

any consideration of reasonable costs associated with the training of residents. Indeed, section 1886(h)(1) of the Act provides that, instead of payment under section 1861(v) of the Act, “the Secretary shall provide for payment for *such* costs”, which refers back to “the reasonable costs of hospitals for direct graduate medical education costs.” Thus, the statutory provisions governing direct GME payments continue to contemplate that Medicare payments to hospitals will be made for reasonable costs even under the prospective payment that is based on direct GME PRAs and FTE residents. Therefore, we do not believe the statute precludes application of reasonable cost principles, including the principles of redistribution of costs and community support.

Although we do recognize that certain reasonable cost principles are inherently contrary to a prospective payment system, others are compatible and may continue to be relevant, even upon implementation of the prospective payment. For example, in the case cited by the commenter, the Secretary and the court acknowledged that the principle of “cross-subsidization” found in section 1861(v)(1)(A) of the Act does not apply under a prospective payment context. The cross-subsidization provision requires that, in determining the reasonable costs of services, the Medicare program must ensure that it bears fully, but exclusively, “the necessary costs of efficiently delivering covered services” to Medicare beneficiaries. Simply put, the provision requires the Medicare program to pay for all the costs associated with care for its beneficiaries, and no more, so that other parties are not subsidizing care provided to Medicare beneficiaries, and Medicare is not subsidizing care provided to non-Medicare beneficiaries. However, when Medicare payments are determined prospectively, the Medicare program necessarily ceases to be concerned about whether cross-subsidization occurs—in other words, it is expected that a particular provider’s costs may be higher or lower than the prospectively-determined payment (hence, the underlying premise that prospective payment systems create incentives for providers to control costs and operate efficiently).

In contrast, the principles of redistribution of costs and community support are completely congruent with the prospective payment system under section 1886(h) of the Act. Redistribution of costs and community support principles derive from legislative intent that was expressed at the enactment of the Medicare program,

that the program should not assume payment for education costs that were previously funded by other sources. There is no reason to conclude that this intent changed with the enactment of the prospective payment methodology in section 1886(h) of the Act, with the addition of the FTE caps specified in section 1886(h)(4)(e) of the Act, or with the amendments that allow hospitals to count residents training in nonhospital sites for purposes of direct GME and IME payments. We do not believe that Congress intended by any of these enactments to enable an expansion in Medicare direct (or indirect) GME payments that result from cost shifting to hospitals. Rather, we believe section 1886(h) of the Act and later amendments were primarily directed toward limiting expansion of Medicare direct GME and IME payments. Therefore, we believe that the principles of redistribution of costs and community support are consistent with, and continue to be applicable under, the current direct GME payment system.

We also believe it is appropriate to cite the Supreme Court in the *Thomas Jefferson* case. The commenters believed that the scope of the Supreme Court’s opinion that supported the agency’s application of the principles of redistribution of costs and community support is limited to the calculation of hospitals’ reasonable costs of GME for the purpose of determining the base period PRA. However, as we stated above, the statutory provisions governing direct GME payments continue to contemplate that Medicare payments to hospitals will be made for “such costs” even under the prospective payment methodology specified in section 1886(h) of the Act. In calculating the base year PRAs, the Agency allowed hospitals to count FTE residents where the hospitals were incurring direct GME costs associated with training those residents. This policy was clearly consistent with the principles of redistribution of costs and community support because the calculation of base year PRAs was dependent on the proper counting of FTE residents. Any opinion from the Court on the application of the principles to the base year costs would equally apply to FTE resident counts. Therefore, we believe the relevance of the *Thomas Jefferson* case is not limited to the establishment of base year costs, as the commenters suggested. Rather, the Court’s opinion recognized that the principles of redistribution of costs and community support legitimately continue to apply under section 1886(h) of the Act. The Supreme Court’s opinion is entirely relevant to the calculation of

direct GME payments to hospitals in cost reporting periods on or after the PRA base year.

Finally, to address the commenters’ reference to the 1989 final rule to support the argument that CMS interpreted the statute to preclude consideration of costs in connection with counting FTE residents, we note that the cited rule is *replete* with suggestions that CMS expected hospitals to continue to incur some level of direct GME costs for training residents, even under the direct GME PRA-based payment methodology. For example, the final rule at 54 FR 40298 states:

“Nothing in section 1886(h) of the Act indicates that the bearing of costs in connection with particular residents is a factor in determining who should be counted. The law simply requires the Secretary to determine the average amount incurred to train residents during the specified base period and to make GME payments for the residents in the hospital’s programs thereafter on that basis. There was no authorization to establish a two-tiered system to account both for residents whom the hospital incurs full training costs and for residents whom hospitals incur only supervisory and overhead costs because the residents’ salaries are paid by another entity.” (*Ibid.*)

We believe the language quoted above from the 1989 rule is exemplary of the Agency’s mindset (as well as of the mindset of the commenter in that rule) that the question of whether costs were incurred by the hospital was, and would continue to be, a consideration for purposes of direct GME payment.

*Comment:* One commenter appeared to agree with what we stated in the proposed preamble at 68 FR 27216 that because IME regulations on counting residents at nonhospital sites cross-reference the direct GME nonhospital provisions, the provisions on redistribution of costs and community support would equally apply to IME FTE counts, as well as direct GME FTE counts, when counting residents in nonhospital settings. However, the commenter requested clarification on the issue of whether IME FTE residents counts in hospital settings would be subject to the community support and redistribution of costs provisions.

Another commenter argued that the redistribution of costs and community support principles do not apply to FTE counts for purposes of IME payment. This commenter argues that there is no evidence indicating that a teaching hospital’s operating costs bear any relation to past or present sources of funding for residents’ training.