

GME Central

NEW YORK'S DIRECT LINE TO GRADUATE MEDICAL EDUCATION NEWS

NYS Legislature Overrides Governor's Budget Veto; HCRA GME Pool Extended Through June 2005

On May 14, 2003, New York Governor George E. Pataki vetoed large portions of the budget bills passed overwhelmingly by both houses of the State Legislature. The following day, both houses of the New York State Legislature overrode all of the Governor's 119 budget vetoes. The Legislature's action means that its budget for State fiscal year 2003–04 is the law of the land, barring any litigation that may invalidate the Legislature's budget. This means that over \$600 million in new hospital cuts and taxes, \$400 million in new nursing

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Medicare Releases Proposed Rule for 2004 with New Requirement for Training in Nonhospital Sites

Proposed Rule Does Not Clarify Policy for Clinical Base-Year Training

In May 2003, the Centers for Medicare & Medicaid Services (CMS) issued its proposed rule regarding changes to the hospital inpatient

prospective payment system (PPS) for Federal fiscal year 2004. In addition to proposals regarding the operating PPS standardized amounts, the wage index, outliers, discharges

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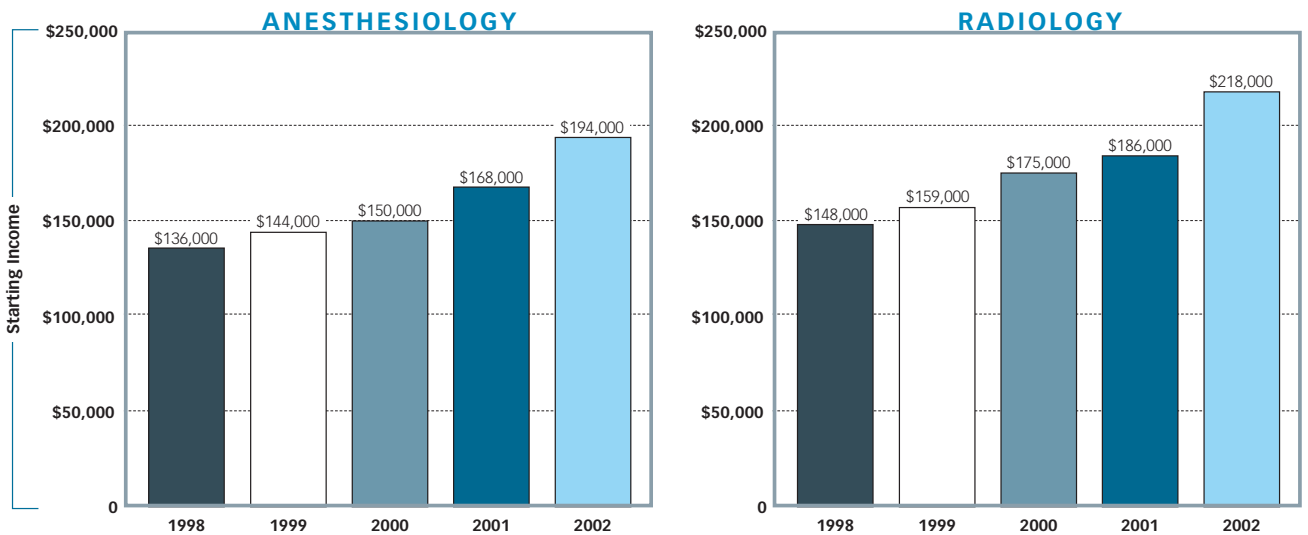
CHWS Survey Reports Increased Starting Income for Anesthesiologists and Radiologists in New York

A report released recently by the Center for Health Workforce Studies (CHWS), University at Albany, indicated that several in-demand specialties have shown a marked increase in the median starting income being offered to new graduates.

As reported in the Winter 2003 issue of *GME Central*, physicians graduating from programs in anesthesiology and radiology, among others, experienced especially strong demand. In addition, the starting income for physicians in these two

specialties has increased dramatically over the last five years. The data are based on CHWS's annual resident exit survey, which tracks demand for physicians in general, and by specialty, using several key indicators. ■

Trends in Median Starting Income, Anesthesiology (General) and Radiology, New York State, 1998–2002



Source: CHWS, *Survey of Residents Completing Training, 1998–2002*.

