

nonhospital site. We believe that the commenter in the 1998 rule simply did not agree with the additional regulatory requirement finalized in the 1998 final rule that the hospital must also incur the supervisory physician costs for purposes of incurring "all or substantially all of the costs," and hoped to label this new regulatory requirement as a "cost shift" in order to avoid it. As we have explained, it appears that there has been no redistribution in the case described by the 1998 final rule commenter because it can be inferred that the hospital had incurred at least some of the direct GME costs (the residents' salaries) since the inception of the program.

Therefore, we believe the language the commenter quotes from the 1998 rule is consistent with our clarifications in this final rule on redistribution of costs and community support. In addition, the language cited by the commenter supports our interpretation of the policy on counting residents in nonhospital sites that it was intended to address the situation when hospitals rotate residents from the hospital to the nonhospital site.

*Comment:* Some commenters disputed the CMS interpretation of Congressional intent as discussed in the preamble of the proposed rule (see 68 FR 27213). One commenter stated: "there is no support in the legislative history of the non-provider setting amendments [the 1986 and 1997 amendments of the Act] for the Secretary's view that these changes were not intended to shift new costs to hospitals in support of on-going training in non-provider settings \* \* \* it can be reasonably inferred that Congress was aware, and even intended, that some costs of existing residency training programs in non-provider settings would be shifted to hospitals in order for the hospitals to qualify for direct GME and IME funding under the 1986 and 1997 amendments of the Act." Similarly, another commenter stated that the Secretary "must look elsewhere to the statute [other than section 1886(h)(4) of the Act] for support for his proposed rule; he cannot simply create out of whole cloth an interpretation that is inconsistent with the amendment's other provisions."

*Response:* The commenters would have us interpret and implement policy in a statutory vacuum. We believe we have reasonably discerned Congressional intent by interpreting the plain language of the statute at sections 1886(d)(5)(B) and 1886(h) of the Act *in conjunction with* the accompanying legislative history of these sections.

As we stated in the preamble to the proposed rule, Congress has delegated broad authority to the Secretary to implement a policy on the count of FTE residents for purposes of calculating direct GME and IME payments. In section 1886(d)(5)(B) of the Act (IME), the statute does not specify at all how FTE counts should be determined, and the plain language in the statute under section 1886(h)(4) of the Act (direct GME) indicates that the Secretary "shall establish rules" for direct GME consistent with the statute. We also considered the deference expressed in the conference agreement that accompanied Pub. L. 105-33, which established a cap on the number of allopathic and osteopathic residents a hospital may count—"[T]he Conferees recognize that such limits raise complex issues, and provide for specific authority for the Secretary to promulgate regulations to address the implementation of this provision." (H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess., 821 (1997)).

Thus, in the absence of statutory specificity on determining FTE counts and the declared Congressional delegation of authority to the Secretary on the subject are *clear* indications that Congress has given the Secretary broad discretion to promulgate reasonable regulations in order to implement the policy on the counting of residents for direct GME and IME payments.

In addition, we have *not*, as the second commenter suggests, "created out of whole cloth" an interpretation of the policy concerning counting residents in nonhospital settings that is "inconsistent with the amendment's other provisions," nor do we at all believe that "it can be reasonably inferred that Congress was aware, and even intended, that some costs of existing residency training programs in non-provider settings would be shifted to hospitals in order for the hospitals to qualify for direct GME and IME funding under the 1986 and 1997 amendments of the Act," as the first commenter suggests. Rather, as we have stated, we believe that when Congress created the provisions on counting resident FTEs in nonhospital settings, it was creating a monetary incentive for hospitals to rotate residents *from* the hospital *to* nonhospital settings. We have drawn this conclusion, as we explained, from the legislative history of both the direct GME and IME provisions authorizing payments to hospitals for training in nonhospital settings. First, legislative history associated with passage of the direct GME provision (as part of Pub. L. 99-509) indicates that Congress intended to broaden the scope of

settings in which a hospital could train its residents and still receive separate direct GME cost reimbursement, and to provide incentives to hospitals for training residents in primary care programs. The Conference committee report indicates that "[s]ince it is difficult to find sufficient other sources of funding [than hospitals and Medicare] for the costs of such training, [that is, training in freestanding primary care settings such as family practice clinics or ambulatory surgery centers] *assignments to these settings* are discouraged. It is the Committee's view that training in these settings is desirable, because of the growing trend to treat more patients *out of the inpatient hospital setting* and because of the encouragement it gives to primary care." (Emphasis added.) (H.R. Rep. No. 99-727, 99th Cong., 1st Sess., 70 (1986).)

Thus, from the inception of the policy allowing payment for training in nonprovider sites, we believe Congress intended to create a monetary incentive for hospitals to rotate residents from the hospital to the nonhospital settings. We do not believe Congress intended for hospitals to be paid for residents who had previously been training at nonhospital sites without hospital funding.

Further, in the Conference committee report accompanying the provision of Pub. L. 105-33 that authorizes IME payment for training in nonhospital settings, Congress stated that "[t]he conference agreement includes new permission for *hospitals to rotate residents through nonhospital settings*, without reduction in indirect medical education funds." (Emphasis added.) (H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess., 817 (1997).)

We note that, prior to enactment of Pub. L. 105-33, if a hospital rotated a resident from the hospital to train at a nonhospital site, the hospital could not count the time the resident spent at the nonhospital site for purposes of Medicare IME payments. As a result, the "loss" of IME payments acted as a disincentive and discouraged hospitals from rotating residents out of the hospital. It appears from the legislative history that Congress authorized hospitals to count residents in nonhospital sites for IME purposes as a specific incentive to encourage hospitals to rotate their residents to nonhospital sites (and not to encourage hospitals to incur the costs of a program at a nonhospital site that had already been funded by other sources). This legislative intent becomes more apparent when the nature of the Medicare IME payment is considered.