infections among abdominal hysterectomy and colonic procedures performed at the applicable hospital. The pooled SSI SIR would be scored in the same manner as all measures finalized for the HAC Reduction Program (refer to Figure A in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50723), which is also included above in this proposed rule). To determine a Domain 2 score, we are proposing taking the average of the three CDC HAI SIR scores. We noted in the FY 2014 IPPS/LTCH PPS final rule that there will be instances in which applicable hospitals may not have data on all four measures and therefore a set of rules was finalized to determine how to score each Domain. We are proposing to follow the same finalized rules used to determine scoring of Domains 1 and 2 (FY 2014 IPPS/LTCH PPS final rule (78 FR 50723 through 50725)0 and the proposed changes in section IV.I.6.b. of this proposed rule. We invite public comments on this proposal.

In addition, for FY 2016 we are proposing to weight Domain 1 at 25 percent, and Domain 2 at 75 percent. We are proposing to decrease Domain 1's weight from 35 percent to 25 percent for two reasons. First, with the implementation of CDC's SSI measure, we believe the weighting of both domains needs to be adjusted to reflect the addition of a fourth measure; and second, in keeping with public comments from the FY 2014 IPPS/LTCH PPS final rule, MedPAC and others stated that Domain 2 should be weighted more than Domain 1. Finally, the Total HAC Score for applicable hospitals would be the sum of the weighted scores from Domain 1 (weighted at 25 percent) and Domain 2 (weighted at 75 percent). We invite public comments on this proposal.

f. Proposed Rules To Calculate the Total HAC Score for FY 2016

We are proposing to adopt the ''Proposed Clarification of FY 2015 Finalized Narrative of Rules to Calculate the Total HAC Score'' as discussed in section IV.I.3.e. of the preamble of this proposed rule. We invite public comments on this proposal.

7. Future Considerations for the Use of Electronically Specified Measures

We believe that collection and reporting of data through health information technology will greatly simplify and streamline reporting for many CMS quality reporting programs. Through electronic reporting, hospitals will be able to leverage EHRs to capture, calculate, and electronically submit quality data submitted to CMS for the Hospital IQR Program. CMS has become aware of some hospitals and health systems that have developed or adopted a methodology to identify and measure all-cause harm through their electronic health record (EHR) systems. Some hospitals and health systems are able to use the results of these electronic measures to address adverse events at the point of care and to track improvement over time. Many of these measures capture a broad range of common hospital-acquired conditions that may not be captured by existing national measures (examples include measures of adverse drug events and hypoglycemia). Given that these measures are captured using clinical data from EHR systems, collection of HAC data will allow CMS to align measures across multiple settings.

We are seeking comment as to whether the use of a standardized electronic composite measure of all-cause harm should be used in the HAC reduction program in future years in addition to, or in place of, claims-based measures assessing HACs. We welcome any suggestions of specific all-cause harm electronic measures, including detailed measure specifications. Specifically, we invite public comments on the feasibility and the perceived value of such a measure, and what would be the most appropriate weighting of this measure in the Total HAC Performance Score. In addition, we are requesting suggestions on the timeframe for which such standardized electronic composite measure of all-cause harm should be proposed.

We intend for the future direction of electronic quality measure reporting to significantly enhance the tracking of HACs under the HAC Reduction Program. We will continue to work with measure stewards and developers to develop new measure concepts, and conduct pilot, reliability and validity testing as part of efforts to promote the adoption of Certified Electronic Health Record Technology in hospitals.

K. Payments for Indirect and Direct Graduate Medical Education (GME) Costs (§§ 412.105 and 413.75 Through 413.83)

1. Background

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) and as currently implemented in the regulations at 42 CFR 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved graduate medical education (GME) programs. Section 1886(h)(2) of the Act sets forth a methodology for the determination of a hospital-specific base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable direct costs of GME in a base period by its number of full-time equivalent (FTE) residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, October 1, 1983 through September 30, 1984). The base year PRA is updated annually for inflation. In general, Medicare direct GME payments are calculated by multiplying the hospital's updated PRA by the weighted number of FTE residents working in all areas of the hospital complex (and at nonprovider sites, when applicable), and the hospital's Medicare share of total inpatient days.

Section 1886(d)(5)(B) of the Act provides for a payment adjustment known as the indirect medical education (IME) adjustment under the hospital inpatient prospective payment system (IPPS) for hospitals that have residents in an approved GME program, in order to account for the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment are located at 42 CFR 412.105. The hospital's IME adjustment applied to the DRG payments is calculated based on the ratio of the hospital's number of FTE residents training in either the inpatient or outpatient departments of the IPPS hospital to the number of inpatient hospital beds.

The calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count. Generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. Therefore, Congress, through the Balanced Budget Act of 1997 (Pub. L. 105–33), established a limit on the number of allopathic and osteopathic residents that a hospital may include in its FTE resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for direct GME in its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit based on the FTE count for IME during that cost reporting period is

applied effective for discharges occurring on or after October 1, 1997. Dental and podiatric residents are not included in this statutorily mandated cap.

The Affordable Care Act made a number of statutory changes relating to the determination of a hospital's FTE resident count for direct GME and IME payment purposes and the manner in which FTE resident limits are calculated and applied to hospitals under certain circumstances. Regulations implementing these changes are discussed in the November 24, 2010 final rule (75 FR 72133) and the FY 2013 IPPS/LTCH PPS final rule (77 FR 53416).

2. Proposed Changes in the Effective Date of the FTE Resident Cap, 3-Year Rolling Average, and Intern- and Resident-to-Bed (IRB) Ratio Cap for New Programs in Teaching Hospitals

Section 1886(h)(4)(H)(i) of the Act requires the Secretary to establish rules for calculating the direct GME caps for new teaching hospitals that are training residents in new medical residency training programs established on or after January 1, 1995. Under section 1886(d)(5)(B)(viii) of the Act, such rules also apply to the establishment of a hospital's IME cap on the number of FTE residents training in new programs. We implemented these statutory requirements in rules published in the August 29, 1997 **Federal Register** (62 FR 46002 through 46008) and in the May 12, 1998 **Federal Register** (63 FR 26323 through 26325 and 26327 through 26336). Generally, under existing regulations at 42 CFR 413.79(e)(1) (for direct GME) and 42 CFR 412.105(f)(1)(vii) (for IME), if a hospital did not train any allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins to participate in training residents in a new medical residency training program (allopathic or osteopathic) on or after January 1, 1995, the hospital's unweighted FTE resident cap (which would otherwise be zero) may be adjusted based on the sum of the product of the highest number of FTE residents in any program year during the third year of the first new program's existence, for each new residency training programs established during that 3-year period, and the minimum accredited length for each type of program. The number of FTE resident cap slots that a teaching hospital receives for each new program may not exceed the number of accredited slots that are available for each new program. Once a hospital's FTE resident cap is established, no subsequent cap adjustments may be made for new programs, unless the teaching hospital is a rural hospital. A rural hospital's FTE resident caps may be adjusted for participation in subsequent new residency training programs. A hospital that did not train any allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, may only receive a permanent FTE resident cap adjustment for training residents in a truly ''new'' residency training program; no permanent cap adjustment would be given for training residents associated with an existing program. That is, if a hospital that did not train any allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, serves as a training site for residents in a program that exists or existed previously at another teaching hospital that remains open, that ''new'' teaching hospital does not receive a ''new program'' cap adjustment because it is not participating in training residents in a truly ''new'' program. However, it may be possible for that ''new'' teaching hospital to receive a temporary cap adjustment if it enters into a Medicare GME affiliation agreement with the existing teaching hospital as specified at § 413.79(f) (for direct GME) and § 412.105(f)(1)(vi) (for IME). (For a detailed discussion of the distinctions between a new medical residency training program and an existing medical residency training program, we refer readers to the August 27, 2009 final rule (74 FR 43908 through 43920). For a detailed discussion regarding participation in Medicare GME affiliation agreements, we refer readers to 74 FR 43574.)

For new programs started prior to October 1, 2012, hospitals that did not yet have an FTE resident cap established had a ''3-year window'' in which to participate in and ''grow'' new programs, before the FTE resident caps for IME and direct GME were permanently set for the hospital beginning with the fourth program year of the first new program start. In the FY 2013 IPPS/LTCH PPS final rule (77 FR 53415 through 53425), we revised the regulations at § 413.79(e) to increase the cap-building period for new programs from 3 years to 5 years. That is, for a hospital that did not yet have an FTE resident cap established, the hospital's FTE resident cap is effective beginning with the sixth program year of the first new program's existence. This revised policy is effective for urban hospitals that first begin to participate in training residents in their first new program on or after October 1, 2012, and for rural hospitals that start a new program on or after October 1, 2012. In that final rule, we also finalized a methodology used to calculate a cap adjustment for an individual hospital if residents in a new program rotate to more than one hospital (or hospitals). The methodology is based on the sum of the products of the following three factors: (1) The highest total number of FTE residents trained in any program year, during the fifth year of the first new program's existence at all of the hospitals to which the residents in that program rotate; (2) the number of years in which residents are expected to complete the program, based on the minimum accredited length for each type of program; and (3) the ratio of the number of FTE residents in the new program that trained at the hospital over the entire 5-year period to the total number of FTE residents that trained at all hospitals over the entire 5-year period. Finally, we made minor revisions to the regulation text at §§ 413.79(e)(2) through (e)(4) for purposes of maintaining consistency throughout § 413.79(e). We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53415 through 53425) for further details regarding the methodology for calculating the FTE resident caps.

While the FY 2013 IPPS/LTCH PPS final rule discussed the methodology for calculating the FTE resident caps to be effective beginning with the sixth program year of the first new program's existence, for hospitals that do not yet have FTE resident caps established, that final rule did not discuss when the 3-year rolling average for IME and direct GME or the intern- and resident-to-bed (IRB) ratio cap for IME is effective for FTE residents training in new programs. The regulations regarding the 3-year rolling average and the IRB ratio cap with respect to new medical residency training programs were established in the following **Federal Register** rules: the FY 1998 IPPS final rule with comment period (62 FR 46002 through 46008); the May 12, 1998 final rule (63 FR 26323 through 26325 and 26327 through 26336); FY 2000 IPPS final rule (64 FR 41518 through 41523); and the FY 2002 IPPS final rule (66 FR 39878 through 39883). Specifically, the regulations at § 412.105(f)(1)(v) regarding the 3-year rolling average and new medical residency training programs for IME state: ''If a hospital qualified for an adjustment to the limit established under paragraph (f)(1)(iv) of this section for new medical residency programs created under paragraph (f)(1)(vii) of

this section, the count of residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph (f)(l)(v) for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph, for each new program started, the period of years equals the minimum accredited length for each new program. The period of years for each new program begins when the first resident begins training in each new program.'' In addition, the regulations for the interaction of the IRB ratio cap and new medical residency training programs for IME at § 412.105(a)(1)(ii) state: ''The exception for new programs described in paragraph (f)(1)(vii) of this section applies to each new program individually for which the full-time equivalent cap may be adjusted based on the period of years equal to the minimum accredited length of each new program.''

The regulations at § 413.79(d)(5) regarding the interplay of the 3-year rolling average with new medical residency training programs for direct GME similarly state: ''If a hospital qualifies for an adjustment to the limit established under paragraph (c)(2) of this section for new medical residency programs created under paragraph (e) of this section, the count of the residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph (d), for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph (d), for each new program started, the period of years equals the minimum accredited length for each new program. The period of years begins when the first resident begins training in each new program.''

Therefore, the FTE resident caps for IME and direct GME are *always* effective beginning with the start of the sixth program year of the first new program started for urban hospitals that do not yet have FTE resident caps established (§ 413.79(e)(1)(iii)), and for rural hospitals, beginning with the start of the sixth program year of each new individual program started (§ 413.79(e)(3)), regardless of the fact that other new programs may have started after the start of the first new program. However, the timing of when the 3-year rolling average for IME and direct GME and the IRB ratio cap for IME are first applied is dependent upon the minimum accredited length of each new program started within the 5-year window. For example, new teaching Hospital A participates in training residents in new medical residency training programs for the first time beginning on July 1, 2013. On July 1, 2013, Hospital A participates in training residents in a new family medicine program (minimum accredited length is 3 years), on July 1, 2014, it also participates in training residents in a new sports medicine fellowship (minimum accredited length is 1 year), and on July 1, 2015, it also participates in training residents in a new general surgery program (minimum accredited length is 5 years). For the purpose of establishing Hospital A's FTE resident caps, the 5-year growth window for Hospital A closes on June 30, 2018, and the IME and direct GME FTE resident caps for Hospital A are effective on July 1, 2018, the beginning of the sixth program year of the first new program's existence; that is, family medicine. However, the 3-year rolling average and the IRB ratio cap are effective at different points in time. Because the family medicine residency is 3 years in length, FTE residents in the new family medicine program are subject to the 3-year rolling average and the IRB ratio cap beginning on July 1, 2016. Because the sports medicine fellowship is a 1-year program, and it started on July 1, 2014, the number of sports medicine FTE residents must be included in the 3-year rolling average and is subject to the IRB ratio cap effective on July 1, 2015. Lastly, the FTE residents in the new general surgery program would only be subject to the rolling average and the IRB ratio cap effective July 1, 2020. The Medicare cost report worksheets on CMS Form 2552–10 for IME (Worksheet E, Part A) and for direct GME (Worksheet E–4) currently can accommodate reporting of FTE residents separately based on whether those FTE residents are in new medical residency training programs and are not subject to the FTE resident cap (line 16 of Worksheet E, Part A, and line 15 of Worksheet E–4). However, these cost report worksheets are not designed to accommodate reporting of FTE residents that are exempt from the FTE resident cap, but *are* subject to the rolling average and IRB ratio cap, because the ''period of years'' equal to the minimum accredited length of each new program started has already expired. The reverse also may occur, as in the example above with the new general surgery program started by Hospital A, where the FTE resident caps are effective July 1, 2018, but the number of FTE residents in the general surgery program would not be subject to the rolling average or the IRB ratio cap until July 1, 2020. Complicating matters further is the fact that, while the effective dates of these policies associated with new medical residency training program FTE residents are effective on a program year basis (that is, July 1), many teaching hospitals do not have a fiscal year that begins on July 1. Therefore, under the existing policy, the number of FTE residents needs to be prorated, and special accommodations need to be made to calculate the portion of FTE residents that are subject to the FTE resident cap, the 3-year rolling average, and the IRB ratio cap for the respective portions of the hospital's cost reporting period occurring on and after July 1. Integrating the rolling average, the IRB ratio cap, and the FTE resident caps for residents in new medical residency training programs in an accurate manner on the Medicare cost report has proved challenging to the point where we have had to deal with each instance brought to our attention by the new teaching hospital or by a Medicare contractor on an individual and manual basis (in order to ensure application of a consistent methodology). In fact, the Medicare cost report instructions direct the hospital to do the following: for CMS Form 2552–10, Worksheet E, Part A, line 10—''. . . Contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. . . .''; for CMS Form 2552–10, Worksheet E–4, line 6—''. . . Contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or greater than 3 years. . . .''