Medicare Releases Proposed Rule for 2004 with New Requirement for Training in Nonhospital Sites, continued from page 1

to post-acute care settings, and defining available beds for payment purposes, the proposed rule included a new requirement that hospitals must satisfy in order to count resident training at nonhospital sites for purposes of direct medical education (DME) and indirect medical education (IME) payments. The new requirement is that the Medicare program will only allow hospitals to claim residents training in nonhospital settings for DME or IME payments if a hospital had continuously incurred the direct training costs for the residents in the relevant program since the beginning of the training program. This determination will be made by the fiscal intermediary (FI) as of January 1, 1999, although the proposed rule notes that the FI has discretion to disallow nonhospital site training costs prior to that date if the FI is able to determine that the requirement had not been met

prior to January 1, 1999. In the case of a hospital newly incurring the direct costs of training in a nonhospital setting, the proposed rule states that the hospital is allowed to count the time of *additional* residents training in the non-

Medicare has a longstanding policy not to allow redistribution of medical education costs that had been supported by the community onto the Medicare program.

hospital setting only if it is incurring the direct costs of *all* residents training in the nonhospital setting.

According to the proposed rule, the reason for the new

ECFMG Clarifies Institutional Requirement for Non-standard Programs and CSA Transition

The Educational Commission for Foreign Medical Graduates (ECFMG) has clarified a component of the requirements that must be satisfied in order for it to sponsor J-1 physicians for participation in certain “non-standard” training programs. Following discussions with the academic medicine community and the U.S. Department of State, the ECFMG announced recently that it will continue to sponsor J-1 physicians in non-standard programs as long as the appropriate specialty board of the American Board of Medical Specialties (ABMS) recognizes the program, as evidenced by a letter of support, and additional requirements are met, including that all accreditable programs within the sponsoring institution are in “good standing” with the Accreditation Council for Graduate Medical Education (ACGME). A question had been raised recently as to whether an institution having a residency program on probation can satisfy this requirement. The ECFMG has clarified that having one or more programs on probationary accreditation does not preclude the institution from attesting that the programs are in good standing. According to the ECFMG, “good standing” assumes all ACGME-accreditable programs are authorized to accept resi-

dents for training, that residents are able to continue to progress appropriately through their educational sequence, and that residents in the program receive credit toward Board certification as a result of the training. According to the ECFMG, the spirit of the joint discussions that resulted in this policy assumes that the institution’s graduate medical education committee is involved in oversight of all educational training activities including remediation efforts being taken by a probationary program to ensure the success of a corrective action plan.

Clinical Skills Assessment Transition

A Clinical Skills Examination (CSE) will become part of the U.S. Medical Licensing Exam (USMLE) in mid-2004. The CSE will complement the current USMLE Steps. Currently, international medical school graduates (IMGs) must pass a separate clinical skills assessment (CSA) in order to be certified to train in U.S. residency programs. Upon implementation of the CSE, the ECFMG will no longer administer the CSA, and IMGs will be required to pass the CSE in order to receive ECFMG certification. ■

requirement is that Medicare has a longstanding policy not to allow redistribution of medical education costs that had been supported by the community onto the Medicare program. The Balanced Budget Act of 1997 (BBA) allows hospitals to claim the time residents spend training in nonhospital sites for DME and IME payments if the hospital can show that it is incurring all or substantially all of the costs of training the residents in that nonhospital setting. The proposed rule states that it was the intention of this BBA provision to create an incentive to move training from hospitals to non-hospital settings. The proposed rule notes that because dental residents in particular are outside the resident cap imposed by the BBA, the Medicare program has become aware of shifting of costs from dental clinics to hospitals, and the proposed rule describes this practice as contrary to its longstanding community support and redistribution principles for payment.

Clinical Base-Year Issue

The proposed rule did not, as expected, clarify Medicare GME payment policy with regard to residents undergoing a year of broad-based clinical training prior to entering the specialty part of their program. Due to the inadequate supply of transitional-year program positions and other reasons, residents training in specialties that require a year of this broad-based training (for example, diagnostic radiology) have done a preliminary year of training within another specialty program—most

Residents training in transitional-year programs and preliminary-year programs should be treated identically with respect to Medicare GME payment policy.

home cuts, over \$70 million in home health cuts and taxes, a reduction in eligibility for the Family Health Plus program, and a variety of other proposals that would have devastated New York's health care community will not be enacted this year. In addition, the Health Care Reform Act (HCRA) and all of its pools will be extended through June 30, 2005, without any major reductions in funding. Given the State budget deficit, this outcome is remarkable. The health care community owes a deep debt of gratitude to Assembly Speaker Sheldon Silver and Senate Majority Leader Joseph Bruno, as well as the majorities in both houses, for their strong support throughout this debate.

