

proposed definition of “redistribution of costs” at proposed § 413.86(b). As proposed, the definition states:

*“Redistribution of costs means an attempt by a hospital to increase the amount it is allowed to receive from Medicare under this section by counting FTE residents who were in medical residency programs where the costs of the programs had previously been incurred by the educational institution.”* In particular, the commenter objected to the first part of the definition: “an attempt by a hospital to increase the amount it is allowed to receive from Medicare.” The commenter believed that the phrase was unnecessary to the definition and should be deleted.

*Response:* We understand the concern of the commenter. However, we have used “the attempt” language at § 413.86(b) for the proposed definition of “redistribution of costs” primarily because we have adopted the language of the existing regulation at § 413.85(c) that defines “redistribution of costs” (now applicable to costs of approved nursing and allied health education activities). The language was not intended to be offensive. Rather, we meant it to be descriptive of a possible motive for a redistribution of costs. In light of the commenter’s suggestion, we are revising the language to be purely descriptive of the scenario of the redistribution and not reflect a possible motive. Accordingly, we are revising the language at § 413.86(b) to state: “Redistribution of costs” occurs when a hospital counts FTE residents in medical residency programs and the costs of the programs had previously been incurred by an educational institution. In the future, we will consider conforming changes to the definition of “redistribution of costs” at § 413.85(c) as well.

*Comment:* Some commenters believed that, through the enactment of the 1996 cap on the count of allopathic and osteopathic residents, Congress has already dealt with the problem that CMS is attempting to revisit with the proposed rule. The commenters believed that when Congress exempted the dental residents from the caps, it intended to create hospital incentives for dental training. The commenters believed that the CMS redistribution of costs and community support policy contradicts this Congressional intent.

*Response:* We do not believe that when Congress instituted the caps on the count of residents with the Balanced Budget Act of 1997, it was aware that inappropriate counting of FTE residents could occur through redistribution of costs. CMS, itself, did not become aware that many hospitals were engaging in

these cost shifting arrangements, very often involving dental residents since at least October 1, 1997, when hospitals were authorized to count FTE residents for purposes of IME payments, as well as direct GME payments, for training in nonhospital sites. As we stated above, it is only since the audits by our fiscal intermediaries of the fiscal year ending 1998 and 1998 cost reports that have occurred within the last 2 years that CMS became aware that significant cost shifting was taking place. Therefore, we do not believe Congress would have been in a position to consider whether to authorize cost shifting in its 1997 legislation. Thus, we do not believe, as the commenters do, that Congress expected, or tacitly condone, cost shifting to dental residents as a result of exempting the dental residents from the 1996 caps. Rather, we believe that when Congress exempted dental residents from the 1996 caps, it intended to allow more dental training to occur in the hospital, not to authorize cost shifting from dental schools to hospitals and to the Medicare program.

*Comment:* One commenter asked what types of costs the hospital is required to incur for training in nonhospital sites in order for there to be no redistribution of costs or community support. Specifically, the commenter described a scenario under which a teaching hospital and a medical school are related parties and asked whether the teaching hospital is required to pay for the teaching physician services relating to offsite rotations at a medical school clinic before the FTE residents participating in the rotation can be counted for purposes of IME or direct GME payment.

*Response:* We understand from the scenario described by the commenter that hospital-based residents are being rotated to the medical school clinic. As such, we assume that the hospital is already incurring at least the residents’ salary and fringe benefits. Therefore, when rotating the residents to the clinic, the hospital is incurring at least some of the direct GME costs of training the residents. Under these circumstances, a redistribution of costs has not taken place. However, according to the requirements for counting FTE residents in nonhospital settings under § 413.86(f)(4), among other requirements, the hospital is required to incur the portion of the teaching physicians’ salaries and fringe benefits attributable to direct GME (by the term “related party,” we are assuming that the medical school clinic is not provider-based as specified under § 413.65, and therefore, is not considered part of the hospital). Thus,

under the commenter’s scenario, the hospital may be prohibited from counting the FTE residents, not because of redistribution of costs but because of failure to incur “all or substantially all of the cost” under § 413.86(f)(4) if the hospital is not incurring the supervisory physician’s salary attributable to direct GME.

*Comment:* A number of commenters argued that the proposed application of the redistribution of costs and community support principles is bad public policy from the perspective of access, quality and cost-effectiveness of oral health care.

*Response:* We understand that dental training programs provide much needed oral health care to the American public and did not intentionally target them with our policy on redistribution of costs and community support. However, we believe much of the inappropriate cost shifting to hospitals and to the Medicare program is related to dental residency programs—which is probably due to the fact that dental residents are exempted from the statutory 1996 FTE caps. Although we regret that publication of this rule may upset some newly formed relationships between hospitals and dental schools, we continue to believe that the Medicare program should not pay for nonhospital dental residency training that had previously been funded by other sources, without any sponsorship by hospitals or the Medicare program.

*Comment:* One commenter stated that by establishing a PRA floor equal to 85 percent of the locality-adjusted national average PRA, Congress created an exception to the principles of community support and redistribution of costs. The commenter noted that this floor increased reimbursement to a number of teaching hospitals around the country whose own PRAs were low “precisely” because the community or another educational institution had been bearing the training costs in the GME PRA base year. Therefore, the commenter argued, the PRA floor “picked up” some of those disallowed costs, and that Medicare is, in effect, currently paying for those costs in the PRAs that were raised to the floor.

*Response:* The commenter is referring to section 311 of the Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113), which, for FY 2001, established a floor PRA at 70 percent of the locality-adjusted national average PRA, and to section 511 of the Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554), which, for FY 2002, established a floor PRA at 85 percent of the locality-adjusted national average PRA. Regulations concerning