

"We note that the proposed revisions in the proposed rule inadvertently did not include community support as the basis for an offset from the allowed cost of a GME or nursing and allied health program. In this final rule, we restate our longstanding policy that Medicare will share in the costs of educational activities of providers where communities have not assumed responsibility for financing these programs. Medicare's policy is to offset from otherwise allowable education costs, community funding for these activities." (66 FR 3368)

We note the instructions that CMS (then HCFA) gave to its Regional Offices in the 1990 audit instructions for purposes of calculating the direct GME base period PRA specifically addressed redistribution of costs and community support in the GME context:

"Where costs for services related to medical education activities have historically been borne by the university, it is assumed the community has undertaken to support these activities, and subsequent allocation of these costs to a hospital constitutes a redistribution of costs from an educational institution to a patient care institution. In such a situation, these costs are not allowable under the Medicare program. (See 42 CFR 413.85(c) and HCFA Pub. 15-1, § 406). For example, if in the past the hospital did not identify and claim costs attributable to the time teaching physicians spent supervising I&Rs [interns and residents] working at the hospital, it is assumed that these costs were borne by the university. Therefore, the hospital may not claim these costs in subsequent cost reports." (Instructions for Implementing Program Payments for Graduate Medical Education to ARAs for Medicare, Director of Office of Financial Operations of the Health Care Financing Administration, BPO-F12, February 12, 1990.)

Furthermore, the regulation at § 413.85(c) that was originally issued in the **Federal Register** on September 30, 1986 (51 FR 34793) (which was further refined, but conceptually left unchanged, as of March 12, 2001) addressed the Congressional intent not to increase program costs, as well. That paragraph (c) stated:

Educational Activities. Many providers engage in education activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties.* * * Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with operations, it is not

intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The Secretary of Health and Human Services interpreted this provision to deny reimbursement of educational costs that were borne in prior years by a hospital's affiliated medical school. The U.S. Supreme Court affirmed the Secretary's interpretation of the redistribution of costs regulation in *Thomas Jefferson University v. Shalala* ("Thomas Jefferson"), 512 U.S. 504 (1994). The Court found of § 413.85(c) that:

"The regulation provides, *in unambiguous terms*, that the 'costs' of these educational activities will not be reimbursed when they are the result of a 'redistribution,' or shift, of costs of an 'educational' facility to a 'patient care' facility." (Emphasis added.) (Thomas Jefferson, 512 U.S. at 514). Thus, the Supreme Court in *Thomas Jefferson* held that it is well within the Secretary's discretion to interpret the language at § 413.85(c), which was specifically derived from the legislative history of the original enacting Medicare legislation quoted above, to impose a substantive limitation on medical education payment.

The Supreme Court's opinion in *Thomas Jefferson* lends substantial support and credibility to CMS' longstanding policy on community support and redistribution of costs in the GME context.

e. Application of Redistribution of Costs and Community Support Principles.

As we have described above, we have discovered an inappropriate application of Medicare direct GME and IME payment policies relating to the counting of FTE residents in nonhospital settings. As stated previously, we believe that: (1) Congress has given the Secretary broad discretion to implement policy on FTE resident counts; (2) Congress intended that the nonhospital site policy for both direct GME and IME would encourage hospitals to move resident training from the hospital to nonhospital settings, not to enable nonhospital sites to shift the costs of already established residency programs in the nonhospital site to the hospital; and (3) since the inception of the Medicare program, CMS' policy has been consistent with the intent of Congress that Medicare would only share in the costs of medical education until the community assumes the costs. The Supreme Court has specifically found that CMS' implementation of the redistribution of costs and community

support principles is "reasonable." (*Thomas Jefferson*, 512 U.S. at 514.)

Accordingly, in the May 19, 2003 proposed rule, we proposed that residents training at nonhospital sites may be counted in a hospital's FTE resident count only where the principles of redistribution of costs and community support are not violated. We proposed this policy to address the inappropriate practice of nonhospital sites shifting costs to hospitals solely to allow the hospitals to count residents training in the nonhospital sites. However, we believe the concepts of redistribution of costs and community support are equally relevant to the counting of FTE residents by a hospital in general.

We note again that the Medicare program has a long tradition of applying redistribution of costs and community support principles to medical education payments. As we have stated above, both the House and Senate Committee reports accompanying Pub. L. 89-97 (the 1965 authorizing Medicare statute) indicate that Congress intended Medicare to share in the costs of medical education only where the community has not stepped in to incur them.

We believe it is appropriate to employ the principles of redistribution of costs and community support to specifically address the inappropriate scenarios described above whereby hospitals attempt to inflate their FTE resident counts by assuming payment of training costs for residents in nonhospital sites that were previously funded by a nonhospital entity. Therefore, we proposed to specify the application of the redistribution of costs and community support principles by adopting the definitions (with some modification to reflect the methodology for counting FTE residents applicable to GME) of "community support" and "redistribution of costs" at § 413.85(c), which relate to nursing and health education program costs, for use at § 413.86(b), which relates to GME. In addition, we proposed a general rule at proposed § 413.86(i) on the application of community support and redistribution of costs principles to the counting of FTE residents for GME. We proposed to (1) make the provisions under § 413.86(f) relating to determining the number of FTE residents subject to the provisions of the proposed § 413.86(i); (2) add a proposed § 413.86(f)(4) in order to clarify that the principles of redistribution of costs and community support are applicable to the counting of FTE residents, including when the residents are training in nonhospital settings; and (3) making the