

GME Central

NEW YORK'S DIRECT LINE TO GRADUATE MEDICAL EDUCATION NEWS

Medicare Final Rule Codifies GME Community Support and Redistribution Principle

On August 1, 2003, the Centers for Medicare & Medicaid Services (CMS) published its final rule for the Federal fiscal year 2004 inpatient prospective payment system (IPPS) rates, which took effect on October 1, 2003. In the final rule, CMS reviewed the wage index calculation used to determine the payment rates, lowered the Medicare outlier payment threshold by 39% from what was in the earlier proposed rule, proceeded with its expansion of the number of diagnosis-related groups (DRGs) affected by the policy to reimburse discharges to post-acute care as transfer cases, and clarified its payment rules for nursing and allied health educational activities. In addition, an important GME payment policy issue that had been discussed in the proposed rule was finalized (see page 2).

continues on page 2

Senators Weigh in on Repealing IME Cut

On August 1, 2003, 13 Republican and 27 Democratic U.S. senators sent a letter to Senate Majority Leader Bill Frist (R-TN) to express support for repealing the Medicare reimbursement rate cut to teaching hospitals that took effect on October 1, 2002. The cut is costing New York teaching hospitals \$140 million annually. The letter, which was spearheaded by Senators Kay Bailey Hutchison (R-TX) and Edward M. Kennedy

(D-MA), stated that the senators would like to see the final Medicare prescription drug bill, which is currently being negotiated by House and Senate leaders, increase the indirect medical education (IME) adjustment to 6.5% and keep it at that level for the next 10 years. The letter was also signed by Senators Charles E. Schumer, Hillary Rodham Clinton, Frank Lauten-

continues on page 3



VOLUME 6, NUMBER 3
2003

INSIDE

2

Resident Working Hours Update

4

In the Spotlight:
Craneware

5

Reimbursement
Essentials:
Empire Clinical Research
Investigator Program

6

HIPAA Transaction
Sets Deadline

Resident Working Hours Update

DOH and IPRO Release Resource Documents

The NYS Department of Health (DOH) and its contracted survey organization, IPRO, have prepared a comprehensive resource document for use by hospital administrators and residency program directors to assist compliance efforts with the State regulations on resident working hours and conditions. IPRO also recently prepared a document outlining the relationship between the State regulations and the new Accreditation Council for Graduate Medical Education (ACGME) duty hour requirements, which went into effect July 1, 2003.

Hospital Compliance Resource Document

DOH and IPRO prepared a comprehensive resource document that reviews the many issues and questions that DOH and IPRO staff have heard over the past several years as the surveys have been conducted. DOH shared a draft version of this document with Greater New York Hospital Association (GNYHA), which then provided extensive comments, with the goal of clarifying key areas and ensuring maximum usability of the document by a variety of interested parties, including hospital administrators, compliance officers, GME administrators, residency program directors, and residency trainees.

The first section of the document briefly reviews several key points regarding the regulations, the survey process, and some issues that have been raised (for example, privacy of patient-specific information) in the context of the surveys. The second section is in a question-and-answer format and covers specific aspects of the regulations, including the 24-consecutive-hour limitation, the use of transition time, moonlighting policies, and the surgical exemption. The document also describes how DOH assesses compliance with these components of the regulations. Many of the questions in the document have been raised at the numerous DOH-IPRO briefing sessions and meetings held by GNYHA over the past several years.

New York State–ACGME Comparison Guidelines

IPRO has also prepared a chart that compares the main areas of the State regulations with the ACGME requirements. As GNYHA has noted, the areas of difference that may have a practical impact on compliance efforts among New York hospitals include the allowances for transition time after night call and, in particular, the minimum time standard for required nonworking periods.

