

# GME Central

NEW YORK'S DIRECT LINE TO GRADUATE MEDICAL EDUCATION NEWS

## Medicare Prescription Drug Legislation Mandates Redistribution of Unused Resident Positions

In addition to creating a voluntary outpatient prescription drug benefit, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (DIMA), which was recently signed into law by President George W. Bush, includes a provision that reduces a teaching hospital's resident full-time equivalent (FTE) cap number, as determined under the Balanced Budget Act (BBA), if the hospital reported "unused" positions on its last settled, or submitted, cost report ending on or before September 30, 2002. The Secretary of the U.S. Department of Health and Human Services (HHS) would be authorized to redistribute a portion of these reduced resident positions to qualifying hospitals and thereby increase the receiving hospitals' BBA resident FTE cap number by that amount effective for portions of cost-reporting periods occurring on or after July 1, 2005.

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## Federal COGME Report Calls for Increase in Number of Physicians Trained

The Federal Council on Graduate Medical Education (COGME), an advisory body to Congress and the U.S. Department of Health and Human Services, recently accepted a commissioned report indicating that the nation is facing a physician shortage and recommending a 15% increase in the number of students graduating

from U.S. medical schools over the next decade. The report also calls for a similar expansion in the number of residency positions.

The analysis indicated that while the supply of physicians is expected to increase over the next two decades, demand for services is like-

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# New York Hospitals Show Substantially Improved Compliance in Resident Working Hours

The New York State Department of Health (DOH) sent a letter recently to New York teaching hospitals in which the Commissioner noted that the compliance rate for the resident working hours regulations improved substantially in the second year of the hospital reviews by IPRO. DOH contracts with IPRO to conduct these reviews. DOH also notes that during the final quarter of IPRO's second-year reviews, 74% of the annual compliance reviews found facilities in compliance. The third year of the IPRO contract began on October 1, 2003. Greater New York Hospital Association's understanding is that this positive trend is continuing as the third-year reviews have commenced. DOH also notes in the letter that a total of 13 facilities have been fined for noncompliance and that hospitals should expect that the level of oversight and attention to these regulations will continue. ■

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## Determination of the Reduction Amount

The bill directs the HHS Secretary to compare each hospital's BBA resident FTE cap number with the resident FTE number as determined under the DIMA (called the "reference resident level"). This DIMA reference resident level is the number of resident FTEs reported in the most recent cost-reporting period of the hospital ending on or before September 30, 2002, for which a cost report has been settled, or submitted and subject to audit, as determined by the HHS Secretary.

If the hospital's DIMA reference resident FTE level is lower than the BBA resident FTE cap number, then, effective for portions of cost-report periods occurring on or after July 1, 2005, a hospital's resident FTE cap number will be reduced by 75% of the difference between the two figures. So, for example, if a hospital's BBA resident FTE cap number is 100, and the hospital's DIMA reference resident FTE level is determined to be 80, then the hospital's new resident FTE cap would become 85, as follows:

$$100 - [0.75 \times (100 - 80)] = 100 - (0.75 \times 20) = 100 - 15 = 85$$

The provision would not apply to a hospital with fewer than

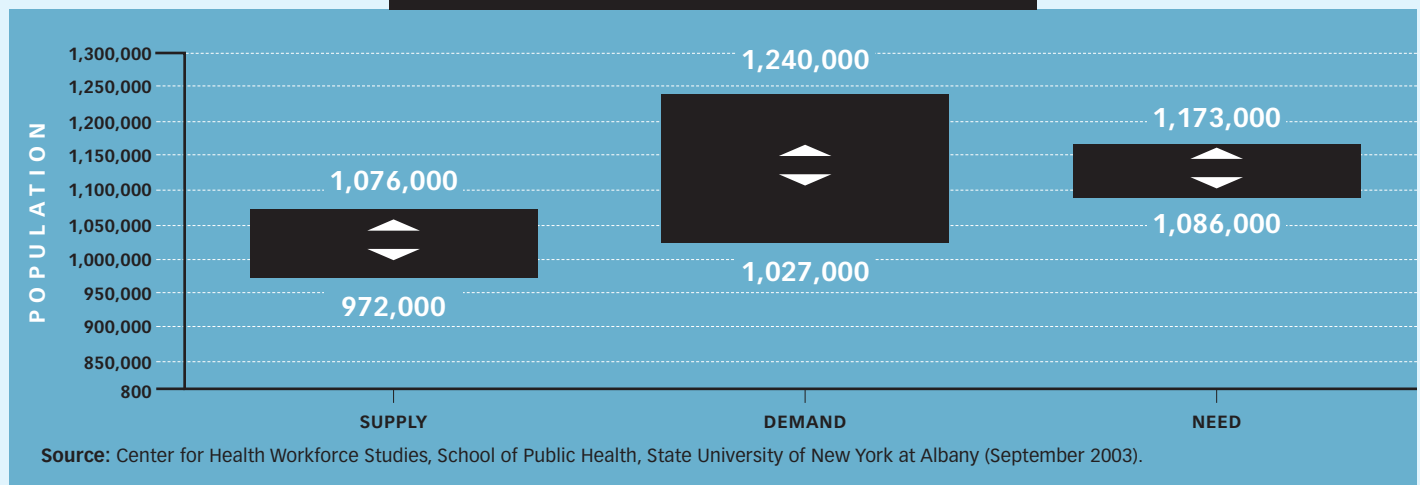
Federal COGME Report Calls for Increase in Number of Physicians Trained, continued from page 1

