

The Medicare IME payment is inherently a payment that reflects the increased operating costs of treating inpatients as a result of the hospital having a residency program. For example, as explained in the September 29, 1989 final rule (54 FR 40286), the indirect costs of medical education might include added costs resulting from an increased number of tests ordered by residents as compared to the number of tests normally ordered by more experienced physicians.

The IME payment is an “add-on” adjustment that is made for each Medicare discharge from the areas subject to the IPPS in a teaching hospital. The authorization by Congress for IME payments relating to nonhospital services while residents are training at nonhospital sites would be absurd if not viewed as an incentive to transfer existing residency training from the hospital to the nonhospital setting. We do not believe Congress intended to permit IME payments to be allowable to the hospital that is incurring “all or substantially all the costs” of residents training in nonhospital sites except in the situations where either the hospital rotated residents from the hospital to the nonhospital settings or where the hospital started new programs in the nonhospital settings (and incurred the direct GME costs from the programs’ inception). The illustrative situations described above and in the proposed rule in which nonhospital sites, such as dental schools, are shifting the costs of existing programs to the hospitals are not consistent with the intent of Congress to encourage hospitals to rotate residents from the hospital setting to nonhospital sites.

Thus, we believe Congress intended both cited provisions of the Act on counting residents in nonhospital sites for purposes of direct GME and IME payments to be limited to situations in which hospitals rotate residents from the hospital to the nonhospital settings, and *not* situations in which nonhospital sites transfer the costs of an existing program at a nonhospital site to the hospital.

Comment: One commenter cited section 1886(h)(5)(J) of the Act to support the general argument that CMS lacks the authority under the statute to “impose additional conditions” on counting FTE residents training in nonhospital sites—that is, the principles of redistribution of costs and community support. The commenter stated:

This conclusion is further supported by Congress’ treatment of family practice residency programs. In 42 U.S.C. § 1395ww(h)(5)(J), Congress provided a

special payment provision for family practice residency programs. Specifically, Congress authorized hospitals to claim costs related to such programs even if, during the GME prospective payment base year—a year reimbursed under the reasonable cost system and a year to which the community support principle applied—the cost of such programs had been paid by the United States, a State, a political subdivision of the State, or an instrumentality of the State or political subdivision. Congress also provided that, in the event that such program payments were part of the PRA calculation during the GME base year, the payment in future years would be reduced “in an amount equal to the proportion of such program funds received during the cost reporting period involved * * *.” Thus, Congress has spoken to the issue of whether hospitals may claim costs in the current year if those costs have been paid in the past by third parties, and it has allowed reduction in current-year payments only if: (1) During the GME PPS base year, a third party had paid for the cost of the hospital’s family practice residency program; and (2) as a result, the hospital had received a PRA that included an “estimate of the amount that would have been recognized as reasonable * * * if the hospital had not received such funds.” 42 U.S.C. § 1395ww(h)(5)(J)(i). In all other situations, I submit, Congress does not permit the Secretary to reduce payments in the current year simply because, in the past, some third party may have paid the cost.

Response: We disagree with the commenter that section 1886(h)(5)(J) of the Act supports the assertion that “Congress has spoken to the issue” of whether a hospital may claim third party costs and has allowed reductions in direct GME reimbursement resulting from redistribution of costs or community support in only the very limited circumstance of that exception in the Act. Generally, section 1886(h)(5)(J) of the Act did two things: first, in subparagraph (J)(i)(1), Congress specifically allowed a hospital that *only* has an approved training program in family medicine and received a PRA in the base year of less than \$10,000 for its family practice program, to receive a revised PRA that reflects the inclusion of “funds from the United States, a State, or a political subdivision of a State * * *” for the hospital’s family practice program. Thus, the provision recognizes that ordinarily such funds would not be included in the hospital’s base year per resident amount (because they were not incurred by the hospital in the base year). However, Congress explicitly created a narrow exception to the “cost finding” principles to allow such a hospital to include Federal, State, or local government grants to be included in the hospital’s PRA base year calculation. Second, subparagraph (J)(i)(2) requires that direct GME payment to such a hospital that received

a revised PRA amount under subparagraph (J)(i)(1) must also be reduced in subsequent cost reporting periods by the proportionate amount of funding the hospital receives from Federal, State, or local government payments. In other words, what subparagraph (J)(i)(2) does is to prohibit this hospital from receiving duplicative payments for the same GME program—both through the adjusted PRA and through continued Federal, State, and local government funding.

The commenter argues that subparagraph (J)(i)(2) is the “only” situation where Congress has “spoken” about reductions in current year payment because of third party reimbursement. However, as we stated above, we believe the effect of subparagraph (J)(i)(2) is to prevent of duplicative payments for the same program that could otherwise occur in the narrow circumstances of the exception provided by section 1886(h)(5)(J), and has nothing to do with the continued applicability of the principles of redistribution of costs and community support. To the contrary, as we have stated, we believe that subparagraph (J)(i)(1) addresses a limited theoretical “retroactive redistribution” of costs and community support to allow a very narrow *exception* of allowing costs to be included in direct GME payment. Thus, we believe section 1886(h)(5)(J) of the Act would support our assertion that Congress intends application of redistribution of costs and community support to direct GME payment (except in the narrow circumstance of the type of hospital described in that section), rather than support the commenter’s contrary assertion that the section is inconsistent with our proposal on application of the principles.

Comment: One commenter suggested that the redistribution of costs and community support principles at nonhospital sites should apply on a “year-by-year basis,” such that if another entity funds a training program during a particular fiscal year, the hospital would not be allowed to include the residents in its count for that fiscal year.

Response: We believe the commenter’s suggestion of a “year-by-year basis” policy is, in effect, already in place under existing Medicare policy without reference to the redistribution of costs or community support principles. Under the existing policy, where another entity funds a training program in a particular year while the residents are training at a nonhospital site—that is, incurs the residents’ salaries and fringes, and the supervisory