that CMS cannot on the one hand say the hospital needs to pay those costs, and on the other say that those costs can't be included in the cost reports.
Regulatory Burden/Impracticability

We cannot conceive of how programs would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS’s newly defined “patient care time” from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Even if it could be done, where would the funding come from to pay for the staff person or two that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden, assuming one could even meet the requirements.

To reiterate, we urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to patient care experiences of residents during their residency training.

Sincerely,

Caryl Heaton, DO
Society of Teachers of Family Medicine

Mary Frank, MD, President
American Academy of Family Physicians

Sam Jones, MD, President
Association of Family Medicine Residency Directors

Warren Newton, MD, President
Association of Departments of Family Medicine

Perry Dickinson, MD, President
North American Primary Care Research Group