ly to grow even more rapidly. According to the report, the three major factors driving the increase in demand will be the projected U.S. population growth of 18% between 2000 and 2020, the aging of the population as the number of Americans over age 65 increases from 35 million in 2000 to 54

million in 2020, and the changing age-specific per capita physician utilization rates, with those under age 45 using fewer services and those over age 45 using more services.

The report notes that changing work patterns of physicians, such as decreases in working hours, could lead to greater

## MINIMUM AND MAXIMUM PROJECTIONS OF PHYSICIAN SUPPLY, DEMAND, AND NEED, 2020



250 beds and located in a rural area. The DIMA states that the provision will be applied to hospitals that are members of the same Medicare GME affiliated group as of July 1, 2003. So, presumably, if two or more hospitals had elected to form a Medicare GME affiliated group, and had an agreement in place on July 1, 2003, then the comparison of the BBA resident FTE cap number and the DIMA reference resident FTE level would be performed on an aggregate basis, and the reduction in the resident FTE cap would be made in the aggregate.

### **Potential Exceptions to the Reduction Determination**

The DIMA specifies that the reduction provision does not apply “to residency positions attributable to” a demonstration project approved as of October 31, 2003. While that statement would presumably apply to the seven hospitals that completed the New York Medicare GME Demonstration Project, it is not clear how it might apply to hospitals that made resident FTE reductions in the context of the demonstration but withdrew prior to the completion of the demonstration. Greater New York Hospital Association will be seeking clarification regarding the exact applicability of this statement in the DIMA.

A hospital may invoke two potential exceptions in order to make “a timely request” to the HHS Secretary in order to

adjust its DIMA reference resident FTE level prior to a reduction. The first allows the Secretary to use the cost-reporting period that includes July 1, 2003, in order to adjust for the expansion of an existing residency program. The second allows the Secretary to adjust the DIMA reference resident FTE level to include the number of residents who were approved by an accrediting organization as of January 1, 2002, but not reflected in the number determined using the standard methodology.

### **Terms of the Redistribution**

The HHS Secretary is authorized to provide aggregate increases to qualifying hospitals’ BBA resident FTE cap numbers as long as the total does not exceed the “estimate” of the aggregate reductions to hospitals that lose the unused positions. The increases to hospitals’ BBA resident FTE cap numbers can be made for portions of cost-reporting periods on or after July 1, 2005. The DIMA states that a consideration for a hospital receiving the redistributed positions should be the likelihood of the hospital filling the positions within the first three cost-reporting periods beginning on or after July 1, 2005.

### **Priority for Redistribution**

In making a determination regarding which hospitals will receive the redistributed resident positions, the DIMA directs

shortfalls, while increases in productivity could moderate any shortfalls. As a result of these trends, the report recommends the increase in U.S. medical school production. In addition, the report notes that “the current cap on the number of residents and fellows eligible for Medicare reimbursement strongly discourages teaching hospitals from increasing the number of residents.”

These findings follow other recent reports from physician workforce experts that call into question the earlier policy

recommendations by COGME and others regarding what was then described as an impending physician “surplus,” as well as Federal legislation that limits funding for Medicare GME. During the early 1990s, COGME had issued several reports recommending that the nation use various means, including placing a cap on Medicare-funded residency positions at 110% of the number of U.S. medical school graduates, to reduce the production of physicians; COGME had also recommended that the output of primary care physi-

## **SUMMARY OF COGME’S PROPOSED RECOMMENDATIONS**

- End the 110-50/50 goal.
- Promote efforts to increase physician productivity and to increase contribution to care by nurse practitioners, physician assistants, and other non-physicians.
- Track supply, demand, and need; undertake comprehensive national reassessment within four years.
- Impose a modest increase in new physicians driven by a 15% increase in medical school capacity by the year 2015 (3,000 graduates) and a parallel increase in the Medicare GME cap.
- Have a mix of specialties driven by specialty-specific studies.
- Expand National Health Service Corps and other programs to increase access to underserved populations.

