

place inside the hospital or in a nonhospital setting, in a new residency program, the hospital may be eligible to count the FTE residents as specified by the regulations under § 413.86(g)(6).

Consistent with the policy on redistribution of costs and community support discussed above, if a hospital incurs the direct GME costs of *additional* FTE residents training in an existing program in a hospital setting where the costs of the existing program had been incurred by a nonhospital entity and the hospital has continuously funded the *additional* residents in the existing program in the hospital setting since the date the residents first began training there, the redistribution of costs or community support principles would not prohibit the hospital from counting the additional FTE residents for purposes of direct GME and IME payments.

We note that, under existing policy, to count residents in a nonhospital setting, a hospital is required to incur for “all or substantially all of the costs of the program” in that setting. In other words, a hospital is required to assume financial responsibility for the *full* complement of residents training in a nonhospital site in a particular program in order to count any FTE residents training there for purposes of IME payment. A hospital cannot count any FTE residents if it incurs “all or substantially all of the costs” for only a portion of the FTE residents in that program training setting. This policy is derived from the language of the IME and direct GME provisions of the statute on counting residents in nonhospital settings; both sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act state that the hospital must incur “all, or substantially all, of the costs for the training program in that setting.” (Emphasis added.) In contrast, as explained earlier, it is permissible under the proposed policy on the application of the redistribution of costs and community support principles for the hospital to count FTE residents where the hospital incurs direct GME costs of FTE residents that are *added* to an existing program, even though the hospital may not count the existing FTE residents due to the application of the redistribution of costs or community support rules. In the nonhospital setting, as a result of the interaction of these two separate FTE counting requirements—(1) that the hospital must not violate the redistribution of costs and the community support principles in order to count the resident FTEs in the nonhospital settings, and (2) that the hospital must incur “all or substantially all” of the costs for the training program

in that setting—a hospital would be prohibited from counting FTE residents added to an existing program at a nonhospital site unless the hospital incurs all or substantially all of the costs of training *all* of the residents in that program at that setting. That is, even if the hospital incurs all or substantially all of the costs for all of the training program at the nonhospital site, the hospital would only be able to count the additional FTE residents who were not excluded by application of the redistribution of costs or community support principles.

For example, training in a general dentistry program with 10 FTE residents has taken place at a school of dentistry for 20 years. The school of dentistry has been incurring the training costs of the general dentistry residents since the inception of the program. Beginning in 2003, the school of dentistry has decided to add an additional 5 FTE residents to the program, and Hospital A decides to incur “all or substantially all” the costs of those 5 additional FTE residents only. Applying the policy concerning redistribution of costs and community support in combination with the policy on incurring all or substantially all of the costs, the hospital could not count the additional 5 FTE residents in the dental school since it is not paying for all or substantially all of the costs of the program. Even if the hospital were to incur all or substantially all of the costs for the training program for all 15 FTE residents, the hospital could not count the 10 FTEs that were part of the existing general dentistry program because of the redistribution of costs and community support principles; it would be a redistribution of costs for the hospital to begin to incur direct GME costs of the 10 FTE residents when the dental school had previously been incurring those costs.

We note that such a result does not occur when a *new program* is established in the nonhospital site. If, from the outset of the program, the hospital incurs direct GME costs and also incurs “all or substantially all” of the costs for the training program for all the new residents training at the site, there would be no redistribution of costs or community support, and the hospital could count all of those residents in the new program in its FTE count (subject, of course, to the hospital’s 1996 FTE resident cap).

We also note that the interaction of the two provisions discussed above—redistribution of costs and community support, and “all or substantially all”—does not occur when counting FTE residents training inside the hospital,

since a hospital is not required to incur “all or substantially all” of the costs for the training program inside the hospital.

Furthermore, if one hospital had incurred the direct GME costs of training residents in a particular program in a nonhospital site from one point in time, for example, 1995 through 1999, and then another hospital consecutively incurs the costs from 2000 and thereafter, the second hospital may be eligible to receive direct GME and IME payments for training the FTE residents from the point in time where the second hospital incurred the direct GME costs, and the redistribution and community support exclusions would not apply. The second hospital may be eligible to receive Medicare direct GME and IME payments because the costs were incurred previously by a hospital, and not either the community or the university. Therefore, there was neither community support nor redistribution of costs.

The following are some examples to clarify how these proposed policies would be implemented:

Example 1

Since 1995, 10 FTE residents in an internal medicine program have been training in the Community Clinic. In accordance with the current provisions of § 413.86(f), Hospital A has incurred all or substantially all of the costs of training the 10 FTE residents since 1995. Assuming the current provisions of the regulations at §§ 412.105(f)(1)(ii)(C) and 413.86(f)(3) and (f)(4) are met, Hospital A may continue to receive IME and direct GME payments for 10 FTE residents because Hospital A had incurred direct GME costs continuously (as evidenced by contemporaneous documentation since January 1, 1999), as specified in our proposed regulation.

Beginning July 1, 2004, in addition to continuing to incur all or substantially all of the costs of the first 10 FTE internal medicine residents training in the nonhospital site, Hospital A also incurs all or substantially all of the costs of training an additional 3 FTE internal medicine residents at that site. Accordingly, beginning July 1, 2004, Hospital A may count all 13 FTE residents training in the Community Clinic for purposes of direct GME and IME payments, assuming Hospital A does not exceed its FTE cap for IME and direct GME.

Example 2

Since 1995, 2.25 dental FTE residents in a dental school program were training in a dental clinic at the dental school. While the 2.25 FTEs were training at the