

physician costs ("all or substantially all of the costs"), the hospital may not include the residents in its FTE count for that fiscal year. This requirement, of course, is independent of the redistribution of costs and community support policy. It is based on the statutory requirement that allows a hospital to count residents training at nonhospital sites only if the hospital has incurred for all or substantially all of the costs of the program at that site during the hospital's fiscal year.

*Comment:* One commenter stated that the 1989 final rule made clear that a hospital's resident count may also include residents for whom "community support was received" through a State or local grant. Similarly, another commenter stated "certain family medicine training programs that may have received outside funds, for example, State dollars, at any time in the past will be prohibited [by the hospital we proposed] from receiving GME reimbursement."

Similarly, another commenter stated that "it is axiomatic" that State-supported and public teaching hospitals receive State appropriations to support their residency programs. The commenter urged CMS to clarify that the application of the redistribution of costs and community support principles would not apply to State or local appropriations to public hospitals, with respect to the counting of FTE residents in either the hospital or the nonhospital setting.

*Response:* As we explained in the 1989 final rule (54 FR 40302), grants that were restricted (those grants that were designated by the donor to pay for certain specified provider costs) or unrestricted were considered allowable costs of the hospital (including direct GME costs) when Medicare paid hospitals on a reasonable cost basis. The policy allowing payment to hospitals for costs that had been funded by grants was authorized by section 901 of the Omnibus Budget Reconciliation Act (OBRA) of 1980 (Pub. L. 96-499), which added section 1134 of the Act. Section 1134 of the Act applies to "the reasonable costs of services provided by nonprofit hospitals or critical access hospitals." Section 1134(1) of the Act specifies that a "grant, gift or endowment or income therefrom which is to or for such a hospital \* \* \*" may not be deducted from the operating costs of such hospitals that are paid on a reasonable cost basis. Therefore, when hospitals were paid on a reasonable cost basis for direct GME costs, the "community support" that came from "grants, gifts, or endowments" was allowable under Medicare. We are

clarifying in this final rule, that under the direct GME prospective payment methodology under section 1886(h) of the Act, if a hospital had received a grant, gift or endowment to subsidize its residency programs at the hospital, and the hospital requested direct GME payment for training the residents, it would not be considered community support. Under section 1134 of the Act, it is as if the hospital had itself incurred the cost for which it had received the grant subsidy. For example, if in 2003 a hospital received a State grant to fund its family practice program at the hospital, the grant would not be considered community support under our regulation. This is because we would treat the hospital as if itself incurred the costs for the family practice program, instead of the State grant.

However, we note that this policy would *not* include ordinary State and local appropriations. As we mentioned in the January 12, 2001 final rule at 66 FR 3367, "In administrative, legal and policy matters, we have consistently maintained that State appropriations for the cost of medical education activities constitute community support that is to be offset from a provider's allowable costs." Therefore, if a program were entirely funded by State or local appropriations, an inappropriate redistribution of costs would occur if the hospital subsequently begin to incur the costs of the residency program—for training inside or outside the hospital. Although, for most hospitals that receive State and local appropriations for their residency programs, the hospitals continuously incur (since the inception of the programs) some direct GME costs, there would be no disallowance of FTEs due to community support.

We contrast the situation of a grant to a hospital with the situation of a grant to a nonhospital site. If, hypothetically, nonhospital sites were reimbursed by Medicare on a reasonable cost basis, and the nonhospital site had received grants to subsidize all of the direct GME costs for the residency program there, under section 1134 of the Act, we would treat the costs the grant subsidized as if they were costs of the nonhospital site. If a hospital then tried to incur the direct GME costs, this *could* be a redistribution of costs or community support issue, since the hospital would be claiming FTE residents who had historically trained at the nonhospital site for whom the community had assumed the cost of that training, as described in the scenarios at 68 FR 27213.

*Comment:* Several commenters objected to the sentence in the preamble to the proposed rule that stated: "\* \* \*

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." One commenter explained that there are a number of situations where a hospital is truly incurring the cost of having a resident at a site, but the hospital is not incurring the cost of the entire complement of residents. "For example, if two different hospital programs each elect to send residents to the same clinic, under the interpretation in the [proposed rule], neither of the two hospitals would be able to count any of the residents because neither of the two programs would incur the cost of the full complement of residents." Another commenter believed that "this change" runs contrary to other current Medicare policies that focus on the resident rather than the program. The commenter believed that both the direct GME and IME regulations "are replete with references to 'resident' rather than 'program'." The commenter believed that "residency program" is referenced only in the context of the requirement that, for residents to be counted for direct GME and IME payments, they must be part of an "approved program" (§ 413.86(f)(1)).

*Response:* We understand the concerns of the commenters about the requirement for a hospital to incur "all or substantially all of the cost" of training residents in a training program at a nonhospital site. However, we *do not* believe this is a *change* in policy. We believe that the policy that requires a hospital to incur the cost of "the program" in the nonhospital site has existed since the passage of the direct GME provisions, section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509), and the passage of the IME provision, section 4621(b)(2) of the Balanced Budget Act of 1997 (Pub. L. 105-33), that permitted hospitals to continue to count residents in nonhospital sites, for purposes of direct GME and IME payment, if the hospital incurred "all or substantially all of the cost" of residents training in the program.

As we explained in the proposed rule, 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.) Therefore, we believe a better reading of this language is that hospitals must incur all