

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 clinic, the dental school paid for all of the costs of the dental program. Prior to July 1, 2000, Hospital A signed a written agreement with the clinic to incur all or substantially all of the costs of training the 2.25 FTE residents, from July 1, 2000 and onward. Thus, beginning with July 1, 2000, the dental school no longer incurred the costs of the program at this nonhospital site. In this scenario (even if Hospital A inappropriately received direct GME and IME payments for the 2.25 FTEs since July 1, 2000), Hospital A may not receive direct GME or IME payment for the 2.25 FTE residents training in the clinic because there would have been a redistribution of costs associated with training these 2.25 FTE residents from the dental school to the hospital.

#### *Example 3*

Since 1995, 2.25 FTE residents in a family practice program were training in a physicians' group practice. While the 2.25 FTEs were training at the physicians' practice, a school of medicine paid for the costs of the family practice residency program. Prior to July 1, 2000, Hospital A signed a written agreement with the physicians' practice to send 1 additional family practice FTE resident to the physicians' practice and to incur all or substantially all of the costs of training the original 2.25 FTE residents and the 1 additional FTE, from

July 1, 2000 and onward. Thus, beginning with July 1, 2000, the school of medicine no longer incurred the costs of the program at this nonhospital site. Hospital A may not count the 2.25 FTE residents that had been training since 1995 in that physicians' practice for purposes of direct GME and IME payments because the training costs were shifted from the school of medicine to the hospital. However, Hospital A may count the 1 FTE resident the hospital began to rotate for training in the physicians' practice because there was no cost-shifting for that resident and Hospital A incurred "all or substantially all" of the costs of the entire family practice program in the physicians' office setting.

#### *Example 4*

Residents in a surgery program have been rotating from a hospital to two nonhospital clinics, Clinic A and Clinic B, since 1996. The training of the surgery residents in Clinic A has been supported by a nonhospital institution since 1996, while the hospital has incurred all or substantially all of the costs of the surgery residents in Clinic B since 1996. The hospital cannot count the surgery FTE residents training in Clinic A, even if it begins to pay for all of the costs of the program at that site, since a nonhospital institution had supported the training in Clinic A since 1996 (in other words, the redistribution of costs and community support principles would prohibit the hospital from counting these FTE residents). However, if the hospital continues to incur all or substantially all of the costs of the surgery residents in Clinic B, the hospital may count the FTE residents training in Clinic B for purposes of direct GME and IME payments because there would be no cost-shifting to the hospital for these residents and the hospital would incur all or substantially all of the costs for the training program in that setting.

We received a large number of comments from the public on this proposal. Following is a summary of these comments and our responses:

*Comment:* Some commenters supported our proposed application of redistribution of cost and community support to direct GME. One commenter stated: "We believe that the proposed changes \* \* \* will result in more accurate and consistent reimbursement to providers. The changes provide more definitive guidance to providers and to intermediaries in applying the regulations. In addition, the changes will more closely match Medicare reimbursement with actual IPPS-type services. This is especially true in the

case of dental residents, who typically spend little or no time caring for patients receiving IPPS type services."

*Response:* We agree with the commenters' assertions and appreciate the commenters' support of our proposals on redistribution of costs and community support.

*Comment:* Many commenters disagreed with our proposed application of redistribution of cost and community support to direct GME. In general, they believed they did not receive proper notice of the application of the principles. One commenter stated: "[t]he proposed change to the rules midstream, and only with respect to subsequent payment years, distorts the balance on which the established payment formula depends." Other commenters believed that, in the past, CMS has never suggested that incurring the costs of offsite training in the then-current year would be a condition to hospitals' claiming those costs in future years. The commenters contended that nowhere in the regulations promulgated has CMS stated that, in order to receive GME and IME payments, a hospital must meet an additional requirement of incurring the training costs since the inception of the training program. The commenters believed it is inequitable to impose such a "retroactive requirement."

The commenters stated that many hospitals that were contemplating whether to initiate a training program in a nonhospital setting, notified CMS in advance of establishing such a program, and requested CMS's approval. One commenter stated that, in numerous cases, "including some of the cases discussed in the regulatory preamble, CMS issued a written approval of the proposed training program. In such approval letters, CMS never mentioned the redistribution of costs and community support principles."

Finally, another commenter stated that there is nothing in the direct GME and IME statutes that supports CMS' decision to apply redistribution of costs and community support principles.

*Response:* The principles of redistribution of cost and community support associated with Medicare's payments for GME have been in existence for over 35 years, that is, since the inception of the Medicare program in 1965. The principles have been continually reiterated in various regulations, manual provisions, and implementing instructions to fiscal intermediaries. We do not believe we have given the public any reason to conclude that the principles would not continue to be applicable. Several examples of our views on the principles