Healthcare Education Project

In addition, this outcome could not have been achieved without the strong advocacy of Greater New York Hospital Association (GNYHA) members and their support for the Healthcare Education Project, a joint effort of GNYHA and 1199 SEIU. Through the Project, GNYHA was able to mount an unprecedented television, radio, direct mail, and phone-banking campaign that made all the difference and was unmatched by any other group in the State. The Project sent mail to an estimated 2 million households, generating approximately 300,000 post-cards. Through the phone-banking campaign, the Project was able to patch over 10,000 callers directly through to the offices of their State Senators. Finally, a door-to-door canvassing campaign resulted in visits to approximately 35,000 residences throughout the State. ■

commonly, medicine—in order to satisfy this training requirement. The Medicare program treats a trainee as a full resident for DME payment purposes for the number of years of the resident's "first specialty," and provides 50% DME reimbursement after that point, with the result that hospitals training these residents have been disadvantaged because the Medicare program views the trainee as a "medicine resident" (with three years to complete the specialty) rather than a "radiology resident" (with five years needed to complete the specialty). The Medicare program takes this view even if the resident has simultaneously matched into both a preliminary-year position and the advanced position in the specialty. Greater New York Hospital Association and others in the academic medicine community are advocating vigorously for a clarification of this policy so that residents training in transitional-year programs and preliminary-year programs are treated identically with respect to Medicare GME payment policy. ■

IN THE SPOTLIGHT



GNYHA Ventures, Inc., a subsidiary of Greater New York Hospital Association (GNYHA), and CNAPSIS, LLC, recently announced a strategic partnership. CNAPSIS, LLC, has developed a Web-based tool, *CMEOffice*, designed to automate the entire Continuing Medical Education (CME) administration process for hospitals. Following an extensive evaluation process, GNYHA Ventures determined that *CMEOffice*, developed in conjunction with CME industry leaders and providers, offers a cost-effective solution to address the complex CME administrative challenge that many hospitals face today.

CMEOffice reduces paperwork, enhances data reporting, and helps hospitals satisfy CME regulatory and compliance requirements. Some unique features offered to assist CME professionals in their daily administrative tasks are online registration and payment processing of CME programs for physicians and participants, customized registration forms, and remote registration and attendance functions. Additionally, the system enables hospitals to coordinate registration, reporting, and data collection activities across different departments and organizations, streamline reporting of Grand Rounds attendance, and reduce the possibility of generating inaccurate data. Through the use of this innovative product, CME professionals can restructure their existing relationships with medical institutions to improve regular communications, generate new revenues, and further streamline the administrative process.

For more information about CNAPSIS, contact Gayle White at GNYHA Ventures, Inc., (212) 506-5479.

Reimbursement Essentials: Medicare GME Affiliated Agreements

Under the Balanced Budget Act (BBA), the number of residents for which teaching hospitals can receive both Medicare direct medical education (DME) and indirect medical education (IME) payments is generally capped at the level reported during the 1996 Medicare cost report year. A teaching hospital may, however, receive Medicare GME reimbursement for a number of residents in excess of its 1996 cap by entering into a Medicare GME affiliated agreement with one or more other hospitals.

The BBA included an exception to the strict resident caps for teaching hospitals in order to grant those hospitals a degree of flexibility in forming new affiliations and rotating residents under those affiliations. That is, although the Congress did want to control Medicare GME reimbursement by imposing the resident caps, it did not want to hamper the ability of teaching hospitals to create new relationships with other teaching hospitals that would support the delivery of sound medical education. For this reason, the Medicare program allows teaching hospitals to enter into these agreements, which effectively raise and lower individual hospital caps as long as the sum total of the cap adjustments nets to zero. Although this flexibility has been granted since July 1999, the requirements for hospitals electing to form a Medicare GME affiliated group were modified somewhat in 2002, effective for the period beginning July 2003.

Qualifying as an Affiliated Group

The Medicare program defines three means by which multiple hospitals may qualify as a Medicare GME affiliated group. They are:

- two or more hospitals that are located in the same or a contiguous metropolitan statistical area (MSA) and have a shared rotational arrangement;
- two or more hospitals that are listed jointly as the sponsor of a residency program and have a shared rotational arrangement; and
- two or more hospitals that are under common ownership and have a shared rotational arrangement.

Adjustments Within the Agreement

Two or more hospitals that wish to enter into a Medicare GME affiliation agreement for a particular residency program year must provide a copy of that written agreement to both the Centers for Medicare & Medicaid Services and the local fiscal intermediary by July 1, the first day of the

residency program year. The agreement must specify each hospital's base year resident cap numbers and the adjustment being made to each hospital's cap for both DME and IME payments. In addition, the agreement must specify the adjustment to each participating hospital's resident count resulting from the shared rotational arrangements among the hospitals.

Shared Rotational Arrangements

A shared rotational arrangement refers to a residency training program under which at least one resident participates in training at two or more teaching hospitals. Effective July 2003, each hospital in the Medicare GME affiliated group must have a shared rotational arrangement with at least one other hospital in the group, and all hospitals within the group must be linked by a series of such shared rotational arrangements.