The Medicare contractors, in turn, have been instructed to contact CMS for instructions on how to report the number of FTE residents that are still within the ''period of years'' of the new program. The ''three years'' referenced in the Form 2552–10 cost report instructions are based on the 3-year growth window for new medical residency training programs that is in effect for new programs started prior to October 1, 2012, when, within the 3-year growth window, new teaching hospitals also may have started new

medical residency training programs with different minimum accredited lengths. (We note that while the previous Form 2552–96 cost report did not include the same instructions, CMS did deal with the reporting of the number of FTE residents in new medical residency training programs on an individual basis when requests for assistance were brought to its attention.) However, these instructions also apply for new medical residency training programs started with different minimum accredited lengths on and after October 1, 2012.

In this proposed rule, we are proposing to simplify and streamline the timing of when FTE residents in new medical residency training programs are subject to the FTE resident cap, the 3-year rolling average, and the IRB ratio cap, both for urban teaching hospitals that have not yet had FTE resident caps established under § 413.79(e)(1) and for rural teaching hospitals that may or may not have FTE resident caps established under § 413.79(e)(3). That is, we are proposing that the methodology for calculating the FTE resident caps for hospitals that participate in training residents in new medical residency training programs would continue to be the same methodology instituted in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53415 through 53425) for new medical residency training programs started on or after October 1, 2012, specified at § 413.79(e)(1). However, once the FTE resident caps are calculated, we are proposing to change the timing of when the FTE resident caps would be effective, to synchronize the effective dates and the application of the 3-year rolling average and the IRB ratio cap with each applicable hospital's fiscal year begin date. Specifically, we are proposing that the FTE resident caps would continue to be calculated as finalized in the FY 2013 IPPS/LTCH PPS final rule—the methodology is based on the sum of the products of the following three factors: (1) The highest total number of FTE residents trained in any program year, during the fifth year of the first new program's existence at all of the hospitals to which the residents in that program rotate; (2) the number of years in which residents are expected to complete the program, based on the minimum accredited length for each type of program; and (3) the ratio of the number of FTE residents in the new program that trained at the hospital over the entire 5-year period to the total number of FTE residents that trained at all hospitals over the entire 5-year period. However, once calculated in this manner, we are proposing that, instead of the FTE resident caps being effective beginning with the sixth program year of the first new program start, those *FTE resident caps, rolling average, and IRB ratio cap would be effective beginning with the applicable hospital's cost reporting period that precedes the start of the sixth program year of the first new program started.* Using the example of Hospital A that we presented earlier, assume Hospital A has a January 1 to December 31 cost reporting year. The first new program started, family medicine, was started on July 1, 2013. A sports medicine fellowship and a general surgery program also were started timely within the 5-year growth window. Hospital A has 5 program years to grow its FTE resident caps, from July 1, 2013 through June 30, 2018. The FTE resident caps would be calculated based on the 5 program years in accordance with the methodology established at § 413.79(e)(1) in the FY 2013 IPPS/LTCH PPS final rule; therefore, the hospital would wait until after June 30, 2018 to obtain the FTE counts to calculate the FTE resident caps. However, we are proposing that those IME and direct GME FTE resident caps, once calculated after June 30, 2018, instead of being effective on July 1, 2018, *would be effective at the beginning of Hospital A's cost reporting period that precedes July 1, 2018; that is, the FTE resident caps for Hospital A would be effective permanently on January 1, 2018, the start of Hospital A's cost reporting period that precedes the start of the sixth program year of the first new program started.* The hospital could file its fiscal year end December 31, 2018 cost report including the FTE resident caps applicable to the entire cost reporting period accordingly.

As noted earlier, we are proposing that, for all new medical residency training programs in which the hospital participates during the 5-year growth window, the FTEs in those new programs also would be subject to the 3-year rolling average and the IRB ratio cap simultaneously with the effective date of the FTE resident caps, at the beginning of the applicable hospital's cost reporting period that precedes the beginning of the sixth program year of the first new program started. Again, using the example of Hospital A that we presented earlier, the FTE residents in the family medicine program, the sports medicine fellowship, and the general surgery program would all be subject to the 3-year rolling average and IRB ratio cap beginning on January 1, 2018. With regard to reporting on the Medicare cost report, for Hospital A's fiscal year end dates of December 31, 2013 through and including December 31, 2017, we are proposing that the number of FTE residents in the family medicine program, the sports medicine fellowship, and the general surgery program would be reported so as *not* to be included in the IME rolling average or the IRB ratio cap, and so as *not* to be included in the direct GME rolling average. (On the CMS Form 2552–10, for Hospital A's fiscal year end dates of December 31, 2013 through and including December 31, 2017, this means that the number of FTE residents in the family medicine program, the sports medicine fellowship, and the general surgery program would be reported on Worksheet E, Part A, line 16, and on Worksheet E–4, line 15). However, on Hospital A's cost report for fiscal year ending December 31, 2018, the number of FTE residents in these three programs would be subject to the FTE resident cap, the 3-year rolling average, and the IRB ratio cap, and would be reported accordingly. (On the CMS Form 2552–10, for Hospital A's cost report for fiscal year ending December 31, 2018, this means that none of the FTE residents in these three programs would be reported on Worksheet E, Part A, line 16 for IME, and Worksheet E–4, line 15 for direct GME. Instead, all of the FTE residents would be reported on Worksheet E, Part A, line 10 for IME, and Worksheet E–4, line 6 for direct GME, in order to be subject to the FTE resident cap, the 3-year rolling average, and the IRB ratio cap.) We note that once the 3-year rolling average is effective in that cost reporting period that includes the sixth program year of the first new program started, the number of FTE residents in the new programs also must be reported both as part of the prior year FTE resident counts and the penultimate FTE resident counts, in order to effectuate the 3-year rolling average calculation on the IME Worksheet E, Part A, and the direct GME Worksheet E–4, respectively.

In the example that we presented earlier, Hospital A has a fiscal year that begins on January 1. If Hospital A's fiscal year begin date would have been October 1, then, as proposed, while the sixth program year of the first new program started would still be July 1, 2018, the FTE residents caps, the 3-year rolling average, and the IRB ratio cap would be effective on October 1, 2017, the fiscal year begin date that precedes July 1, 2018, the sixth program year. If Hospital A's fiscal year begin date would have been July 1, the FTE

residents caps, the 3-year rolling average, and the IRB ratio cap would instead be effective on July 1, 2017, the fiscal year begin date that precedes July 1, 2018, the sixth program year.

We understand that this proposal, if finalized, would reduce the amount of time that the new medical residency training programs would be exempt from the FTE resident caps. However, even though we are proposing to make the effective date of the FTE resident caps earlier than under current policy, because we also are proposing that the calculation of the FTE resident caps would still be based on the highest total number of FTE residents trained in any program year, during the fifth year of the first new program's existence at all of the hospitals to which the residents in that program rotate, a new teaching hospital would still have the full 5 program years to grow its program(s), and its FTE resident caps would reflect a full 5 years of growth. Therefore, because, by the fifth program year, a program should, in most typical circumstances, have grown to its full capacity, barring unusual circumstances, the FTE resident caps that would take effect under the proposed policy at the beginning of the fiscal year that precedes the sixth program year should accommodate the FTE resident count training in the fifth and subsequent program years. Therefore, we believe that this proposal to streamline and synchronize the effective dates of the FTE resident caps, the 3-year rolling average, and the IRB ratio cap not only is easier to comprehend and to implement, but also is reasonable and equitable in its effect on the IME and direct GME payments of hospitals establishing FTE resident caps. Specifically, if this proposal is finalized, there would no longer be a need for CMS Form 2552–10, Worksheet E, Part A, line 10 and Worksheet E–4, line 6 to instruct hospitals to contact their contractor for instructions on how to complete those lines, as both hospitals and Medicare contractors would understand how to report the number of FTE residents in new programs, even when those programs have different accredited lengths. Instead, hospitals and Medicare contractors would follow the methodology instituted in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53415 through 53425) to calculate the FTE resident caps for new medical residency training programs started on or after October 1, 2012, and once the FTE resident caps are calculated, hospitals and Medicare contractors would implement the FTE resident caps, the 3-year rolling average, and the IRB ratio cap effective beginning with the applicable hospital's cost reporting period that precedes the start of the sixth program year of the first new program started. Under this proposed methodology, FTE residents and FTE resident caps would no longer need to be prorated, and we would no longer need to make special accommodations to calculate the portion of FTE residents that are subject to the FTE resident cap, the 3-year rolling average, and the IRB ratio cap for the respective portions of the hospital's cost reporting period occurring on and after July 1. The existing CMS Form 2552–10 already accommodates this proposed methodology, unlike the complicated process currently in place. Thus, clarity, efficiency, and payment accuracy would be improved for hospitals, contractors, and CMS.

With regard to rural hospitals that, under § 413.79(e)(3) of the regulations, may receive FTE resident cap adjustments at any time for participating in training residents in new programs, we are proposing a similar policy, with modifications reflecting the fact that each new program in which the rural hospital participates receives its own 5-year growth window before the rural hospital's FTE resident cap is adjusted based on that new program. That is, we are proposing that, for rural hospitals, the FTE resident caps, the 3-year rolling average, and the IRB ratio cap *for each new program started would be effective beginning with the applicable hospital's cost reporting period that precedes the start of the sixth program year of each new program started.* For example, rural Hospital B has a fiscal year that begins on January 1. It starts a family medicine program on July 1, 2013, and a general surgery program on July 1, 2016. The sixth program year for the family medicine program begins on July 1, 2018. The sixth program year for the general surgery program begins on July 1, 2021. With regard to Medicare cost reporting, during Hospital B's fiscal years end dates of December 31, 2013 through and including December 31, 2017, the number of family medicine FTE residents would be reported so as *not* to be included in the IME 3-year rolling average or the IRB ratio cap, and so as *not* to be included in the direct GME 3-year rolling average. (This means that on CMS Form 2552–10, during Hospital B's fiscal year end dates of December 31, 2013 through and including December 31, 2017, the number of family medicine FTE residents would be reported on Worksheet E, Part A, line 16 for IME, and on Worksheet E–4, line 15, for direct GME. Instead, the number of family medicine FTE residents would be reported on Worksheet E, Part A, line 16, and Worksheet E–4, line 15.) Then, beginning with Hospital B's cost report for fiscal year ending December 31, 2018, the number of FTE residents in *only the family medicine program* would be subject to the FTE residents caps, the 3-year rolling average, and the IRB ratio cap, and would be reported accordingly in order to be subject to the FTE resident cap, the 3-year rolling average, and the IRB ratio cap. (This means that on CMS Form 2552–10, beginning with Hospital B's cost report ending December 31, 2018, the number of family medicine FTE residents would be reported on Worksheet E, Part A, line 10 for IME, and Worksheet E–4, line 6 for direct GME.) Because the general surgery program started on July 1, 2016, for Hospital B's fiscal year end dates of December 31, 2016 through and including fiscal year end date of December 31, 2020, the number of general surgery FTE residents would be reported (on Worksheet E, Part A, line 16) so as *not* to be included in the IME 3-year rolling average or the IRB ratio cap, and (on Worksheet E–4, line 15), so as *not* to be included in the direct GME 3-year rolling average. Then, beginning with Hospital B's cost report for fiscal year ending December 31, 2021, the number of FTE residents in the *general surgery program* would be subject to the FTE resident caps, the 3-year rolling average, and the IRB ratio cap, and would be reported accordingly (on Worksheet E, Part A, line 10 for IME, and Worksheet E–4, line 6 for direct GME), in order to be subject to the FTE resident cap, the 3-year rolling average, and the IRB ratio cap. We note that once the 3-year rolling average is effective in that cost reporting period that includes the sixth program year of each new program started, the number of FTE residents in the new programs also must be reported as part of the prior year FTE resident counts, and the penultimate FTE resident counts, in order to effectuate the 3-year rolling average calculation on the IME Worksheet E, Part A, and the direct GME Worksheet E–4, respectively.

We are proposing that this policy regarding the effective dates of the FTE residency caps, the 3-year rolling average, and the IRB ratio cap for FTE residents in new medical residency training programs would be consistent with the methodology for calculation of the FTE resident caps as described in the FY 2013 IPPS/LTCH PPS final rule, and implemented in the regulations at

§§ 413.79(e)(1) and (e)(3). That is, because the policy providing a 5-year growth period for establishing the FTE resident caps (§§ 413.79(e)(1) and (e)(3)) is effective for new programs started on or after October 1, 2012, this proposal is effective for urban hospitals that first begin to participate in training residents in their first new medical residency training program, and for rural hospitals, on or after October 1, 2012. We also are proposing to revise the regulations for IME and direct GME, respectively, at § 412.105(a)(1)(ii) for the IME IRB ratio cap, at § 412.105(f)(1)(v) for the IME 3-year rolling average, and at § 413.79(d)(5) for the direct GME 3-year rolling average to reflect that the exception from the IRB ratio cap and the 3-year rolling average for new programs applies to each new program individually during the cost reporting periods prior to the beginning of the applicable hospital's cost reporting period that precedes the start of the sixth program year of the first new program started, for hospitals for which the FTE cap may be adjusted in accordance with § 413.79(e)(1), and prior to the beginning of the applicable hospital's cost reporting period that precedes the start of the sixth program year of each individual new program started, for hospitals for which the FTE cap may be adjusted in accordance with § 413.79(e)(3). After the applicable hospital's cost reporting period that precedes the start of the sixth program year of the first new program started for hospitals for which the FTE cap may be adjusted in accordance with § 413.79(e)(1), and after the applicable hospital's cost reporting period that precedes the start of the sixth program year of each individual new program started for hospitals for which the FTE cap may be adjusted in accordance with § 413.79(e)(3), FTE residents participating in new medical residency training programs are included in the hospital's IRB ratio cap and the 3-year rolling average.

