

provide GME payments for significant rural residency training.

b. Inclusion of Rural Track FTE Residents in the Rolling Average Calculation. Section 1886(h)(4)(G) of the Act, as added by section 4623 of Public Law 105–33, provides that, for a hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's FTE resident count for direct GME payment purposes equals the average of the actual FTE resident count for that cost reporting period and the preceding cost reporting period. Section 1886(h)(4)(G) of the Act requires that, for cost reporting periods beginning on or after October 1, 1998, a hospital's FTE resident count for direct GME payment purposes equals the average of the actual FTE resident count for the cost reporting period and the preceding two cost reporting periods (that is, a 3-year rolling average). This provision phases in over a 3-year period any reduction in direct GME payments to hospitals that results from a reduction in the number of FTE residents below the number allowed by the FTE cap. We first implemented this provision in the August 29, 1997 final rule with comment period (62 FR 46004) and revised § 413.86(g)(5) accordingly. Because hospitals may have two PRAs, one for residents in primary care and obstetrics and gynecology (the "primary care PRA"), and a lower PRA for nonprimary care residents, we revised our policy for computing the rolling average for direct GME payment purposes (*not* for IME) in the August 1, 2001 final rule (66 FR 39893) to create two separate rolling averages, one for primary care and obstetrics and gynecology residents (the "primary care rolling average"), and one for nonprimary care residents. Effective for cost reporting periods beginning on or after October 1, 2001, direct GME payments are calculated based on the sum of: (1) The product of the primary care PRA and the primary care rolling average; and (2) the product of the nonprimary care PRA and the nonprimary care FTE rolling average. (This sum is then multiplied by the Medicare patient load to determine Medicare direct GME payments).

Section 407(c) of Public Law 106–113, which amended sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to create the rural track provision, provided that, in the case of an urban hospital that establishes a separately accredited rural track, "* * * the Secretary shall *adjust the limitation under subparagraph (F)* in an appropriate manner insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas" (emphasis

added). Subparagraph (F) of the Act is the provision that establishes a cap on the number of allopathic and osteopathic FTE residents that may be counted at each hospital for Medicare direct GME payment purposes. Thus, the provision authorizes the Secretary to allow for an increase to an urban hospital's FTE cap on allopathic and osteopathic residents in certain instances when an urban hospital establishes a rural track program. Although the rural track provision effectively allows an increase to the urban hospital's FTE cap by adjusting the FTE limitation under subparagraph (F), the statute makes no reference to subparagraph (G), the provision concerning the rolling average count of residents. That is, the statute does not provide for an exclusion from the rolling average for the urban hospital for those FTE residents training in a rural track.

Since we implemented this rural track provision in the August 1, 2000 interim final rule with comment period (65 FR 47033), we have interpreted this provision to mean that, except for new rural track programs begun by urban teaching hospitals that are establishing an FTE cap for the first time under § 413.86(g)(6)(i), when an urban hospital establishes a new rural track program or expands an existing rural track program, FTE residents in the rural track that are counted by the urban hospital are included in the hospital's rolling average calculation immediately. Although we have not specified in the regulations that rural track FTE residents counted by an urban hospital are included in the hospital's rolling average FTE resident count, this has been our policy. The Medicare cost report, Form CMS–2552–96 (line 3.05 on Worksheet E, Part A, for IME payments, and on line 3.02 on Worksheet E–3, Part IV, for direct GME payments), reflects this policy. Accordingly, FTE residents in a rural track program are to be included in the urban hospital's rolling average count for IME and direct GME for cost reporting periods beginning on or after April 1, 2000.

We are proposing to revise the regulations at § 413.86(g)(5) to add a new paragraph (vii) to clarify that, subject to regulations at § 413.86(g)(12), except for new rural track programs begun by urban hospitals that are first establishing an FTE cap under § 413.86(g)(6)(i), when an urban hospital with an existing FTE cap establishes a new program with a rural track (or an integrated rural track), or expands an existing rural track (or an integrated rural track) program, the FTE residents

in that program that are counted by the urban hospital are included in the urban hospital's rolling average FTE resident count immediately. We also are proposing to revise §§ 413.86(g)(12)(i)(A), (g)(12)(ii)(B), and (g)(12)(iv)(A) to indicate that for the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average, training in the rural track at the urban hospital.

4. Technical Change Relating to Affiliated Groups and Affiliation Agreements

Section 1886(h)(4)(H)(ii) of the Act permits, but does not require, the Secretary to prescribe rules that allow institutions that are members of the same affiliated group (as defined by the Secretary) to elect to apply the FTE resident limit on an aggregate basis. This provision allows the Secretary to give hospitals flexibility in structuring rotations within a combined cap when they share a resident's time. Consistent with the broad authority conferred by the statute, we established criteria for defining an "affiliated group" and an "affiliation agreement" in both the August 29, 1997 final rule (62 FR 45965) and the May 12, 1998 final rule (63 FR 26317). We further clarified our policy concerning affiliation agreements in the August 1, 2002 final rule (67 FR 50069).

We are aware that there has been some confusion at times among members of the provider community when using the term "affiliation agreement," since the term is used in contexts other than for Medicare GME payment purposes. For example, an "affiliation agreement" is a term historically used in the academic community that generally relates to agreements made between hospitals and medical schools or among sponsors of medical residency education programs. To help prevent further confusion, we are proposing to change the term in the regulations to "Medicare GME affiliation agreement." We believe this will help to distinguish these agreements used for purposes of GME payments from agreements used for other purposes in the provider community. We are proposing to revise the regulations at § 413.86(b) to state "Medicare GME affiliated group," and "Medicare GME affiliation agreement," and we are making similar revisions to § 413.86(g)(4)(iv), (g)(7)(i) through (v), and § 412.105(f)(1)(vi) for IME payment purposes.