

inappropriate counting), or to residents training *inside* the hospital—inpatient or outpatient. Thus, it is technically possible to have a redistribution of direct GME costs for the training of residents inside the hospital setting (as well as in the nonhospital setting). Therefore, we are not adopting the commenter's suggestion to limit application of the principles to § 413.86(f)(4) (the nonhospital site provision). However, we note that we believe a redistribution of *all* of the direct GME costs for training that occurs in a hospital setting would be rare. *All* of the direct costs of the program—resident salaries, teaching physician salaries, overhead expenses, etc., would need to be redistributed to an outside entity in order for there to be a disallowance of direct GME FTE residents for training inside the hospital due to redistribution of costs or community support.

We contrast this application of the principles of redistribution of costs and community support in the current prospective payment system that depends upon PRA and FTE resident counts to application of the principles in the previous reasonable cost payment methodology that was based on cost finding and cost allocations. Under the former reasonable cost methodology, a hospital was eligible to receive direct GME payment for those direct GME costs that it incurred; however, any direct GME costs that were redistributed to the hospital were not allowable. We note that 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.)

Thus, under the previous cost payment scheme, the principles of redistribution of costs and community support were applied to direct GME reasonable cost payment using a cost finding methodology. In contrast, in the current context where payment is no longer based solely on reasonable costs incurred, but on PRA and FTE resident counts, if the hospital can demonstrate that it has continuously incurred *some* of the direct GME costs of training the residents since the inception of the residency program at a training site, then no redistribution of costs or community support has taken place. As noted, current direct GME payments are no longer based on detailed cost finding of allowable costs of hospitals. Therefore, we believe it is appropriate to require that a hospital demonstrate that there has been no redistribution of costs or community support by proving that the hospital has incurred *some* of the direct GME costs of the program continuously since the inception of the program. Finally, contrary to the commenter's assertion, we believe we have been consistent with the other Medicare policies on counting residents, including the policy cited by the commenter concerning the prohibition on counting residents training at other hospitals. (See the August 1, 2002 final rule (67 FR 60077). As stated above, there would be no redistribution of costs or community support if a hospital counts a resident when another hospital incurs the resident's salary, as long as the first hospital still incurs other direct GME costs associated with the training of that resident. In any case, as we explained above and also in the proposed rule, the principles of redistribution of costs and community support are not applicable to cost shifted between the hospitals, only costs shifted between a hospital and educational institutions or other organizations that are not Medicare providers.

*Comment:* One commenter stated that a hospital was “required” to include in the calculation of its average per resident amount, time spent in the hospital by residents who were paid by “other entities.” This commenter quoted the September 29, 1989 final rule: “the 1989 GME rule was modified after publication of the proposed rule in order ‘to require Medicare hospitals to count residents who are working in their facility even if the residents’ salaries are fully paid by other entities, either Federal or non-Federal. This revised policy will *apply to both GME base period and cost reporting periods subject to the new payment*

*methodology.*” 54 FR 40299 (emphasis added).”

*Response:* We believe the language quoted above by the commenter from the 1989 final rule has been taken out of context. In essence, the commenter has generalized from the language selectively quoted above to support an argument that Medicare would have required a hospital to count resident time when the residents were “paid by other entities,” thereby supporting the commenter's argument that Medicare not only condones redistribution of costs but, in fact, would seem to “require” them. However, we believe the language quoted by the commenter from a particular comment and response in the 1989 rule, if quoted in its full context, actually supports the CMS policy on the application of the principles of redistribution of costs and community support that as long as the hospital has continuously incurred at least some of the direct GME cost of the residency program since the inception of the program, there has been no redistribution of costs or community support and the hospital may count the FTE residents. Specifically, the commenters in that rule at 54 FR 40298 asked in relevant part: “A particular problem referred to was the treatment of residents who are paid by medical schools, faculty practice plans, and others rather than by hospitals that participate in Medicare. It was pointed out that teaching hospitals incur other costs such as teaching physicians’ salaries and overhead costs in connection with these residents, and it would be unfair not to count these residents for payment purposes.” In our response to this comment, we stated, also in relevant part on 54 FR 40299: “we note that some of the comments have led us to believe that, in addition to Federally-employed residents (for example, residents in Veterans Administration or Department of Defense programs), a significant number of residents are paid a salary by non-Federal, nonprovider entities (for example, medical schools or philanthropic agencies). As noted by the commenters, although no hospital participating in Medicare incurs salary costs for these residents, *hospitals do incur other substantial GME costs associated with these residents.* Therefore, we are modifying our proposed rule to require Medicare hospitals to count residents who are working in their facility even if the residents’ salaries are fully paid by other entities, either Federal or nonfederal.” (Emphasis added). It becomes apparent when the language quoted by the