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Residents Can Be Hazardous to a Community Hospital's Medicare Health

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Although Medicare graduate medical education reimbursement can be a helpful source of financing to facilitate resident training, many community hospitals have suffered a "gotcha" moment when trying to establish new programs. The Medicare program has sliced a third of Medicare payments to some of these hospitals because there happened to have been a resident or two training on-site prior to the start of the new program. Hospital systems with community hospitals may deem it prudent not to allow residents to train on-site at these hospitals until they are ready to be full-fledged teaching institutions.

Even before the inception of ObamaCare, the physician shortage was growing acute. According to the Association of American Medical Colleges (AAMC), there will be a physician shortage of more than 130,000 throughout the United States by 2025. To address this problem, medical schools have been increasing their enrollments, but once these students graduate, they need somewhere to go to undertake their residencies. Yet, because of a 1997 law, the number of residency positions has not increased beyond the initial 26,000 in place at the time. In light of increased medical school enrollment, there will be a significant shortage of residency positions as early as 2016. One would think under the circumstances that Medicare would do all that it could under the law to remove roadblocks to creating new positions, but the truth, sadly, is otherwise.

Medicare pays teaching hospitals based on two components: direct graduate medical education (DGME) payments and indirect medical education (IME) payments. Generally, DGME accounts for about 1/3 of the total payment, and IME is the balance. Total amounts are often around $120,000 per full-time equivalent resident (FTE). FTEs are capped at 1997 levels, but hospitals that have never had a teaching program can establish a new cap by participating in a new medical residency training program. It is therefore ideal for medical schools and academic medical centers to partner with community hospitals that have never been involved in teaching, but there is a catch.

One of the elements of the DGME calculation is the "per-resident amount," which is the calculation of all the direct and indirect expenses associated with a residency, divided by FTEs. This number is generally calculated in the first or second year of becoming a teaching hospital. Once established, it can only be updated but never entirely recalculated. That begs the question: when exactly does a hospital become a "teaching hospital" that has established a per-resident amount?

The Medicare program has unofficially, but consistently, taken the counterintuitive view that any involvement in the teaching of residents, including residents in established programs for which the hospital did not seek or receive payment, irrevocably taints the hospital. Hospitals may not even be aware that a resident was training on-site, as is the case when, say, a mentoring physician brought the resident on-site without seeking formal permission. Because hospitals are often unaware of the training, they certainly do not understand that they need to file a protective per-resident amount calculation, resulting in that value being set at zero. This means that a full third of the potential reimbursement for a new program is set at zero as well.

Any community hospital that has not yet intentionally become a teaching hospital, and any academic medical center considering partnering with such a hospital should carefully consider whether there is this hidden liability. For instance, there should be a review of whether there have been agreements between the hospital and a GME program providing for the training of residents on-site and whether there have ever been payments made for the resident's time. No fact should be viewed as critical, but rather a totality of the facts and circumstances test should be applied. Once those facts have been reviewed, it should be determined if a memo to the file will suffice, or whether a disclosure to the Medicare Contractor or CMS Central is necessary. In any event, if a hospital has not yet been tainted, it should exercise every effort possible to avoid the quandary by blocking residents from coming onsite for any training purposes at all. Finally, to the extent that hospitals view this policy as inequitable, they should make it clear to CMS that they disagree with this position and seek its change.

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