

or substantially all of the cost for the full complement of residents in the training program at the nonhospital site.

We note that the policy that requires the hospital to incur the cost of the program does appear to be somewhat of a departure from other current Medicare policies on graduate medical education that focus on the resident rather than the program, as the commenter suggests. However, we believe the statutory provisions cited above require hospitals to assume the cost of the full complement of residents training in the program at the nonhospital sites in order to count any FTE residents training at that site.

In addition, as we noted at 68 FR 27217 of the proposed rule, and also above, under policy on the application of the redistribution of costs and community support principles, it is permissible for the hospital to count FTE residents where the hospital incurs direct GME costs of FTE residents that are added to an existing program, even though the hospital is not permitted to count the existing FTE residents due to the application of the redistribution of costs or community support rules. In the nonhospital setting, as a result of the interaction of these two separate FTE-counting requirements—(1) that the hospital must not violate the redistribution of costs and the community support principles in order to count the resident FTEs in the nonhospital settings; and (2) that the hospital must incur “all or substantially all” of the costs for the training program in that setting—a hospital would be prohibited from counting FTE residents added to an existing program at a nonhospital site unless the hospital incurs all or substantially all of the costs of training all of the residents in that program at that setting. That is, even if the hospital incurs all or substantially of the costs for all of the training program at the nonhospital site, the hospital would only be able to count the additional FTE residents who were not excluded by application of the redistribution of costs or community support principles.

*Comment:* Several comments cited a letter from CMS (then the Health Care Finance Administration, or “HCFA”) dated March 30, 1999 to C. Scott Litch of the American Association of Dental Schools (now the American Dental Education Association). Specifically, these commenters cited a sentence in the letter to Mr. Litch which stated: “If a hospital establishes a new relationship with a dental clinic and meets the conditions for counting residents training outside the hospital, the hospital may count more residents

currently for indirect and direct graduate medical education than were counted in 1996 if those residents are dental residents.” One commenter stated that the “new relationship” referred to in the letter from CMS presupposes the existence of an ongoing program whose costs presumably had been met by means other than the hospital before the affiliation with a nonhospital dental clinic began. This commenter believed that this letter provided assurance to many hospitals that new affiliations with preexisting dental programs were permissible.

*Response:* We do not agree with the commenter that the sentence in the letter to Mr. Litch “presupposes the existence of an ongoing program” where the costs of such a program “had been met by means other than the hospital”. Rather, we believe the “new relationship” between the hospital and the dental clinic could be reconciled with application of the principles of redistribution of costs and community support and characterized by two possible interpretations, both of which would allow for the counting of residents in nonhospital sites—(1) where the hospital would rotate residents from the hospital to the nonhospital site; or (2) where the hospital would fund new training slots at the nonhospital site (the dental clinic referred to in the Mr. Litch’s letter). Such assignments from the hospital to the dental clinic, or new residency training slots, would be the “new relationship,” but in either case, no redistribution would occur. Therefore, we do not believe the letter from 1999 is necessarily inconsistent with the principles of redistribution of costs and community support described in the proposed rule.

*Comment:* Many commenters, while remaining generally opposed to application of redistribution of costs and community support principles, requested that if CMS were to finalize the proposed rule, CMS apply the principles prospectively. One commenter, a dental school, explained that it had just admitted a new class of residents, many of whom will not complete their programs until 2006. The commenter believed that, in the application of the principles, CMS seeks to remove all Medicare funding for these residents retroactively. Along a similar vein, another commenter pointed out in support of the suggestion to apply the principles only prospectively, that the implementation of the proposed regulation would result in “substantial dislocation and hardship to hospitals, dental and other schools, and the residents themselves.” Therefore, the

commenter believed CMS should indicate specifically in the final rule that such changes will only be applied to a provider’s cost reporting period beginning on or after October 1, 2003, and CMS should not apply its final GME policy on redistribution of costs and community support to any prior cost reporting periods that remain open or unsettled, or are settled but potentially subject to reopening under the Medicare rules.

In addition, several commenters requested clarification regarding the effective date for the proposed application of the principles of redistribution of costs and community support to FTE counts. Specifically, the commenters point to the following language in the proposed rule:

- “A hospital must continuously incur direct GME costs of residents training in a particular program at a training site since the date the residents first began training in that site in order for the hospital to count the FTE residents.” (68 FR 27215)

- “We propose \* \* \* to identify January 1, 1999, as the date our fiscal intermediaries should use to determine whether a hospital or another entity has been incurring the costs of training in a particular program at a training setting.” (68 FR 27216)

- “[i]f the fiscal intermediaries determine that there is a redistribution of costs or community support exists with respect to certain residents prior to January 1, 1999, a disallowance of direct GME and IME payment with respect to those FTE residents would certainly be required.” (68 FR 27216)

- “We are proposing that, effective October 1, 2003, in order for a hospital to receive IME and direct GME payment, the hospital must have been continuously incurring the direct GME cost of residents training in a particular program since the date the residents first began training in the program in order for the hospital to count the FTE residents.” (68 FR 27417)

*Response:* We have stated that we believe the principles of redistribution of costs and community support are *longstanding* Medicare policy. While we have reminded the public of the continuing application of the principles in various regulations and program guidance, we also recognize that CMS has not had occasion to invoke them in Agency policy expressions relating specifically to direct GME payments since the direct GME PRA base year.

As we have stated, we believe redistributions would occur only in rare circumstances for residency training inside the hospital. Between 1987 and 1997 when hospitals could count FTE