**Source:** Center for Health Workforce Studies, School of Public Health, SUNY Albany (September 2003).

the Secretary to distribute the positions to teaching hospitals in the following priority order:

- hospitals located in rural areas;
- hospitals located in urban areas that are not categorized as large urban areas; and
- hospitals that wish to use the position(s) for a specialty training program not otherwise found in the state in which the hospital is located.

The bill mandates that no more than 25 additional FTE positions will be made available “with respect to any hospital.”

### **Medicare GME Reimbursement Associated with the Redistributed Positions**

Medicare direct GME and indirect medical education (IME) reimbursement associated with the redistributed positions will be calculated using a different methodology than that for other approved resident positions. For the direct GME reimbursement calculation, the bill specifies that the per resident amount (PRA) used for the redistributed positions will be the national average PRA, adjusted for the locality in which the hospital is located. For the IME reimbursement calculation, the bill specifies that the percentage adjustment to the diagnosis-related group payment will be 2.7%. ■

cians and non-primary care physicians be split 50-50 (referred to as the 110-50/50 goal). While the Federal government never adopted this specific recommendation, the Balanced Budget Act of 1997 did place a cap on the number

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**While the supply of physicians is expected to increase over the next two decades, demand for services is likely to grow even more rapidly.**

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of Medicare-funded residency positions at the 1996 level. Since that time, teaching hospitals across the country have been forced to balance institutional GME planning goals with these limits on Medicare funding.

The report, entitled *Physician Workforce Policy Guidelines for the U.S., 2000 to 2020*, was prepared by the Center for Health Workforce Studies (CHWS) at the State University of New York (SUNY) at Albany, under contract to the U.S. Health Resources and Services Administration. ■

## IN THE SPOTLIGHT



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### **Nursing Spectrum: CE Direct**

GNVHA Ventures, Inc. and Nursing Spectrum have formed a strategic alliance, that brings the benefits of Nursing Spectrum's *CE Direct* to Greater New York Hospital Association (GNVHA) members at a discount. One of the largest providers of accredited online continuing education (CE) programs for nurses, Nursing Spectrum is an RN-led communications company that promotes nursing through publications and CE. With *CE Direct*, health care institutions can offer online CE courses directly to their nursing staff. Institutional participation is a convenient way to track and pay for nurses' CE courses, and eliminates the administrative expense of processing individual CE reimbursement requests. *CE Direct* also offers:

- a convenient way to fulfill CE requirements, because courses can be taken anytime from anyplace with a PC and Internet connection;
- an online inventory of more than 250 course modules with a wide range of subjects including critical care, medical-surgical nursing, oncology, cultural competency, professional issues, and others;
- special sections with topic-specific requirements for nurses who maintain licenses in multiple states;
- course modules accredited through the American Nurses Credentialing Center's Commission on Accreditation, American Association of Critical Care Nurses, and New Jersey Department of Education Professional Development; and
- modules mandated in NYS and approved by the NYS Education Department.

*CE Direct* gives institutions total control to decide which nurses are eligible and how long they can access the service. Nursing Spectrum will keep track of which modules are taken and provide on-demand reports. ■

*For additional information about CE Direct, contact Gayle White at GNVHA, at (212) 506-5479.*

# Medicare Bill Includes Temporary Increase in IME Payments

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (DIMA) includes several provisions affecting teaching hospitals in addition to the provision that redistributes unused resident positions (see story on page 1, “Medicare Prescription Drug Legislation Mandates Redistribution of Unused Resident Positions”). The DIMA increases the indirect medical education (IME) adjustment from the current 5.5% for every 10% increase in the ratio of interns and residents to beds to 6.0% on April 1, 2004; to 5.8% on October 1, 2004; and to 5.55% on October 1, 2005. This change will provide teaching hospitals in New York State with approximately \$100 million more than current law would provide during that time period. On October 1, 2006, however, the IME adjustment would be reduced to 5.35%, which would reduce payments to New York’s teaching hospitals by approximately \$25 million. On October 1, 2007, the IME adjustment would return to the current level of 5.5%.

## Exception to Initial Residency Period for Two-Year Geriatric Programs

The DIMA clarifies that one- or two-year geriatric programs are not to be counted against a resident’s initial residency period (IRP). The general Medicare rule is that a resident’s IRP is calculated on the basis of the minimum number of

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**In the usual case, a geriatric fellowship would not be considered within the IRP since it follows a categorical residency program that leads to Board eligibility.**

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years required in order to attain first Board eligibility. In the usual case, a geriatric fellowship would not be considered within the IRP since it follows a categorical residency program that leads to Board eligibility.

