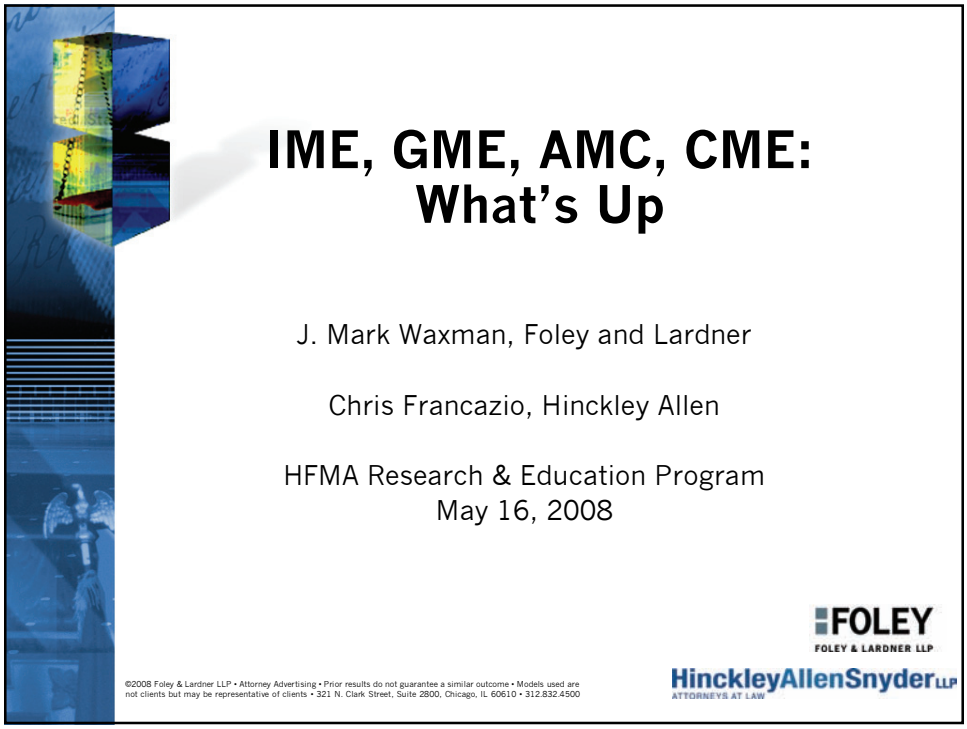

IME, GME, AMC, CME: What's Up

J. Mark Waxman, Foley and Lardner

Chris Francazio, Hinckley Allen

HFMA Research & Education Program
May 16, 2008

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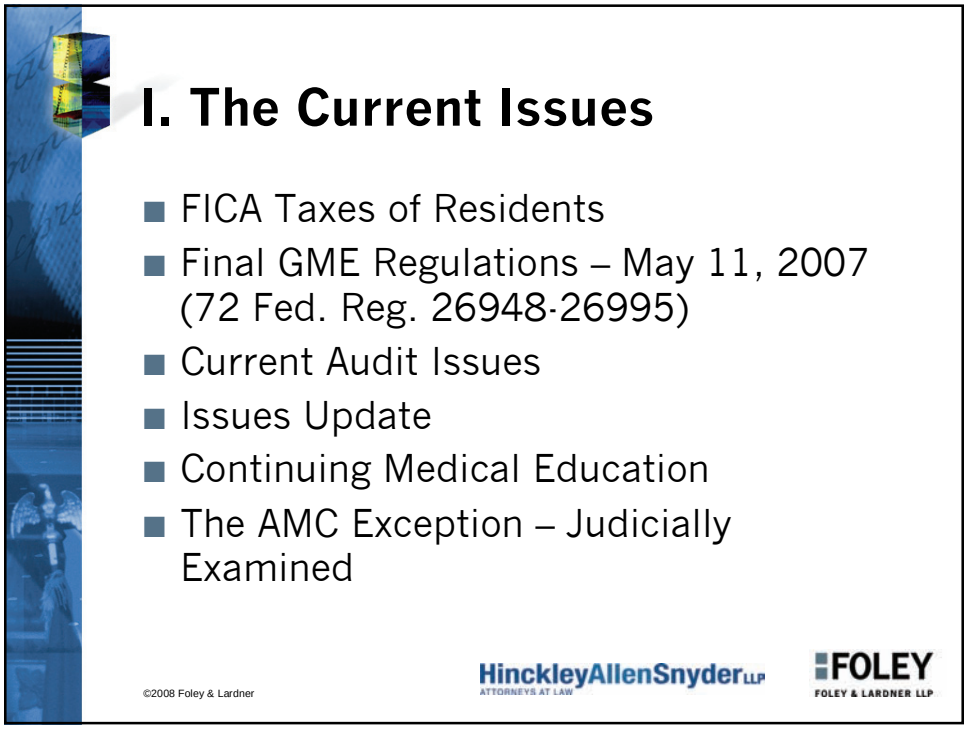

