CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Beaumont Hospital, Wayne (f/k/a Oakwood Annapolis Hospital) **Provider** **vs.** Wisconsin Physicians Services **Medicare Administrative Contractor**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending:** 12/31/08, 12/31/09, and 12/31/12) **Review of:** PRRB Dec. No. 2018-D33 **Dated:** April 17, 2018

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). . The CMS' Center for Medicare (CM) submitted comments, requesting reversal of the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. The Medicare Administrative Contractor (MAC) submitted comments, requesting reversal of the Board's decision. Comments were also received from the Provider requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether, the Provider is entitled to higher direct graduate medical education (DGME) and indirect medical education (IME) full-time equivalent (FTE) resident caps for a new family medicine residents training program.

The Board held that the MAC improperly calculated the Provider's GME and IME FTE resident caps, and directed the MAC to adjust the Provider's new family medicine resident training program cap to 29.28 for both GME and IME. In reaching this determination, the Board compared the regulations as written in 2007 and as modified in 2012 and concluded that no adjustment was required for out-rotations since the residents were only spending a portion of the year at other hospitals and not the entire program year at the other hospitals. The Board

concluded that the 2012 regulation was not a modification, but rather a change to the way out-rotations were handled in the calculation of the GME/IME FTE caps for new medical residency training programs.

SUMMARY OF COMMENTS

The MAC submitted comments requesting that the Administrator reverse the Board decision. The MAC contended that the 2012 regulation was not a modification, but rather a clarification of the ambiguous language of the 2007 regulation with respect to FTE residents that trained at one hospital for less than an entire program year. The 2012 regulation merely clarified the 2007 regulation by specifying that residents spending less than a full year at one hospital, but out-rotated to other participating hospitals, are to be included in the calculation. Finally, the MAC argued that the Provider's methodology of counting residents could result in IME and GME FTE caps greater than the number of approved accredited slots available to the Provider.

Based on the Board's discussion, CM stated that, it appeared that the Board only looked at the regulations text in effect in 2007, but failed to review the relevant Federal Register preamble discussions which explained the regulations text in effect in 2007. There are established legal principles that preamble language that is not codified in the regulations text can be binding substantive rules, and that great deference is given to an agency's accompanying preamble language. Had the Board consulted the relevant preamble discussions, the Board would have seen that CMS (then HCFA) explicitly discussed, not only full year out-rotations, but also partial out-rotations, thereby addressing the concept that the overall cap adjustment would have to be apportioned among multiple hospitals that train the residents in the first 3 years of the program's existence.

CM pointed out that, specifically, the July 31, 1999 IPPS *Federal Register* (64 FR 41518-20) provided the most relevant discussion of the regulations text to which the Board and Provider referred. While CM believed that this July 31, 1999 *Federal Register* addressed how to calculate the FTE resident caps in situations of both whole year out-rotations and partial year out-rotations, but acknowledged this point could have been clearer in this rulemaking regarding the numerous graduate medical education changes introduced by the Balanced Budget Act (BBA) of 1997. It was not until the FY 2013 IPPS rulemaking, as finalized in the August 31, 2012 *Federal Register* (77 FR 53416), that CMS formally made corrections and clarifications to the preamble language and regulations text at §413.79(e) to better elucidate the policies developed in the 1999 rulemaking.

CM described the application of the policies and calculations in the July 31, 1999 *Federal Register* to this particular case. The Board and the Provider are incorrect to assert that the 2012 regulations are a change in policy from the 2007 regulations (with the exception of the actual change in the new program growth window from 3 years to 5 years, effective October 1, 2012), and that the Board is also incorrect that the 2007 and 2012 regulations treat out-rotations differently regarding full year out-rotations versus partial year out-rotations. CM noted that the regulations as written in 2007 were first implemented in the July 30, 1999 IPPS final rule (64 FR 41519 - 41520). The preamble to this final rule specifically addresses rotations to other hospitals

for both whole years and partial years (64 Fed. Reg. 41519 - 41520). In response to comments CMS stated: "In situations where the residents spend partial years at different hospitals during the first 3 years of the new residency program, each hospital that trains the residents receives an adjustment to its cap based on [the] product of the highest number of residents in any program year during the third year of the first program's existence and the minimum accredited length of the program." In addition to this *Federal Register* preamble language discussing the concept of residents training for partial years at multiple hospitals, the regulations text implemented at the time at 42 CFR § 413.86(g)(6)(i) (now § 413.79(e)(1)) clearly state the requirement that a new teaching hospital's cap is adjusted " . . . based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program (emphasis added, July 31, 1999, 64 Fed. Reg. 41542).

