

commenter on this final rule is read in context that, even as far as back as the 1989 final rule, we acknowledged that hospitals may count the FTE residents where other entities may have incurred the residents' salaries, but where the hospitals still "incur other substantial GME costs associated with these residents." This view is entirely consistent with the CMS application of redistribution of costs and community support. In a scenario where a nonhospital entity, such as a medical school, incurs the residents' salaries, we continue to believe that the hospital may count the FTE residents if the hospital can demonstrate that it has incurred other direct GME costs, such as the supervisory physician salaries, since the inception of the program.

*Comment:* One commenter argued that when we explained our policy in the July 31, 1998 **Federal Register** (63 FR 40954) to require a written agreement indicating that the hospital must provide reasonable compensation for physicians' supervision of residents' training in the nonhospital setting, "nothing was said about an additional requirement that a hospital must have continuously incurred this additional cost, as well as the residents' compensation required under the prior regulations, since the inception of the training program." This commenter further makes the point that in the final rule at 63 FR 40986, in response to a comment that hospitals did not compensate nonhospital sites for supervisory teaching physician costs and it would not be fair to shift these costs to teaching hospitals, CMS responded:

Hospitals and nonhospital sites will have 5 months following publication of this final rule to negotiate agreements that will allow hospitals to continue counting residents training in nonhospital sites for indirect and direct GME. These arrangements are related solely to financial arrangements for training in nonhospital sites. We do not believe that the agreements regarding these financial transactions will necessitate changes in the placement and training of residents.

In response to the comment that it is unfair to shift costs to the hospital, we believe that it is appropriate to include supervisory costs in the nonhospital site as part of "all or substantially all" of the costs that hospitals must incur to count the resident. Currently, the hospital is able to count the resident even though the costs for that resident may be lower during the time when the resident trains outside the hospital. At the same time, the nonhospital site may have incurred costs for which it received no compensation. We believe that requiring the hospital to incur the costs associated with training in the nonhospital site is equitable to both the hospital and the nonhospital site and is consistent with the statutory requirement

that the hospital must incur "all or substantially all" of the costs.

(63 FR 40995 (emphasis added by commenter).)

The commenter believed that this explanation of the changes to the GME and IME rules, effective January 1, 1999, "belies CMS' current assertion of a longstanding policy of applying the redistribution of costs and community support principles in the determination of the resident counts used to compute payment for GME and IME."

*Response:* The commenter has used the language quoted above from the 1998 final rule to argue that when CMS (then HCFA) described the policy on counting residents in nonhospital sites for IME, "nothing was said about an additional requirement that a hospital must have continuously incurred this additional cost \* \* \* since the inception of the training program." The commenter has inferred from the language quoted above that CMS has *not* had a longstanding policy of applying the redistribution of costs and community support principles.

However, we believe the language actually *supports* the longstanding existence of our policy in two ways. First, the quoted language demonstrates the agency's view that the nonhospital site policy was written from the standpoint of addressing the counting of residents when hospitals *rotate* residents from the hospital to the nonhospital site. Second, the quoted language is also indicative of the Agency's policy that as long as the hospital has continuously incurred at least some of the direct GME cost of the residency program since the inception of the program, there has been no redistribution of costs or community support and the hospital may count the FTE residents (assuming that other requirements are met).

Specifically, the comment relating to the portion of the 1998 final rule quoted above stated at 63 FR 40994, in relevant part: "One commenter noted that some arrangements between hospitals and nonhospital settings for the training of residents predate the GME base year. This commenter stated that hospitals did not compensate nonhospital sites for supervisory teaching physician costs and it would not be fair to shift these costs to teaching hospitals. *The commenter also stated that teaching hospitals have already entered into written agreements with nonhospital sites under the existing rules.*" (Emphasis added.) In addition, as quoted above in the comment, we responded, in relevant part at 63 FR 40995 (with different emphasis):

\* \* \* hospitals and nonhospital sites will have 5 months following publication of this final rule to negotiate agreements that will allow hospitals to *continue counting residents* training in nonhospital sites for indirect and direct GME. These arrangements are related solely to financial arrangements for training in nonhospital sites. We do not believe that the agreements regarding these financial transactions will necessitate changes in the placement and training of residents.

In response to the comment that it is unfair to shift costs to the hospital, we believe that it is appropriate to include supervisory costs in the nonhospital site as part of "all or substantially all" of the costs that hospitals must incur to count the resident. Currently, the hospital is able to count the resident even though the costs for that resident may be lower *during the time when the resident trains outside the hospital*. At the same time, the nonhospital site may have incurred costs for which it received no compensation. We believe that requiring the hospital to incur the costs associated with training in the nonhospital site is equitable to both the hospital and the nonhospital site and is consistent with the statutory requirement that the hospital must incur "all or substantially all" of the costs. *Ibid.*

We believe the quoted comment and response from the 1998 rule paint a picture of a hospital that has had a pre-existing relationship with a nonhospital site involving *rotation of residents from the hospital to the nonhospital site for a period of time* during the residency program. The language we emphasized in the response—that the hospital may "*continue to count residents*" when they train in the nonhospital sites, and that the hospital "may count the resident even though the costs for the resident may be lower *during the time when the resident trains outside the hospital*"—clearly refers to a rotational arrangement between the hospital and the nonhospital site. In addition, according to the circumstances described by the commenter in the 1998 rule, the hospitals had been incurring the residents' salaries, a direct GME cost, because they had formerly complied with the earlier regulation requiring that hospitals incur residents' salaries for purposes of meeting "all or substantially all of the costs" under § 413.86(f)(3). We had no reason to believe that the hospitals had not incurred at least the residents' salaries since the inception of the training program (the commenters state that the arrangements "predate the GME base year"). In that event, the counting of residents in the nonhospital sites would not result in a redistribution of costs if, as of January 1, 1999, the hospital was required to incur the additional direct GME cost for supervisory physician costs while the residents rotate to the