3. Proposed Changes to IME and Direct GME Policies as a Result of New OMB Labor Market Area Delineations

a. New Program FTE Resident Cap Adjustment for Rural Hospitals Redesignated as Urban

As stated earlier in this proposed rule, under existing regulations, a new teaching hospital that starts training residents for the first time on or after October 1, 2012, has 5 years from when it first begins training residents in its first new program to build its FTE resident cap. If the teaching hospital is a rural teaching hospital, it can continue to receive permanent cap adjustments for training residents in new programs after the initial 5-year cap-building period that applies to new teaching hospitals ends. (We refer readers to section IV.K.2. of the preamble of this proposed rule for a discussion of our proposal to change the effective dates for when the FTE resident cap, the 3-year rolling average, and the IRB ratio cap are applied to new teaching hospitals and to new programs at rural teaching hospitals.)

In section III.B. of the preamble of this proposed rule, we discuss the policies we are proposing to implement as a result of the new OMB labor market area delineations announced in the February 28, 2013 OMB Bulletin No. 13–01. As a result of the new OMB delineations, some teaching hospitals may be redesignated from being located in a rural area to an urban area, thereby losing their ability to increase their FTE resident caps for new programs started after their initial 5-year cap-building period ends. We have been asked whether a rural teaching hospital that already has a cap and is redesignated as urban while it is in the process of establishing another new program(s) can still receive a permanent cap adjustment for that new program(s). We believe that because the hospital had already started training residents in the new program(s) while it was rural, the former rural hospital should be permitted to continue building its new program(s) and receive a permanent FTE resident cap adjustment for that new program(s). Therefore, we are proposing to revise the regulations to allow a hospital that was rural as of the time it started training residents in a new program(s) and is redesignated as urban for Medicare payment purposes during its cap-building period for that program(s) to be able to continue building that program(s) for the remainder of the cap-building period and receive a permanent FTE resident cap adjustment for that new program(s). Once the cap-building period for the new program(s) that was started while the hospital was still rural expires, the teaching hospital that has been redesignated as urban would no longer be able to receive any additional permanent cap adjustments. We are proposing that the teaching hospital must be actively training residents in the new program while it is still rural, that is, prior to the redesignation taking effect, in order for the hospital to continue receiving a cap adjustment for the new program. For example, if a rural hospital begins training residents in a new internal medicine program on July 1, 2013, and begins training residents in a new general surgery program on July 1, 2014, and the rural hospital is redesignated as urban effective on October 1, 2014, the teaching hospital would be able to continue receiving a cap adjustment for both the new internal medicine program and the new general surgery program after it has been redesignated as urban. However, if the rural hospital is redesignated as urban effective on October 1, 2014, and started training residents in a new internal medicine program on July 1, 2013, but did not start training residents in a new general surgery program while it was still rural, that is, prior to October 1, 2014, the teaching hospital would receive a permanent cap adjustment for the new internal medicine program, but would not receive a cap adjustment for the new general surgery program. We are proposing to revise the regulations at § 412.105(f)(1)(iv)(D) for IME and § 413.79(c)(6) for direct GME to implement this proposed change. We are proposing that these regulatory revisions be effective for cost reporting periods beginning on or after October 1, 2014. The proposed regulations at § 412.105(f)(1)(iv)(D) read as follows: ''A rural hospital redesignated as urban after September 30, 2004, as a result of the most recent census data and implementation of the new labor market area definitions announced by OMB on June 6, 2003, may retain the increases to its FTE resident cap that it received under paragraphs (f)(1)(iv)(A) and (f)(1)(vii) of this section while it was located in a rural area. Effective for cost reporting periods beginning on or after October 1, 2014, if a rural hospital is redesignated as urban due to the most recent OMB standards for delineating statistical areas adopted by CMS and was training residents in a new program prior to the redesignation becoming effective, the redesignated urban hospital may retain any existing increases to its FTE resident cap and receive an increase to its FTE resident cap for the new program in which it was training residents when the redesignation became effective, in accordance with paragraph (f)(1)(vii) of this section.'' The proposed regulations at § 413.79(c)(6) read as follows: ''A rural hospital redesignated as urban after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003, may retain the increases to its FTE resident cap that it received under paragraphs (c)(2)(i), (e)(1)(iii), and (e)(3) of this section while it was located in a rural area. Effective for cost reporting

periods beginning on or after October 1, 2014, if a rural hospital is redesignated as urban due to the most recent OMB standards for delineating statistical areas adopted by CMS, and was training residents in a new program prior to the redesignation becoming effective, the redesignated urban hospital may retain any existing increases to its FTE resident cap, and receive an increase to its FTE resident cap for the new program in which it was training residents when the redesignation became effective, in accordance with paragraph (e) of this section.''

b. Participation of Redesignated Hospital in Rural Training Track

To encourage the training of residents in rural areas, section 407(c) of Public Law 106–113 amended section1886(h)(4)(H) of the Act to add a provision that, in the case of a hospital that is not located in a rural area (an urban hospital) that establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the urban hospital's cap on the number of FTE residents under subparagraph (F), in an appropriate manner in order to encourage training of physicians in rural areas. Section 407(c) of Public Law 106–113 was made effective for direct GME payments to hospitals for cost reporting periods beginning on or after April 1, 2000, and for IME payments applicable to discharges occurring on or after April 1, 2000. We refer readers to the August 1, 2000 interim final rule with comment period (65 FR 47033 through 47037) and the FY 2002 IPPS final rule (66 FR 39902 through 39909) where we implemented section 407(c) of Public Law 106–113.

The regulations at § 413.79(k) specify that, subject to certain criteria, an urban hospital may count the FTE residents in the rural track in addition to those FTE residents subject to its cap up to a ''rural track FTE limitation'' for that hospital. In the FY 2006 IPPS final rule, we revised the regulations at § 413.79(k) to add a new paragraph (7) to state that if an urban hospital had established a rural track program with a rural hospital and that hospital subsequently becomes urban due to the implementation of the new labor market area definitions announced by OMB on June 6, 2003, the urban hospital may continue to adjust its FTE resident limit for rural track programs established before the implementation of the new labor market area definitions. We also stated that, in order for the urban hospital to receive a cap adjustment for a new rural track program, the urban hospital must establish a rural track program with hospitals that are designated rural based on the most recent geographical location designations adopted by CMS (70 FR 47456; 47489).

As discussed earlier in this section, we are proposing to implement, effective October 1, 2014, the new OMB labor market area delineations announced in the February 28, 2013 OMB Bulletin No. 13–01. As a result of the new delineations, certain areas can be redesignated from urban to rural or from rural to urban, which may, in turn, affect GME policies that require the participation of rural teaching hospitals. For example, as noted above, in order for an urban teaching hospital to receive a FTE resident cap adjustment for training residents in a rural track, the residents must rotate for more than one-half of the duration of the program to a rural hospital(s) or rural nonprovider(s) site. We have received a question as to what happens to a rural track when a rural hospital that is participating as the rural site is redesignated as urban, while the rural track for the urban hospital is in the process of being established. That is, what happens to the rural track when the rural hospital is redesignated as urban during the period that is used to establish the urban hospital's rural track FTE limitation, *prior* to the effective date of the urban hospital's rural track FTE limitation being established?

Existing regulations at § 413.79(k)(7) address the scenario where a rural hospital that is participating as the rural site is redesignated as urban, *after* the rural track FTE limitation for the urban hospital has already become effective. Specifically, the regulations at § 413.79(k)(7) state that if an urban hospital had established a rural track with a hospital located in a rural area and that rural area subsequently becomes an urban area due to the most recent census data and implementation of new labor market area definitions announced by OMB June 6, 2003, the urban hospital may continue to adjust its FTE resident limit for the rural track programs established prior to the adoption of the new labor market area definitions. Therefore, consistent with the existing regulations at § 413.79(k)(7) and with our proposal to allow rural hospitals redesignated as urban to continue receiving a FTE resident cap adjustment for new programs that started while the redesignated hospital was still rural, we are proposing to revise the existing regulations applicable to urban hospitals generally. Specifically, we are proposing to address the status of the ''original'' urban hospital's rural track FTE limitation, in the situation where a rural hospital that is participating in the original urban hospital's rural track is located in an area redesignated by OMB as urban *during the 3-year period* that is used to calculate the urban hospital's rural track FTE limitation. We are proposing that, in these situations, the original urban hospital's opportunity to receive a rural track FTE limitation would not be negatively impacted by the fact that the rural hospital with which it has partnered to be the rural site for its rural training track is located in an area redesignated by OMB as urban *during the 3-year period* that is used to calculate the urban hospital's rural track FTE limitation. That is, we are proposing that the original urban hospital may receive a rural track FTE limitation for that new rural track program.

With regard to the status of the rural hospital that is partnered with the urban hospital to serve as a rural training site for the rural training track program, as mentioned earlier, existing regulations at § 413.79(k)(7) address the scenario where a rural hospital that is participating as the rural site is redesignated as urban, *after* the rural track FTE limitation for the urban hospital has already become effective. (We note that we are proposing to apply the existing policy at § 413.79(k)(7), which applies to redesignations that occurred on June 6, 2003, in a similar manner, to redesignations announced by OMB after June 6, 2003, as well.) In addition, we are proposing that once the rural hospital is redesignated as located in an urban area due to the implementation of the new OMB labor market area delineations, regardless of whether that redesignation occurs during the 3-year period that is used to establish the rural track FTE limitation for the urban hospital, or after the 3-year period that is used to establish the rural track FTE limitation for the urban hospital, the redesignated urban hospital can no longer qualify as the rural site and the ''original'' urban hospital would not be able to count those residents under its rural track FTE limitation if it continues to use the redesignated urban hospital as the rural site for purposes of the rural track. However, because the redesignated urban hospital was rural when residents started training in the rural track, we are proposing to provide for a 2-year transition period during which either of the following two conditions must be met in order for the ''original'' urban hospital to be able to count the residents under its rural track FTE limitation

when the 2-year transition period ends: (1) the redesignated newly urban hospital must reclassify back to rural under § 412.103 of the regulations; or (2) the ''original'' urban hospital must find a new geographically rural site to participate as the rural site for purposes of the rural track. We note that we are proposing to apply these two criteria both in the case where the rural hospital is redesignated as urban *after* the urban hospital already has its rural track FTE limit established, and also in the case where the rural hospital is redesignated as urban *during* the 3-year period when the rural track program is still growing, *prior* to the rural track FTE limit being established. This 2-year transition period would begin when new OMB labor market area delineations take effect for Medicare payment purposes and would end exactly 2 years from that date. During this 2-year transition period, we would hold the ''original'' urban hospital harmless and would pay the ''original'' urban hospital for the FTE residents in the rural track. At the end of the 2-year transition period, in order for the urban hospital to receive payment for a rural track program under § 413.79(k)(1) or (k)(2), either the redesignated urban hospital must be granted reclassification as rural under § 412.103 or the ''original'' urban hospital must already be training FTE residents at a geographically rural site. We note that, because the rural reclassification provision of § 412.103 only applies to IPPS hospitals and for purposes of section 1886(d) of the Act, it only applies to IPPS hospitals for IME payment purposes and not for direct GME payment purposes because direct GME is authorized under section 1886(h) of the Act. Therefore, if the redesignated hospital reclassifies as rural under § 412.103, the ''original'' urban hospital would only be able to count FTE residents towards its rural track FTE limitation for IME payment purposes, but not for direct GME payment purposes. In addition, we note that this discussion has centered on the scenario where a rural hospital that is the rural site for purposes of the rural track has been redesignated as urban. Under such a scenario, the redesignated urban hospital does have an option to reclassify as rural. However, as noted above, the reclassification only applies to IPPS hospitals for IME payment purposes. If a nonprovider site is functioning as the rural site under § 413.79(k)(2) for purposes of the rural track and the area where that nonprovider site is located is redesignated as urban, the nonprovider site would not have the option of reclassifying as rural and, therefore, the ''original'' urban hospital would be required to find a new geographically rural site within the 2-year transition period in order for the ''original'' urban hospital to receive payment for a rural track program under § 413.79(k)(1) or (k)(2).

The following examples illustrate how the proposed policy would be applied to a rural track in which the rural site is a hospital and the rural hospital has been redesignated as urban:

- An urban teaching hospital and a rural teaching hospital are participating in training residents in a new rural track program that begins July 1, 2014. Effective October 1, 2014, the rural hospital is redesignated as urban. We are proposing that the timeframe for the urban hospital to build the rural track program for purposes of calculating its rural track FTE limitation would continue to be through June 30, 2017. During the time period of October 1, 2014 to September 30, 2016, the redesignated urban hospital would continue participating as a rural hospital and the urban hospital would count FTE residents it is training that are in the rural track for IME and direct GME. However, in order for the ''original'' urban hospital to continue to get paid for its rural track program after September 30, 2016, then, by September 30, 2016, the redesignated urban hospital must either reclassify as rural under § 412.103 of the regulations for purposes of IME payment only, or the urban hospital must find a new geographically rural hospital or nonprovider site to train the residents in the rural track for more than one-half of their training. If neither of these conditions is met, by September 30, 2016, the ''original'' urban hospital would not able to receive payment for that specific program as a rural training track under § 413.79(k)(1) or (k)(2) because it would no longer meet the requirement that more than one-half of the training must be provided in a rural setting.
- Another scenario could be one in which the rural hospital is redesignated as urban after the 3-year cap-building period for the rural track has passed. For example, the rural track program began July 1, 2007, but effective October 1, 2014, the rural hospital is redesignated as urban. We are proposing in this scenario that, by September 30, 2016, either the redesignated urban hospital must reclassify to rural under § 412.103 for purposes of IME payment only, or the ''original'' urban hospital must find a new geographically rural site that can participate as the rural site for purposes of the rural track. If neither of these conditions is met by September 30, 2016, the ''original'' urban hospital would not be able to receive payment for that specific program as a rural track under § 413.79(k)(1) or (k)(2) because it would no longer meet the requirement that more than one-half of the training must be provided in a rural setting.