In this case, the total allowed cap amounts for DGME and IME respectively is 30, because the family medicine program as a whole was accredited for 30 positions (10 positions for Program Year 1, 10 positions for Program Year 2, 10 positions for Program Year 3). In both the 2007 and the 2012 versions of the regulations, as quoted above, there is a requirement that "the adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program."

CM pointed out that the Provider argued it should receive DGME and IME caps of 29.28, which is the product of 9.76 Program Year (PY) 1-- FTE residents (the highest number of residents in any program year during the third year of the first program's existence), and 3 years (the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program, which is 3 years for family medicine). However, by the Provider's logic, and also adhering to the plain reading of the 2007 regulations and July 30 1999 preamble, the same methodology would be applied to calculate the caps of the other participating hospitals, resulting in a product for each hospital that would also be 29.28. If each hospital would receive separate FTE resident caps of 29.28, then the total caps awarded would be 87.84 (29.28 x 3 participating hospitals in this case), an impossible outcome, as the entire program is only accredited for 30 positions. Furthermore, the regulations at 42 CFR § 412.105(f)(1)(iii) for IME and §413.78(b) for DGME state that a hospital cannot claim the time spent by residents training at another hospital. By taking 29.28 as its own DGME and IME FTE resident caps, the Provider is taking more than its legal and fair share of the 30 accredited positions.3 Therefore, it is illogical and incorrect for the Provider and Board to assert that no step should be taken in the calculation of the FTE resident caps to account for the portion of time spent at the other two hospitals. Only by accounting for the time spent at each hospital respectively, by multiplying the overall cap adjustment of 29.28 by the percentage of time spent at each hospital over 3 years, can we be assured that the limit of 30 accredited positions is not exceeded. In this case, since 81.87 percent of the DGME training time and 81.54 percent of the IME training time was at the Provider, this results in a DGME FTE resident cap of 23.96 and an IME cap of 23.87, as the MAC correctly calculated. Had the other 2 hospitals been eligible for cap adjustments, their shares of the overall cap of 29.28 would have been calculated as follows for the DGME and IME,

respectively, for each Hospital where the residents trained and as a total: Dearborn (23-0020): 5.06 5.15; Wayne (23-0142) 23.96 23.87; Trenton (23-0176) 0.25 0.25; Totals: 29.274, 29.275. In sum, CM agreed with the MAC's calculations for the Provider's DGME and IME FTE resident caps for the new family medicine program. We recommend that the Administrator reverse the Board's findings and therefore, affirm that the Provider's DGME FTE resident cap is 23.96 and the IME FTE resident cap is 23.87.

The Provider commented that the Board's decision should be upheld. The Board was required to decide the following: 1.Whether the MAC applied the appropriate version of the applicable governing regulation, 42 C.F.R. § 413.79(e)(l). The Provider contended that the 2007 version applies (the "'2007 Regulation), while the MAC relies on the 2012 version (the "2012 Regulation"); 2. Whether it was appropriate for the MAC to adjust for out-rotations in determining the FTE Caps. The Provider maintained that under the 2007 Regulation the MAC should not have adjusted for out-rotations, while the MAC maintained that under the 2012 Regulation it appropriately adjusted for out-rotations; and 3. If the Board finds that it was appropriate for the MAC to adjust for out-rotations in determining the FTE Caps (which the Provider disputes), whether the MAC determined the FTE CAPS consistent with the 2007 Regulation.

As a preliminary matter the Provider pointed out that it is important for the Administrator to recognize that this case is unique, and likely not capable of repetition, because there was a five year gap between the end of the Provider's cap growing period (2008) and the MAC's determination of the FTE Caps (2013). During this intervening period, CMS promulgated the 2012 Regulation, effective October 1, 2012. But for this gap, the MAC would have determined the FTE Caps in 2008 based on the 2007 Regulation and this appeal most likely would have been unnecessary. For the Administrator to affirm the decision of the PRRB based on the unique facts of this case not only is entirely appropriate, but it would not establish precedent because it is extremely unlikely that a case with the same or similar facts will recur.