## Clinical Base-Year Clarification

The Conference Agreement that accompanies the DIMA includes a clarification regarding the determination of the IRP for residents pursuing training in a specialty that

requires a clinical base-year of training. For certain specialties that require a year of broad-based clinical training prior to the more specialized years of the training (e.g., diagnostic radiology, dermatology, etc.), residents often satisfy that clinical base-year requirement by training in the first year of a three-year categorical residency program, such as gen-

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**The initial residency period for any residency for which the ACGME requires a preliminary or clinical year of training is to be determined in the resident’s second year of training.**

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eral internal medicine, rather than in a one-year freestanding transitional-year program. For those residents who train in the first year of the three-year categorical residency program, the Medicare program assigns them an IRP of “3” despite the fact that they had no intention of completing their training in this three-year program and go on to the more specialized training in the second year. This lower IRP assignment has resulted in downweighting in the final year or years of the more specialized years of the resident’s training and lower direct GME payments.

Greater New York Hospital Association (GNYHA) and other organizations had been advocating with the Centers for Medicare & Medicaid Services (CMS) to address this issue within the inpatient rule-making process in 2003, but it was not addressed in either the proposed or final rule. The Conference Agreement states:

*The conferees also clarify that under section 1886(h) (5)(f), the initial residency period for any residency for which the ACGME [Accreditation Council for Graduate Medical Education] requires a preliminary or clinical year of training is to be determined in the resident’s second year of training.*

GNYHA is very pleased that the conferees chose to clarify this point, and will work with CMS to try to ensure that this clarification is incorporated into the Medicare direct GME reimbursement system. ■

# HHS Modification of J-1 Visa Waiver Application Guidelines Excludes Hospitals

The U.S. Department of Health and Human Services (HHS) recently modified its application guidelines for institutions to request waivers of the two-year foreign residency requirement for physicians with J-1 visas who wish to engage in clinical care. The J-1 visa, which is an exchange visitor visa, is normally granted to a foreign national with the understanding that at the conclusion of the visa period, the foreign national will return to his or her last country of residence.

HHS had announced in December 2002 that the agency would begin to accept applications to sponsor J-1 visa physicians as an interested government agency (IGA) for the purpose of waiving the foreign residency requirement for both clinical care and research programs. This requirement may be waived at the request of an IGA and the approval of the U.S. Department of State if the physician agrees to deliver health care services for three years in primary care or mental health professional shortage areas (HPSAs) or medically underserved areas (MUAs). In recent years, the U.S. Department of Housing and Urban Development and the U.S.

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**The limit that each state is allowed to request as an interested government agency through its Department of Health or similar agency each year was raised from 20 to 30.**

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Department of Agriculture had withdrawn from participation as IGAs for the purpose of sponsoring J-1 visa physicians for waivers of the return-home requirement. In the meantime, the limit that each state is allowed to request as an IGA through its Department of Health or similar agency each year was raised from 20 to 30.

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**In June 2003, HHS issued guidelines for applying to act as an interested government agency for the purpose of a waiver prior to October 1, 2003.**

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In June 2003, HHS had issued guidelines for applying to the agency to act as an IGA for the purpose of a waiver prior to October 1, 2003, the beginning of the new Federal fiscal year (FFY). These guidelines limited the program to those physicians who had completed a residency in primary care or psychiatry and were willing to work in an HPSA or MUA. The modified application guidelines are effective for the current FFY, which ends September 30, 2004. During this period, HHS will only process applications from a facility located in an HPSA with a score of 14 or higher, and which is one of the following:

- a health center as defined within the Public Health Service Act;
- a rural health clinic within the Social Security Act; or
- a Native American/Alaskan Native tribal medical facility. ■



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*GME Central* is a quarterly publication of Greater New York Hospital Association (GNYHA). *GME Central* is free for GNYHA member institutions. The publication can be purchased by nonmembers for \$100 per year. If you would like to subscribe to *GME Central*, please contact Kathy Corbett at GNYHA, 555 West 57th Street, 15th Floor, New York, NY 10019; phone, (212) 506-5473; fax, (212) 262-6350.

## **ABOUT GNYHA**

Greater New York Hospital Association is a trade association that represents 250 not-for-profit hospitals and continuing care facilities, both voluntary and public, in the New York metropolitan area and throughout the State, as well as New Jersey, Connecticut, and Rhode Island.