

costs to the Medicare program for this provision will be \$1 to \$2 million per year.

C. Prohibition Against Counting Residents Where Other Entities Have Previously Incurred the Training Costs

As we explain in section IV.F.2. of the preamble of this final rule, under section 1886(h) of the Act, hospitals may count the time that residents spend training in nonhospital sites if they meet certain conditions, including incurring "all or substantially all" of the costs of training at the nonhospital site. Legislative history indicates that the purpose of this provision is to encourage hospitals to provide more training outside the traditional hospital environment.

It has come to our attention that hospitals have been incurring the costs of and receiving direct GME and IME payment for residency training that had previously been occurring in nonhospital settings, without the financial support of the hospitals. We believe that where no new or additional training is provided in these nonhospital settings, the receipt of Medicare payment in such cases is contrary to Congressional intent and is, therefore, inappropriate. In addition, it violates Medicare's redistribution of costs and community support principles, which state that Medicare will not share in the costs of educational activities of a hospital that represent a redistribution of costs from a university or the community to the hospital. Accordingly, we are revising our policy concerning counting residents to ensure that, effective for portions of cost reporting periods occurring on or after October 1, 2003, Medicare GME payments are not made to hospitals for training that had already been in place in the absence of the hospital's financial support. However, we also are providing that, for an FTE resident who began training in a residency program on or before October 1, 2003, and with respect to whom there has been a redistribution of costs or community support, the resident may continue to be counted by a hospital as an FTE resident until the resident has completed training in that program, or until 3 years after the date the resident began training in that program, whichever comes first.

By prohibiting payment for residency training that had been previously supported by nonhospital institutions, this change will reduce the amount of direct GME and IME payments received by hospitals. Although we cannot estimate the impact on programs nationally, we are aware that two hospitals in New York were receiving over \$10 million annually for payments for dental residents training in nonhospital sites. Another hospital in Boston was receiving over \$2 million annually for dental residents training at a dental school.

D. Rural Track GME Training Programs

1. Reduction in the Time Required for Training Residents in a Rural Area

As explained in section IV.F.3. of the preamble of this final rule, under existing regulations, if an urban hospital rotates residents to a separately accredited rural track program in a rural area for two-thirds

of the duration of the training program, the urban hospital may receive an increase in its FTE cap to reflect the time those residents train at the urban hospital. When we first implemented these regulations, we did so based on our understanding that the Accreditation Council for Graduate Medical Education (ACGME) requires that at least two-thirds of the duration of the program be spent in a rural area. However, it has come to our attention that, while the ACGME generally follows a one-third/two-thirds model for accreditation, the rural training requirement is actually somewhat less than two-thirds of the duration of the program. Therefore, we are revising the regulations to state that if an urban hospital rotates residents to a separately accredited rural track program in a rural area for more than 50 percent of the duration of the training program, the urban hospital may receive an increase in its FTE cap to reflect the time those residents train at the urban hospital. We estimate that this provision will only slightly increase Medicare payments for IME and direct GME costs.

2. Inclusion of Rural Track FTE Residents in the Rolling Average Calculation

As explained in section IV.F.4. of the preamble of this final rule, when we first issued the regulations concerning residents training in a rural track program, we inadvertently did not specify in regulations that these residents would be included in the hospital's rolling average count of FTE residents used for computing GME payment. We are making this technical clarification to the regulations. We believe that this provision will not have a budget impact because it is a clarification of existing policy.

D. Impact of Application of RCE Limits

As discussed in section IV.G. of this final rule, we are updating the RCE limits by applying the most recent economic index. In this final rule, we are announcing an update of the limits, as required by § 415.70(f)(3) and does not alter any regulations or policy. The RCE limits apply only to providers paid on a reasonable cost basis and to compensation a physician receives from a provider for services that benefit patients generally or otherwise but that are not eligible for payment under the physician fee schedule. Also, the limits do not apply to costs of physician compensation that are attributable to furnishing inpatient hospital services paid under the IPPS or that are attributable to GME costs. In addition, RCE limits do not apply to the costs CAHs incur in compensating physicians for services. As a result of the application of the RCE limits, we estimate the costs associated with the updated limits for calendar year 2004 to be approximately \$11 million.

VIII. Impact of Changes in the Capital PPS

A. General Considerations

Fiscal year 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective

methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (see § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the capital Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the capital Federal rate (see § 412.344). As we state in section V. of the preamble of this final rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2004 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

In accordance with § 412.312, the basic methodology for determining a capital prospective payment system payment is: (Standard Federal Rate) × (DRG weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share (DSH) Adjustment Factor + Indirect Medical Education (IME) Adjustment Factor, if applicable).

In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the March 2003 update of the FY 2002 MedPAR file and the March 2003 update of the Provider Specific File that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the December 2002 update of the most recently available hospital cost report data (FY 2001) to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the March 2003 update of the FY 2002 MedPAR file, we simulated payments under the capital prospective payment system for FY 2003 and FY 2004 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general hospital inpatient prospective payment systems (Indian Health Service Hospitals and hospitals in Maryland) are excluded from the simulations.