Previous to July 2003, teaching hospitals under common ownership did not need to have a shared rotational arrangement requirement to qualify as a Medicare GME affiliated group.

This shared rotation requirement has existed for entering into a Medicare GME agreement since July 1999 for those hospitals that qualify as an affiliated group as a result of location in the same or a contiguous MSA or as a result of joint sponsorship of a residency program. Previous to July 2003, however, teaching hospitals under common ownership did not need to have a shared rotational arrangement requirement in order to qualify as a Medicare GME affiliated group. The Medicare program has added this requirement for hospitals under common ownership because of concerns that in isolated cases, hospitals under common ownership have shared residency positions, although no formal academic relationship has existed between the hospitals. According to CMS, the intent of the Medicare affiliation group cap exception is to allow for these shared rotation arrangements, and the requirement has therefore been extended to all hospitals electing to enter into such agreements. ■

GNYHA Survey Indicates Challenges to Efficient Patient Flow Through the ED

A recent survey conducted by Greater New York Hospital Association (GNYHA) of its member hospitals identified myriad issues that have an impact on patient flow through the emergency department (ED). As ED volume in New York continues to increase (see Figure 1), hospitals are being challenged to absorb additional patients and manage their flow through the ED in order to minimize “bottlenecks” and increase the efficient use of limited resources. Among the findings of the survey are:

- Hospitals with automated tracking systems, which can assist in measuring and identifying patterns and trends that have an impact on effective patient flow, reported more success in

monitoring the flow of patients through the ED.

- Insufficient bed availability—in particular, critical care beds—is a primary impediment to efficient patient flow through the ED (see Figure 2).
- A shortage of ED nurses and ancillary support staff, and inadequate laboratory and turnaround time, were also reported as impediments in some hospitals.

GNYHA is continuing to work on ED patient flow issues and will use the results of this survey to identify system gaps, best practices, advocacy needs, and educational opportunities on behalf of member hospitals. ■

Figure 1. Emergency Department Volume in New York State, 1996–2000 (N=174)

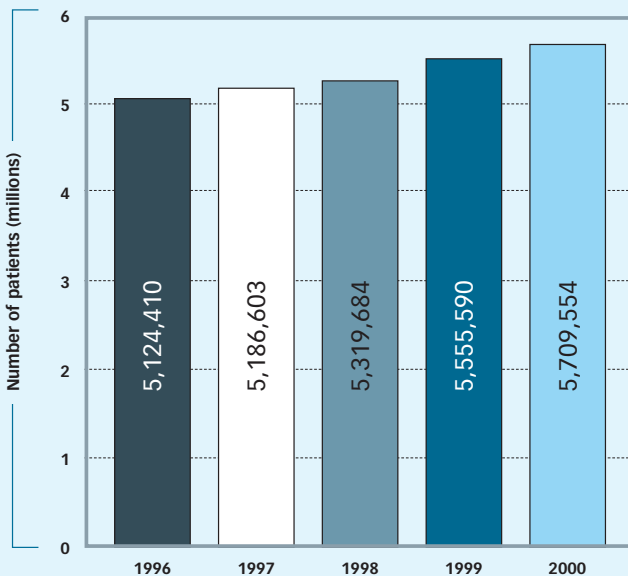
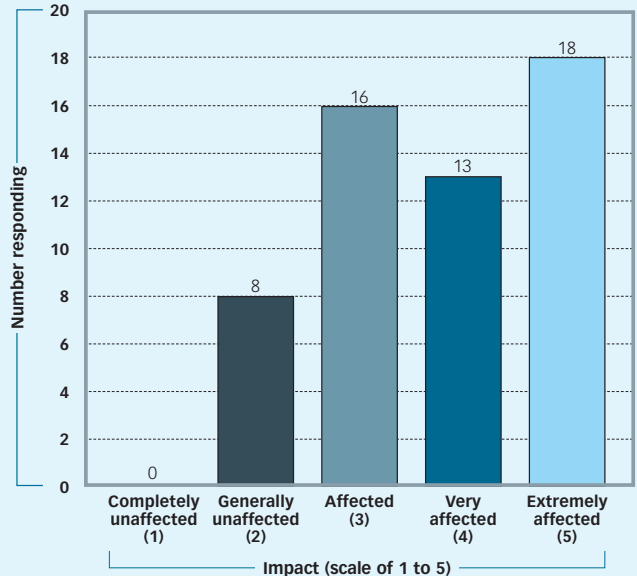


Figure 2. Impact of Availability of Critical Care Beds on Emergency Department Patient Flow (N=55)



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ABOUT GNYHA

Greater New York Hospital Association is a trade association that represents 200 not-for-profit hospitals and continuing care facilities, both voluntary and public, in the New York metropolitan area.