

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).

In addition, in response to the argument by the provider that CMS (then HCFA) had been silent in internal operating instructions in a 1978 operating memorandum on the policies of redistribution and community support, as well as in another exchange of memoranda in 1982 and other agency documentation, the Court stated that the omission in these documents of discussion of redistribution and community support is not indicative of a contrary policy on GME reimbursement: "* * * the mere failure to address [the redistribution principle in an intermediary letter] hardly establishes an inconsistent policy on the part of the Secretary." *Thomas Jefferson*, 512 U.S. at 516.

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 legislation that enacted Medicare, to impose a substantive limitation on medical education payment, even in the arguably novel context of calculating a hospital's GME costs for purposes of the base year PRA.

To address the commenters' point that CMS "never mentioned the redistribution of costs and community support principles" in CMS "approval letters" to hospitals that requested "approval" from CMS in advance of establishing a relationship with a nonhospital site in order to count the residents training in that setting, we note that when the letters were written to CMS in fiscal year end 1999–2002, it was not clear at all from the incoming correspondence that hospitals were not, in fact, rotating the hospital-based residents to the nonhospital setting in accordance with statutory intent. In other words, it was not clear from the incoming correspondence that a redistribution of costs was being contemplated by the hospitals. In addition, the letters did not explicitly mention that the costs of the program were currently being borne by the community in the contemplated arrangements. In the last 2 or 3 years, when hospitals met with or wrote to CMS for guidance on the nonhospital site policy under § 413.86(f)(4), we provided responses that were limited to the scope of the inquiries. We answered questions about the requirements of § 413.86(f)(4). It did not seem necessary to bring up the issue of "redistribution"

or "community support" because it was not apparent that the community had previously incurred the direct GME costs. It was not until the relatively recent audits by our fiscal intermediaries of the fiscal year ending 1998 and 1999 cost reports of certain hospitals that CMS became aware that cost shifting was occurring. With this awareness came the necessity to explicitly reassert and explain the application of the longstanding Medicare principles of redistribution of costs and community support.

Comment: Several commenters have stated that the principles of redistribution of cost and community support do not apply in determination of a hospital's FTE resident count for direct GME. One commenter argued, in part relying on a Federal district court case, *Episcopal Hospital v. Shalala*, 1997 U.S. Dist. Lexis 8701 (E.Da.Pa. 1997), to state: "* * * CMS has argued, and the courts have agreed, that Medicare cost principles have no effect with respect to the direct GME payment method prescribed by section 1886(h) of the Act * * * these principles implement the statutory provision in section 1861(v) of the [Social Security] Act for payment of reasonable cost." This commenter also quoted extensively from the September 29, 1989 final rule to argue that the GME regulation "construes the GME statute so as to preclude consideration of allowable costs incurred in connection with a resident's training."

Similarly, another commenter believed that Congress "replaced the old reasonable cost payment system" with a prospective payment methodology, and that those principles that formed the basis for reasonable cost payments for GME were no longer relevant. The commenter believed the redistribution of costs and community support principles have no application to the current payment methodology, which relies on FTEs and PRAs.

Several commenters also disputed our citation to the *Thomas Jefferson* case for application of the principles to FTE counts. The commenters believed that CMS should not use this case in support of our policy because the case did not discuss applying the principles to the counting of residents. In addition, they believe the case was "very limited" and "only discussed the establishment of base year resident costs, which were used in developing base payment rates."

Response: We disagree with the commenters that the principles of redistribution of costs and community support do not apply in determination of a hospital's FTE resident count for direct GME. When Congress enacted

section 1886(h) of the Act as part of section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) on April 7, 1986, it did not altogether "preclude" consideration of allowable costs in connection with a resident's training, as the first commenter suggests. Upon enactment of the new legislation, CMS (then HCFA) considered a hospital's allowable reasonable costs, and applied reasonable cost principles (*including* redistribution of costs and community support, as we have explained) to calculate a hospital's direct GME costs and FTE resident count in order to determine hospital-specific PRAs in the base year. Although in cost reporting years after the PRA base year, the applicable PRAs are largely determined by the statute, we believe that *costs* continue to be a factor in determining the number of FTE residents that may be counted by a hospital. For example, a hospital may only count FTE residents training *at the hospital* for which, as repeatedly described in the September 29, 1989 final rule, the hospital almost necessarily incurs *some* direct GME costs. Hospitals may also count FTE residents training in nonhospital sites *only if* the hospital incurs all or substantially all the training *costs* of the program at that site (and meets other regulatory requirements.) Thus, it cannot be said that our view of the statute "precludes" consideration of allowable costs associated with training residents.

Although Congress did implement a prospective payment system for direct GME costs by enacting section 902 of COBRA 1985, we do not believe this means that all reasonable cost principles are no longer applicable under the revised system. Section 1886(h)(1) of the Act provides that: "[n]otwithstanding section 1861(v) [defining reasonable cost], instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection." The statute literally provides that the reasonable cost payment method in section 1861(v) of the Act does not apply to section 1886(h)(3) of the Act (but those principles do apply to the remainder of section 1886(h) of the Act), which is the paragraph that specifies the general prospective payment formula for direct GME (the direct GME PRA). Thus, section 1886(h)(1) of the Act does not, as the commenter suggested, preclude