We note that if the ''original'' urban hospital was not able to meet one of the two proposed conditions noted earlier in this section by the end of the 2-year transition period, but at some point later is able to meet one of the two proposed conditions, we are proposing that the ''original'' urban hospital would be able to ''revive'' and use its already established rural track FTE limitation from that point forward. In the instance where the ''original'' urban hospital's rural track FTE limitation was not set because the hospital was not able to meet one of the two proposed conditions by the end of the 2-year transition period, which fell within the 3-year cap-building timeframe, but at some point later is able to meet one of the two proposed conditions, we are proposing that the ''original'' urban hospital would be able to have a rural track FTE limitation calculated and established based on the highest number of FTE residents in any program year training in the rural track in the third year of the program, even if during the third year of the program, the ''original'' urban hospital was not in compliance with the two proposed conditions. Consistent with similar policy discussed in the FY 2002 IPPS final rule (66 FR 39905), it would be the responsibility of the hospitals involved to provide the necessary information regarding the rotations of the residents in the third program year to the Medicare contractor in order for the calculation to be completed and the rural track FTE limit to be set.

In summary, we are proposing that any time a rural hospital participating in a rural track is in an area redesignated by OMB as urban after residents started training in the rural track and during the 3-year period that is used to calculate the urban hospital's rural track FTE limitation, the urban hospital may receive a cap adjustment for that rural track after it has been redesignated as urban. Furthermore, we are proposing that, regardless of whether the redesignation of the rural hospital occurs during the 3-year period that is used to calculate the urban hospital's rural track FTE limitation, or after the 3-year period used to calculate the urban hospital's rural track FTE limitation, the redesignated urban hospital can continue to be considered a rural hospital for purposes of the rural track

for up to 2 years. However, by the end of those 2 years, either the redesignated urban hospital must reclassify as rural under § 412.103 for purposes of IME payment only (in addition, this reclassification option only applies to IPPS hospitals, not nonprovider sites) or the ''original'' urban hospital must have found a new site in a geographically rural area that will serve as the rural site for purposes of the rural track in order for the ''original'' urban hospital to receive payment under § 413.79(k)(1) or (k)(2).

We are proposing to revise the regulations at § 413.79(k)(7) to implement these provisions and to establish that these changes would be effective for cost reporting periods beginning on or after October 1, 2014. The proposed regulations at § 413.79(k)(7) read as follows: ''(i) Effective for cost reporting periods beginning prior to October 1, 2014, if an urban hospital had established a rural track training program under the provisions of this paragraph (k) with a hospital located in a rural area and that rural area subsequently becomes an urban area due to the most recent census data and implementation of the new labor market area definitions announced by OMB on June 6, 2003, the urban hospital may continue to adjust its FTE resident limit in accordance with this paragraph (k) for the rural track programs established prior to the adoption of such new labor market area definitions. In order to receive an adjustment to its FTE resident cap for a new rural track residency program, the urban hospital must establish a rural track program with hospitals that are designated rural based on the most recent geographical location designations adopted by CMS. (ii) Effective for cost reporting periods beginning on or after October 1, 2014, if an urban hospital had started a rural track training program under the provisions of this paragraph (k) with a hospital located in a rural area and, during the 3-year period that is used to calculate the urban hospital's rural track FTE limit, that rural area subsequently becomes an urban area due to the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data, the urban hospital may continue to adjust its FTE resident limit in accordance with this paragraph (k) and subject to paragraph (k)(7)(iii) for the rural track programs established prior to the adoption of such new OMB standards for delineating statistical areas. (iii) Effective for cost reporting periods beginning on or after October 1, 2014, if an urban hospital had established a rural track training program under the provisions of this paragraph (k) with a hospital located in a rural area and that rural area subsequently becomes an urban area due to the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data, regardless of whether the redesignation of the rural hospital occurs during the 3-year period that is used to calculate the urban hospital's rural track FTE limit, or after the 3-year period used to calculate the urban hospital's rural track FTE limit, the urban hospital may continue to adjust its FTE resident limit in accordance with this paragraph (k) based on the rural track programs established prior to the change in the hospital's geographic designation. In order for the urban hospital to receive or use the adjustment to its FTE resident cap for training FTE residents in the rural track residency program that was established prior to the most recent OMB standards for delineating statistical areas adopted by CMS, one of the following two conditions must be met by the end of a 2-year period that begins when the most recent OMB standards for delineating statistical areas are adopted by CMS: The hospital that has been redesignated from rural to urban must reclassify as rural under § 412.103 of this chapter, for purposes of IME only; or the urban hospital must find a new site that is geographically rural consistent with the most recent geographical location delineations adopted by CMS. In order to receive an adjustment to its FTE resident cap for an additional new rural track residency program, the urban hospital must establish a rural track program with sites that are geographically rural based on the most recent geographical location delineations adopted by CMS.''

We also have determined that there is an outdated, incorrect reference included in the definition of ''Rural track FTE limitation'' under § 413.75(b). The reference included in the definition is ''§ 413.79(l)''. The correct reference is ''§ 413.79(k)''. Therefore, we are proposing to make a technical correction to the definition of ''Rural track FTE limitation'' so that it reads ''means the maximum number of residents (as specified in § 413.79(k)) training in a rural track residency program that an urban hospital may include in its FTE count and that is in addition to the number of FTE residents already included in the hospital's FTE cap.''

4. Proposed Clarification of Policies on Counting Resident Time in Nonprovider Settings Under Section 5504 of the Affordable Care Act

In the November 24, 2010 final rule with comment period (75 FR 71808, 72134 through 72141, and 72153), we implemented section 5504 of the Affordable Care Act regarding counting resident time in nonprovider settings. We also mentioned the scope of section 5504 of the Affordable Care Act in the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27638) and final rule (78 FR 50735). Section 5504(a) of the Affordable Care Act made changes to section 1886(h)(4)(E) of the Act to reduce the costs that hospitals must incur for residents training in nonprovider sites in order to count the FTE residents for purposes of Medicare direct GME payments on a prospective basis. Notably, section 5504(a)(3) of the Affordable Care Act amended the Act effective for ''cost reporting periods beginning on or after July 1, 2010,'' for direct GME, to permit hospitals to count the time that a resident trains in activities related to patient care in a nonprovider site in its FTE count if the hospital incurs the costs of the residents' salaries and fringe benefits for the time that the resident spends training in the nonprovider site. Section 5504(b)(2) of the Affordable Care Act made similar changes to section 1886(d)(5)(B)(iv) of the Act for IME payment purposes, with the provision being effective for discharges occurring on or after July 1, 2010, for IME. In connection with those periods and discharges, if more than one hospital incurs the residency training costs in a nonprovider setting, under certain circumstances, sections 5504(a)(3) and (b)(2) of the Affordable Care Act allow each hospital to count a proportional share of the training time that a resident spends training in that setting, as determined by a written agreement between the hospitals. When Congress enacted section 5504 of the Affordable Care Act, it retained the statutory language which provides that a hospital can only count the time so spent by a resident under an approved medical residency training program in its FTE count if that one single hospital by itself ''incurs all, or substantially all, of the costs for the training program in that setting.'' In doing so, Congress also revised the statutory language in sections 5504(a)(1) and (b)(1) to explicitly make this longstanding substantive standard and requirement applicable to ''cost reporting periods beginning before July 1, 2010'' for direct GME, and to ''discharges occurring on

or after October 1, 1997, and before July 1, 2010,'' for IME (sections 1886(d)(5)(B)(iv)(I) and 1886(h)(4)(E)(i) of the Act). Beginning at least as early as 1988, the Secretary consistently noted in the preamble of various rules that the statute only allowed a hospital to count the time that its residents spent training in a nonprovider site in the FTE resident count for direct GME and IME purposes if that single hospital incurred ''all of substantially all'' of the costs of the training program in that setting. For a full discussion of the longstanding substantive standard and requirement that a hospital can only count residents training if that one single hospital incurs all or substantially all of the costs for the training, we refer readers to the discussion in the November 24, 2010 final rule with comment period (75 FR 72134 through 72141), in the May 11, 2007 final rule (72 FR 26953 and 26969), and in the August 1, 2003 final rule (68 FR 45439).

Section 5504(c) of the Affordable Care Act specifies that the amendments made by the provisions of sections 5504(a) and (b) ''shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education . . . or for direct graduate medical education costs. . . .'' The date of enactment of the Affordable Care Act was March 23, 2010.

In the November 24, 2010 final rule with comment period, we revised the regulations at § 412.105(f)(1)(ii)(E) for IME and §§ 413.78(f) and (g) for direct GME to reflect the changes made by section 5504 of the Affordable Care Act. Section 413.78(g) is the implementing regulation that corresponds to the statutory amendments set forth in sections 5504(a)(3) and (b)(2) of the Affordable Care Act. The introductory regulatory language of § 413.78(g) explicitly states that paragraph (g) governs only ''cost reporting periods beginning on or after July 1, 2010.'' Paragraph (g)(5) of § 413.78 also expressly states that the paragraph is limited to ''cost reporting periods beginning on or after July 1, 2010.'' Accordingly, we have repeatedly stated, and we believe that the existing regulation makes plain, that paragraph (g) of § 413.78 ''is explicitly made applicable only to 'cost reporting periods beginning on or after July l, 2010,' whereas earlier cost reporting periods are governed by other preceding paragraphs of § 413.78'' (78 FR 50735). In addition, we also revised the definition of ''all or substantially all of the costs for the training program in the nonhospital setting'' in the regulations at § 413.75(b) to reflect that both the statute and regulations require that, for cost reporting periods beginning on and after July 1, 2007 and before July 1, 2010, one hospital must by itself incur ''all or substantially all of the costs'' of the residents training in the nonprovider site in order for the hospital to receive Medicare IME and direct GME payment for that training. Finally, we also revised the IME regulations at § 412.105 to reflect these statutory amendments, by incorporating by reference § 413.78(g).

Despite the fact that sections 5504(a) and (b) of the Affordable Care Act provide clear effective dates with respect to the amendments provided therein to sections 1886(h)(4)(E) and 1886(d)(5)(B)(iv) of the Act, and that the preamble discussion of the implementation of these provisions and further discussion of the statutory amendments in the November 24, 2010 final rule with comment period and in the August 19, 2013 final rule provide further explanation that, specifically, nothing in section 5504(c) overrides those effective date (75 FR 72136), we have received questions about the applicability of section 5504(c) and the associated regulation text at § 413.78(g)(6). Specifically, questions have been raised with respect to the applicability of sections 5504(c) of the Affordable Care Act and § 413.78(g)(6) of the regulations to periods prior to July 1, 2010, particularly if a hospital had, as of March 23, 2010, appealed an IME or direct GME issue for a settled cost reporting period occurring prior to July 1, 2010. As noted earlier, section 5504(c) of the Affordable Care Act provides that the amendments made by the provisions of sections 5504(a) and (b) ''shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of . . . [March 23, 2010] on the issue of payment for indirect costs of medical education . . . or for direct graduate medical education costs. . . .''

Upon revisiting the existing regulation text, we determined that § 413.78(g)(6) was not written in a manner that is as consistent with section 5504(c) of the Affordable Care Act and reflective of our reading of that provision and our policy as it could be. Specifically, § 413.78(g)(6) states, ''The provisions of paragraphs (g)(1)(ii), (g)(2), (g)(3), and (g)(5) of this section cannot be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which there is a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.'' In this proposed rule, we are reiterating our existing interpretation of the statutory amendments made by sections 5504(a), (b), and (c) of the Affordable Care Act and also proposing to clarify the regulation text implementing these provisions by revising the language at § 413.78(g)(6) to read more consistently with the language in section 5504(c) of the Affordable Care Act and to ensure no further confusion with respect to the applicability of section 5504(c) of the Affordable Care Act and § 413.78(g)(6) of the regulations.

We believe that sections 5504(a) and (b) of the Affordable Care Act contained three primary directives (a fourth regarding recordkeeping requirement is tangential to this discussion): (1) Under sections 5504(a)(1) and (b)(1) of the Affordable Care Act (sections 1886(h)(4)(E)(i) and 1886(d)(5)(B)(iv)(I) of the Act), for ''cost reporting periods beginning before July 1, 2010'' for direct GME, and for ''discharges occurring on or after October 1, 1997, and before July 1, 2010'' for IME, these sections explicitly retained the statutory language that provides that a hospital can only count the time so spent by a resident under an approved medical residency training program in its FTE count if a hospital by itself ''incurs all, or substantially all, of the costs for the training program in that setting''; (2) under sections 5504(a)(3) and (b)(2) of the Affordable Care Act (sections 1886(h)(4)(E)(ii) and 1886(d)(5)(B)(iv)(II) of the Act), for ''cost reporting periods beginning on or after July 1, 2010'' for direct GME, and for ''discharges occurring on or after July 1, 2010'' for IME, these sections eliminated the ''all or substantially all'' requirement, instead requiring a hospital to incur the residents' salaries and fringe benefits for the time spent at the nonprovider site; and (3) under sections 5504(a)(3) and (b)(2) of the Affordable Care Act (sections 1886(h)(4)(E)(ii) and 1886(d)(5)(B)(iv)(II) of the Act), for ''cost reporting periods beginning on or after July 1, 2010'' for direct GME, and for ''discharges occurring on or after July 1, 2010'' for IME, these sections created a new provision with regard to allowing more than one hospital to share the costs of residents training in a nonprovider setting under certain circumstances, in order for each hospital to count a proportional share of the FTE training time in the nonprovider setting.