More specifically, the Provider established a new medical education program to train family practice residents on July 1, 2004. Under the governing regulation, 42 C.F.R. 413.79(e)(l), the Provider had a three-year window in which to build its permanent FTE Caps. The three year window ended as of June 30, 2007. Thus, the version of 42 C.F.R. 413.79(e)(l) in effect during the three year window, i.e., as of June 30, 2007, applied to the MAC's determination of the FTE Caps. (The "2007 Regulation.") Ordinarily, the MAC would have computed the FTE Caps in 2008, and would have applied the 2007 Regulation, thus likely obviating the need for this appeal. The MAC, however, did not compute the FTE Caps until 2013, and in so doing applied the version of 42 C.F.R. 413.79(e)(l) that was effective for new residency programs established on or after October 1, 2012. (The "2012 Regulation.") The MAC's delay in determining the FTE Caps was because, four years after the Provider established the new residency program, CMS required the MAC to reopen and to determine that program was not "new," but instead was a "relocation." The Provider appealed to the Board, which decided in favor of the Provider. See Oakwood Annapolis Hospital, PRRB Dec. No. 2012-D4 (December 30, 2011) (Medicare and Medicaid Guide (CCH) 82781).

First the Provider argued that CMS contends that the 2012 Regulation "clarified," and did not reflect a change in policy from, the original 1999 rulemaking. The Provider demonstrated, that this contention is erroneous. But, as preliminary matter, the Administrator should find that CMS conceded, as the MAC conceded before the PRRB, that the MAC applied the 2012 Regulation. The Administrator should further find, therefore, that CMS conceded that in 2013 the MAC applied the 2012 Regulation for determining the Provider's FTE Caps, although the Provider's three-year cap growing period ended in 2007. The Administrator should also find, therefore, that the MAC would have applied the 2007 Regulation, without any "clarification" contained in the 2012 Regulation, had the MAC determined the FTE Caps in 2008.

The Provider stated that the Administrator of course is aware that absent express statutory authority a regulation cannot be applied with retroactive effect. *See Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988). CMS cites no such statutory authority in the instant case. Instead, the entire justification that CMS offers for the MAC's application of the 2012 Regulation to a cap growing period that ended in 2008 is that it is a "clarification." The Provider demonstrates below that the 2012 Regulation is a change in law, not a clarification. But even if it is a clarification, CMS lacks authority to apply it retroactively. In the event, as it should, the Administrator finds that in fact the 2012 Regulation is not a mere clarification, the Administrator should find as a matter of law that application of the 2012 Regulation constituted unlawful retroactive rule making.

The Administrator should find that, on its face, the 2012 Regulation is effective as of October 1, 2012 and does not apply to prior periods. CMS contended that the Administrator is required to give weight to preamble comments. The Administrator's review of the notice and comment rule making regarding the 2012 Regulation reveals that its purpose was to apply to new teaching programs that began training residents on or after 10/1/2012. See 77 Fed. Reg. 27976 at 279880-279881 (May 11, 2012). ("We are proposing that this change would apply to new teaching hospitals that begin training residents in new programs for the first time on or after October 12, 2012.") Specifically, CMS stated that the change in methodology regarding residents training at more than one hospital applied only to teaching programs commencing on or after October 1, 2012: "In addition, we are proposing to change the regulation text at§ 413.79(e) (l)(i) to reflect a methodology to calculate a new teaching hospital's cap adjustment if the residents in the new training program are training at more than one hospital. We are proposing that these changes would be effective for a hospital that begins training residents for the first time on or after October 1, 2012." (77 Fed. Reg. 27976 at 27980-27981).These statements the Provider contended should end the inquiry.