I. The Current Issues

- FICA Taxes of Residents
- Final GME Regulations – May 11, 2007 (72 Fed. Reg. 26948-26995)
- Current Audit Issues
- Issues Update
- Continuing Medical Education
- The AMC Exception – Judicially Examined

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II. FICA Taxes on Medical Residents – A Winning Streak

- IRS Regulations Ruled Invalid – T.D. 9167, 2004
  - Inconsistent with FICA
  - Primary function test rejected
  - The student exclusion (26 U.S.C. §3121 (b)(10)) prevails
  - Impossible to separate education from patient care
  - No FTE exception to the definition of student

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II. FICA Taxes on Medical Residents – A Winning Streak

- Multiple cases
  - U.S. v. Mt. Sinai Medical Center of Florida, Inc. (5/18/07)
  - Mayo Foundation for Medical Education and Research v. U.S. (8/3/07)
  - Regents of University of Minnesota v. U.S. (4/1/08)

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III. DGME Regulations – Final Rules

- Non-provider settings
  - Pre – 7/1/07
  - Post – 7/1/07
    - The new option: 42 C.F.R. §413.78(f)
      - Written Agreement
        - Between hospital and non-hospital site
        - Before training begins
      - Hospital will incur at least 90% of the total costs of resident's salary and fringes (and travel and lodging where applicable)
      - While resident is training in non-hospital site
      - And the details

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Over the past several years the requirements to claim non-provider rotations have become more explicit but costly.

Non-Provider Rotations

After 10/1/97:
- IME can be claimed in addition to DME
- Patient care activity is performed at the non-provider site
- Written agreement must indicate that the resident's compensation for training time to be paid for by the hospital

Between 1/1/99 and 10/1/04:
- All of the above, plus:
  - Written agreement must indicate hospital will incur resident and physician cost, and amount it is paying to the physician
  - Hospital must incur all or substantially all of the costs for the training program at the site

After 10/1/04 and before 7/1/07:
- All of the above, but can prove 3 month payment window in lieu of written agreement

After 7/1/07:
- All of above, can use 90% cost threshold and national data to arrive at payment amount

There are very few instances where CMS believes there are no faculty costs for non-provider rotations, notably solo practitioners.

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An example of the new non-provider methodology for a family medicine rotation, with three hours of teaching time as a proxy:

Specialty	Median Salary	Hours	Cost of Teaching
Surgery	$327,902	40	$ 24,593
		Total Teaching Costs	$ 24,593

Program	PGY Level	Salary and Benefits
Family medicine	1	$ 55,914
	Total Resident Costs	$ 55,914
	Total Program Costs	$ 80,506
	90% of Amount:	$ 72,456
	Total teaching costs to be paid	$ 16,542

- **Faculty costs in the community vary greatly by specialty. The range of median salaries is from $162,192 (Pediatrics & Adolescent-Developmental Behavioral) to $579,400 (Orthopedic Surgery – Spine).**

Note: Median salary data from the 2007 American Medical Group Association Compensation Survey Data Report.