Separately from sections 5504(a) and (b) of the Affordable Care Act, section 5504(c) of the Affordable Care Act, as mentioned earlier, specifies that the

amendments made by the provisions of sections 5504(a) and (b) ''shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of'' March 23, 2010, the date of the enactment of the Affordable Care Act, on the issue of payment for IME and direct GME. When we proposed to implement section 5504(c) in the August 3, 2010 proposed rule (75 FR 46385) and when we implemented section 5504(c) in the November 24, 2010 final rule with comment period (75 FR 72136), we had to consider what new meaning it was adding to sections 5504(a) and (b) of the Affordable Care Act because unlike, for example, section 5505 of the Affordable Care Act which has an effective date *prior* to enactment of the Affordable Care Act and, therefore, would apply to prior cost reporting periods, section 5504's applicable effective date for the new standards it creates was July 1, 2010, a date that came *after* enactment of the Affordable Care Act and was fully prospective. As we stated in the November 24, 2010 final rule with comment period (75 FR 72136), ''Section 5504(c) is fully prospective with an explicit effective date of July 1, 2010, for the new standards it creates. Nothing in section 5504(c) overrides that effective date. Section 5504(c) merely notes that the usual discretionary authority of Medicare contractors to reopen cost reports is not changed by the provisions of section 5504; it simply makes clear that Medicare contractors are not required by reason of section 5504 to reopen any settled cost report as to which a provider does not have a jurisdictionally proper appeal pending. It does not require reopening in any circumstance; and the new substantive standard is, in any event, explicitly prospective. We believe if Congress had wanted to require such action or to apply the new standards to cost years or discharges prior to July 1, 2010, it would have done so in far more explicit terms.'' We also noted in that rule (75 FR 72139) that ''[the] statute does not provide CMS discretion to allow the counting of resident time spent in shared nonprovider site rotations for cost reporting periods beginning prior to July l, 2010.'' We continue to believe that Congress was clear in amending sections 1886(h)(4)(E) and 1886(d)(5)(B)(iv) of the Act to provide for new standards to be applied only prospectively, effective for cost reporting periods beginning on or after, and discharges occurring on or after, July 1, 2010. We also continue to believe that the plain meaning of section 5504(c) of the Affordable Care Act is that the Secretary is not required to reopen a cost report when there is *no* jurisdictionally proper appeal pending as of March 23, 2010, the date of the enactment of the Affordable Care Act, on the issue of payment for IME and direct GME. Therefore, we believe that section 5504(c) of the Affordable Care Act is merely a confirmation of the Secretary's existing discretionary authority in one particular context, and that sections 5504(a) and (b) of the Affordable Care Act and their effective dates become all the more prominent, and are not affected by section 5504(c).

As noted earlier, we revised the regulations at § 412.105(f)(1)(ii)(E) for IME, and § 413.78(g) for direct GME, to reflect the changes made by section 5504 of the Affordable Care Act in the November 24, 2010 final rule with comment period. We reiterate here that the introductory language of § 413.78(g) explicitly states that paragraph (g) governs only ''cost reporting periods beginning on or after July 1, 2010'' and paragraph (g)(5) also expressly states that the paragraph is limited to ''cost reporting periods beginning on or after July 1, 2010'' (78 FR 50735 and 78 FR 27639). As we noted before, we believe that the paragraphs of the regulations which precede paragraph (g), particularly paragraphs (c) through (f), consistent with the statute, make clear that a hospital may only count the time so spent by a resident under an approved medical residency training program in its FTE count, in connection with its pre-July l, 2010 cost reporting periods and pre-July l, 2010 patient discharges, if that one single hospital by itself ''incurs all, or substantially all, of the costs for the training program in that setting.'' Separately, we believe that the new standards set forth in sections 5504(a)(3) and (b)(2) of the Affordable Care Act and implemented by regulation at §§ 413.78(g) and 412.105(f)(1)(ii)(E), allowing cost sharing under certain circumstances do *not* ever apply to pre-July 1, 2010 cost reporting periods and pre-July l, 2010 patient discharges. Moreover, we continue to believe the language in paragraph (g)(6) (along with the remainder of paragraph (g)) only applies to cost reporting periods beginning on or after July 1, 2010 and does *not* apply retroactively to cost reporting periods beginning before July 1, 2010. We had intended that the language under § 413.78(g) do no more than simply paraphrase the language in section 5504(c) of the Affordable Care Act.

Accordingly, we believe that it is apparent that the provisions of sections 5504(a)(3) and (b)(2) of the Affordable Care Act are not to be applied prior to July l, 2010, irrespectively of whether a hospital may have had a jurisdictionally proper appeal pending as of March 23, 2010, on an IME or direct GME issue from a cost reporting period occurring prior to July 1, 2010.

In this proposed rule, we are reiterating our existing interpretation of the statutory amendments made by sections 5504(a) and (b) of the Affordable Care Act and also are proposing to clarify the regulatory text that implements these provisions by revising the § 413.78(g)(6) to be more consistent with the language at section 5504(c) of the Affordable Care Act. We are proposing to revise the regulatory language to read as follows: ''The provisions of paragraphs (g)(1)(ii), (g)(2), (g)(3), and (g)(5) of this section shall not be applied in a manner that requires reopening of any settled cost reports as to which there is not a jurisdictionally proper appeal pending as of March 23, 2010, on direct GME or IME payments. Cost reporting periods beginning before July 1, 2010 are not governed by paragraph (g) of this section.'' The IME regulations at § 412.105(f)(1)(ii)(E) include a reference to § 413.78(g)(6); therefore, no proposed change is needed to this section.

5. Proposed Changes to the Review and Award Process for Resident Slots Under Section 5506 of the Affordable Care Act

In the past, if a teaching hospital closed, its direct GME and IME FTE resident cap slots would be ''lost'' because those cap slots are associated with a specific hospital's Medicare provider agreement, which would be retired upon the hospital's closure. Under existing regulations at § 413.79(h) for direct GME and § 412.105(f)(1)(ix) for IME, a hospital that is training FTE residents at or in excess of its FTE resident caps and takes in residents displaced by the closure of another teaching hospital may receive a temporary increase to its FTE resident caps so that it may receive direct GME and IME payment associated with those displaced FTE residents. However, those temporary FTE resident caps are tied to those specific displaced FTE residents, and the temporary caps expire when those displaced residents complete their training program.

Section 5506 of the Affordable Care Act amended section 1886(h)(4)(H) of the Act to add a new clause (vi) that instructs the Secretary to establish a process by regulation under which, in the event a teaching hospital closes, the

Secretary will permanently increase the FTE resident caps for hospitals that meet certain criteria up to the number of the closed hospital's FTE resident caps. The Secretary is directed to ensure that the aggregate number of FTE resident cap slots distributed shall be equal to the aggregate number of slots in the closed hospital's direct GME and IME FTE resident caps, respectively. For a detailed discussion of the regulations implementing section 5506 of the Affordable Care Act, we refer readers to the November 24, 2010 final rule with comment period (75 FR 72212 through 72238) and the FY 2013 IPPS/LTCH PPS final rule (77 FR 53434 through 53448).

a. Effective Date of Slots Awarded Under Section 5506 of the Affordable Care Act

In distributing slots permanently under the provisions of section 5506 of the Affordable Care Act, section 5506(d) provides that ''the Secretary shall give consideration to the effect of the amendments made by this section on any temporary adjustment to a hospital's FTE cap under § 413.79(h) . . . (as in effect on the date of enactment of this Act) in order to ensure that there is no duplication of FTE slots . . .'' In consideration of this statutory language, in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53437), we stated that in distributing slots permanently under section 5506, we would be cognizant of the number of FTE residents for whom a temporary FTE cap adjustment was provided under existing regulations at § 413.79(h), and when those residents will complete their training, at which point the temporary slots associated with those displaced residents would then be available for permanent redistribution. Therefore, in initially developing ranking criteria and application materials that we would use to award available slots, we considered how to interpret this statutory language at section 5506(d) of the Affordable Care Act within the context of our existing GME regulations and section 5506's amendment to section 1886(h) of the Act generally.

In the November 24, 2010 final rule with comment period and the FY 2013 IPPS/LTCH PPS final rule (75 FR 72216 and 77 FR 53436, respectively), we discussed the various ranking criteria that we would use for hospitals applying for slots from closed hospitals. Currently, if after distributing the slots from a closed hospital to increase the FTE caps for applying hospitals that fall within Ranking Criteria One, Two, and Three, there are still excess slots available and any of those excess slots are associated with displaced residents for whom temporary cap adjustments under § 413.79(h) are in place, any slots awarded to hospitals that fall within Ranking Criteria Four through Eight are permanently assigned only once the displaced residents have completed their training and the temporary cap adjustments associated with those residents have expired. That is, in applying the requirement for ''no duplication of FTE slots'' set forth in section 5506(d), we currently consider all temporary cap adjustments received by hospitals on a national basis and not specifically the hospital that is applying for cap slots under section 5506, when deciding the effective date for slots permanently awarded to hospitals applying under Ranking Criteria Four through Eight. Specifically, in the November 24, 2010 final rule with comment period, we stated that we believe the ''no duplication of FTE slots'' requirement applies across all hospitals. Therefore, although a hospital may not have received a temporary cap adjustment under § 413.79(h), other hospitals may have taken in residents and received temporary cap adjustments for the same program, and we believed that the appropriate policy was to delay the slots associated with that program from being permanently distributed until it is known that any and all temporary cap adjustments for those slots have expired (75 FR 72227) Applying this policy to an example, if Hospital A is training displaced residents and is receiving a temporary cap adjustment under § 413.79(h) for training those residents and Hospital B, which is not receiving a temporary cap adjustment for training any displaced residents, has applied under Ranking Criterion Five to expand its internal medicine program, as explained in the November 24, 2010 final rule with comment period, we would only award permanent slots under section 5506 to Hospital B on a flow basis; that is, effective after each displaced resident completes his/her training, and, therefore, the temporary cap adjustments associated with that resident expire at Hospital A.

However, the policy of applying the ''no duplication of FTE slot'' requirement at section 5506(d) of the Affordable Care Act to all hospitals rather than simply to each specific hospital that is applying for slots has thus far proven to be a very complex process due to the number of displaced residents and the timing of multiple graduation dates which must be tracked and considered when awarding slots on a permanent basis. We believe this practice has delayed the awarding of slots and is also unnecessarily burdensome for hospitals applying under Ranking Criteria Four through Eight that are not receiving any cap adjustments for training displaced residents under § 413.79(h). We believe the current policy that we apply for ''no duplication of FTE slots'' is unnecessarily burdensome for these hospitals because, instead of receiving their permanent slots under section 5506 as soon as possible, the hospitals may receive their section 5506 awards with staggered effective dates due to the graduation dates of displaced FTE residents training at other hospitals that did receive temporary adjustments under § 413.79(h). While we believe that awarding permanent slots to a hospital that is simultaneously receiving a temporary cap adjustment for training displaced FTE residents under § 413.79(h) would clearly be a duplication of FTE slots and contrary to the statutory directive, we believe there is flexibility in interpreting this statutory language and that the statute does not require such a policy to be applied to hospitals that are *not* receiving temporary cap adjustments under § 413.79(h). Furthermore, in considering the specific statutory language regarding ''no duplication of FTE slots,'' section 5506(d) in part provides that ''The Secretary of Health and Human Services shall give consideration to the effect of the amendments made by this section on any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act) in order to ensure that there is no duplication of FTE slots.'' Because this language refers to ''a hospital,'' we believe the statute provides us with the flexibility to apply the ''no duplication of FTE slots'' requirement on a hospital-specific basis, considering separately whether each hospital did or did not receive a temporary cap adjustment under § 413.79(h), rather than on a national all-hospital basis. Bearing in mind the statutory language and our experience to date in awarding slots as well as the unnecessary burden placed on hospitals that are receiving section 5506 slots, but are not receiving temporary cap adjustments under § 413.79(h), we believe it is appropriate to propose a policy that would provide for a more efficient and faster method for awarding of slots to hospitals applying under Ranking Criteria Four through Eight. Therefore, we are proposing that, effective for section 5506 application

rounds announced on or after October 1, 2014, for purposes of applying the requirement for ''no duplication of FTE slots,'' we would only require that there be no duplication of FTE slots on a hospital-specific basis. That is, in determining the effective date for slots awarded permanently under section 5506, we would only be concerned with whether the hospital that is applying for slots is also receiving a temporary cap adjustment under § 413.79(h) for training displaced residents. When awarding slots to the applying hospital, we would not be concerned whether any other hospital is receiving a temporary cap adjustment for training displaced residents under § 413.79(h). For example, if Hospital A is receiving a temporary cap adjustment under § 413.79(h) for training displaced residents in its general surgery program but is applying under Ranking Criterion Five to start a pediatrics program and Hospital B is *not* receiving a temporary cap adjustment for training displaced residents and is applying under Ranking Criterion Eight to expand a cardiology program, in awarding section 5506 slots, we would only allow Hospital A to receive a permanent adjustment to its FTE cap for training residents in its pediatrics program once its temporary adjustments for the displaced residents training in the general surgery program have expired. We would not consider displaced residents when awarding section 5506 slots to Hospital B.

In conjunction with our proposal to interpret the ''no duplication of FTE slots'' requirement to apply on a hospital-specific basis to hospitals that are receiving temporary cap adjustments under § 413.79(h), we are proposing to amend the effective dates of section 5506 slots received under Ranking Criteria Four through Eight for those hospitals that are *not* receiving temporary cap adjustments under § 413.79(h). (We refer readers to section IV.K.5.c. of the preamble of this proposed rule where we discuss our proposal to amend Ranking Criteria Seven and Eight.) Existing policy requires that slots awarded under Ranking Criteria Four through Eight for expanding an existing residency training program or starting a new residency training program are effective the later of when a hospital can demonstrate to the MAC that the slots associated with a new program or program expansion are actually filled and, therefore, are needed as of a particular date (usually July 1, possibly retroactive), or the July 1 after displaced residents complete their training. If a hospital is awarded slots under Ranking Criterion Eight for cap relief, slots are effective the date of CMS' award announcement, or the July 1 after displaced residents complete their training, whichever is later. However, because we are proposing an alternative approach to interpreting section 5506(d) that would permit us to apply the ''no duplication of FTE slots'' requirement on a hospital-specific basis, we are proposing to change the effective date for slots received under Ranking Criteria Four through Eight so that if a hospital is *not* receiving a temporary cap adjustment under § 413.79(h), the slots awarded under section 5506 would be effective when the hospital can demonstrate to its MAC that the slots needed for a new program or program expansion are actually filled and, therefore, are needed as of a particular date (usually July 1, possibly retroactive). If a hospital is awarded slots under Ranking Criteria Four through Eight and *is* receiving a temporary cap adjustment to train displaced residents under § 413.79(h), the current policy would apply such that the slots are awarded on a permanent basis, the later of when a hospital can demonstrate to the MAC that the slots associated with a new program or program expansion are actually filled and, therefore, are needed as of a particular date (usually July 1, possibly retroactive), or the July 1 after an equivalent amount of a displaced FTE resident(s) complete their training. For example, assume in a hypothetical situation that there is a closed teaching hospital, and that another hospital takes in two displaced FTE residents, for which the hospital is receiving a temporary cap adjustment under § 413.79(h). One resident is graduating on June 30, 2016, and the second resident is graduating on June 30, 2018. Assume that when the section 5506 Round is announced, the hospital also applies for two slots to expand an internal medicine program under Ranking Criterion Five. In January of 2017, CMS awards two permanent slots to the hospital under Ranking Criterion Five. For the program year starting July 1, 2017, the hospital successfully demonstrates to the MAC that it filled the two additional internal medicine positions. Because one displaced FTE resident already graduated on June 30, 2016, the MAC may approve one slot on a permanent basis effective July 1, 2017. However, the hospital would have to wait until July 1, 2018, to receive from the MAC the permanent slot for the second displaced internal medicine resident because the second displaced FTE resident is not graduating until June 30, 2018.