The Provider noted that CM contended that the Administrator is required to give weight to preamble comments. Should the Administrator give weight to the preamble commentary, review of the preamble comments of CMS in promulgating the 2012 Regulation belies the notion that it is a clarification. First, the CM does not cite any statement in the preamble to the 2012 Regulation that it clarifies prior policy dating back to 1999, much less to 2007. Nor did the MAC cite any such statement in its pleadings and presentation before the Board or in the MAC. Comments submitted to the Administrator for review. Second, review of the CMS commentary regarding the 2012 Regulation can result in only one conclusion, i.e., that the clear intention of

CMS was to apply the changed methodology only to new teaching programs that began training residents on or after 10/1/2012. See 77 Fed. Reg. 27976 at 27978 (May 11, 2012) ("'We are proposing that this change would apply to new teaching hospitals that begin training residents in new programs for the first time on or after October 12, 2012.")

Notably, CMS used the word "change." Surely a "change" differs from a "clarification." Specifically, CMS stated that the change in methodology regarding residents training at more than one hospital applied only to teaching programs commencing on or after October 1, 2012: "In addition, we are proposing to change the regulation text at § 413.79(e)(1)(i) to reflect a methodology to calculate a new teaching hospital's cap adjustment if the residents in the new training program are training at more than one hospital. We are proposing that these changes would be effective for a hospital that begins training residents for the first time on or after October I, 2012." (77 Fed. Reg. 27976 at 27980-27981) (Emphasis added.) Thus, CMS itself states in the preamble that the 2012 Regulation was a change effective for teaching programs established on or after October 1, 2012. CMS concedes that the 2012 regulation was applied to determine the Provider's FTE Caps. The Administrator must find, therefore, that the MAC's application of the 2012 Regulation constitutes unlawful retroactive rulemaking. The Provider argued that the Balanced Budget Act of 1997, Public Law 105-32 (the "BBA") established the FTE Caps on the computation of the GME Payment and the IME Adjustment. In the earliest rule implementing this provision of the BBA, CMS explained how the permanent FTE Caps were to be established, 62 Fed. Reg. 45966 (August 29, 1997). Thus, CMS (then HCFA) provided the following guidance regarding the then current methodology:" For example, assume a hospital that did not receive any direct GME payment in its cost reporting period ending December 31, 1994 (the hospital's most recent cost reporting period ending before January 1, 1995) established an internal medicine program and receives direct GME payment for residents beginning a training program on July 1, 1998. The hospital's cap would be adjusted to reflect the resident cap for residents in the internal medicine program for its cost reporting periods ending in 1998 and 1999. In the hospital's cost reporting period ending December 31, 2000 (the third cost reporting period in which the hospital has residents), there are five first-year FTE residents participating in the hospital's internal medicine program. Since the minimum length listed for internal medicine programs in the Graduate Medical Education Directory is 3 years, this hospital's unweighted FTE cap can subsequently be adjusted by up to 15 FTEs. "

The Provider also argued, that CMS did not state that any adjustment for out-rotations should be made. Subsequently, CMS provided further guidance by identifying the single situation in which out-rotations would be taken into account. 64 Fed. Reg. 24734 (May 7, 1999). CMS explained as follows: "Sections 4I3.86(g)(6)(i) and 413.86(g)(6)(ii) specify that the adjustment to the cap is also based on the number of years in which residents are expected to complete each program accredited length for the type of program. We are proposing to add language to clarify how to account for situations in which the residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital. In this situation, the adjustment to the FTE cap is based on the number of years the residents are training at each hospital, not the minimum accredited length for the type of program. If we were to use the minimum accredited length for the program in this case, the total adjustment to the cap might exceed the total accredited slots available to the hospitals participating in the program. In the May

12, 1998 final rule (63 FR 26334), we specified that the adjustment to the FTE cap may not exceed the number of accredited resident slots available. " Thus, the 2007 Regulation, which is applicable to the Provider's cap growing period of 2004-2007, provides as follows:

> (1) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (c) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new p r o g r a m .
>
> (i) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

The Provider argued that the agency's interpretation of its own regulations is not entitled to deference, and should be set aside, if it is inconsistent with the plain meaning of the regulation and other indications of the Secretary's intent when the regulation was adopted. *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994). As is evident from the clear and unambiguous language of the 2007 Regulation, no adjustment is required for out-rotations unless a resident spends one or more entire program years at two or more hospitals. Even that situation is limited, however, to where the hospital to which residents out-rotate are eligible to receive an adjustment to its FTE cap: "the adjustment to each respective hospital's cap." Here, the parties stipulated that neither of the two hospitals to which the Provider's residents out-rotated were eligible to receive, and in fact did not receive, an adjustment to their FTE caps. See Stipulation, Paragraphs 11 and 13. Under the 2007 Regulation, therefore, no adjustment for out-rotations was appropriate under the facts of this case where: (1) the residents did not out-rotate for an entire program year, and (2) neither of the two hospitals to which the residents out-rotated received an increase in their FTE Caps or in their GME Payment or IME Adjustment .