The ACGME allows up to six hours for transition time, although the State still has a three-hour maximum limit. In the case of those

Medicare Final Rule Codifies GME Community Support and Redistribution Principle, continued from page 1

Community Support and Redistribution-of-Cost Principles

In the final rule, CMS revised its regulations to codify Medicare's community support and redistribution-of-cost principles and apply them to resident counts. The prohibitions against cost-shifting were applied with particular focus after 1984, when Medicare ceased reimbursing hospitals for direct graduate medical education (DGME) based on the actual costs they incurred and instead implemented a prospective payment system based upon a hospital's approved per resident amount (PRA). In determining hospitals' approved PRAs, Medicare disallowed costs that were found to have been borne previously by the community or redistributed to the hospital from another entity such as a medical school. The new regulation now applies these principles by requiring that a hospital must continuously incur DGME costs of residents training in a particular program at a training site since the date the residents first began training at that program, in order for the hospital to count the FTE residents.

The codification of these cost-shifting prohibitions applies to counts of residents training at both hospital and non-hospital settings. Any finding that the new provisions have not been met will lead to a disallowance of claimed FTEs. While CMS

maintains that the prohibitions against cost-shifting have always existed and are not new, they will not be applied to disallow resident full-time equivalent (FTE) counts for cost-reporting periods prior to October 1, 2003. For example, if a fiscal intermediary determines that impermissible cost-shifting has occurred since 1999, it would disallow those FTEs for periods beginning as of October 1, 2003, but not before. In addition, in order to avoid disrupting training that has begun or for which certain actions have been taken in reliance on a prior understanding of the rules, FTE counts for residents who began training in non-hospital settings on or before October 1, 2003, and who would otherwise be found to represent impermissible cost-shifting, will not be disallowed for three years or upon the completion of their programs, whichever comes earlier.

Counting Residents in Non-hospital Settings

While the new rule applies to both hospital and non-hospital training, the impetus for these changes arose in the context of training in non-hospital settings. Current regulations permit hospitals to count residents in non-hospital settings for both DGME and indirect medical education (IME) if certain conditions are met, including that the residents spend their time in patient care activities and there is a written agreement between

New York hospitals that choose to utilize the State's surgical exemption, which allows for an extended work period for surgical programs under certain conditions, the ACGME limitation of six additional hours following a 24-consecutive-hour on-call period would mean that a maximum of 30 consecutive hours would be allowable to comply with both the State and the ACGME requirements. For non-surgical programs and surgical programs not using the State's surgical exclusion provision, the State limit of 27 hours (24 consecutive hours, plus up to three hours of transition time) would apply.

Following vigorous advocacy by GNYHA and others regarding the ACGME's proposed strict nonworking period minimum requirement of 10 hours, the ACGME modified the requirement in part to indicate that the goal is adequate rest time and teaching institutions should try to accommodate 10-hour nonworking periods. In light of that modification, a GME committee and residency program that believes it is only able to provide the State-mandated eight-hour nonworking period would be expected to document the reasons for needing that accommodation and, in particular, should note the educational reasons for requesting the accommodation.

Copies of the documents are available from Tim Johnson of GNYHA at tjohnson@gnyha.org or (212) 506-5420.

Unannounced Surveys

In response to a letter sent to DOH Commissioner Antonia C.

the hospital and non-hospital site stating that the hospital will incur all or substantially all of the costs of the program, which is defined as resident salaries and fringe benefits and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to DGME. Hospitals are also required to provide some reasonable compensation to the non-hospital site for supervisory teaching activities, and the written agreement must specify how the non-hospital site is compensated.

Thus, in non-hospital training situations, the prohibition against cost-shifting is paired with the requirement that hospitals incur all or substantially all of the costs of training in that program. The hospital must demonstrate that it has continuously incurred some DGME costs since the inception of the program at that site for the residents it wishes to claim. Then, it must fulfill the "all or substantially all" and other requirements of the non-hospital regulation. In this regard, the preamble section of the final rule states that if a hospital wishes to count any FTEs training at a non-hospital site, it must incur the costs for the *full complement* of residents training in the *program* at the non-hospital site.

