

any overhead expenses of the programs). We also understand that there are dental clinics at these dental schools that treat patients (that is, are involved in "patient care activities").

As a result of the provisions that Congress added to allow hospitals to count FTE residents and receive IME payment, as well as direct GME payment, if the hospital incurs "all or substantially all" the costs of training residents in nonhospital settings, a significant number of dental schools are shifting the resident training costs of the dental programs from the schools to the hospital, and thus to the Medicare program, when the hospitals count the FTE dental residents training in these dental schools (that is, "nonhospital sites") under the regulations at § 413.86(f)(4). Furthermore, in the case of training dentists at dental school clinics, as a result of this cost-shifting and because dental residents are excepted from the cap, hospitals are receiving significant amounts of Medicare direct GME and IME payments when they have incurred relatively small costs of the residents training in a dental school.

The following actual situations are illustrative of the inappropriate application of Medicare direct GME and IME policy that we have found:

- An academic medical center hospital associated with a university has been training allopathic residents for at least 20 years. Prior to 1999, the university's affiliated dental school had always incurred the costs of dental residency programs at the dental school. Beginning with the hospital's cost report for its fiscal year ending in 1999, for the first time ever, the hospital has requested direct GME and IME payment for an additional 67 FTE residents because the hospital claims it has begun to incur "all or substantially all" of the costs of the dental residents training in the university's affiliated dental school, in accordance with the regulations at § 413.86(f)(4).

- A university dental school in one State has been incurring the costs of dental residency programs at its dental school for several years. Beginning in FY 1999, a teaching hospital in a neighboring State decided to begin incurring "all or substantially all" of the costs of the dental residents training in the dental clinics in the program (which is located in a different State from the hospital) in order to receive Medicare direct GME and IME payment for an additional 60 FTE residents.

- In another situation, a teaching hospital on the East Coast of the United States has requested direct GME and IME payment for an additional 60 FTE

dental residents, some of whom are training in dental programs at nonhospital sites located in Hawaii, New Mexico, and the Netherlands, because it has begun to incur "all or substantially all" of the costs of dental residents training in those remote "nonhospital sites". Prior to 1999, the costs for these dental programs were funded by nonhospital sources.

We note that such inappropriate cost-shifting practices are by no means limited to the dental school context. Indeed, we understand that there are some hospitals with resident counts below their direct GME and IME FTE resident caps that have recently (as of October 1, 1997, when it became possible to receive significant IME payments under the amendment made by Pub. L. 105-33) started to incur "all or substantially all" of the costs of residents who had been training at sites outside of the hospital without any financial assistance from the hospital, in order for the hospital to count those FTE residents and receive Medicare direct GME and IME payments for the additional residents. The actual costs of the programs that are being shifted from nonhospital entities to hospitals are relatively small, compared to the direct GME and IME payments that hospitals receive as a result of incurring "all or substantially all" of the training costs.

- In another example, an academic medical center hospital in one State asked Medicare to allow it to count an additional 10 FTEs for both direct GME and IME payment, beginning with its fiscal year ending 1999 cost report, because the hospital claims it is incurring all or substantially all of the costs of training osteopathic family practice residents in a walk-in clinic. The osteopathic family practice residency program had previously been sponsored by this clinic for several years and the residents do not participate in any training at the hospital.

c. Congressional Intent. Congress has delegated broad authority to the Secretary to implement a policy on the count of FTE residents for purposes of calculating direct GME and IME payments. For IME payment, section 1886(d)(5)(B) of the Act simply states that "the Secretary shall provide for an additional payment amount" which includes "the ratio of the hospital's full-time equivalent interns and residents to beds." The methodology to compute the count of FTE residents for IME is not established in the statute. Similarly, for direct GME, section 1886(h)(4)(A) of the Act states that "the Secretary shall establish rules consistent with this paragraph for the computation of the

number of full-time equivalent residents in an approved medical residency training program."

Although not in the context of the general rules for counting FTE residents, Congress similarly acknowledged its intent to defer to the Secretary with respect to the rules for implementing "limits" or caps on the number of FTE residents hospitals may count for purposes of direct GME and IME payment. The conference agreement that accompanied Pub. L. 105-33, which established a cap on the number of allopathic and osteopathic residents a hospital may count, states—

"[T]he Conferees recognize that such limits raise complex issues, and provide for specific authority for the Secretary to promulgate regulations to address the implementation of this provision. The Conferees believe that rulemaking by the Secretary would allow careful but timely consideration of this matter, and that the record of the Secretary's rulemaking would be valuable when Congress revisits this provision." (H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess., 821 (1997).

The absence of statutory specificity on determining FTE counts in these situations and the declared Congressional delegations of authority to the Secretary on the subject are clear indications that Congress has given the Secretary broad discretion to promulgate reasonable regulations in order to implement the policy on the counting of residents for direct GME and IME payments.

When Congress enacted the nonhospital site provisions for both direct GME and IME, Congress intended to address application of the FTE count policy to situations where the training site had been the hospital. The intent was to create incentives for hospitals to move resident training from the hospital to nonhospital settings. We believe that Congress did *not* intend for hospitals to be able to add to their FTE counts residents that had historically trained outside the hospital in other settings. Training in those nonhospital settings had historically occurred without Congress offering any financial incentive to hospitals to move the training out of the hospital.

This Congressional intent is evident in the legislative history of both the direct GME and the IME provisions on nonhospital settings. First, legislative history associated with passage of the direct GME provision (as part of Pub. L. 99-509) indicates that Congress intended to broaden the scope of settings in which a hospital could train its residents and still receive separate direct GME cost reimbursement, and to