Part B payment policies. The commenter seemed to suggest that, in conducting the Part A base year audits, the agency excluded all costs associated with teaching activities that were related to patient care. This suggestion, however, is incorrect. Indeed, as the commenter acknowledged, time spent supervising residents in patient care was allocable to Part A under the audits if there was no attending physician relationship. Furthermore, although the commenter also asserted that 100 percent of a physician's time was allocable to Part B "in the absence of appropriate documentation," it follows that time spent supervising residents could have been allocated to Part A if the hospital or the physician provided appropriate documentation. Thus, contrary to the commenter's suggestion, teaching activities related to patient care were, or could have been, included in the Part A base year costs. We believe we should not perpetuate inappropriate Part B policies simply because hospitals and physicians failed to properly claim or document Part A costs in the base

The commenter also indicated that, under the proposed rule, certain teaching activities would not be reimbursed under Part B even though they were reimbursed under Part B previously (incorrectly or otherwise). This might relate to activities such as discussions about patient charts with a resident when the teaching physician was not present during the visit itself. The commenter stated that, in the proposed rule, we claimed incorrectly that lost Part B revenues could be collected through Part A. Contrary to the commenter's suggestion, we did not mean to suggest that services that were previously, but no longer, paid for under Part B would be paid for through increased payments under Part A. Rather, we meant to indicate that, at times in the past, improper payments may have been made.

We believe that our policies adequately reimburse hospitals and teaching physicians for the activities of teaching physicians. First, the services of the interns or residents themselves are payable under separate mechanisms. Thus, to the extent that services are provided by interns and residents who are largely unsupervised, Medicare pays for the direct costs of those services through GME payments. Second, consistent with the criteria in Intermediary Letter 372, the teaching physician may receive Part B payment as long as the physician is present for the service. Finally, we are providing further flexibility for billing in this final rule, so that services may now be paid

for under Part B even though the same services could *not* previously be properly billed to Part B; specifically, under this final rule, more than one teaching physician may bill Part B with respect to a particular hospital inpatient stay, whereas under Intermediary Letter 372, only a single attending physician could properly bill Part B.

In short, hospitals and physicians will not, as alleged, be systematically underreimbursed under the policies reflected in this final rule. The Part A payment encompasses costs of supervising residents that were (or could have been) properly allocated and substantiated for the base year. Teaching physicians may continue to receive Part B payment under the physical presence requirement reflected in Intermediary Letter 372. And Part B payment may now be made under circumstances in which payment could not properly be made under Intermediary Letter 372.

Comment: Many commenters believed that we developed the teaching physician proposal because we had concluded that beneficiaries in teaching hospitals receive substandard care when the teaching physician is not present during the service or procedure.

Response: The policy was not intended to specifically address quality concerns. Rather, the policy addresses payment issues, in particular, identifying when it is appropriate to make Medicare Part B payment to teaching physicians who oversee the services of interns and residents.

It is important to distinguish between the services of interns and residents and the services of teaching physicians. Medicare fiscal intermediaries pay teaching hospitals for the services of interns and residents. Those services are described in sections 1861(b) and 1832(a) of the Act and are paid under the methodology established by section 1886(h) of the Act. Thus, the fiscal intermediaries are already paying teaching hospitals for services furnished to beneficiaries by residents. The graduate medical education costs payable through the section 1886(h) methodology also encompass any costs associated with the supervisory services of teaching physicians that were appropriately allocated during the base period for that methodology (fiscal year

Particularly in light of these other payments, we believe that, if we are to pay a fee to another physician who is medically responsible for the services the resident is furnishing to the beneficiary, it is entirely appropriate to require as a condition of payment that the supervising physician furnish a direct, personal physician service to the

beneficiary. This is the basis for the payment of physician services under Medicare. If the resident has personally furnished the service to the beneficiary and the intermediary is paying the teaching hospital for Medicare's share of the services performed by the resident, we believe it is appropriate not to pay a full fee to a supervising physician who was not present when the service was furnished. Furthermore, the Medicare beneficiary is responsible for a 20 percent coinsurance amount for that physician's services as well as any deductible liability. We believe it is fully consistent with a resource-based fee schedule that the physician in whose name the service is billed furnishes a service to the beneficiary.

Comment: Many commenters stated that residency programs cannot afford to furnish services to Medicare beneficiaries without Medicare payment.

Response: Medicare fiscal intermediaries pay approximately \$7 billion annually in direct and indirect medical expenses to teaching hospitals for the costs associated with approved GME programs.

Comment: Some commenters expressed concern about the term "key portion" in determining when the teaching physician should be present. They stated that it is often difficult to define the key portion of a service or procedure. Many commenters expressed their concern with the lack of a clear definition of what constitutes the key portion of every service or procedure. Many other commenters contended that the key portion of the teaching physician's services takes place during the teaching physician's discussions of the case with the resident before and after a visit or procedures. This argument was made by physicians in both medical and surgical specialties.

Response: We proposed the concept of the key portion of a service or procedure to provide flexibility and to avoid requiring the presence of the teaching physician for the duration of every service or procedure billed in his or her name. Many of the commenters expressed the view that the key portion—and the most meaningful portion—of the teaching physician's service to the beneficiary actually takes place in the absence of the beneficiary. We do not agree with this interpretation of key portion because it blurs the distinction between teaching oversight and actually furnishing an identifiable service to the beneficiary.

While we recognize the concern that it may be difficult to determine the key portion for a particular service, this concept is necessarily general because it