We are not proposing any changes to the effective date for slots awarded under Ranking Criterion One, Ranking Criterion Two, or Ranking Criterion Three. Consistent with existing policy, if a hospital is applying under Ranking Criterion One or Ranking Criterion Three and is *not* receiving a temporary cap adjustment for training displaced residents under § 413.79(h), the effective date of the section 5506 slots is the date of the hospital closure. If a hospital is applying under Ranking Criterion One or Ranking Criterion Three and is receiving a temporary cap for training displaced residents under § 413.79(h), the effective date of the section 5506 slots is after the displaced resident(s) graduate. If a hospital *is* receiving a temporary cap for training displaced residents under § 413.79(h), and is applying under Ranking Criterion One or Ranking Criterion Three and is also separately applying under Ranking Criterion Four or subsequent Ranking Criteria, for slots awarded under Ranking Criteria One or Three, the effective date of the section 5506 slots is after the displaced resident(s) graduate. For slots awarded under Ranking Criteria Four or subsequent Ranking Criteria, the slots are awarded the later of when a hospital can demonstrate to the MAC that the slots associated with a new program or program expansion are actually filled and, therefore, are needed as of a particular date (usually July 1, possibly retroactive), or the July 1 after an equivalent amount of a displaced FTE resident(s) at the hospital complete their training. Therefore, for such a hospital, the effective dates of slots awarded under Ranking Criteria One/Three, and Ranking Criteria Four through Eight might coincide. Also, consistent with existing policy, if a hospital is applying under Ranking Criterion Two, the effective date of the permanent award of section 5506 slots is the date of the hospital closure. We discuss these existing policies in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53437 through 53445).

The following list includes the current and proposed ranking criteria along with the current and proposed effective dates.

- *Current Ranking Criterion One:* The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed

(that is, same residents, possibly the same program director, and possibly the same (or many of the same) teaching staff).

• *Proposed Ranking Criterion One:* The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, possibly the same program director, and possibly the same (or many of the same) teaching staff). The applying hospital's FTE resident caps were erroneously reduced by CMS under section 1886(h)(8)(A)(i) of the Act, contrary to the statutory exception at section 1886(h)(8)(A)(ii)(I) of the Act, and CMS Central Office was made aware of the error prior to posting of the FY 2015 IPPS proposed rule on the CMS Web site. (This language reflects the proposed modification of Ranking Criterion One. We refer readers to section IV.K.5.c. of the preamble of this proposed rule where we discuss this proposed modification.)

○ *Current Policy:* If the hospital is receiving a temporary cap adjustment, slots are effective the day after the graduation date(s) of actual displaced resident(s). If the hospital is not receiving a temporary cap adjustment, slots are effective with the date of the hospital closure.

○ *Proposed Policy:* No change.

• *Current Ranking Criterion Two:* The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. If the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed was with a hospital that itself has closed or is closing, preference would be given to an applying hospital that was listed as a participant in the next most recent Medicare GME affiliation agreement (but not one which was entered into more than 5 years prior to the hospital's closure) of which the first closed hospital was a member before the hospital closed, and that applying hospital received slots from the closed hospital under the terms of that affiliation agreement.

• *Clarified Ranking Criterion Two:* The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement or emergency Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement or emergency Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement, or emergency Medicare GME affiliation agreement. If the most recent Medicare GME affiliation agreement or emergency Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed was with a hospital that itself has closed or is closing, preference would be given to an applying hospital that was listed as a participant in the next most recent Medicare GME affiliation agreement or emergency Medicare GME affiliation agreement (but not one which was entered into more than 5 years prior to the hospital's closure) of which the first closed hospital was a member before the hospital closed, and that applying hospital received slots from the closed hospital under the terms of that affiliation agreement. (This language reflects our clarification in this proposed rule regarding inclusion of emergency Medicare GME affiliation agreements in Ranking Criterion Two. We refer readers to section IV.K.5.d. of the preamble of this proposed rule where we discuss this clarification.)

○ *Current Policy:* Slots are effective with the date of the hospital closure.

○ *Proposed Policy:* No change.

• *Ranking Criterion Three:* The applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training (that is, the applying hospital is permanently expanding its own existing programs).

○ *Current Policy:* If the hospital is receiving temporary cap adjustment, slots are effective the day after the graduation date(s) of actual displaced resident(s). If the hospital is not receiving a temporary cap adjustment, slots are effective with the date of the hospital closure.

○ *Proposed Policy:* No change.

• *Ranking Criterion Four:* The program does not meet Ranking Criteria 1, 2, or 3, and the applying hospital will use additional slots to establish a new or expand an existing geriatrics residency program.

• *Ranking Criterion Five:* The program does not meet Ranking Criteria 1 through 4, the applying hospital is located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program.

• *Ranking Criterion Six:* The program does not meet Ranking Criteria 1 through 5, and the applying hospital is not located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program.

• *Current Ranking Criterion Seven:* The applying hospital will use additional slots to establish or expand a primary care or general surgery program, but the program does not meet Ranking Criterion 5 or 6 because the hospital is also separately applying under Ranking Criterion 8 for slots to establish or expand a nonprimary care or nongeneral surgery program and/or for cap relief.

• *Proposed Ranking Criterion Seven:* The applying hospital will use additional slots to establish or expand a primary care or general surgery program, but the program does not meet Ranking Criterion 5 or 6 because the hospital is also separately applying under Ranking Criterion 8 for slots to establish or expand a nonprimary care or nongeneral surgery program. (This language reflects our proposal in this proposed rule to revise Ranking Criteria Seven and Eight. We refer readers to section IV.K.5.c. of the preamble of this proposed rule where we discuss our proposals to amend Ranking Criteria Seven and Eight.)

○ *Current Policy for Ranking Criteria Four through Seven:* The later of when the hospital can demonstrate to the MAC that the slots associated with a new program or program expansion are actually filled, and therefore, are needed as of a particular date (usually July 1, possibly retroactive), or the July 1 *after* displaced residents complete their training.

○ *Proposed Policy for Ranking Criterion Four through Proposed Ranking Criterion Seven:* If the hospital is receiving a temporary cap adjustment for training displaced residents, the later of when the hospital can demonstrate to the MAC that the slots associated with a new program or program expansion are actually filled, and therefore, are needed as of a particular date (usually

July 1, possibly retroactive), or the July 1 *after* displaced residents complete their training. If the hospital is *not* receiving a temporary cap adjustment, when the hospital can demonstrate to the MAC that the slots needed for a new program or program expansion are actually filled, and therefore, are needed as of a particular date (usually July 1, possibly retroactive).

- *Current Ranking Criterion Eight:* The program does not meet Ranking Criteria 1 through 7, and the applying hospital will use additional slots to establish or expand a nonprimary care or a nongeneral surgery program or for cap relief.
- *Proposed Ranking Criterion Eight:* The program does not meet Ranking Criteria 1 through 7, and the applying hospital will use additional slots to establish or expand a nonprimary care or a nongeneral surgery program. (This language reflects our proposal in this proposed rule to revise Ranking Criterion Eight. We refer readers to section IV.K.5.c. of the preamble of this proposed rule where we discuss our proposals to amend Ranking Criterion Eight.)

○ *Current Policy:* If slots are for starting or expanding a nonprimary care or nongeneral surgery program, the effective date is same as that for Ranking Criteria Four through Seven. If slots are for cap relief (under current policy), the effective date is the effective date of CMS' award announcement, or *after* displaced residents complete their training, whichever is later.

○ *Proposed Policy for Proposed Ranking Criterion Eight:* If the hospital is receiving a temporary cap adjustment for training displaced residents, the later of when the hospital can demonstrate to the MAC that the slots associated with a new program or program expansion are actually filled and, therefore, are needed as of a particular date (usually July 1, possibly retroactive), or the July 1 *after* displaced residents complete their training. If the hospital is not receiving a temporary cap adjustment, when the hospital can demonstrate to the MAC that the slots needed for a new program or program expansion are actually filled, and therefore, are needed as of a particular date (usually July 1, possibly retroactive).

In summary, we are proposing that, effective for section 5506 application rounds announced on or after October 1, 2014, the statutory provision at section 5506(d) requiring the Secretary to consider temporary cap adjustments under § 413.79(h) and to ensure no duplication of FTE slots, be interpreted in a manner such that the requirement for ''no duplication of FTE slots'' is applied on a hospital-specific basis rather than across all hospitals receiving temporary cap adjustments under § 413.79(h). Consistent with this proposed change, we are proposing to amend the effective date for slots received under Ranking Criteria Four through Eight so that if a hospital is *not* receiving a temporary cap adjustment under § 413.79(h), the slots awarded under section 5506 would be effective when the hospital can demonstrate to its MAC that the slots needed for a new program or program expansion are actually filled and, therefore, are needed as of a particular date (usually July 1, possibly retroactive).

b. Proposal To Remove Seamless Requirement

Under current policy, if a hospital is applying under Ranking Criterion One or Three, the hospital must show that it is seamlessly replacing displaced FTE residents with new FTE residents once the displaced residents graduate (75 FR 72219 and 72221 through 72222). We have stated that in instances where a hospital seamlessly operates an entire program or part of a program from the closed hospital (or takes over an entire program prior to the hospital's closure), such a hospital is demonstrating a strong commitment to maintain GME programs in the community for the long term and should we awarded slots under higher ranking criteria (75 FR 72216). Therefore, we required that, in order to receive slots under Ranking Criterion One and Three, the applying hospital must demonstrate that upon graduation of the displaced FTE residents that it is training, the slots held by those displaced FTEs are seamlessly replaced with new FTE residents (75 FR 72219 and 72221 through 72222). In the FY 2013 IPPS/LTCH PPS final rule (77 FR 53441), in response to concerns associated with the seamless requirement and timeline used by the National Resident Match Program or other resident match services, we revised the seamless requirement. We stated that in the instance where a teaching hospital closed after December 31 of an academic year, in order for a hospital to qualify under Ranking Criterion One or Three for cap slots associated with displaced FTE residents who will graduate June 30 of the academic year in which the applying hospital took in the displaced FTE residents, the applying hospital must be able to demonstrate that it will fill slots vacated by displaced FTE residents by July 1 of the second academic year following the hospital closure. However, in the instance where a teaching hospital closed before December 31 of an academic year, in order for a hospital to qualify under Ranking Criterion One or Three for cap slots associated with displaced FTE residents who will graduate June 30 of the academic year in which the applying hospital took in the displaced FTE residents, the applying hospital must be able to demonstrate that it will seamlessly fill slots vacated by displaced FTE residents by that July 1; that is, the day immediately after the June 30 that the displaced FTE residents graduate (77 FR 53441 through 53442). We also revised the CMS Application Form to instruct a hospital applying under Ranking Criterion One or Three to list the names and graduation dates of specific displaced residents who, upon their graduation, have been or will be seamlessly replaced by new residents (77 FR 53446). Because Ranking Criteria One and Three fall under Demonstrated Likelihood Criterion 2, the hospital is taking over all of part of an existing residency program from the closed hospital, or expanding an existing residency training program, the requirement to include a list with the names and graduation dates of specific displaced residents who have been or will be seamlessly replaced was added under Demonstrated Likelihood Criterion 2 on the CMS Application Form.

In addition to the match deadlines associated with the National Resident Matching Program and match deadlines associated with matching into osteopathic programs, we have recently been made aware of other match deadlines associated with certain fellowship programs. From the experience we have had so far in reviewing section 5506 applications, where we have observed the complexity of tracking various match deadlines as well as the intersection between these deadlines and when the section 5506 awards are announced by CMS, we are proposing to remove the seamless requirement for slots awarded under Ranking Criterion One and Three effective for section 5506 application rounds announced on or after October 1, 2014. We are not proposing to make any other additional changes to Ranking Criterion One or Three; that is, the hospital must still be training displaced residents and must either take over or have taken over an entire program from the closed hospital and continue operating that program in the same manner in which it was operated by the closed hospital or the hospital must take over part of a closed hospital's program and permanently expand its own program as a result of training displaced

residents. Hospitals would continue to be required to submit supporting documentation when applying under Ranking Criterion One or Three that indicates that they have made a commitment to take over the closed hospital's program or that they have made the commitment to permanently expand their own residency training program resulting from taking over part of a closed hospital's program.

In determining the effective date of slots awarded under Ranking Criterion One or Three where the hospital has been training residents that were displaced by the closed hospital and receiving a temporary cap adjustment under § 413.79(h), the hospital would work with its MAC to determine when it could be permanently awarded the slots based on the graduation dates of the displaced residents it is training. Consistent with our proposal, we are proposing to remove the following requirement under Demonstrated Likelihood Criterion 2 on the CMS Application Form: ''Hospitals applying for slots under option (a) which correlates to Ranking Criterion 1 or (b) which correlates to Ranking Criterion 3 must list the names and graduation dates of specific displaced residents who, upon their graduation, have been or will be seamlessly replaced by new residents. The list may be added as an attachment to this application.'' We are proposing to replace this requirement with the following requirement under Demonstrated Likelihood Criteria 1 and 2'' ''Please indicate Y or N: As of the time of submitting this application, are you receiving a temporary cap adjustment for IME and/or direct GME under 42 CFR 413.79(h) for residents displaced by the closure of the hospital subject to this Round of section 5506? (Y/N)'' so that we are aware which hospitals are receiving temporary cap adjustments for training displaced residents under § 413.79(h), and when we award slots, we would know which hospitals to instruct to work with their MACs to determine when the slots could be permanently awarded to them based on the graduation dates of the displaced residents they are training.

