

residents training in nonhospital sites for purposes of direct GME payments, but not IME payments, we did not observe the kinds of inappropriate counting of FTE residents we described in our proposed rule. It is only since hospitals have been allowed to count FTE residents training in nonhospital sites for purposes of IME payment, that CMS has become aware that cost shifting has become prevalent in the hospital industry, which has implicated the principles of redistribution of costs and community support. Therefore, in general, we are implementing a prospective effective date of October 1, 2003, for purposes of payment. That is, for direct GME, effective for portions of cost reporting periods beginning with October 1, 2003, and for IME, effective for discharges occurring on or after October 1, 2003, a hospital must have been continuously incurring direct GME costs 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. We note that the effective dates apply only as they relate to disallowances of FTEs and bear no relation to determinations of redistributions or community support. Therefore, in general, a fiscal intermediary that determines that a redistribution of costs has taken place for a particular hospital prior to October 1, 2003, may disallow FTEs based on that determination beginning with October 1, 2003. For example, if a fiscal intermediary determines that a redistribution of costs has occurred that affected 10 FTEs for direct GME and IME during the hospital's cost report ending in fiscal year ending in 1999, the fiscal intermediary would take disallowances for those 10 FTEs, but not until October 1, 2003, for purposes of direct GME and IME payment.

In addition, because we have received a large number of public comments expressing surprise and confusion regarding our policy on these principles, we are grandfathering residents who began training in a program on or before October 1, 2003. That is, an FTE resident who began training in a residency program on or before October 1, 2003 (the effective date of this final rule), and with respect to whom there has been a redistribution or community support, may continue to be counted by a hospital for purposes of direct GME and IME payments after October 1, 2003, until the resident has completed training in that program, or until 3 years after the date the resident began training in that program, whichever comes first. We believe continued direct GME and

IME payments to the hospital while the "redistributed" residents finish their training for up to 3 years is appropriate to address many situations in which nonhospital sites have made arrangements with hospitals to shift the costs of training those residents. We understand that, in nonhospital sites, virtually all dental residency programs are of a duration of 3 years in length or less. This policy addresses the situation pointed out by the dental school commenter and other commenters that a school may have just admitted a new class of residents, many of whom will not complete 3-year programs until 2006.

We note that this prospective "grandfather" policy *does not* apply to resident FTEs with respect to whom there has been a redistribution of costs or community support, and who begin training after October 1, 2003. In addition, those residents described above who began training in a program on or before October 1, 2003, may be counted until those particular residents finish their training in that program (or 3 years, whichever comes first). In order to count such residents, we are requiring that hospitals identify those residents (by social security number) to their fiscal intermediary and specify the length of time the hospital will be counting these FTE residents for direct GME and IME payment purposes.

We note that the policy described above that effectively "grandfathers" residents who began their training on or before October 1, 2003, applies only as it relates to payments to hospitals for those specified FTE residents, and bears no relation to determinations of whether a redistribution of costs or community support has taken place. Therefore, if a fiscal intermediary determines that a redistribution of costs has taken place with respect to residents counted by a particular hospital even prior to October 1, 2003, the intermediary will disallow any FTEs based on that determination, beginning October 1, 2003, except for the "grandfathered" residents. Hospitals that continue to count grandfathered FTE residents (where the costs of whom had been redistributed) may only do so until those residents finish their training in the specific program they were training in on or before or to October 1, 2003 (which would be no later than September 30, 2006, 3 years after October 1, 2003).

For example, a fiscal intermediary determines for a hospital's FYE December 31, 2003 cost report that a redistribution of costs has taken place with respect to certain FTEs the hospital counted for direct GME and IME (that is, the costs of training residents at a

nonhospital site were incurred by a university from 1990 through 1999). Assume that 5 FTEs began training in a 2-year orthodontics program in a dental school on July 1, 2003, and another 5 residents begin their training in the same program on July 1, 2004. The 5 FTEs who began training on July 1, 2003, are "grandfathered," and, therefore, the fiscal intermediary would not disallow these 5 FTEs as of October 1, 2003. The hospital may continue to count these 5 FTEs that began training on July 1, 2003 through June 30, 2005, when they finish the 2-year orthodontics program. We note that subsequent to completion of the 2-year orthodontics program on June 30, 2005, if any of these 5 FTEs participate in additional GME training programs, the fiscal intermediary would disallow these FTEs because disallowances for redistribution of costs and community support relate to FTE slots and not specific residents.

However, the 5 FTEs that began training in the 2-year orthodontics program on July 1, 2004 are not "grandfathered," and, therefore, beginning July 1, 2004 of the hospital's December 31, 2004 cost report, the fiscal intermediary will disallow IME and direct GME payment associated with these 5 FTE slots.

*Comment:* Commenters disputed the situations we cited in the preamble to the proposed rule that were supposed to be illustrative of what we believe to be inappropriate application of Medicare direct GME and IME policy at 68 FR 27213. One commenter, in particular, requested information on the identity of programs cited in the examples.

*Response:* We do not believe it is appropriate to disclose the identities of those cited in the examples. Therefore, we are unable to respond to the commenters' points on the matter, except to state that the situations in the examples represent what we believed are the more "egregious" scenarios involving redistribution of costs and community support principles and inappropriate counting of FTE residents, we note that the same issues arise, and the same principles apply, whether the counting of residents relates to training that is taking place in another country, another State, or on the same hospital campus, as the hospital.

*Comment:* One commenter believed that CMS's policy on the application of the redistribution of costs and community support will lead to considerable, "but needless," litigation over what it means to "incur" the costs of off-site training.

*Response:* We disagree with the commenter and see no reason to be