

clinic, the dental school paid for all of the costs of the dental program. Prior to July 1, 2000, Hospital A signed a written agreement with the clinic to incur all or substantially all of the costs of training the 2.25 FTE residents, from July 1, 2000 and onward. Thus, beginning with July 1, 2000, the dental school no longer incurred the costs of the program at this nonhospital site. In this scenario (even if Hospital A inappropriately received direct GME and IME payments for the 2.25 FTEs since July 1, 2000), Hospital A may not receive direct GME or IME payment for the 2.25 FTE residents training in the clinic because there would have been a redistribution of costs associated with training these 2.25 FTE residents from the dental school to the hospital.

#### *Example 3*

Since 1995, 2.25 FTE residents in a family practice program were training in a physicians' group practice. While the 2.25 FTEs were training at the physicians' practice, a school of medicine paid for the costs of the family practice residency program. Prior to July 1, 2000, Hospital A signed a written agreement with the physicians' practice to send 1 additional family practice FTE resident to the physicians' practice and to incur all or substantially all of the costs of training the original 2.25 FTE residents and the 1 additional FTE, from July 1, 2000 and onward. Thus, beginning with July 1, 2000, the school of medicine no longer incurred the costs of the program at this nonhospital site. Hospital A may not count the 2.25 FTE residents that had been training since 1995 in that physicians' practice for purposes of direct GME and IME payments because the training costs were shifted from the school of medicine to the hospital. However, Hospital A may count the 1 FTE resident the hospital began to rotate for training in the physicians' practice because there was no cost-shifting for that resident and Hospital A incurred "all or substantially all" of the costs of the entire family practice program in the physicians' office setting.

#### *Example 4*

Residents in a surgery program have been rotating from a hospital to two nonhospital clinics, Clinic A and Clinic B, since 1996. The training of the surgery residents in Clinic A has been supported by a nonhospital institution since 1996, while the hospital has incurred all or substantially all of the costs of the surgery residents in Clinic B since 1996. The hospital cannot count the surgery FTE residents training in Clinic A, even if it begins to pay for all

of the costs of the program at that site, since a nonhospital institution had supported the training in Clinic A since 1996 (in other words, the redistribution of costs and community support principles would prohibit the hospital from counting these FTE residents). However, if the hospital continues to incur all or substantially all of the costs of the surgery residents in Clinic B, the hospital may count the FTE residents training in Clinic B for purposes of direct GME and IME payments because there would be no cost-shifting to the hospital for these residents and the hospital would incur all or substantially all of the costs for the training program in that setting.

3. Rural Track FTE Limitation for Purposes of Direct GME and IME for Urban Hospitals that Establish Separately Accredited Approved Medical Programs in a Rural Area (§§ 412.105(f)(1)(x) and 413.86(g)(12)) a. Change in the Amount of Rural Training Time Required for an Urban Hospital to Qualify for an Increase in the Rural Track FTE Limitation. To encourage the training of physicians in rural areas, section 407(c) of Pub. L. 106–113 amended sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to add a provision that, in the case of an urban hospital that establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, an adjustment shall be made to the urban hospital's cap on the number of residents. For direct GME, the amendment applies to payments to hospitals for cost reporting periods beginning on or after April 1, 2000; for IME, the amendment applies to discharges occurring on or after April 1, 2000.

Section 407(c) of Pub. L. 106–113 did not define a "rural track" or an "integrated rural track," nor are these terms defined elsewhere in the Act or in any applicable regulations.

Currently, there are a number of accredited 3-year primary care residency programs in which residents train for 1 year of the program at an urban hospital and are then rotated for training for the other 2 years of the 3-year program to a rural facility(ies). These separately accredited "rural track" programs are recognized by the Accreditation Council of Graduate Medical Education (ACGME) as "1–2" rural track programs. As far as CMS is able to determine, ACGME is the only accrediting body to "separately accredit" rural track residency programs, a requirement specified in Pub. L. 106–113.

We implemented the rural track program provisions of section 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to address these "1–2" programs and to account for other programs that are not specifically "1–2" programs but that include rural training components. As stated above, since there is no existing definition of "rural track" or "integrated rural track," we define at § 413.86(b) a "rural track" and an "integrated rural track" as an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital(s) or to a rural nonhospital site(s). We have previously noted that the terms "rural track" and "integrated rural track," for purposes of this definition, are synonymous.

To implement these provisions, we revised § 413.86 to add paragraph (g)(11) (since redesignated as (g)(12)), and § 412.105 to add paragraph (f)(1)(x) to specify that, for direct GME, for cost reporting periods beginning on or after April 1, 2000, or, for IME, for discharges occurring on or after April 1, 2000, an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may, under certain circumstances, include in its FTE count residents in those rural tracks, in addition to the residents subject to the FTE cap at § 413.86(g)(4). (See the August 1, 2000 interim final rule with comment period (65 FR 47033) and the August 1, 2001 IPPS final rule (66 FR 39902)). These regulations specify that an urban hospital may count the residents in the rural track in excess of the hospital's FTE cap up to a "rural track FTE limitation" for that hospital. We defined this rural track FTE limitation at § 413.86(b) as the maximum number of residents (as specified in § 413.86(g)(12)) training in a rural track residency program that an urban hospital may include in its FTE count, in addition to the number of FTE residents already included in the hospital's FTE cap.

Generally, the rural track policy is divided into two categories: rural track programs in which residents are rotated to a rural area for at least two-thirds of the duration of the program; and rural track programs in which residents are rotated to a rural area for less than two-thirds of the duration of the program. Currently, family practice is the only specialty that has separately accredited rural track programs. As previously noted, to account for other specialties that have program lengths greater than