In summary, we are proposing to remove the seamless requirement currently included as part of Ranking Criterion One or Three. We also are proposing to remove from the CMS Application Form, the following requirement: ''Hospitals applying for slots under option a) which correlates to Ranking Criterion 1 or b) which correlates to Ranking Criterion 3 must list the names and graduation dates of specific displaced residents who, upon their graduation, have been or will be seamlessly replaced by new residents. This list may be added as an attachment to this application.''

c. Proposed Revisions to Ranking Criteria One, Seven, and Eight for Applications Under Section 5506

In the November 24, 2010 final rule with comment period (75 FR 72223), we finalized the Ranking Criteria within each of the three first statutory priority categories (that is, same or contiguous CBSAs, same State, and same region) to be used to rank applications for assignment of slots under section 5506 of the Affordable Care Act. For each application, we assigned slots based on Ranking Criteria, with Ranking Criterion One being the highest ranking and Ranking Criterion Seven being the lowest. For a detailed discussion of the ranking categories, we refer readers to the November 24, 2010 final rule with comment period (75 FR 72212 through 72240).

After reviewing applications submitted during the first section 5506 application process (those applications that were due to CMS on April 1, 2011), we observed that the overwhelming majority of applications fell under Ranking Criterion Seven; that is, the applying hospital seeks the slots for purposes that do not fit into any of Ranking Criterion One through Ranking Criterion Six. These applications included applications from hospitals that applied for FTE cap slots for both primary care and/or general surgery and for nonprimary care specialties as well as applications for general cap relief. The sheer number of applications we received under Ranking Criterion Seven indicate a need to further prioritize among the applicants that would have qualified under Ranking Criterion Seven. Therefore, in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53434 through 53437), we finalized changes to the Ranking Criteria, replacing Ranking Criterion Seven with two separate Ranking Criteria (Ranking Criterion Seven and Ranking Criterion Eight) resulting in a total of eight Ranking Criteria. Under the Ranking Criteria, as modified by the FY 2013 IPPS/LTCH PPS final rule, a hospital that is applying both for the purpose of establishing or expanding primary care or general surgery programs, and in addition is requesting slots for the purpose of establishing or expanding nonprimary care or nongeneral surgery programs and/or for cap relief must submit an application requesting additional FTE slots for its primary care or general surgery programs under Ranking Criterion Seven. The hospital's request for additional FTE slots to establish or expand a nonprimary care or nongeneral surgery program and/or for additional FTE slots for cap relief would then be made under Ranking Criterion Eight. Prior to this change, if a hospital applied for additional FTE slots to establish or expand both a primary care or general surgery program in addition to a nonprimary care or nongeneral surgery program and/or for additional FTE slots for cap relief, all of its applications (with the exception of Ranking Criteria One through Three) would fall under Ranking Criteria Seven. For a complete list of the Ranking Criteria, we refer readers to section IV.K.5.a. of the preamble of this proposed rule, which discusses the background for preservation of resident cap positions from closed hospitals under section 5506 of the Affordable Care Act.

After reviewing applications and making awards under several more rounds of section 5506 applications, we have observed that, as hospital closings continue to occur, there has been a significant increase in the time between a hospital's closure and the announcement of section 5506 awards by CMS. We believe that this delay is partly due to the administratively burdensome task of processing, reviewing, and responding to such a large number of applications for each hospital closure, or each round of section 5506 awards. When implementing section 5506 in the November 24, 2010 final rule with comment period (75 FR 72212 through 72249), we initially envisioned the reviewing of applications and awarding of section 5506 FTE slots as being a more streamlined and expedient process. However, as a practical matter, we have found that process has been much more resource and time intensive than we had originally anticipated. This is partly due to the time and resources needed to properly apply the process established by CMS in reviewing section 5506 applications and awarding FTE cap slots. Since the initial implementation of section 5506, we have attempted to be responsive to these unexpected delays by refining the ranking criteria to make the review process less administratively burdensome. However, these changes did not alleviate the process to the desired extent. Furthermore, we have observed that, while many of the applications submitted to CMS are applications requesting FTE slots for purposes of general cap relief, we have more often than not awarded no slots at all for cap relief. This is due in large part to the limited number of slots

available (many of the closed teaching hospitals did not have large FTE resident caps) and an overwhelming demand for those slots from applicants who apply for FTE slots for reasons other than cap relief. Since we finalized the modified Ranking Criterion Seven and added Ranking Criterion Eight in the FY 2013 IPPS/LTCH PPS final rule, we have announced three new rounds of section 5506 applications due to the closures of six hospitals. We have received a total of 424 applications from hospitals seeking cap relief. Of those 424 applications, only 6 applications were ultimately awarded FTE slots, which is only 1.42 percent of the total cap relief applications. We believe that the ratio of cap relief awardees to cap relief applications does not warrant the administrative burden and the delay in announcements of section 5506 awards that result from the large number of cap relief applications submitted to CMS that are invariably denied. Therefore, in an effort to streamline the review process and to facilitate publishing section 5506 awards in a more timely manner, we are proposing to modify Ranking Criterion Eight so that Ranking Criterion Eight would only apply to hospitals seeking FTE slots to establish or expand a nonprimary care or nongeneral surgery program. Ranking Criterion Eight would no longer be applicable to hospitals seeking FTE cap slots for cap relief. Our proposal to eliminate section 5506 awards of FTE slots for cap relief is consistent with current policy goals to increase training in primary care and general surgery. By proposing to eliminate awarding of FTE slots for residents that are already being trained by a hospital, there will be more FTE resident slots available to award to other hospitals seeking to establish or expand a primary care or general surgery program under Ranking Criteria Four through Seven.

Accordingly, we are proposing to revise Ranking Criterion Eight so that it reads as follows:

Proposed Ranking Criterion Eight: The program does not meet Ranking Criteria 1 through 7, and the applying hospital will use additional slots to establish or expand a nonprimary care or a nongeneral surgery program.

In light of the modifications we are proposing to Ranking Criterion Eight, we believe it is also necessary to modify the language of proposed Ranking Criterion Seven to specify the types of applications that would properly be made under this Ranking Criterion; that is, we are proposing to remove the reference to cap relief from Ranking Criterion Seven so that it read as follows:

Proposed Ranking Criterion Seven: The applying hospital will use additional slots to establish or expand a primary care or general surgery program, but the program does not meet Ranking Criterion 5 or 6 because the hospital is also separately applying under Ranking Criterion 8 for slots to establish or expand a nonprimary care or nongeneral surgery program.

Separately, we also are proposing a change related to Ranking Criterion One. Current ranking Criterion One is for an applying hospital that assumed an entire program or programs from the hospital that closed. We are proposing to revise Ranking Criterion One to provide priority to hospitals in one scenario. Section 5503 of the Affordable Care Act amended section 1886(h) of the Act by adding new paragraph (8), which provided for the permanent reduction and distribution of residency slots. Section 1886(h)(8)(A)(ii) of the Act provides specific exceptions to the application of the reduction at section 1886(h)(8)(A)(i) of the Act, and expressly states: ''Exceptions—This subparagraph shall not apply to (I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds.'' The November 24, 2010 final rule with comment period (75 FR 72147) describes the agency's interpretation of this statutory provision. As of the time that this proposed rule is posted on the CMS Web site, we are aware of one instance in which CMS erroneously reduced a hospital's FTE resident cap contrary to this statutory exception. We are proposing to amend Ranking Criterion One under section 5506 to provide priority to a hospital which had FTE resident cap slots erroneously removed under section 5503 contrary to the statutory exception at section 1886(h)(8)(A)(ii)(I) of the Act. We are proposing to revise Ranking Criterion One as follows:

□ *Ranking Criterion One. The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, possibly the same program director, and possibly the same (or many of the same) teaching staff). The applying hospital's FTE resident caps were erroneously reduced by CMS under section 1886(h)(8)(A)(i) of the Act, contrary to the statutory exception at section 1886(h)(8)(A)(ii)(I) of the Act, and CMS Central Office was made aware of the error prior to posting of the FY 2015 IPPS proposed rule on the CMS Web site.*

d. Clarification to Ranking Criterion Two Regarding Emergency Medicare GME Affiliation Agreements

Ranking Criterion Two gives preference to applying hospitals that received slots under the terms of a Medicare GME affiliation agreement from the closed hospital. Under section 1886(h)(4)(H)(ii) of the Act, hospitals may form a Medicare GME affiliated group and elect to aggregate their respective FTE resident caps and apply them on an aggregate basis. The regulations at 42 CFR 413.75(b) and 413.79(f) implemented this statutory provision, providing specific rules for sharing FTE resident cap slots among members of the Medicare GME affiliated group, one such rule being that member hospitals must have a ''shared rotational arrangement.'' A ''shared rotational arrangement'' is defined at 42 CFR 413.75(b) as a residency training program under which a resident(s) participates in training at two or more hospitals in that program. Specifically, Ranking Criterion Two states the following:

Ranking Criterion Two. The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. If the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed was with a hospital that itself has closed or is closing, preference would be given to an applying hospital that was listed as a participant in the next most recent Medicare GME affiliation agreement (but not one which was entered into more than 5 years prior to the hospital's closure) of which the first closed hospital was a member before the hospital closed, and that applying hospital received slots from the closed hospital under the terms of that affiliation agreement.

A question has been raised as to whether hospitals that were members of an emergency Medicare GME affiliation agreement with the closed hospital prior to its closure may be considered under Ranking Criterion Two as well. The regulations at 42 CFR 413.79(f)(7)

govern emergency Medicare GME affiliation agreements, which are applicable in the instance where a statutory section 1135 waiver is invoked. In this situation, due to emergency conditions, the ''home'' hospital is unable to continue to train its residents. Therefore, under the terms of the emergency Medicare GME affiliation agreement, the ''home'' hospital may agree to temporarily transfer FTE resident cap slots to ''host'' hospitals that would train the displaced residents during the emergency period.

In the November 24, 2010 final rule with comment period (75 FR 72216), we stated that ''section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, directs the Secretary to give preference to hospitals that are members of the same affiliated group as the hospital that closed. We believe that, generally, if the applying hospital was affiliated to receive slots from the hospital that closed, then the applying hospital was relying on that number of FTE resident slots that it received in order to maintain its fair share of the cross-training of the residents in the jointly operated programs. In the absence of those slots received from the closed hospital, the applying hospital may not be able to continue training that number of FTE residents, and those same residents would not only be displaced from the closed hospital, but might essentially become 'displaced' from the affiliated hospitals in which they were used to doing a portion of their training. Accordingly, we proposed this ranking criterion to allow hospitals that were affiliated with the closed hospitals to at least maintain their fair share of the training of the residents in the programs that they had jointly operated with the closed hospital.''

In determining whether Ranking Criterion Two may encompass emergency Medicare GME affiliation agreements, we considered the key differences and similarities between regular Medicare GME affiliation agreements and emergency Medicare GME affiliation agreements. Regarding the differences, in the case of emergency affiliations, there may not have been historical cross-training or jointly operated programs between the applicant hospital and the hospital that closed. Furthermore, after the natural disaster that precipitates the section 1135 waiver, the ''home'' hospital would be in no condition to train its share of residents, which is why the ''shared rotational arrangement'' requirements at 42 CFR 413.79(f)(2) for regular Medicare GME affiliation agreements are waived for emergency Medicare GME affiliation agreements. However, it is often true with emergency affiliations that a hospital agrees to take over the training of the hospital in need, ''receiving'' FTE cap slots and residents from the ''home'' hospital, thereby creating the training relationship. In the event where, following the disaster that triggers the section 1135 waiver, a hospital should actually close, the ''host'' hospital that accepted the residents perhaps might even continue to train its share of the residents in the program after the hospital closes. Therefore, emergency affiliation agreements are similar to regular affiliation agreements in that the ''host'' hospital *received* FTE cap slots from the ''home'' hospital to train the ''home'' hospital's residents. Further, in the event that the ''home'' hospital closes, triggering a Round of section 5506, the ''host'' hospital also would need those FTE cap slots in order to continue training the share of its program for which it had taken responsibility under the emergency Medicare GME affiliation agreement before the ''home'' hospital closed.

As we stated in the November 24, 2010 final rule with comment period (75 FR 72219 through 72220), ''we believe the intent of section 5506 is to *promote continuity and limit disruption in residency training.* In that light, we believe it is logical to give preference to a hospital that received slots under the terms of the Medicare GME affiliation agreement *so that the hospital could continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement, avoiding the displacement of even more residents. . . .*'' We further stated that we ''. . . are only giving preference to hospitals that *received* slots from the closed hospital under the terms of the Medicare GME affiliation agreement, so that the hospital could continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. . . .'' Finally, we stated ''that the hospital or hospitals that were most recently affiliated with and received slots from the closed hospital would have the most immediate need for those slots.''

While the circumstances may vary, we believe that ''host'' hospitals under emergency Medicare GME affiliation agreements could fulfill much of the same role as hospitals that received slots from the hospital that closed under regular Medicare GME affiliation agreements. That is, continuity of training would be encouraged and disruption would be mitigated, to the extent that the ''host'' hospital could document to CMS that it would continue to ''train at least the number of FTE residents it had trained under the terms of the'' emergency Medicare GME affiliation agreement, and in doing so, would demonstrate it has the ''most immediate need for those slots'' as compared to another hospital. Given these similarities between regular Medicare GME affiliation agreements and emergency Medicare GME affiliation agreements, we believe that the existing Ranking Criterion Two may be read to already encompass emergency Medicare GME affiliation agreements. Accordingly, we are clarifying the existing Ranking Criterion Two to include emergency Medicare GME affiliation agreements, to read as follows:

☐ *Ranking Criterion Two. The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement or emergency Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement or emergency Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement, or emergency Medicare GME affiliation agreement. If the most recent Medicare GME affiliation agreement or emergency Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed was with a hospital that itself has closed or is closing, preference would be given to an applying hospital that was listed as a participant in the next most recent Medicare GME affiliation agreement or emergency Medicare GME affiliation agreement (but not one which was entered into more than 5 years prior to the hospital's closure) of which the first closed hospital was a member before the hospital closed, and that applying hospital received slots from the closed hospital under the terms of that affiliation agreement.*

We are making these changes to Ranking Criterion Two in the Section 5506 Application Form.

We are including below a revised Section 5506 Application Form that reflects all of the proposed changes discussed above.

