

of program(s) had been transferred by the hospital to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the hospital had continued to incur the costs of both the classroom and clinical training portions of the programs while the program(s) were operated by the educational institution. We estimate that the costs to the Medicare program of this proposal would be approximately \$10 to \$20 million. We do not believe many hospitals fit the criteria described above of previously receiving Medicare payment for direct operation of nursing or allied health education program(s) and then transferring operation of the program(s) to a wholly owned subsidiary educational institution, all the while incurring the classroom and clinical training costs of the program(s).

In addition, we are also proposing that, for portions of cost reporting periods beginning on or after October 1, 2003, a hospital that meets the criteria described above may continue to receive reasonable cost payments for clinical training costs incurred by the hospital for the nursing and allied health education program(s) that were operated by the hospital prior to the date the hospital transferred operation of the program(s) to its wholly owned subsidiary educational institution (and ceased to be a provider-operated program). We are further proposing that, with respect to classroom costs, only those classroom costs incurred by the hospital for the courses that were paid by Medicare on a reasonable cost basis and included in the hospital's provider-operated program(s) could continue to be reimbursed on a reasonable cost basis. We estimate the costs to the Medicare program for this proposal would be \$1 to \$2 million per year.

#### *C. Prohibition Against Counting Residents Where Other Entities Have Previously Incurred the Training Costs*

As we explain in section IV.F.2. of the preamble of this proposed rule, under section 1886(h) of the Act, hospitals may count the time that residents spend training in nonhospital sites if they meet certain conditions, including incurring "all or substantially all" of the costs of training at the nonhospital site. Legislative history indicates that the purpose of this provision is to encourage hospitals to provide more training outside the traditional hospital environment.

It has come to our attention that hospitals have been incurring the costs of and receiving direct GME and IME payment for residency training that had previously been occurring in nonhospital settings, without the financial support of the hospitals. We believe that where no new or additional training is provided in these nonhospital settings, the receipt of Medicare payment in such cases is contrary to Congressional intent and is, therefore, inappropriate. In addition, it violates Medicare's anti-redistribution principle, which states that Medicare will not share in the costs of educational activities of a hospital that represent a redistribution of costs from the community to the hospital. Accordingly, we are proposing to revise our policy concerning counting residents to

ensure that Medicare IME and direct GME payments are not made to hospitals for training that had already been in place in the absence of the hospital's financial support. We are proposing that effective October 1, 2003, in order for a hospital to receive IME and direct GME payment, the hospital must have been continuously incurring the direct GME costs of residents training in a particular program since the date the resident first began training in the program in order for the hospital to count the FTE residents.

By prohibiting payment for residency training that had been previously supported by nonhospital institutions, this proposal would reduce the amount of direct GME and IME payments received by hospitals. Although we cannot estimate the impact on programs nationally, we are aware that two hospitals in New York were receiving over \$10 million annually for payments for dental residents training in nonhospital sites (including a site in Hawaii). Another hospital in Boston was receiving over \$2 million annually for dental residents training at a dental school.

#### *D. Rural Track GME Training Programs*

##### *1. Reduction in the Time Required for Training Residents in a Rural Area*

As explained in section IV.F.3 of the preamble of this proposed rule, under existing regulations, if an urban hospital rotates residents to a separately accredited rural track program in a rural area for two-thirds of the duration of the training program, the urban hospital may receive an increase in its FTE cap to reflect the time those residents train at the urban hospital. When we first implemented these regulations, we did so based on our understanding that the Accreditation Council for Graduate Medical Education (ACGME) requires that at least two-thirds of the duration of the program be spent in a rural area. However, it has come to our attention that, while the ACGME generally follows a one-third/two-thirds model for accreditation, the rural training requirement is actually somewhat less than two-thirds of the duration of the program. Therefore, we are proposing to revise the regulations to state that if an urban hospital rotates residents to a separately accredited rural track program in a rural area for more than 50 percent of the duration of the training program, the urban hospital may receive an increase in its FTE cap to reflect the time those residents train at the urban hospital. We estimate that this proposal would only slightly increase Medicare payments for IME and direct GME costs.

##### *2. Inclusion of Rural Track FTE Residents in the Rolling Average Calculation*

As explained in section IV.F.4 of the preamble of this proposed rule, when we first issued the regulations concerning residents training in a rural track program, we inadvertently did not specify in regulations that these residents would be included in the hospital's rolling average count of FTE residents used for computing GME payment. We are proposing to make this technical clarification to the regulations. We believe that this proposed provision would not have a budget impact because it is a clarification of existing policy.

## **VIII. Impact of Proposed Changes in the Capital PPS**

### *A. General Considerations*

Fiscal year 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: Fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the Federal rate and their hospital-specific rate (see § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the Federal rate (see § 412.344). As we state in section V. of the preamble of this proposed rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2004 capital prospective payment system payments for most hospitals are based solely on the Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

In accordance with § 412.312, the basic methodology for determining a capital prospective payment system payment is: (Standard Federal Rate) × (DRG weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share (DSH) Adjustment Factor + Indirect Medical Education (IME) Adjustment Factor, if applicable).

In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the December 2002 update of the FY 2002 MedPAR file and the December 2002 update of the Provider Specific File that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the December 2002 update of the most recently available hospital cost report data (FY 2000) to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for