The preamble section also notes that a hospital that continuously incurs resident salaries and benefits while the residents train in a non-hospital site would not be redistributing costs if the non-hospital site later incurs other DGME costs such as

Novella, M.D., M.P.H., Dr.P.H., DOH has indicated an unwillingness to alter the current survey protocol. Although GNYHA appreciates that DOH has reviewed the issue with IPRO staff and has improved the process since the start of the IPRO contract, GNYHA continues to hear from its members about the

Senators Weigh in on Repealing IME Cut, continued from page 1

berg, and Jon Corzine. This letter is similar to another one authored by Congressman Christopher Shays (R-CT), which garnered the support of 47 Republican signatories, including New York metropolitan area Congressmen Peter King, Vito Fossella, and Christopher Smith. The Shays letter was sent in September. Greater New York Hospital Association (GNYHA) has been working with teaching hospitals nationwide, as well as the Association of American Medical Colleges and the American Hospital Association, to repeal the IME cut, and is grateful to the New York and New Jersey members of Congress for their support.

Meanwhile, the House and Senate conference committee charged with ironing out the differences between the Medicare prescription drug bills passed by the House and Senate earlier this year has announced tentative agreement on several portions of the bill, including regulatory reform

supervising physician salaries in that site. The hospital would, however, still have to meet the requirements for claiming FTEs in non-hospital settings in order to count the residents. CMS also noted that for both hospital and non-hospital sites, if a hospital incurs the DGME costs of a new program, it should be able to count residents in that program.

Redistribution of Costs Among Hospitals

Where one hospital takes over costs borne previously by another hospital, the preamble section of the final rule notes that it would be unlikely for impermissible cost-shifting to occur because costs borne previously by a hospital are not the same as costs borne previously by the community or another educational institution. Thus, if one hospital had incurred DGME costs in a non-hospital site for a certain period of time, and then another hospital consecutively incurred such costs, the second hospital would likely be eligible to count the residents for DGME and IME from the point when it assumed the costs because the costs had been incurred previously by a hospital.

Training of Dental Residents

In the proposed rule, CMS discussed several non-hospital training situations that it believed had involved impermissi-

disruption that occurs as a result of these unannounced surveys, and particular decisions about the timing of the visits. GNYHA will continue to reiterate that, because the majority of these on-site surveys are not complaint investigations but annual compliance reviews, this policy should be modified. ■

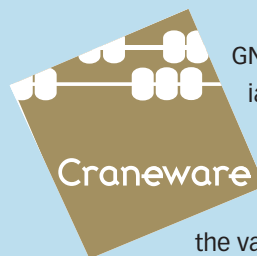
provisions (designed to make the Medicare program easier to understand for both beneficiaries and providers) and a Medicare prescription drug discount card. The regulatory reform section of the bill contains a number of provisions that are strongly supported by the provider community, including a prohibition on retroactive application of new regulations and policies, a mandatory waiting period of 30 days before a substantive policy change can take effect, a prohibition on sanctions if a provider follows written, erroneous guidance from the government or its fiscal intermediaries, and reform of the provider appeals process. The agreement also contains a provision to provide timely data to hospitals so they can accurately compute the disproportionate share hospital patient percentage. Conference committee members continue to work with the goal of completing Medicare prescription drug legislation in October. ■

ble cost-shifting to the Medicare program. While its examples were not limited to the training of dental residents, these programs were a particular focus of discussion. The examples included situations where hospitals and dental schools had entered into agreements fulfilling the specifications of the non-hospital training regulations and under which hospitals assumed training costs as of a certain point in time, but where prior to the effective date of the agreements, the dental schools had borne the costs of training. CMS was troubled by these arrangements, which, combined with the exemption of dental residents from the FTE resident cap imposed by the Balanced Budget Act of 1997, resulted in increased hospital FTE counts.

