

reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.86(f)(4).

- If an urban hospital rotates residents in the rural track program to a rural hospital(s) for less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the rural hospital may not include those residents in its FTE count (if the rural track is not a new program under § 413.86(g)(6)(iii), or if the rural hospital's FTE count exceeds that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation.

- If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for a period of time that is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less 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, subject to the requirements under § 413.86(f)(4).

We also proposed to make a conforming change to § 412.105(f)(1)(x) to make these proposed provisions applicable to IME payments for discharges occurring on or after October 1, 2003.

We believe the proposal produces a more equitable result than the existing policy; the proposal encompasses what we believe to be all situations in which the ACGME separately accredits rural track programs and in which residents in the programs spend a majority of the time training in rural settings, fulfilling the intent of Congress for Medicare to provide GME payments for significant rural residency training.

Comment: Several commenters supported our proposal that, effective for cost reporting periods beginning on or after October 1, 2003, an urban hospital would be allowed to include residents in its FTE count above its FTE cap for the time that the residents train at the urban hospital, if the residents rotate to a separately accredited rural track program in a rural area for more than one-half of the duration of the program. The commenters believed that this proposed policy better reflects Congressional intent to encourage training in rural areas, while allowing

residency programs the flexibility to rotate residents back to urban areas for needed clinical experiences that are not available in the rural setting.

One commenter recommended that the proposal should reduce the required rural training time even further, since research suggests that more than 50 percent of family practice residents who spend as little as 3 months training in rural areas end up practicing in rural settings.

Response: We agree with the commenters 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. However, we do not agree that urban hospitals should be allowed to receive an increase in their FTE caps to include residents in its FTE count for the time that the residents train at the urban hospital, if the residents rotate to a rural area for one-half or less than one-half of the duration of the program. As we stated in the August 1, 2001 **Federal Register** (66 FR 39904-39905), we interpret section 1886(h)(4)(H)(iv) of the Act as only allowing for an urban hospital to receive an adjustment under the rural track provision if the rural track program is "separately accredited." In order to be separately accredited as a rural track, the program must meet the ACGME's "1-2" criteria; that is, the residents are typically spending approximately two-thirds of the duration of the program in the rural area. We also explained that while we agree that post-residency retention in rural areas is important, we also believe it is important to prevent hospitals from receiving adjustments to their FTE caps in situations when only a nominal amount of training occurs in the rural area. Therefore, we are not adopting the commenter's request to allow an urban hospital to receive an increase in its FTE caps to include residents in its FTE count for the time that the residents train at the urban hospital, if the residents rotate to a rural area for one-half or less than one-half of the duration of the program.

Comment: One commenter that works for a community health center (CHC) that treats a high percentage of patients below the poverty line expressed concern about the detrimental effects that shrinking hospital revenues are having on the training of family practice residents at the CHC and at other rural and community-based settings. The commenter noted that doubling the number of CHCs is a goal of the

President, and urged that, if there should be further "restraint" on teaching programs, programs that expand into CHCs should be exempt from such restrictions.

Response: We appreciate the comment. However, we note that since we did not specifically make any proposals related to residency training in community health centers, this comment is outside the scope of this final rule. Therefore, we are not responding to it at this time.

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 Pub. L. 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