

concerned that these clarifications would result in any more litigation than other Medicare payment policies that are conditioned on whether a provider incurs costs. For example, for several decades, Medicare policy required that hospitals "incur" costs in order to receive payment from Medicare. The Medicare statute and regulations currently require that a hospital incur certain costs in order to count FTE residents training in nonhospital sites for purposes of direct GME and IME payments. We are unsure why the requirement under the policy on redistribution of costs and community support that a hospital "incur" the direct GME cost continuously for a residency program at a training site is any more complex than other cost requirements under Medicare.

*Comment:* One commenter suggested that we craft a narrower solution to the issue of inappropriate counting of FTE residents in nonhospital sites by focusing the language on salary and benefits for residents. The commenter believed that CMS could state that, unless the hospital in 1999 had incurred the costs of salary and benefits for FTE residents who were training in offsite locations, the hospital may not receive direct GME and IME payment for training those FTE residents at the nonhospital sites today.

*Response:* We do not believe a policy such as the one the commenter suggested—determining redistribution of costs based upon whether a hospital continuously incurs the residents' salaries and benefits during training in the nonhospital site—is necessary or appropriate. This is because, under the policy on redistribution of costs and community support we describe in the proposed rule and in this final rule, a hospital that continuously incurs the residents' salaries and benefits (from 1999 or before) while the residents train in the nonhospital site, or even inside the hospital, would *not* be redistributing costs if the nonhospital site later incurs the other direct GME costs (such as supervisory physician salaries) in the nonhospital site. There would be no redistribution of costs because the hospital would have continuously incurred at least some of the direct GME costs (the residents' salaries and benefits) since the inception of the program. However, we note that even if there has not been a redistribution of costs or community support with FTE residents training in a nonhospital site in such a scenario, the hospital would still need to meet the requirements in the existing regulations (at § 413.86(f) and § 412.105(1)(ii)(c)) in order to count

those FTE residents for purposes of direct GME and IME payment.

For example, Hospital A has had a family practice program with 10 FTE residents for about 20 years, for which the hospital has incurred the residents' salaries and fringes and some other (but not all) direct GME costs for the program. For the first time, in fiscal year ending 2003, Hospital A rotates 2 FTE residents to an ambulatory clinic (a nonhospital site), and fulfills the requirements at § 413.86(f)(4), including incurring "all or substantially all of the costs" of the training program in the nonhospital site. There is no redistribution of costs with respect to these 2 FTE residents because Hospital A has continuously incurred some of the direct GME costs of the program—the residents' salaries—and therefore it may count the 2 FTE residents training at the clinic (up to the hospital's FTE cap), since it also has complied with the requirements at § 413.86(f)(4).

*Comment:* Some commenters suggested that the application of redistribution of costs and community support principles would impose large administrative burdens on hospitals to demonstrate which entity has been "continuously incurring" the costs of the residency training. One commenter stated: "[t]his burden would be additive to a policy that already is fraught with excessive administrative requirements."

One commenter asked if hospitals would be required to document responsibility for the costs of training residents prior to January 1, 1999.

*Response:* If the hospital has continuously been incurring at least some of the direct GME costs (for example, resident salaries or supervisory physician salaries) since the inception of the residency program, we do not believe any additional documentation is necessary beyond which hospitals are already required to maintain. If resident or supervisory physician salaries, for instance, are paid through the hospital payroll, the hospital will have kept documentation of such costs for Federal tax purposes.

In response to the second comment, we stated in the proposed rule that January 1, 1999 should be used by our fiscal intermediaries as the date for determinations of whether a hospital or another entity has been incurring the costs of a training in a particular program at a training site for purposes of determining whether there has been a redistribution of costs or community support. This date was chosen as an administrative convenience because we believe it could otherwise be difficult for our fiscal intermediaries to obtain contemporaneous documentation that

the hospitals have appropriately been incurring costs in earlier years. Therefore, we believe that, for purposes of determining redistribution of costs or community support, most hospitals would only be required to maintain appropriate documentation to demonstrate that they have continuously been incurring the direct GME costs from January 1, 1999 forward. However, as we mentioned in the proposed rule, if the fiscal intermediaries determine that there was a redistribution of costs or community support for a fiscal year ending for a cost report for a particular hospital prior to January 1, 1999, the hospital would be required to show contemporaneous documentation to prove otherwise.

*Comment:* One commenter stated that it may be difficult to track residents that have been funded by some type of community support. The commenter described a scenario where a program at a hospital has four internal medicine residents and one is covered by some type of community support for a 3-year period. The commenter stated that it may be difficult to track that slot over the next 5, 10, or 20 years to avoid submitting it for future direct GME or IME payments.

*Response:* As we stated above, we understand there may be administrative issues that hospitals must confront in their efforts to comply with the principles of redistribution of costs and community support. However, we do not believe it would very difficult to track the FTEs in a program that receives community support. Once the FTE residents for which community support is received have been identified, the hospital will know the number of FTE residents to remove from the count that is submitted in future cost reports (all of which will be subject to audit by our fiscal intermediaries). Using the commenter's example, if direct GME costs for one out of four FTEs in an internal medicine program is identified as being entirely subsidized by community support for three years (the duration of an internal medicine program), the hospital would know to refrain from counting one FTE in future cost reports, even after the 3 years of training for a particular resident has passed. This is because, as the commenter seemed to understand, the redistribution of costs and community support principles are applied to the FTE resident training slots of a hospital; the principles are not associated with a particular resident, to which the principles could apply differently from year to year.

*Comment:* One commenter disagreed with the choice of words used in the