

*Response:* In response to the commenters' concerns regarding the application of the redistribution of costs principles and community support to counting residents for purposes of determining payments for IME for training in hospital settings, we agree with the commenters; the redistribution of costs and community support principles do not apply to FTE counts for residents training in *hospital settings* for purposes of IME payment. As we have explained in several regulations, the object of IME payments associated with resident training in hospital settings is to address the additional indirect operating costs that teaching hospitals incur in furnishing patient care (see 66 FR 39896 or 54 FR 40286). Even if the redistribution of costs and community support principles could theoretically apply to training inside the hospital, we do not know how *all* of these additional indirect operating costs incurred by a hospital could be "redistributed" to a nonhospital entity or could be borne by the community. As long as the hospital had consistently incurred at least some of those indirect costs, there could be no violation of redistribution of costs and community support principles, and no resulting disallowance of FTEs in calculating the hospital's IME adjustment. In any event, as stated above, we agree with the commenters because we believe the legislative history that gave rise to the principles of redistribution of costs and community support was focused on Medicare payments for direct GME.

However, we note that, for training that occurs in nonhospital settings, the application of the principles of redistribution of costs and community support to direct GME FTE counts does have implications for IME payment for residency training in nonhospital settings. Under existing § 412.105(f)(1)(ii)(C), which is 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 § 413.86(f)(4)(iv) (the paragraph that specifically applies redistribution of costs and community support principles to FTE counts for purposes of direct GME) 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, IME payments are based on the concept that, as a direct result of the hospital's resident training program, the hospital incurs increased indirect costs for patient care. When Congress added section 1886(d)(5)(B)(iv) of the Act as part of Pub. L. 105–33, the circumstances under which IME payments to a hospital could be made were broadened to allow the hospital to count the number of residents training outside the hospital setting under certain conditions, even though it is clear residents training outside the hospital cannot have any impact on the hospital's indirect patient care costs. Nevertheless, Congress authorized hospitals to receive IME payments by allowing hospitals to count FTE residents training in a nonhospital setting in accordance with section 1886(d)(5)(B)(iv) of the Act. As we have stated, we believe Congress intended the provisions of Pub. L. 105–33 to create an incentive (or remove a disincentive), 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. However, we believe IME payment to the hospital would be contrary to Congressional intent if there is a redistribution of costs or community support associated with residents training in a nonhospital site. We also believe the IME payment to the hospital was only intended by Congress to encourage the hospital to rotate residents from the hospital to the nonhospital site, not to encourage (or enable) existing training programs to transfer their costs to the hospital and thereby expand the hospitals Medicare IME payments.

In addition, when Congress added section 1886(d)(5)(B)(iv) to the Act as part of Pub. L. 105–33, the statutory authority for IME payment for residents training at a nonhospital site 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 Pub. L. 105–33; section 1886(d)(5)(B)(iv) of the Act.) The statute requires a hospital to incur "all or substantially all of the costs for the training program" in the nonhospital

setting in order to count FTE residents training there for purposes of both direct GME and IME payment. The link between the IME regulation at existing § 412.105(f)(1)(ii)(c) and direct GME regulations at § 413.86(f)(4) implement this shared statutory requirement. As we have stated, we believe Congress intended hospitals to facilitate training in nonhospital sites that would not have occurred without the hospital's sponsorship, and for the hospital also to incur direct GME costs of the program in the nonhospital site as a precondition to counting the FTE residents training in nonhospital settings for purposes of IME payment. Thus, in the situation where a hospital currently is incurring direct GME costs at the nonhospital site but there has been a redistribution of costs or community support, a disallowance of direct GME payments, as well as a disallowance of IME payments, is appropriate.

*Comment:* One commenter noted that proposed § 413.86(i) (redistribution of costs and community support provision) applies not only to subparagraph (f)(4), the nonhospital site provision, but also to the remaining provisions of paragraph (f) and also to paragraphs (g)(4) through (g)(6). The commenter requested that CMS specify that the principles affect only the counting of residents in nonhospital sites and not the count of residents being trained in hospitals, both the inpatient and outpatient settings. In addition, this commenter believes such a clarification would also be consistent with other Medicare policy on counting FTE residents, such as the policy detailed in the August 1, 2002 final rule (67 FR 50077) concerning when residents rotate to other hospitals: "which entity may count the residents for IME and Direct GME payments is based on where the actual training occurs, not which hospital is incurring the costs."

*Response:* While the primary reason we proposed to make the principles of redistribution of costs and community support explicit in the direct GME regulations was to specifically address the inappropriate scenarios described in the proposed rule whereby hospitals increase their FTE resident counts by assuming payment of training costs for residents in nonhospital sites that were previously funded by a nonhospital entity, we do not believe the principles are applicable in only this circumstance. In other words, the principles of community support and redistribution of costs apply generally to direct GME FTE counts, as we have explained. This holds true whether the counts relate to residents training in nonhospital sites (where we have seen the most