

of redistribution of cost and community support were mentioned in the proposed rule. These included:

Both the House and Senate Committee reports accompanying Pub. L. 89-97 (the authorizing Medicare statute) indicate that Congress intended Medicare to share in the costs of medical education *only* in situations in which the community has not stepped in to incur them:

"Many hospitals engage in substantial education activities, including the training of medical students, internship and residency programs, the training of nurses and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, *until the community undertakes to bear such education costs in some other way*, that a part of the net cost of such activities \* \* \* should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program." (Emphasis added.) (S. Rept. No. 404, 89th Cong., 1st Sess., 36 (1965); H.R. Rept. No. 213, 89th Cong., 1st Sess., 32 (1965).)

The principle behind the congressional committee report language for Pub. L. 89-97 that Medicare would share in the costs of educational activities until communities bore them in some other way has guided Medicare policy on educational activities from the inception of the Medicare program.

The regulations that evolved from the authorizing legislation, first published on November 22, 1966 (31 FR 14814), as well as Chapter 4 of the Provider Reimbursement Manual in 1971, echoed the congressional committee report language from 1965 that Medicare would share in the costs of educational activities until communities bore them in some other way.

As recently as the final rule published in the **Federal Register** on January 12, 2001, we stated:

"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)

Although the above language was written in the context of a regulation that clarified Medicare policy for

provider (hospital) operated nursing and allied health education programs, we note that GME and nursing and allied health education programs were historically paid under the same regulations (the latest of which was codified at § 413.85) and the same cost principles. The quoted language is indicative of this relationship and the Agency's mindset that, while direct GME may have changed in the method of payment to a prospective payment, some principles, such as redistribution of cost and community support, continue to apply as they do with nursing and allied health education at § 413.85(c). Further evidence of continued application is at existing § 413.85(c) in the definition of "redistribution of cost": "\* \* \* costs for a school of nursing or allied health education or a medical school that were incurred by an educational institution and were not allowable to the provider [hospital] in its prospective payment or a rate-of-increase limit base year cost report, or graduate medical education per resident amount calculated under § 413.86, are not allowable costs in subsequent fiscal years." (Emphasis added.) Therefore, even codified in regulations now is a policy that applies the principle of redistribution of cost to direct GME payments *in subsequent years*.

Furthermore, § 413.85(c), which was a codification of longstanding Medicare policy, was originally issued in the **Federal Register** on September 30, 1986 (51 FR 34793) and was further refined, but conceptually left unchanged, as of March 12, 2001 (*see* 66 FR 3358). Section 413.85(c) addressed the Congressional intent not to increase program costs resulting from redistribution of 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."

We note that the guidance 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, section 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.)

We believe we have continually put the public on notice that the Medicare program has applied and continues to apply the principles of redistribution of costs and community support to payments for education costs, including direct GME payments to hospitals. Therefore, we *do not* believe that we have proposed changes to the rules "in midstream" as one commenter suggested. Nor do we believe, as the commenters suggested, that we have proposed a "retroactive requirement." We have never disavowed the principles of redistribution of cost and community support. Rather, we have continually promulgated rules and program guidance on the application of the principles since the inception of the Medicare program.

We again point to the Supreme Court case, *Thomas Jefferson*, to demonstrate CMS' longstanding policy on community support and redistribution of costs in the GME context. In *Thomas Jefferson*, the Secretary of Health and Human Services interpreted the regulation at § 413.85(c) to deny reimbursement of educational costs that were borne in prior years by a hospital's affiliated medical school for purposes of calculating the direct GME base year allowable cost for the PRA. The U.S. Supreme Court affirmed the Secretary's interpretation of the redistribution of costs regulation. The Court found that:

"The regulation [at § 413.85(c)] provides, *in unambiguous terms*, that the 'costs' of these educational activities will not be reimbursed when they are