

§ 413.86(e)(4), if a hospital did not have residents in the 1984 base period but later participates in teaching activities, the fiscal intermediaries calculate a per resident amount based on a weighted average of all the hospitals in the same geographic wage area. There must be at least three hospitals for this calculation. If there are fewer than three hospitals, the regulations require the fiscal intermediary to contact the HCFA Central Office for a determination of the appropriate amount to use.

We proposed to revise the regulations for determining base year per resident amounts for hospitals that participated in residency training after the 1984 base period. Under the proposed changes to § 413.86(e)(4)(i)(B), we sequentially follow the criteria listed below until we would base the weighted average calculation on a minimum of 3 per resident amounts:

- If there are fewer than three hospitals in the hospital's geographic wage area, we would determine a weighted average based on the per resident amounts for all hospitals in the hospital's own wage area, plus hospitals in geographically contiguous wage areas.
- If there are still fewer than three hospitals in the hospital's own wage area, plus hospitals in contiguous wage areas, the weighted average would be based on the per resident amounts for all hospitals in the State.
- If there are fewer than three hospitals in the entire State, the weighted average would be based on the per resident amounts for all hospitals in that State plus hospitals in contiguous States.
- If there are fewer than three hospitals in that State and contiguous States, the weighted average per resident amount would be based on the national average per resident amount.

*Comment:* One commenter stated that our proposed policy appears reasonable but we have not indicated how the policy would affect the per resident amounts for hospitals that previously had their payment amounts determined by HCFA Central Office.

*Response:* The proposed policy simply reflects the methodology in effect prior to this final rule with comment period. As discussed below, we are revising the methodology in this final rule with comment period. However hospitals that previously had a per resident amount determined by HCFA Central Office will be unaffected since policy changes can only be effective prospectively.

*Comment:* Two commenters suggested that the proposed methodology may negatively affect the expansion of

training sites, particularly in rural areas where there might not be three hospitals with established per resident amounts. One of these commenters suggested that the hospital with the new training program be given the option of establishing a per resident amount based on its "cost, not to exceed the higher of the contiguous area average, or the national average cost per resident, perhaps adjusted by the appropriate wage index." The other commenter suggested that if there are fewer than three hospitals, that we use the lower of the new hospital's cost per resident or the national average cost per resident adjusted by the hospital wage index. The commenter suggested that this approach would be consistent with HCFA initiatives to move from historical local or regional cost based payments to national averages. Another benefit of this approach according to this commenter is that it is simple and would overwhelmingly benefit rural hospitals.

*Response:* The per resident amounts vary widely among hospitals nationwide. Given this wide variation, we believe it is difficult to know whether a hospital establishing a new program in any given geographic area will receive a high or low per resident amount using our proposed methodology. Although the first commenter's suggested alternative is similar to the proposed policy, it guarantees a per resident amount for the new hospital that is either equal to or higher than the per resident amount under the proposed methodology if the hospital's own costs exceed the contiguous area average or the national average per resident amount. We find merit in the latter commenter's suggested alternative of using the lower of the hospital's own costs or a national average per resident amount. It has the advantage of being simple and equally as likely to produce an equitable rate as our proposed methodology. We support using the commenter's proposed methodology with a modification.

Thus, effective October 1, 1997 the per resident amount for new teaching hospitals is based on the lower of the hospital's actual per resident costs or:

- The weighted average of the per resident amounts for hospitals located in the same geographic area as that term is used in the prospective payment system under 42 CFR part 412.
- Where there are fewer than three hospitals in a geographic wage area, we will use regional weighted average per resident amounts determined for each of the nine census regions established by the Bureau of Census for statistical and reporting purposes.

2. New Legislative Changes to Direct Graduate Medical Education (Direct GME)

a. Limit on the Count of Residents (§ 413.86(g))

Section 4623 of Public Law 105-33 adds section 1886(h)(4)(F) of the Act to establish a limit on the number of allopathic and osteopathic residents that a hospital can include in its full time equivalent (FTE) count for Direct GME payment. Residents in dentistry and podiatry are exempt from the cap. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted direct medical education FTE count may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996.

Currently, hospitals report their weighted but not their unweighted FTE count on their Medicare cost report. New section 1886(h)(4)(H)(iii) of the Act gives the Secretary authority to collect whatever data are necessary to implement this provision. Hospitals have been required to report resident-specific information to their fiscal intermediaries under longstanding requirements of § 413.86, and we believe it is possible to implement section 1886(h)(4)(F) without mandating significant additional reporting. Since the unweighted direct GME FTE count will be used in calculating direct GME payments, we expect to amend the Medicare cost report to require hospitals to report the unweighted FTE direct GME count for future cost reporting periods. A separate data collection effort will be required to obtain the information for the most recent cost reporting periods ending on or before December 31, 1996.

We believe the hospital's unweighted FTE limit for its most recent cost reporting period ending on or before December 31, 1996 should be based on a 12 month cost reporting period. If the hospital's most recent cost reporting period ending on or before December 31, 1996, is a short period report, the fiscal intermediaries shall make adjustments so that the hospital's unweighted FTE limit corresponds to the equivalent of a 12 month cost reporting period. We are revising § 413.86(g)(4) accordingly.

(1) Counting Residents Based on a 3-Year Average (§ 413.86(g)(5))

Section 1886(h)(4)(C)(iii) of the Act, as added by section 4623 of Public Law 105-33, provides that for the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count for payment