

Medicare patient load to determine Medicare direct GME payments).

Section 407(c) of Pub. L. 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.

In the May 19, 2003 proposed rule, we proposed 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 proposed 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.

*Comment:* Commenters supported our proposal to revise § 413.86(g)(5) to clarify that 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. The commenters stated that allowing immediate inclusion of rural track resident counts will serve to assist urban hospitals in their development of educational partnerships with rural hospitals.

*Response:* We appreciate the commenters support and, as explained below, are adopting revisions to the regulations concerning inclusion of rural track residents in the rolling average count of urban hospitals as final.

Except for new rural track programs begun by urban hospitals that are first establishing an FTE cap under § 413.86(g)(6)(i), or for rural hospitals that are establishing new rural track programs under § 413.86(g)(6)(iii), we are implementing sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to require that FTE residents that are counted by an urban hospital based on the residents’ participation in a rural track are included in the rolling average calculation. Accordingly, for IME and direct GME purposes, unless the rural track program is a new program under § 413.86(g)(13) and qualifies for a cap adjustment under § 413.86(g)(6)(i) or (g)(6)(iii), in instances where an urban hospital increases the number of residents it trains due to the establishment of a new or an expansion of an existing rural track program, the

additional FTE residents in the rural track program are only gradually included (over a 3-year period) in the urban hospital’s FTE count, since they are immediately included in the rolling average calculation of the urban hospital.

The following is an example of how residents in a rural track would be included in the rolling average calculation:

Assume that urban Hospital A, with a fiscal year end (FYE) date of June 30, had 10 unweighted FTE residents training in its cost reporting period ending June 30, 1996, thereby establishing an FTE cap of 10. Hospital A only trains primary care residents. In its cost reporting periods ending on June 30, 2002, and June 30, 2001, Hospital A again trained 10 FTE residents. However, in July 2002, Hospital A starts a rural training track program, adding 2 FTE residents. Since the additional rural track residents are included immediately in the rolling average, in FYE June 30, 2003, Hospital A’s FTE residents for payment purposes equal 10.67 FTEs  $(12 + 10 + 10 / 3)$  and not 12 FTEs  $[(10 + 10 + 10 / 3) + 2]$ , which would be the FTE count if FTEs in a rural track program were not subject to the rolling average calculation.

We are finalizing our proposed revision of § 413.86(g)(5) to add a new paragraph (vii) as explained above. In addition, we are finalizing our revision of §§ 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 the 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).