CMS Application Form

As Part of the Application for the Increase in a Hospital's FTE Cap(s) under Section 5506 of the Affordable Care Act: Preservation of FTE Cap Slots from Teaching Hospitals that Close

Directions: Please fill out the information below for each residency program for which the applicant hospital intends to use the increase in its FTE cap(s). If the hospital is applying for slots for a particular program, but the requested slots in that program qualify under two different ranking criteria, submit two separate application forms accordingly. If the hospital is applying for slots associated with a Medicare GME affiliation agreement with a hospital that closed, that application must be submitted separately from an individual program request.

NAME OF HOSPITAL: _____

MEDICARE PROVIDER NUMBER (CCN): _____

NAME OF MEDICARE CONTRACTOR: _____

CORE-BASED STATISTICAL AREA (CBSA in which the hospital is physically located—write the 5 digit code here): _____

COUNTY NAME (in which the hospital is physically located): _____

Complete the following, as applicable:

1. Name of Specialty Training Program: _____

2. Medicare GME Affiliated Group: ____

(Check one): □ Allopathic Program

□ Osteopathic Program

NUMBER OF FTE SLOTS REQUESTED FOR SPECIFIC PROGRAM (OR OVERALL IF SEEKING SLOTS ASSOCIATED WITH A MEDICARE GME AFFILIATED GROUP) AT YOUR HOSPITAL:

Direct GME:_____

IME:_____

Section A: Demonstrated Likelihood Criteria (DLC) of Filling the FTE Slots

The applicant hospital must provide documentation to demonstrate the likelihood of filling requested slots under section 5506 within the 3 academic years immediately following the application deadline to receive slots after a particular hospital closes. *Please indicate the specific use for which you are requesting an increase in your hospital's FTE cap(s). If you are requesting an increase in the hospital's FTE cap(s) for a combination of DLC1, DLC2, or DLC3, you must complete a separate CMS Application Form for each DLC and specify the distinct criterion from the list below within each Form.*

Demonstrated Likelihood Criterion 1: Establishing a New Residency Program

The hospital does not have sufficient room under its direct GME FTE cap or IME FTE cap, or both, and will establish a new residency program in the specialty.

Please indicate Y or N: As of the time of submitting this application, are you receiving a temporary cap adjustment for IME and/or direct GME under 42 CFR 413.79(h) for residents displaced by the closure of the hospital subject to this Round of section 5506? (Y/N)_____

The hospital must check at least one of the following:

Application for approval of the new residency program has been submitted to the ACGME, AOA or the ABMS **(The hospital must attach a copy.)**

The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program. **(The hospital must attach a copy.)**

The hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). **(The hospital must attach a copy.)**

The hospital has other documentation demonstrating that it has made a commitment to start a new program **(The hospital must attach a copy.)**

Demonstrated Likelihood Criterion 2: Taking Over All or Part of an Existing Residency Program from the Closed Hospital, or Expanding an Existing Residency Program

The hospital does not have sufficient room under its direct GME FTE cap or IME FTE cap, or both, and (a) has permanently taken over the closed hospital's entire residency program, or (b) is permanently expanding its own previously established and approved residency program resulting from taking over *part* of a residency program from the closed hospital, or (c) is permanently expanding its own existing residency program.

Please indicate Y or N: As of the time of submitting this application, are you receiving a temporary cap adjustment for IME and/or direct GME under 42 CFR 413.79(h) for residents displaced by the closure of the hospital subject to this Round of section 5506? (Y/N) _____

The hospital must check at least one of the following:

Application for approval to take over the closed hospital's residency program has been submitted to the ACGME, AOA, or the ABMS, or approval has been received from the ACGME, AOA, or the ABMS. **(The hospital must attach a copy.)**

Application for approval of an expansion of the number of approved positions in its residency program resulting from taking over *part* of a residency program from the closed hospital has been submitted to the ACGME, AOA or the ABMS, or approval has been received from the ACGME, AOA, or the ABMS. **(The hospital must attach a copy.)**

Application for approval of an expansion of the number of approved positions in its residency program has been submitted to the ACGME, AOA or the ABMS, or approval has been received from the ACGME, AOA, or the ABMS. **(The hospital must attach a copy.)**

The hospital currently has unfilled positions in its residency program that have previously been approved by the ACGME, AOA, or the ABMS, and is now seeking to fill those positions. **(The hospital must attach documentation clearly showing its current number of approved positions, and its current number of filled positions).**

The hospital has submitted an institutional review document or program information form concerning the program in an application for approval of an expansion to the program **(The hospital must attach a copy).**

Demonstrated Likelihood Criterion 3: Receiving Slots by Virtue of Medicare GME Affiliated Group Agreement or Emergency Medicare GME Affiliated Group Agreement With Closed Hospital

The hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement ***or emergency Medicare GME affiliation agreement*** of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement ***or emergency Medicare GME affiliation agreement,*** the applying hospital *received* slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement ***or emergency Medicare GME affiliation agreement.*** If the most recent Medicare GME affiliation agreement ***or emergency Medicare***

GME affiliation agreement of which the closed hospital was a member before the hospital closed was with a hospital that itself has closed or is closing, the applying hospital was listed as a participant in the next most recent Medicare GME affiliation agreement ***or emergency Medicare GME affiliation agreement*** (but not one which was entered into more than 5 years prior to the hospital's closure) of which the first closed hospital was a member before the hospital closed, and that applying hospital *received* slots from the closed hospital under the terms of that affiliation agreement. **(Copies of EACH of the following must be attached.)**

Copies of the recent Medicare GME affiliation agreement (or emergency Medicare GME affiliation agreement) of which the applying hospital and the closed hospital were a member of before the hospital closed.

Copies of the most recent accreditation letters for all of the hospital's training programs in which the hospital had a shared rotational arrangement (as defined at § 413.75(b)) with the closed hospital.

Section B. Level Priority Category

(Place an ''X'' in the appropriate box that is applicable to the level priority category that describes the applicant hospital.)

First, to hospitals located in the same core-based statistical area (CBSA) as, or in a CBSA contiguous to, the hospital that closed.

Second, to hospitals located in the same State as the closed hospital.

Third, to hospitals located in the same region as the hospital that closed.

Fourth, if the slots have not yet been fully distributed, to qualifying hospitals in accordance with the criteria established under section 5503, ''Distribution of Additional Residency Positions''

Section C. Ranking Criteria

(Place an ''X'' in the box for each criterion that is appropriate for the applicant hospital and for the program for which the increase in the FTE cap is requested.)

☐ Ranking Criterion One. *The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, possibly the same program director, and possibly the same (or many of the same) teaching staff). The applying hospital's FTE resident caps were erroneously reduced by CMS under section 1886(h)(8)(A)(i) of the Act, contrary to the statutory exception at section 1886(h)(8)(A)(ii)(I) of the Act, and CMS Central Office was made aware of the error prior to posting of the FY 2015 IPPS proposed rule on the CMS Web site.*

Ranking Criterion Two. *The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement* ***or emergency Medicare GME affiliation agreement*** *of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement* ***or emergency Medicare GME affiliation agreement,*** *the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement,* ***or emergency Medicare GME affiliation agreement.*** *If the most recent Medicare GME affiliation agreement* ***or emergency Medicare GME affiliation agreement*** *of which the closed hospital was a member before the hospital closed was with a hospital that itself has closed or is closing, preference would be given to an applying hospital that was listed as a participant in the next most recent Medicare GME affiliation agreement* ***or emergency Medicare GME affiliation agreement*** *(but not one which was entered into more than 5 years prior to the hospital's closure) of which the first closed hospital was a member before the hospital closed, and that applying hospital received slots from the closed hospital under the terms of that affiliation agreement.*

Ranking Criterion Three. *The applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training (that is, the applying hospital is permanently expanding its own existing programs).*

Ranking Criterion Four. *The program does not meet Ranking Criteria 1, 2, or 3, and the applying hospital will use additional slots to establish a new or expand an existing geriatrics residency program.*

☐ Ranking Criterion Five: *The program does not meet Ranking Criteria 1 through 4, the applying hospital is located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program.*

Ranking Criterion Six: *The program does not meet Ranking Criteria 1 through 5, and the applying hospital is not located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program.*

Ranking Criterion Seven: *The applying hospital will use additional slots to establish or expand a primary care or general surgery program, but the program does not meet Ranking Criterion 5 or 6 because the hospital is also separately applying under Ranking Criterion 8 for slots to establish or expand a nonprimary care or non-general surgery program.*

Ranking Criterion Eight: *The program does not meet Ranking Criteria 1 through 7, and the applying hospital will use additional slots to establish or expand a nonprimary care or a nongeneral surgery program.*

Application Process and CMS Central Office Mailing Address for Receiving Increases in FTE Resident Caps

In order for hospitals to be considered for increases in their FTE resident caps, each qualifying hospital must submit a timely application. The following information must be submitted on applications to receive an increase in FTE resident caps:

- The name and Medicare provider number, and Medicare contractor (to which the hospital submits its cost report) of the hospital.

The total number of requested FTE resident slots for direct GME or IME, or both.

A completed copy of the CMS Application Form for each residency program for which the hospital intends to use the requested increase in FTE residents.

Source documentation to support the assertions made by the hospital on the CMS Application Form.

FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent as-filed cost report. Include copies of Worksheets E, Part A, and E–4.

An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, with the following information: ''I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under

federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil, and administrative action, fines and/or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents.''

CMS Central Office Mailing Address

Centers for Medicare & Medicaid Services (CMS)
Director, Division of Acute Care
7500 Security Boulevard
Mailstop C4–08–06
Baltimore, MD 21244–1850

6. Proposed Clarification and Policy Change Applicable To Direct GME Payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for Training Residents in Approved Programs

Under section 1886(k) of the Act, and as implemented in the regulations at 42 CFR 405.2468(f), federally qualified health centers (FQHCs) and rural health clinics (RHCs) may receive payment for the costs of direct GME for training residents in an approved program under certain circumstances. Specifically, the regulations at § 405.2468(f)(1) state: ''Effective for that portion of cost reporting periods occurring on or after January 1, 1999, if an RHC or an FQHC incurs 'all or substantially all' of the costs for the training program in the nonhospital setting as defined in § 413.75(b) of this chapter, the RHC or FQHC may receive direct graduate medical education payment for those residents.'' We refer readers to the July 31, 1998 final rule (63 FR 40986) for a detailed discussion of this longstanding policy. As noted earlier, the regulatory text of § 405.2468(f)(1) incorporates the definition of ''all or substantially all of the costs for the training program in a nonhospital setting'' that is defined at § 413.75(b), as part of a number of definitions applicable generally to hospital direct GME payments and those regulations at § 413.76 through § 413.83. Section 413.75(b) is based on the statutory provision at section 1886(h)(4)(E) of the Act, which establishes the requirements that hospitals must meet in order to receive direct GME payment for residents training in nonprovider settings.

The statutory use of the phrase ''all or substantially all of the costs for the training program in that setting'' is located in section 1886(h)(4)(E) of the Act, as added by section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) (OBRA '86). For a detailed discussion of the implementation of section 9314 of OBRA '86, we refer readers to the September 29, 1989 final rule (54 FR 40292). Section 1886(h)(4)(E) of the Act, as added by OBRA '86, established the requirements that hospitals must meet in order to receive direct GME payment for residents training in nonprovider settings. However, section 5504(a) of the Affordable Care Act made changes to section 1886(h)(4)(E) of the Act to reduce the costs that hospitals must incur for residents training in nonprovider sites in order to count the FTE residents for purposes of direct GME payments. In making these changes to section 1886(h)(4)(E) of the Act, section 5504(a) of the Affordable Care Act amended the Act prospectively, effective with ''cost reporting periods beginning on or after July 1, 2010'' for direct GME, by removing the phrase ''all or substantially all of the costs for the training program in that setting'' and instead permitting hospitals to count the time that residents train in activities related to patient care in a nonprovider site if the hospital incurs the costs of the residents' salaries and fringe benefits for the time that the resident spends training in the nonprovider site. In effect, this amendment reduced the costs that hospitals must incur for residents training in nonprovider settings.

Based on this statutory amendment, in the November 24, 2010 final rule with comment period (75 FR 72134), we revised the regulations at § 412.105(f)(1)(ii)(E) for IME and §§ 413.78(f) and (g) for direct GME to reflect the changes made by section 5504(a) of the Affordable Care Act. In addition, we revised the regulatory definition of ''all or substantially all of the costs for the training program in the nonhospital setting'' in order to implement the statutory amendment and apply the effective date as set forth in the statute to cost reporting periods beginning on or after July 1, 2010. Specifically, the regulations at § 413.75(b), which define ''all or substantially all of the costs for the training program in the nonhospital setting'' were revised as follows:

''(1) Effective on or after January 1, 1999 and for cost reporting periods beginning before July 1, 2007, the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education (GME); and

''(2) Effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to nonpatient care direct GME activities.''

Ultimately, with regard to the costs that hospitals must incur for residents training in nonprovider sites in order to count the FTE residents for purposes of direct GME payments, the phrase ''all or substantially all of the costs for the training program in the nonhospital setting'' no longer applies, effective for cost reporting periods beginning on and after July 1, 2010.

In the November 24, 2010 final rule with comment period (75 FR 72134), we amended the regulations applicable to direct GME payments to hospitals at §§ 413.75(b) and 413.78(g) to reflect the changes made by section 5504(a) of the Affordable Care Act. However, at that time, we inadvertently did not make conforming changes to the regulations at § 405.2468(f)(1) to clarify the requirements that FQHCs and RHCs must meet in order to receive direct GME payment for training residents in their facilities. Therefore, in compliance with our longstanding policy that FQHCs and RHCs must meet the same requirements applicable to teaching hospitals for direct GME payments with respect to training residents in nonprovider settings, in this proposed rule, we are providing clarification that, based on statutory amendments discussed earlier, the applicable policy cross-referenced in § 405.2468(f)(1) has changed for cost reporting periods beginning on or after July 1, 2010. In addition, to ensure statutory and regulatory consistency, we are proposing to revise the regulations at § 405.2468(f)(1) to add a sentence at the end of the paragraph as follows: ''However, in connection with cost reporting periods for which 'all or substantially all of the costs for the training program in the nonhospital setting' is not defined in § 413.75(b) of this chapter, if an RHC or an FQHC incurs the salaries and fringe benefits (including travel and lodging where applicable) of residents training at the RHC or FQHC, the RHC or FQHC may receive direct graduate medical education payment for those residents.''