GNYHA Follow-up Activities

Both the proposed and final rules contain references to using January 1, 1999, as the starting date to determine whether a hospital has continuously incurred training costs. However, the final rule says nothing concrete on this issue and thus it remains somewhat open-ended. CMS plans to issue a program memorandum to its fiscal intermediaries about the regulations, and GNYHA is following up with CMS staff to receive clarification on this and other issues. ■

IN THE SPOTLIGHT



GNYHA Ventures—a for-profit affiliate of Greater New York Hospital Association (GNYHA)—has formed a strategic alliance with Craneware that brings the valuable economic benefits of

Craneware's *Active Chargemaster Professional Toolkit* to GNYHA members. This highly cost-effective software tool is designed to help health care institutions better manage and control their Charge Description Master Files, which house all financial transactions that can be applied to a patient account, including all descriptions and codes needed for billing, payment, and reimbursement. The software will help health care institutions keep their chargemaster files current, accurate, and compliant. This product is also marketed by 3M Health Information Systems and Martin Henry Associates on behalf of Craneware, Inc.

The *Active Chargemaster Professional Toolkit* identifies invalid or obsolete Current Procedural Terminology (CPT) or Healthcare Common Procedural Coding System (HCPCS) codes and suggests replacements for codes that are missing or no longer exist; recommends possible billable codes missing from the master file and identifies common compliance problems by constantly checking against the latest code standards, regulations, and current compliance issues; enables health care facilities to support efficient chargemaster coding via easy access to an up-to-date reference guide of all CPT and HCPCS codes; provides a comprehensive audit trail for every charge code and an online memo feature for each chargemaster item; and increases flexibility by allowing multiple, simultaneous access to permission-controlled segments of the chargemaster. This innovative product will help ensure quicker payments while increasing revenue and reducing bill rejection.

Active Chargemaster is currently in use in more than 300 hospitals throughout the United States.

For more information, contact Gayle White at (212) 506-5479. ■

Reimbursement Essentials: Empire Clinical Research Investigator Program

The Health Care Reform Act of 2000 (HCRA) was extended recently by Governor George Pataki through June 30, 2005. Among its various provisions, HCRA mandates that private payers contribute to a State GME pool. The major portion of this GME pool reimburses teaching hospitals for a portion of the costs associated with training residents through a fixed formula. A small portion of the State GME pool, however, is “carved out” for a special competitive grant program that is designed to advance State policy goals in the area of GME.

The carved-out portion of the overall GME pool, which is often referred to as the State GME incentive pool, totals \$31 million and has four policy components that are weighted and scored in determining an applicant teaching hospital’s institutional score and accounts for up to 85% of the total incentive pool amount. The four State policy goals that make up this scoring determination include reducing

Up to \$4.65 million is set aside each year to partially support the training of young clinical researchers.

the number of non-primary care residents and programs, increasing the proportion of residents training in ambulatory care sites and underserved areas, increasing the proportion of underrepresented minorities in medicine, and providing cultural competence training to residents.

Empire Clinical Research Investigator Program

A fifth component of the GME incentive pool program is administered separately. This component, called the Empire Clinical Research Investigator Program (ECRIP), is designed to address the policy goal of increasing the number of clinical researchers and raising New York’s standing in terms of promoting and advancing clinical research. The program encourages teaching hospitals and GME consortia to train physicians as clinical researchers to advance biomedical research in New York’s academic health centers. To advance this goal, up to \$4.65 million (15% of the incentive pool funding total) is set aside each year to partially

support the training of young clinical researchers. A teaching hospital or GME consortium is eligible to submit clinical research project abstract(s) for the equivalent of a one- or two-year position, and may submit no more than 1% (rounded-up to the nearest whole number) of the number of residents who were training at the teaching hospital(s) in 2000–01.

