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June 12, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

CMS-1533-P
IME Adjustment

Dear Administrator Norwalk:

On behalf of the five family medicine organizations we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS or the Agency) proposed rule entitled *Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates.* (72 Fed. Reg. 24680, May 3, 2007.)

Cumulative harmful impact of changes to graduate medical education

Normally at this point in our comments we would include the sections of the proposal that we support, and express our thanks to CMS for their inclusion. Unfortunately, we find that we can not do that in this case. In fact, in recent months we have been struck by the seemingly constant attack on graduate medical education funding that CMS and the Administration are promoting.

Beginning with last year's August 18, 2006 Medicare Final Rule on changes to FY2007 Inpatient Prospective Payment, there have been four proposed rules (some of which have been finalized) that seem to us to be full-frontal assault on graduate medical education. Taken together we are very fearful that the Administration is systematically unraveling the graduate medical education infrastructure in the United States

For example, below are just a few of the problems that the current set of proposed regulations is causing:

- August 18, 2006 Medicare Final Rule on changes to FY2007 Inpatient Prospective Payment
    - CMS "clarifies" that only time spent by residents on patient care is to be counted for IME purposes in the hospital complex and for direct GME and IME purposes in nonhospital sites.
    - A definition of the term "patient care activities" has been added: "the care and treatment of particular patients, including services for which a physician or other practitioner may bill."
- May 3, 2007, CMS proposes Changes to FY2008 Inpatient Prospective Payment
    - Proposal would remove resident vacation and sick leave time from the formula used to determine IME and DME reimbursement.
- May 11, 2007, Final Rule Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY2008: Annual Payment Rate Updates, and Policy Changes; and Hospital Direct and Indirect Graduate Medical Education Policy Changes
    - Sets up a regulatory and paperwork nightmare for hospitals to comply.
    - Formula must be applied for EVERY preceptor (with resident-specific salary information for each occurrence)
    - Most programs would have to pay most preceptors
    - Group practices acting like solo practices are not exempt
- May 23, 2007, CMS proposed rule would eliminate Medicaid payments for Graduate Medical Education.
    - After more than 40 years of Medicaid support for graduate medical education, the Administration decides the statute doesn't allow such payments.

Collectively these proposals and changes represent a substantial negative impact on graduate medical education. It is more than unfortunate that these proposals would be recommended at a time when the United States is experiencing maldistribution and shortages of physicians, and a sizable portion of the US population is approaching Medicare eligibility. In addition, we are concerned over the cumulative effect on the nation's safety net.

Vacation and Sick time should be included in FTE calculations

Specific to the May 3rd proposal, we find ourselves at a loss to understand the logic behind the rationale of excluding resident vacation and sick leave from the IME and DGME FTE calculations. Historically, such time had always been counted by the Medicare program. Then, in August of 2006 CMS "clarified" the question of how to handle didactic time and included a definition of patient care activities for the first time. This definition ("the care and treatment of particular patients, including services for which a physician or other practitioner may bill") was evidently not well thought out, as it then raised questions concerning vacation and sick time, as well as orientation time. However, based on this new definition, CMS has chosen to exclude vacation and sick time, while at the same time revising the definition to include orientation time. The new definition would read "the care and treatment of

particular patients, including services for which a physician or other practitioner may bill, **and orientation activities as defined at § 413.75(b),**[emphasis added]."

The argument for exclusion of vacation and sick time is circular at best.
There are two problems with this logic. First and foremost, CMS makes the spurious argument that because the ACGME and RRCs are not explicit regarding vacation and sick time, which in turn allows the amount of time to vary from program to program, such time can not be considered part of the training time. We find the parsing of these requirements in this way unconscionable. There are many, many instances where Residency Review Committee (RRC) requirements are open-ended or not explicit in number or content, leaving programs to interpret within a range of behavior or activities, what is acceptable for accreditation.

Our second concern relates to the inclusion of fringe benefits (vacation and sick leave) in the cost equation for deciding how much must be paid by the hospital to a teaching physician in a non-hospital site. CMS spent a great deal of time developing a formula regarding the use of proxies for payment of such teaching time. As part of that formula, the residents' salary **and fringe benefits** [emphasis added] are included to identify what costs the hospital incurs so that a determination can be made as to whether the "all or substantially all" standard has been met, can be made. If these expenses are included for the purposes of identifying hospital costs, how can they be deleted from the time included in FTE count? We find it disconcerting and illogical that at the same time CMS was preparing the final rule regarding non-hospital training time (*Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY2008: Annual Payment Rate Updates, and Policy Changes; and Hospital Direct and Indirect Graduate Medical Education Policy Changes,* (72 Fed. Reg. 26949, May 11, 2007), it takes a contradictory stand in this May 3 proposed rule.

Revision of August 18, 2006 Final Rule Needed
This proposal raises an additional issue relating to a previous rule published by CMS. According to the definitions and logic included in this proposal, CMS should revise its decision regarding didactic time and include it in the definition of a patient care activity.

In our comments to the proposed rule *Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates* (71 Fed. Reg. 23996, April 25, 2006, we made a strong case that most didactic training was indeed important to the training of the resident – in terms of his/her ability to care for patients. In much the same way that CMS has decided that orientation time should be defined as a patient care activity so that "activities that are principally designed to prepare an individual for employment as a resident in a particular setting, or for participation in a particular specialty program and patient care activities associated with that particular specialty program" we believe that didactic time is just a continuation of such training. It is designed to prepare a resident for employment in a particular setting or participation in a particular specialty program, etc.

Here is an example of what we mean. Resident X is meeting with his family physician preceptor after seeing patient Y, who has diabetes along with several co-morbidities. He asks about the tests he should order, to make sure he covered everything medically necessary. This is clearly an example of a patient care activity (services for which a physician may bill) as defined by CMS. But take this conversation one step further. The preceptor then asks resident X what tests he would order if patient Y has two additional co-morbidities. According to CMS's reasoning behind the inclusion of orientation time ("activities that are principally designed to prepare an individual for employment as a resident in a particular setting, or for participation in a particular specialty program and patient care activities associated with that particular specialty program") such time should be included as a patient care activity. We believe the definition of patient care activity should be revised by CMS to accommodate such training.

Conclusion

We urge CMS to amend its definition of patient care activities to include vacation and sick time, as well as including orientation time as it has already proposed.

In addition, we request that CMS re-examine its August 18th final rule regarding didactic time and include didactic time in the definition of patient care activities.

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