

provisions of paragraphs (f) and (g)(4) through (g)(6), and (g)(12) of § 413.86.

We note that our reasons for specifically referencing the applicability of the principles of community support and redistribution of costs at § 413.86(f)(4), the paragraph concerning counting residents training in nonhospital settings for direct GME purposes, are twofold. First, although we are already making the proposed § 413.86(i) applicable to § 413.86(f), which would make the principles applicable to each paragraph under § 413.86(f), in consideration of the inappropriate applications we have identified of the GME FTE-counting policy with respect to counting residents in nonhospital sites, we believe it is appropriate to also specifically address the applicability of the redistribution of costs and community support principles to § 413.86(f)(4). In addition, we note that the proposed reference at § 413.86(f)(4) has implications for IME payment as well, as explained below.

Under existing § 412.105(f)(1)(ii)(C), the rule for the counting of FTE residents training in nonhospital settings for IME payment, there is a specific reference indicating that the criteria set forth in § 413.86(f)(4) must be met in order for a hospital to count the FTE residents training in nonhospital settings for purposes of IME payments. Thus, if under proposed § 413.86(f)(4)(iv) (the paragraph making redistribution of costs and community support principles applicable) a hospital is not permitted to count the FTE residents training in a nonhospital site because of redistribution of costs or community support, the hospital would not be permitted to count the FTE residents for purposes of IME payment as well, because the IME regulation at § 412.105(f)(1)(ii)(C) requires the criteria under § 413.86(f)(4) to be met.

As we have stated above, payment for IME is based on the concept that, as a direct result of the hospital's resident training program, the costs the hospital incurs for patient care are increased. When Congress included section 1886(d)(5)(B)(iv) of the Act as part of Public Law 105–33, the statute expanded the circumstances under which IME payments to a hospital could be made by allowing the hospital to count the number of residents training outside the hospital setting under certain conditions. Even though it is clear that those residents training outside the hospital cannot have any impact on patient care costs to the hospital, Congress nevertheless allowed the hospital to receive IME payments when the hospital counts FTE residents

training in a nonhospital setting in accordance with section 1886(d)(5)(B)(iv) of the Act, where those residents would otherwise have trained in the hospital setting. As we have stated, Congress created an incentive (or removed a disincentive) with the provisions of Public Law 105–33 for hospitals to rotate residents to nonhospital settings by allowing hospitals to continue to receive IME payment as if the residents continued to train in the hospital setting. If there is a redistribution of costs or community support, we believe IME payment to the hospital would be contrary to Congressional intent to encourage the hospital to rotate residents from the hospital to the nonhospital site.

In addition, when Congress included section 1886(d)(5)(B)(iv) of the Act as part of Public Law 105–33, the statutory authority for IME payment was premised on the hospital incurring the direct GME costs of the residents: “all the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency *if the hospital incurs all, or substantially all, of the costs for the training program in that setting.*” (Emphasis added.) (Section 4621(b)(2) of Public Law 105–33; section 1886(d)(5)(B)(iv) of the Act.) We believe Congress intended the hospital to incur direct GME costs of the program in the nonhospital site in order to count the FTE residents training in nonhospital settings for purposes of IME payment. Thus, in the situation where a hospital incurred direct GME costs but there was redistribution of costs or community support, a disallowance of direct GME payments as well as a disallowance of IME payments is appropriate.

Although we are stating generally that the principles of community support and redistribution of cost have applied since the inception of Medicare to graduate medical education payment, as we have stated above, we have identified relatively recent inappropriate application of the nonhospital site policy for counting FTE residents. Therefore, we believe it is appropriate to propose to identify January 1, 1999, as the date our fiscal intermediaries should use to determine whether a hospital or another entity has been incurring the costs of training in a particular program at a training setting for purposes of determining whether there has been a redistribution of costs or community support. We are proposing that January 1, 1999 be used as the date the fiscal intermediaries

should use for determinations, since it may be difficult for our fiscal intermediaries to obtain from hospitals contemporaneous documentation that the hospitals have appropriately been incurring the direct GME costs in earlier fiscal years. We believe the January 1, 1999 date should simplify confirmation by our fiscal intermediaries and hospitals of whether the hospital or another entity had been incurring the costs of the program in particular training settings and whether redistribution of costs or community support had occurred. We have chosen the January 1, 1999 date because of administrative convenience and feasibility, so that necessary data are both valid and available, and in recognition of the fact that our fiscal intermediaries must prioritize their limited audit resources. While we are not requiring our fiscal intermediaries to determine whether a hospital had been incurring the training costs of a program prior to the January 1, 1999 date, if the fiscal intermediaries determine that there is a redistribution of costs or community support exists with respect to certain residents prior to January 1, 1999, a disallowance of direct GME and IME payments with respect to those FTE residents would certainly be required.

Since calculation of a hospital's FTE resident count is dependent upon whether the hospital incurred the training costs, we are proposing to require each teaching hospital and its fiscal intermediary to determine which entity had been incurring the training costs at least since January 1, 1999. For example, if a nonhospital entity, such as a school of medicine or dentistry, had incurred the costs of training the residents anytime on or after January 1, 1999, and a hospital subsequently begins to incur direct GME costs of training those FTE residents, the hospital would not qualify to count those FTE residents for purposes of direct GME and IME payments.

We note that the proposal states that a hospital must have been *continuously* incurring the costs of the training since the date the residents first began training in that program. Accordingly, if a hospital had at one time incurred the costs of training residents in a particular program, whether at the hospital or in a nonhospital setting, but a nonhospital institution later assumed the costs of training in that setting, even if the hospital assumed payment for the training costs again, the hospital could not then count those residents for purposes of direct GME and IME payments.

We note that if a hospital incurs the direct GME costs, whether training takes