Supporting Volunteer Faculty in Graduate Medical Education

Recommendation: Extend by an additional two years the MMA's moratorium on CMS audits with respect to volunteer physicians in family medicine residency programs and expand the moratorium to all specialties, not just family medicine.

Recent rule-making and agency interpretations by the Centers for Medicare and Medicaid Services (CMS) are creating a chilling effect on residency training programs in non-hospital settings where most ambulatory training occurs. These sites include physician offices, nursing homes, and community health centers, cornerstones of ambulatory training for graduate medical education programs.

Since 2002, CMS intermediaries have begun denying, retroactively through audits, the time residents spend in non-hospital settings where faculty are volunteering their services. This has the effect of reducing, by large amounts, the IME and DGME payments a hospital or teaching program receives for residents training in non-hospital settings. This is particularly a concern for osteopathic and allopathic family medicine residency programs that utilize a large proportion of ambulatory training in their educational programs. Other specialties that promote community ambulatory training, such as surgery, internal medicine, OB/GYN also are affected.

If CMS current policy is not halted, hospitals will be forced to train all residents in the hospital setting or eliminate programs. Allowing hospitals to receive payments for the time residents train in a non-hospital setting is sound educational policy and a worthwhile public policy goal that Congress clearly mandated in 1997. The positive outcomes of this Congressional mandate are to:

- Increase the amount of training a resident receives in environments similar to those they will ultimately practice in.
- Enhance access to care for patients in rural and other underserved communities.

- Provide an additional education experience for residents who are considering practicing in rural communities.
- Provide a successful recruitment mechanism for rural and underserved communities in need of physicians.

History of Volunteer Faculty in Graduate Medical Education

Since 1987, hospitals have been allowed to count the time residents spent in non-hospital settings for the purpose of DGME payments, subject to agreements between the hospital and the non-hospital site where training occurred, as long as the hospital incurred "all or substantially all" of the costs associated with the resident. In 1989, the Health Care Financing Administration (HCFA) defined "all or substantially all" of costs as the residents salary and benefits.

In the early 1990s Congress began to consider that the current IME payment policy was limiting the training of residents in ambulatory settings similar to those in which they ultimately will practice. The existing payment formula only accounted for resident training time in a hospital setting. Through the BBA, Congress altered the financial incentives in the Medicare IME system to support training in non-hospital settings. They accomplished this by allowing hospitals to count the training time of residents in non-hospital settings for the purpose of including such time in their Medicare cost reports for both IME and DGME payments.

In 1998, CMS (then HCFA) added the costs of the supervisory physician in those settings to the definition of "all or substantially all." They specified twice in regulation and once in a program memorandum that physician faculty were permitted to volunteer their resident supervisory services in non-hospital settings, as long as such volunteerism was stated clearly in the written agreement between the hospital and ambulatory site.

Congressional Intent

Actions being taken by CMS go against Congressional intent to expand and enhance residency training beyond the hospital setting and to increase access to care by improving the likelihood that physicians will establish practices in rural and underserved areas.

- The Balanced Budget Act of 1997 (BBA) contained provisions intended to both encourage training of residents in rural and underserved areas and in non-hospital settings.
- Congressional intent was to increase the amount of training in non-hospital settings, which more closely resembled the types of environments physicians' would ultimately practice in.
- In support of this, Congress determined that the Federal government should encourage the training of future physicians in the types of medical practices they will work in upon completion of their residencies by allowing hospitals to receive Medicare Indirect Medical Education (IME) payments in addition to Direct Graduate Medical Education (DGME) payments for time residents spent in non-hospital training sites.

Current Law

The Medicare Prescription Drug Modernization and Improvement Act (MMA) (Public Law 108-173) included a provision (Sec 713) which specifies that for one year beginning on January 1, 2004, CMS will not be allowed to continue their practice of disallowing volunteer

faculty, but only for selected programs. Hospitals will be allowed to continue to count osteopathic and allopathic residents in family medicine residency programs in existence as of January 1, 2002, who are training in non-hospital sites without regard to the financial arrangement between the hospital and the supervisory physician. The moratorium should be expanded to all specialties, not just family medicine, because other specialties provide ambulatory training and could be adversely affected by CMS's recent rule-making policy.

Section 713 also requires the Inspector General of DHHS to conduct a study on volunteer physicians and issue a report with any potential recommendations to Congress no later than one year after the law's enactment. Because the report will not be completed in time to permit Congressional review before the moratorium expires, Congress should also extend the moratorium by an additional two years so that Congress will have an appropriate time to review the study and act upon its recommendations.