Having stated "for the record that that we could have been clearer in this rulemaking," CMS somewhat contradicts itself by basing its argument in this case principally on to the following 1999 preamble text: "In situations where the residents spend partial years at different hospitals during the first 3 years of a new residency program, each hospital that trains the residents receives an adjustment to its cap based on [the] product of the highest number of residents in any program year during the third year of the first program's existence and the minimum accredited length of the program." Preliminarily, the Administrator should find that this is a new argument

in this case. The MAC, who with assistance of competent counsel presented the case on behalf of CMS before the PRRB, did not cite this 1999 preamble text. CMS should not be permitted to present this 1999 preamble text at this stage of these proceedings under the Administrator's review, 42 C.F.R.§ 405.1875.

But, even if the Administrator considers the 1999 preamble text, the Administrator should find for any of the following reasons that it does not support the positon of CMS. First, as noted, this provision did not remotely appear in the codified text until the promulgation of the 2012 Regulation. Second, the MAC, which is the agent of CMS, was unaware of this provision. As noted, the MAC did not present this text before the PRRB. Certainly the MAC would have referred to this text in the hearing before the Board if the MAC believed that this provision supported its action. On the contrary, and as the PRRB decision states, the PRRB requested, but the MAC failed to provide, any CMS guidance regarding whether treatment of out-rotations predating the 2012 Regulation. Thus, CMS presents this 1999 preamble statement, regarding which the MAC was ignorant, for the first time in these proceedings. Third, CMS contends that preamble text has the force of law as a codified regulation. The authority on which CMS relies contemplates preamble text appearing in the proposed and the final rule.

The Provider, however, stated that the provision lacks the force of law. The preamble to the proposed rule did not state that an adjustment for out-rotations would be made for less than a full program year. (64 Fed. Reg. 24734 (May 7, 1999)). The Medicare Act, 42 U.S.C. § 1395hh(a)(4), contains the following requirement that a final regulation must be the "logical outgrowth" of the proposed regulation. Last, but by no means least, the only permissible interpretation of the 1999 preamble text is that it applies only where residents rotate from one new teaching hospital to one or more other new teaching hospitals. The clear purpose of that provision would be to assure that no more than one FTE per resident, in the aggregate, is allocated to each of the several each new teaching hospitals' FTE Caps. The key to this interpretation is the phrase: "each hospital that trains the residents receives an adjustment to its cap." Once a teaching hospital's permanent cap is established, it is subject to revision under limited circumstances. Those limited circumstances do not include acceptance of in-rotations from a new teaching hospital. This statement, therefore, can only be intended to apply when the hospital that accepts in-rotations is itself a new hospital. Similarly CMS relies on the 1999 preamble statement that "adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program."14 This problem would arise only if the two other hospitals to which the Provider's residents rotated received adjustments to their FTE Caps. That was not the case before the Board or before the Administrator. The MAC stipulated that the two other hospitals receiving the in-rotations had established GME Caps not subject to adjustment based on the in-rotations. And, the Provider is accredited for 30 slots. The Board found that the Provider was entitled to claim 29.28 slots, i.e., below the total number of 30 accredited slots. The MAC Comments raise this point as well, to which the Provider responded that in any event, the provider argued that the 2012 regulation does not provide for an adjustment of out-rotations in this case. Even if the Administrator finds that the 2012 Regulation applies here, the Administrator must find that, by its very terms, the 2012 Regulation does not provide for an adjustment for out- rotations unless residents rotate to another new teaching hospital. The Administrator should find, therefore, that neither the 2007 Regulation nor the 2012 Regulation

authorized the MAC's adjustment for out-rotations in this case because the out-rotations were not to new teaching hospitals in their cap growing period.

