

these provisions are implemented at § 413.86(e)(4). These provisions were intended, in part, to narrow the disparities (both high and low) in direct GME payments to teaching hospitals across the country. One of the reasons a number of hospitals had low base year PRAs is because a significant amount of their GME costs in the PRA base year was incurred by another entity (that is, the “community”). (Variations in base year PRAs were otherwise due to differences in hospital-specific accounting practices and differences in reimbursement methods for supervising physician and resident salaries.) By providing for increased GME payments to certain hospitals with low PRAs, we do not believe Congress implicitly condoned, or made an exception to, the redistribution of costs and community support principles. We note that Congress provided for an increase to the floor PRA for *all* hospitals that had PRAs below the floor, *not* just to hospitals that, in the base year, did not incur certain GME costs. Rather, we believe Congress intended to provide increased GME payments to hospitals with low PRAs, regardless of the reasons those particular hospitals may have had low PRAs, in an attempt to even out some of the disparity in PRAs, nationally.

*Comment:* A commenter noted that the among the examples cited in the proposed rule at 68 FR 27213 as illustrative of inappropriate application of Medicare IME and direct GME policy, we described a situation where a hospital on the East Coast of the United States is counting dental residents training in nonhospital sites in Hawaii. The commenter believed that we have incorrect information regarding this program, and that there is, in fact, no redistribution of costs from the community to the Medicare program with respect to the program in Hawaii. Specifically, the commenter explained that in August 2002, a hospital in New York placed one dental resident in a clinic located in Honolulu. The New York hospital pays the costs of the resident’s stipend and the supervising faculty’s salary, and there is a written agreement between the hospital and the clinic. The commenter stated that in the future, the program anticipates placing additional residents at other nonhospital sites in Hawaii.

*Response:* As we stated in the preambles to the proposed rule and this final rule, there would be no redistribution of costs or community support if, from the outset of the program, a hospital incurs direct GME costs. Therefore, if, in fact, a hospital in New York has been incurring direct

GME costs for a training program located in a clinic in Hawaii since the program’s inception, then there would be no redistribution of costs or community support. The hospital in New York could count FTE residents training in the nonhospital site as long as the applicable requirements are met.

*Comment:* One commenter that described a scenario in which a university funded a family practice program for many years. However, in 2000, a Federally Qualified Health Center (FQHC) entered into a written agreement with the university and began reimbursing the university for “all or substantially all” of the costs of the program. The FQHC has been receiving Medicare direct GME payments since that time. The commenter stated that under the terms of the proposed rule, this FQHC would be ineligible for receipt of GME payments, since, prior to 2000, the program was funded exclusively by the university.

*Response:* The commenter raised the point that the redistribution of costs and community support principles are applicable to providers other than hospitals that may receive Medicare payments for residency training. Specifically, FQHCs and RHCs under § 405.2468, CAHs under § 413.70, and Medicare+Choice organizations (MCO) under § 422.270 may qualify to receive payments for direct GME costs. We note that the existing regulations at § 405.2468(f)(6) for FQHCs and RHCs, and at § 422.270(c) for MCOs, already clearly state that the allowable direct GME costs of these entities are subject to the redistribution of costs and community support principles in § 413.85(c). We agree with the commenter and are also clarifying the regulations at § 413.86(i) to clearly state that the principles of redistribution of costs and community support apply equally to hospitals, FQHCs, RHCs, CAHs, and MCOs. Therefore, we agree that, in the situation described by the commenter the FQHC would *not* be eligible for Medicare direct GME payments since the family practice program represents a redistribution of costs from the community (that is, the university) to the Medicare program (that is, the FQHC through direct GME payments).

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