

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 or less than 3 years, or that are not "1-2" programs, but may establish separately accredited rural track residency programs that are longer than 3 years, our regulations specify that residents must train in the rural area for "two-thirds of the duration of the program," rather than "2 out of 3 program years," in order for the urban hospital to count FTEs in the rural track (up to the rural track FTE limitation) in addition to the residents included in the hospital's FTE limitation. Thus, for example, under current policy, if a surgery program, which is a 5-year program, were to establish a separately accredited rural track, the urban

hospital must rotate the surgery residents to the rural area for at least two-thirds of the duration of the 5-year program in order to qualify to count those FTEs in excess of the hospital's FTE cap, as provided in § 413.86(g)(12) and § 412.105(f)(1)(x).

Accordingly, our policy for determining whether an urban hospital qualifies for an adjustment to the FTE cap for training residents in rural areas is dependent upon the proportion of time the residents spend training in the rural areas. If the time spent training in rural areas (either at a rural hospital or a rural nonhospital site) constitutes *at least two-thirds* of the duration of the program, then the urban hospital may include the time the residents train *at that urban hospital* in determining GME payments. However, if the urban hospital rotates residents to rural areas for a period of time that is *less than two-thirds* of the duration of the program, although the rural hospital may count the time the residents train at the rural hospital if the program is new, the urban hospital may not include the time the residents train at the urban hospital for GME payment purposes (unless it can do so within the hospital's FTE cap).

When we first implemented this policy on rural tracks, it was consistent with our understanding of how the ACGME accredits rural track "1-2" programs, in which residents train for 1 year of the program at an urban hospital and are then rotated for training years 2 and 3 to a rural facility. We believed that the ACGME did not separately accredit an approved program as a rural track program unless it met this "1-2" condition; that is, the residents were spending one-third of program training in the urban area and two-thirds of the program training in the rural area. However, we have recently learned that there are a few rural track programs that are separately accredited by the ACGME as "1-2" rural track programs, but the residents in these programs are not training in rural areas for at least two-thirds of the duration of the program. We understand that in certain instances in which the case-mix of the rural facilities might not be sufficiently broad to provide the residents with an acceptable range of training opportunities, the ACGME allows the residents in program years 2 and 3 to return to the urban hospital for some training in both years. However, because the training in years 2 and 3 is predominantly occurring at the rural locations, the ACGME still separately accredits the urban and rural portions as a "1-2" program.

The existing regulations at §§ 412.105(f)(1)(x) and 413.86(g)(12) specify two main criteria for an urban hospital to count the time spent by residents training in a rural track while at the urban hospital in excess of the hospital's FTE limitation: (1) the program must be separately accredited by the ACGME; and (2) the time spent training in rural areas (either at a rural hospital or a rural nonhospital site) must constitute *at least two-thirds* of the duration of the program.

We believe that an urban hospital that operates a program that is separately accredited by the ACGME as a "1-2" program, but in which residents train in rural areas for more than half but less than two-thirds of the duration of the program, should still be allowed to count those FTE residents for GME payment purposes. Therefore, to be consistent with the ACGME accreditation practices, in the May 19, 2003 proposed rule, we proposed to revise our regulations. Proposed § 413.86(g)(12) still addressed our policy that an urban hospital qualifies for an adjustment to the FTE cap for training in rural areas based upon the proportion of time the residents spend training in the rural areas. However, instead of using "two-thirds" as the criterion to specify the amount of time residents training in the rural areas under regulations at §§ 413.86(g)(12)(i) through (iv) and 412.105(f)(1)(x), as under current policy, the proposal would use "one-half" as the criterion. This proposal addressed the limited cases where ACGME separately accredits programs as "1-2" rural tracks but residents in those programs train in the rural areas less than two-thirds of the time, although greater than one-half of the time. Specifically, we proposed at § 413.86(g)(12) to state:

- If an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital.
- If an urban hospital rotates residents to a separately accredited rural track program at a rural nonhospital site(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than one-half of the duration of the program for cost