FTE limitations for rural training tracks which are still set at 3 years. This proposed rule would apply the same changes to rural training tracks and remove that discrepancy.

We fully support the effort by CMS to extend the time period allowed for growth under the cap-setting limitations of RTT programs. CMS recognizes the concerns that RTTs, like any training programs, need a sufficient amount of time to grow to completion. The purpose is to establish a rural track FTE limitation that reflects the number of FTE residents whom the program will actually train, once it is fully grown. We appreciate the agency's recognition that there are times and circumstances that require amendment of its regulations in the interests of promoting sound public policy when interpreting and implementing the Medicare statute.

2. CMS Should not Apply a Rolling Average During the Cap-Setting Period of RTTs

As part of that extension of time for the cap-setting period for RTTs the proposal states that "due to the statutory language at sections 1886(d)(5)(B) and 1886(h)(4)(H)(iv) of the Act as implemented in our regulations at §§ 412.105(f)(1)(v)(F) and 413.79(d)(7), except for new rural track programs begun by urban teaching hospitals that are establishing an FTE cap for the first time, FTE residents in a RTT at the urban hospital are subject immediately to the 3-year rolling average for direct GME and IME." In other words, unless the hospital is a brand new teaching hospital, the three-year rolling average will continue to apply to resident FTEs training in the rural track program, even during the five-year RTT cap-building window. We are concerned that the impact of the application of the rolling average to new RTTs is extremely detrimental to institutions' ability to establish new RTTs. Instead, CMS should pay for the entire direct and indirect costs of RTT residents, including during the growth window. We believe CMS continues to take an unduly cramped reading of its statutory authority. That authority clearly establishes "special rules" to support training of physicians in rural areas.

For example, Section 1886(h)(4)(H)(iv) of the Social Security Act provides : *Nonrural hospitals operating training programs in rural areas.—In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an* ***appropriate manner*** *[emphasis added] insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas.*

In addition, other statutory language relating to new facilities states the following: *`(i) NEW FACILITIES- The Secretary shall,* ***consistent with the principles*** *[emphasis added] of subparagraphs (F) and (G), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas."*

For the purpose of providing adjustments to the limitations for hospitals establishing residency training programs in rural areas and giving special consideration for new facilities, CMS should not apply the rolling average at the inception of the RTT to help address the nation's need of physicians for these areas. We believe that the special consideration for new facilities should apply because for greater than 50 percent of the time the programs' residents will be situated in a new facility – a new training site – and not in the urban "mother" hospital. Basically the effect of this rule is that urban hospitals will lose one complete years' worth of claims for RTT FTEs. That loss will be spread over 2-4 years, but will be a net loss. The hospital will have to absorb these early losses. Below is a spreadsheet (personal communication, Louis Sanner, MD, May 4, 2016) showing the impact of this loss under various existing scenarios. The dollar amount of these lost resident FTE claims can be