A hospital may still substantiate a non-provider rotation without using this methodology, but would need to do so by providing actual financial data provided by the teaching physician.

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III. DGME Regulations – Final Rules

- Non-provider settings
  - Some open issues
    - Timing of the new agreements
    - How broad/flexible can an agreement be?
- Use of proxies for physician compensation
  - AMGA Medical Group Compensation and Financial Survey
  - Medicare Salary Data
  - Permitted to use actual salary data.

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III. DGME Regulations – Final Rules

- Contracting Approaches
  - Master Contract approach
  - Attachments with each year's financial calculations and payment arrangements
- Use of Medical Education Consortium
- Hospital and site under the same umbrella?

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IV. Current Audit Issues (GME and IME)

- Non-hospital training and the new rules
- Research and "didactic" time (time spent in seminars, grand rounds, etc.)
- Face-to-face patient care time

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Recent policy "clarifications" and changes are affecting whether a hospital can claim reimbursement for certain resident activities.

Approved Program Activities

- Clinical research:
  - For IME: must document that the research performed involved the direct care of an individual patient, or led to the diagnosis of an individual patient.
  - DME if part of approved program, not "exclusively" engaged in research.
- Didactic Time:
  - To the extent a trainee is outside of the hospital engaged in non-patient care didactic activity that entails a full workday, then that day must be removed from the resident counts.
  - If performed at a hospital, then only DME can be claimed.
- Vacation Time:
  - Currently claimable for DME and IME
- GME Orientation:
  - Currently claimable for DME and IME

In conjunction with the regulatory reductions in funding, policies around what a resident does and how it gets documented are also impacting reimbursement, even if the activity is required and approved.

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IV. Current Audit Issues (GME and IME)

- New programs
- Clinical base year and CRP
- M&C Days

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V. CME – Still In The News

- The Senate Finance Committee Report
  - Drug industry grants to fund CME
  - A belief that CME programs are used to:
    - Engage in kickbacks
    - Unveiled advertising of drugs
    - Efforts to bias clinical protocols
    - Off-label promotion
- The Industry Response
  - Eli Lilly
  - Pfizer

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V. CME – Still In The News

- Best Practices – ACGME Standards
  1. Independence
  2. Resolution of Personal Conflicts of Interest
  3. Appropriate Use of Personal Support
  4. Appropriate Management of Associated Commercial Promotion
  5. Content and Format Without Commercial Bias
  6. Disclosures Relevant to Potential Commercial Bias

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V. CME – Still In The News

- Internet CME – Special Issues
  - CME not placed on manufacturer's product website
  - Advertising prohibited within educational content
  - Participants must be able to access the CME provider to address questions about the activity.

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VI. Stark and the AMC Exception

- The Basic Exception –
  - 42 U.S.C. §1395 nn(h)(4)(B)(ii)
  - 42 C.F.R. §411.355(e)

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VI. Stark and the AMC Exception

- US ex rel Villafame v. Solinger (4/8/08)
  - The first case applying the AMC exception
  - The Court found –
    - Faculty appointments
    - "Substantial" amounts of clinical and academic services, without rigid timekeeping
    - Salaries set in advance and were fmv.

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VI. Stark and the AMC Exception

- US ex rel Villafame v. Solinger (4/8/08)
  - Interesting features –
    - Role of a "tax" on revenues
    - Use of a "Research Foundation" –
      - Disbursed monies for faculty salaries

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VI. Stark and the AMC Exception

- The IPPS Proposed Rules – April 30, 2008 (73 Fed. Reg. 23528)
  - Revisions to address "stand in the shoes"
  - Two alternative approaches
    - AMC exception governs
    - Create a new exception for to be defined mission support activities

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