American Hospital Association

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March 26, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: (CMS–1529–P) Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, (Vo. 72, No. 21), February 1, 2007

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to its direct graduate medical education (DGME) and indirect medical education (IME) payment policies.

CMS proposes changes relating to Medicare reimbursement for time residents spend working in non-hospital settings, such as physician offices and clinics. Currently, in order for hospitals to receive payments for residents who rotate through non-hospital settings, hospitals must incur "all or substantially all" of the non-hospital site's costs associated with the residents. The proposed rule is intended to reduce the burden on hospitals by allowing the use of proxy data and lowering the cost threshold that must be incurred in order to demonstrate compliance with the "all or substantially all" requirement.

Specifically, CMS proposes to:

- Allow hospitals to assume that three hours of the physicians' time were spent supervising residents each week or to continue collecting actual data;
- Allow hospitals the choice of using national salary data to estimate teaching physicians' costs by specialty or to continue collecting actual data; and

- Create a minimum threshold whereby hospitals must incur at least 90 percent of the sum of residents' salaries, fringe benefits, the portion of the cost of teaching physicians' salaries and fringe benefits attributable to supervision.

PAYMENT FOR DIRECT MEDICAL EDUCATION

The AHA appreciates CMS' effort to reduce the burden currently imposed on hospitals to demonstrate that they have incurred the required costs; however, we still fundamentally disagree with CMS' underlying policy. In April 2005, CMS released a set of "Q&As" explaining that hospitals must pay physicians who train residents in non-hospital settings to compensate them for incurred supervisory costs, even when physicians *volunteer* their time. CMS stated that, "where there is a cost to the non-hospital setting for training residents, we believe that the Medicare program is obligated to ensure that the non-hospital settings receive the funding they are entitled to receive from hospitals under the statute." The government does not customarily intervene in private contracts elsewhere in the Medicare program, nor does it establish such detailed policy when overall program spending is not affected. We are concerned that the proposed extensive requirements are going to influence inappropriately the way in which medical education is conducted. **We urge CMS to rescind the requirement that hospitals reimburse physicians who wish to volunteer their time.**

Three Hour Proxy. CMS proposes to allow hospitals to use three hours per week as a presumptive standard that a teaching physician spends performing non-patient care DGME activities at a non-hospital site. To determine the percentage of the average salary associated with the three hours a teaching physician is presumed to spend in non-patient care DGME activities, a hospital would divide three hours by the number of hours the non-hospital site is open each week. The hospital would then multiply this percentage of time spent in non-patient care DGME activities by the national average salary of the teaching physician's specialty to calculate the cost of the teaching physician's DGME time.

We question whether this will reduce burden, as it will be difficult for hospitals to implement. Resident rotations are rarely devoted to one non-hospital setting for a month or longer. More often, the rotations consist of partial days or partial weeks over a period of time at a non-hospital setting. Residents may even have three or four clinics that they are regularly visiting each week. For example, continuity clinics, which are required for internal medicine residents, are one half-day a week over three years. If hospitals were to assume three hours of supervisory costs per week per clinic, the estimate would be severely inflated. Thus, hospitals would have no choice but to collect specific information on each clinic, which is unduly burdensome given that smaller programs often contract with 50 non-hospitals sites and large programs can contract with hundreds. **Instead, we recommend that CMS allow physicians at non-hospital sites to sign attestation forms estimating their average time spent supervising residents per week.**

Salary Proxies. CMS proposes allowing hospitals to use physician compensation survey data as a proxy to determine the teaching physician costs associated with DGME in a program at a non-hospital site, although the hospital could continue to collect the actual data if it chooses. In

particular, CMS asks for comments on whether it should select the American Medical Group Association's annual *Medical Group Compensation and Financial Survey* to determine the cost of teaching physicians' time attributable to DGME or another physician compensation survey.

We suggest that CMS consider using reasonable cost equivalents (RCE), which are calculated from CMS' data, available to the public and are a stable source of salary proxies. If CMS decides against using RCEs, we would recommend using the Association of American Medical College's (AAMC) Faculty Roster Survey salary data, which is collected annually. The AAMC has an excellent response rate and can make its data publicly available. Although the AAMC's data set is external to CMS, it is well-known and stable.

Cost Threshold. CMS proposes revising the current definition of "all or substantially all of the costs" to require hospitals to incur at least 90 percent of the total costs of residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and benefits attributable to DGME.

The AHA believes 90 percent is higher than "substantially all" suggests. **CMS should reduce this threshold to 75 percent as there is precedent for such a level in other areas of the program and there are no implications for Medicare spending.**

If you have any questions, please feel free to contact me or Danielle Lloyd, senior associate director for policy, at (202) 626-2340 or dlloyd@aha.org.

Sincerely,

Rick Pollack
Executive Vice President