GRADUATE MEDICAL EDUCATION
USE OF VOLUNTEER PHYSICIAN SUPERVISORS IN NON-HOSPITAL SITES

RECOMMENDATION:
Congress should support removing regulatory restrictions on the ability of physicians to volunteer their time as supervisory physicians of residents training in non-hospital settings. Members of the Senate are urged to cosponsor S. 2071 the “Community and Rural Medical Residency Preservation Act of 2005” which would clarify Congressional intent regarding the counting of residents in a nonhospital setting under the Medicare program. Members of the House of Representatives are urged to cosponsor H.R. 4403, the companion bill in the House.

Moreover, the Centers for Medicare and Medicaid Services (CMS) is urged as follows: CMS should adopt the policy that would allow preceptors to attest that at least 90 percent of the time they spend with residents is spent delivering clinical services and that CMS accept such attestations as evidence that "all or substantially all" of the costs are being borne by the hospital. If the physician cannot attest to that time distribution, or should the precepting physician wish to be compensated for time spent in non-patient care activities, then the hospital should pay the precepting physician an amount agreed upon by the parties. Any payment for such teaching is a matter between the hospital and the preceptor and the amount should not be determined by CMS or any formula CMS recommends.

Background
Section 713 of the Medicare Modernization Act (MMA) mandated that the HHS Inspector General report on resident training in nonhospital sites, focusing on volunteer supervisory physicians. Congress called for this report largely because of confusion and ambiguity regarding when hospitals may count resident training time in nonhospital sites for purposes of both direct graduate medical education (DGME) and indirect medical education (IME) payments.

The Medicare statute permits teaching hospitals to claim resident time spent at nonhospital sites if the hospital incurs “all or substantially all” of the training costs at that site. Under the CMS regulations in effect through 1998, this requirement was met if the hospital paid the residents’ stipends and benefits.

Effective January 1, 1999 CMS, on its own authority, changed its regulatory definition of “all or substantially all” to require hospitals to also incur “the portion of the cost of teaching physicians’ salaries and fringe benefits attributable to direct graduate medical education.”

The vast majority of resident supervision is done by volunteer physicians.
To comply with the new regulatory requirements, hospitals modified their written agreements to indicate there are no supervisory costs because the supervising
physician is volunteering. Unfortunately however, even though CMS has recognized the use of volunteer supervisory physicians in two regulation preambles and a program memorandum, they have denied such time retroactively through audits for the hospital’s failure to incur supervisory costs, even though the agreements between the hospital and nonhospital site state that the supervising physician is volunteering.

The MMA also imposed a one-year moratorium (that expired on December 31, 2004) on CMS’ disallowances associated with family practice residents’ training at nonhospital sites by allowing hospitals to count these residents without regard to the financial arrangement between the hospital and the supervisory physician. Audit and denial activity has resurfaced since the end of the moratorium.

On December 8, 2004, the Office of Inspector General (OIG) for HHS released its report, which recommends that CMS recognize volunteer supervisory physicians in nonhospital sites for purposes of DGME and IME payment policy.

The OIG report set forth five alternative methodologies for Medicare to make payments associated with resident training at nonhospital sites. Alternative three is in keeping with the legislation mentioned above, and would:

- allow the teaching hospital and 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. [OIG Report at 11].

AAFP and AFMAA strongly support non-hospital ambulatory training for medical residents. These sites include physician offices, nursing homes, and community health centers – the cornerstones of ambulatory training for graduate medical education programs. These sites provide an important educational experience because of the broad range of patients and conditions treated. Such training also is critical to residents’ education, ensuring they will be exposed to settings where they may ultimately practice.

The Medicare program has a long history of supporting residency training in ambulatory sites. This training is critical because residents need to be educated in settings in which many of them will ultimately practice. Congress also has a long history of statutory language requiring that CMS implement payment policies intended to encourage educational experiences for residents in rural and underserved settings, rather than imposing barriers. The conference report to the BBA specifically requested that CMS give special consideration to facilities that meet the needs of underserved rural areas, and further stated that “The Conferees believe this authority may help alleviate physician shortages in underserved rural areas.”

**Conclusion:**
Given the recommendations of the OIG report, and CMS’s lack of positive response to the report, we believe action by Congress is necessary to persuade CMS to change its regulations and allow for volunteer teaching of residents in non-hospital settings.