Candidate and Project Eligibility

The candidate for the position does not have to be determined at the time of submission, but the person chosen must be **1)** a United States citizen or permanent resident of the United States, and **2)** a graduate of a medical or dental school located in New York, a resident or graduate of a residency training program sponsored by an institution located in New York, or a New York resident. Each candidate must spend no less than 40 hours per week in the position. The research position must be a new position, which has not been funded previously by the institution or supported by grant funding in the past three years.

Research projects may have a project director and must have a sponsor-mentor. The sponsor-mentor must **1)** be employed or contracted for employment by the hospital or paid through its affiliated faculty practice plan, or **2)** maintain a faculty appointment at a medical school located in New York State, or **3)** collaborate with a researcher from another institution. The hospital, medical school, or institution must have received at least one National Institutes of Health research grant since 1998.

A project required in order for a resident to complete an initial residency program is not eligible for the ECRIP position. In particular, the clinical research experience must exceed the minimum research standards that are required by the residency review committee in the specialty in which the physician has trained or is currently training.

ECRIP Reimbursement and In-kind Support

The ECRIP reimburses the teaching hospital \$60,000 per position per year. The funding is intended to cover part or all of the cost of the researcher’s salary and fringe benefits. The ECRIP does not provide reimbursement for additional direct costs or any indirect costs. The teaching hospital is expected to cover these costs, which include supervision, overhead, equipment, and other resources, either through in-kind support or through another source. ■

HIPAA Transaction Sets Deadline Arrives

October 16, 2003, was the deadline for complying with the transactions and code sets provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Greater New York Hospital Association (GNYHA), through its HIPAA Transaction Sets Workgroup, has been working intensively with its member institutions and major payers to achieve compliance and minimize provider cash flow disruption.

Background

The administrative simplification contained in HIPAA has three separate components: transaction standards and code sets, privacy, and security. They require health plans to accept standard formats for all transactions related to enrollment,

Payers' support of a transition period will facilitate a smoother HIPAA implementation in terms of provider cash flow and operations.

pre-certification, claims processing, and payment remittance, and require providers that submit these transactions electronically to use those standard formats. It was expected that many hospital and long term care providers, however, may not have been ready to submit claims in the new HIPAA-prescribed format as of October 16, 2003, and were at risk for some disruption in cash flow due to an elongated payment cycle. Several initiatives are available to hospitals and nursing homes to mitigate this negative cash flow impact, including ensuring payer support of a transition period during which providers might send claims as they do today.

Payer Support of Transition Period

GNYHA has been advocating with commercial and governmental payers for a transition period to ensure there is no disruption in cash flow while implementing these HIPAA transaction requirements. The Centers for Medicare & Medicaid Services (CMS) gave payers permission to implement such contingency plans, including accepting claims in current formats, in July 2003.

Several payers have agreed to such a transition period including Medicare and the NYS Medicaid program. In August 2003, Medicaid announced its contingency plan, which includes a four-month transition period during which providers can send claims in the current format while working toward HIPAA compliance. CMS similarly will accept transactions (e.g., claims) in the current format on and after October 16. CMS will evaluate provider implementation progress on an ongoing basis to determine how long its contingency plan will remain in place. Other payers, including HIP and GHI, have also agreed to a transition period.

A transition period will facilitate a smoother transition to HIPAA compliance with less disruption in payer and provider operations. Providers, however, have continued to work diligently toward compliance since many payers have not announced support of a transition period.

Medicaid Postpones HIPAA Implementation

As noted earlier, Medicaid announced a four-month transition period in August 2003 during which providers may submit claims as they do today. More recently, Medicaid announced that due to unanticipated systems issues, it will not be able to accept HIPAA-compliant claims—that is, providers must submit claims as they do today, until otherwise notified. ■



555 West 57th Street
New York, New York 10019

(212) 246-7100

SUBSCRIBING TO *GME CENTRAL*

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 220 not-for-profit hospitals and continuing care facilities, both voluntary and public, in the New York metropolitan area.