

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, in the May 19, 2003 proposed rule, we proposed 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 proposed to revise the regulations at § 413.86(b) to state “Medicare GME affiliated group,” and “Medicare GME affiliation agreement”. We proposed to make similar revisions to § 413.86(g)(4)(iv), (g)(7)(i) through (v), and § 412.105(f)(1)(vi) for IME payment purposes.

Comment: Commenters supported our proposal to change the terms “affiliated group” and “affiliation agreement”, as defined in § 413.86(b), to “Medicare GME affiliated group” and “Medicare GME affiliation agreement”, respectively. The commenters believed that the changes in terminology will help distinguish these terms from other affiliation agreements that are entered into by hospitals, medical schools, and other institutions that sponsor residency training.

Response: We agree with the commenters and are adopting as final the proposed changes throughout § 412.105 for IME and § 413.86 for direct GME.

Out of Scope Comments Relating to GME

Comment: Several comments addressed miscellaneous IME and direct GME issues, including the initial residency period (IRP) and volunteer physicians.

Response: Because we did not propose any changes in policy concerning these issues, we are unable to respond to these comments at this time. We will consider them for purposes of future rulemaking.

G. Updates to the Reasonable Compensation Equivalent (RCE) Limits (§ 415.70)

1. Background

Under the Medicare program, payment for services furnished by a physician is made under either the Hospital Insurance Program (Part A) or the Supplementary Medical Insurance Program (Part B), depending on the type of services furnished. In accordance with section 1848 of the Act, physicians' charges for medical or surgical services to individual Medicare patients generally are covered under Part B on a fee-for-service basis under the Medicare physician fee schedule. The compensation that physicians receive from or through a provider for services that benefit patients generally (for example, administrative services, committee work, teaching, and supervision) can be covered under Part A or Part B, depending on the provider's setting.

As required by section 1887(a)(2)(B) of the Act, allowable compensation for services furnished by physicians to providers that are paid by Medicare on a reasonable cost basis is subject to reasonable compensation equivalent (RCE) limits. Under these limits, payment is determined based on the lower of the actual cost of the services to the provider (that is, any form of compensation to the physician) or a reasonable compensation equivalent. For purposes of applying the RCE limits, physician compensation costs means monetary payments, fringe benefits, deferred compensation and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician's services.

The RCE limits do not apply to the costs of physician compensation that are attributable to furnishing inpatient hospital services paid under the IPPS or as GME costs. In addition, RCE limits do not apply to the costs CAHs incur in compensating physicians for services. Furthermore, compensation that a physician receives for activities that may not be paid under either Part A or Part B is not considered in applying the RCE limits.

The limits apply equally to all physician services to providers that are payable on a reasonable cost basis under Medicare. If a physician receives any compensation from a provider for his or her physician services to the provider (that is, those services that benefit patients generally), payment to those affected providers for the costs of such compensation is subject to the RCE

limits. The RCE limits are not applied to payment for services that are identifiable medical or surgical services to individual patients and paid under the physician fee schedule, even if the physician agrees to accept compensation (for example, from a hospital) for those services. (However, payments to teaching hospitals that have elected to be paid for these services on a reasonable cost basis in accordance with section 1861(b)(7) of the Act are subject to the limits.)

Section 415.70(b) of the regulations specifies the methodology for determining annual RCE limits, considering average physician incomes by specialty and type of location, to the extent possible using the best available data. On October 31, 1997, the revised RCE limits update methodology was published in the **Federal Register** (62 FR 59075). For cost reporting periods beginning on or after January 1, 1998, updates to the RCE limits are calculated using the Medicare Economic Index (MEI). The inflation factor used to develop the initial RCE limits and, subsequently, to update those limits to reflect increases in net physician compensation was the Consumer Price Index for All Urban Consumers (CPI-U). In 1998, we revised the update methodology for the RCE limits by replacing the CPI-U with the inflation factor for the physician fee schedule (the MEI) to achieve a measure of consistency in the methodologies employed to determine reasonable payments to physicians for direct medical and surgical services furnished to individual patients and reasonable compensation levels for physicians' services that benefit provider patients generally.

2. Updated RCE Limits

In the May 19, 2003 proposed rule, we indicated our intent to publish updated payment limits on the amount of allowable compensation for services furnished by physicians to providers in this FY 2004 IPPS final rule. These revised RCE limits are based on updated economic index data and replace the limits that were published in the **Federal Register** on May 5, 1997 (62 FR 24483). We calculated the revised RCE limits by using the methodology published in the **Federal Register** on October 31, 1997 (62 FR 59075). These limits are specified in the chart below and are effective for cost reporting periods beginning on or after January 1, 2004.

The revised RCE limits are mere updates that have been calculated by applying the most recent economic index data. In the proposed rule, we did