historically were furnished in a hospital setting; and (2) physicians believe that it is cost-effective and efficient to shift the place of service. We believe that the direct costs of providing the service (staff, supplies, equipment, and space) are reflected in the practice expense relative values based on the predominant place of service. Therefore, we believe it is appropriate to apply the site-of-service reduction to these services when they are performed in a setting where we make a payment for the direct costs of providing the service; for example, hospitals and ASCs. However, this issue will be further examined as part of the development of practice expense RVUs for 1998.

Comment: Several commenters misunderstood the proposal. Some implied that we were proposing a reduction in the ASC facility payment rate or reducing payments for office based procedures. One objected to applying the site-of-service payment differential to the hospital setting. One commenter was not convinced the proposal will save money.

Several comments concerned issues not covered under this proposal, for example, objections to removing certain codes from the ASC approved list and requests that particular codes be added or deleted from the ASC list. Another commenter suggested that new criteria are needed for procedures on the ASC list. Another thought we were proposing removing the codes from the ASC list.

Response: The proposal does not affect ASC facility payment rates or physician payments for procedures performed in an office setting. The site-of-service payment differential already applies to the hospital outpatient setting. The proposal is budget neutral and is not intended to reduce Medicare payments. The proposal does not revise procedures on the approved ASC list.

Final Decision: We will extend the site-of-service payment differential to office-based services on the ASC list if those services are performed in an ASC or in a hospital setting. However, when a service that is not on the ASC list is performed in an ASC, the site-of-service payment differential will not apply. The site-of-service list for 1996 appears in Addendum E of this final rule. All additions to the list are identified by an asterisk.

E. Services of Teaching Physicians

1. General Background

Our July 26, 1995 proposed rule (60 FR 38405) discussed Medicare payment for those services furnished under graduate medical education (GME) programs that are not payable through the mechanisms established for direct GME costs by section 1886(h) of the Act. Section 1886(h) addresses Medicare payments to hospitals and hospital-based providers for the costs of approved GME programs in medicine, osteopathy, dentistry, and podiatry. Those costs include residents' salaries and fringe benefits, physician compensation costs for GME program activities that are not payable on a fee schedule basis, and other GME program costs.

Medicare intermediary expenditures under section 1886(h) of the Act for fiscal year 1996 are estimated to be approximately $1.9 billion. In addition, under section 1886(d)(5)(B) of the Act, Medicare makes additional payments to teaching hospitals under the prospective payment system for the higher indirect operating costs hospitals incur by having GME programs. (These are costs other than direct GME costs.) Medicare indirect GME payments for fiscal year 1996 are estimated to be approximately $4.9 billion. Medicare also supports GME programs in teaching hospitals through billings for the services of attending physicians who involve residents in the care of their patients. The amount of Medicare expenditures for these services is not known since attending physicians are not required to distinguish between services they personally furnish and those they furnish as attending physicians in claims submitted to the Part B carriers.

Our proposal addressed services of teaching physicians that are payable on a fee schedule basis, services of residents in settings that are not payable under section 1886(h), and services of moonlighting residents. In addition, the proposed rule addressed, but did not substantially change, existing rules on related issues on Medicare payments for the services of residents in approved GME programs furnished in certain freestanding skilled nursing facilities and home health agencies, and services of residents who are not in approved GME programs. We referred to the section 1886(h) mechanisms to distinguish between that payment methodology and other payment mechanisms.

Title XVIII of the Act provides separate coverage and payment bases for provider services and physician services. Under Medicare, provider services, such as inpatient hospital services and skilled nursing facility services, are covered under Hospital Insurance (Part A) and are paid from the Part A Trust Fund. Outpatient hospital services are covered under Supplementary Medical Insurance (Part B) and are paid from the Part B Trust Fund. Provider services are paid on a prospective payment, reasonable cost, or other payment mechanism through Medicare contractors called ''fiscal intermediaries.'' Physician services and other ''medical and other health services,'' as defined in section 1861(s) of the Act, are generally paid under Part B through Medicare contractors called ''carriers.'' To administer the Medicare program, we must distinguish clearly between provider services and physician services to determine the appropriate payment methodology and the appropriate Trust Fund that is liable for payment.

As discussed in the proposed rule, in part 405 (''Federal Health Insurance for the Aged and Disabled''), subpart D (''Principles of Reimbursement for Services by Hospital-Based Physicians''), current regulations beginning with § 405.480 set forth the basic principles regarding payment for services of physicians who practice in providers. Additional principles applicable to payment for physician services in teaching hospitals appeared in subpart E (''Criteria for Determination of Reasonable Charges; Payment for Services of Hospital Interns, Residents, and Supervising Physicians'') in §§ 405.520 and 405.521. Principles applicable to services of interns and residents appeared in §§ 405.522 through 405.525. Sections 405.465 and 405.466 addressed the payment methodology for teaching hospitals that elect reasonable cost payments for physician services. (See sections 1832(a)(2)(B)(i)(II) and 1861(b)(7) of the Act.) Since the publication of those regulations, the Congress enacted a series of legislative changes that affected payments for these services, and we proposed to revise the regulations to conform to those statutory changes and to clarify current policy.

Section 948 of the Omnibus Reconciliation Act of 1980 (ORA 1980) (Pub. L. 96–499), enacted on December 5, 1980, as amended by section 2307 of the Deficit Reduction Act of 1984 (DEFRA 1984) (Pub. L. 98–369), enacted on July 18, 1984, addressed payments for physician services in teaching settings. (See section 1842(b)(7) of the Act.) Another pertinent legislative change, section 108 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA 1982) (Pub. L. 97–248), enacted on September 3, 1982, added a new section 1887 to the Act. That legislation dealt explicitly with distinguishing between the professional services physicians furnish to individual patients in a provider and services physicians furnish to the provider itself. While section 1887 of the Act does not