The Provider also rebutted the MAC's arguments that it would result in an increase of the accredited slots. The MAC's witness before the PRRB, Mr. Lange, acknowledged that, as stipulated, neither of the hospitals to which the residents out-rotated requested an increase in their FTE caps. Finally in the alternative, the Provider argued that, As depicted in this chart, the out-rotations are subtracted from the total number of PG- I, PG-2 and PG-3 residents during the third year of the residency program's existence. Thus, following the subtraction of out-rotations, PG-3 has the highest number of FTE residents, i.e., 8.89 and 8.67. The permanent FTE Caps, therefore are: DGME: 8.29 x 3 = 26.66 FTEs; IME: 8.67 x 3 = 26.01 FTEs.

Although this specific method is not explicitly stated in the 2007 Regulation, it is entirely consistent with the basic methodology stated in the 2007 Regulation if, assuming arguendo, an adjustment for out-rotations is required. Thus, under the 2007 Regulation the MAC is instructed to identify the program year containing the greatest number of residents during the third year of the program's existence. If an adjustment is required for out-rotations, the methodology depicted above accomplishes the objective by identifying the number of FTE residents in PG-1, PG-2 and PG-3 net of out-rotations. PG-3 has the greatest number of FTE residents net of out-rotations. Multiplying those FTEs times the three years necessary to complete the residency program yields the permanent FTE Caps. If the Administrator finds that an adjustment for out-rotations is appropriate (which the Provider disputes), the Administrator should remand with an order that the MAC compute the effect of the out-rotations in accordance with the data and methodology demonstrated above.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Section 1886(h) of the Social Security Act (Act), currently implemented in the regulations at 42 Code of Federal Regulation (C.F.R.) 413.75 through 413.83,[1] establishes a methodology for determining payments to hospitals for the direct costs of approved GME programs. In general, Medicare direct GME payments are calculated by multiplying the hospital's updated Per Resident Amount (PRA) by the weighted number of Full-Time Equivalent (FTE) residents working in all areas of the hospital complex (and at nonprovider sites, when applicable), and the hospital ratio of Medicare inpatient days to total inpatient days.

Section 1886(d)(5)(B) of the Act, as implemented at 42 C.F.R. §412.105, 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

[1] See 69 Fed. Reg. 48768, 49234-49239 (Aug. 11, 2004). Formerly codified at 42 C.F.R. § 413.86, *et seq.*

GME program, in order to account for the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The hospital's IME adjustment applied to the Diagnosis Related Group (DRG) payments is calculated based on the ratio of the hospital's number of FTE residents training in the inpatient and outpatient departments of the IPPS hospital (and at nonprovider sites, when applicable), to the number of inpatient hospital beds. This ratio is referred to as the IME Intern-and Resident-to-Bed (IRB) ratio.

I. Section 1886(h) and Section 1886(d)(5(B)

GME

For purposes of the graduate medical education (GME) payment, section 1886(h)(2) provides for the determination of hospital specific approved "Full Time Equivalent" (FTE) resident amounts, stating that:

> The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985.

In addition, section 1886(h)(4) requires, in the determination of full-time-equivalent residents, that:

> (A) Rules.—The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.
> (B) Adjustment for part-year or part-time residents.—Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

Congress also established a limitation on number of residents in allopathic and osteopathic medicine at section 1886(h)(4)(F) and (G) of the Act, which states:

> —In general.—
> (i) Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, subject to paragraphs (7) and (8), the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996. …
> (G) Counting interns and residents for FY 1998 and subsequent years.—
> (i) In general.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 1997, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents for determining a hospital's

> graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.
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> IME

Similarly, regarding the IPPS indirect medical education adjustment or IME payment, section 1886(d)(5)(B) states that:

> The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:
> ***
> (v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. The provisions of subsections (h)(4)(H)(vi), (h)(7), and (h)(8)shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subsection (h)(4)(F)(i).

II. Counting Full Time Equivalent (FTE) Residents

Consistent with the foregoing directives regarding the counting of full time equivalent residents and accounting for when a resident spends only a portion of a period with a hospital or simultaneously with more than one hospital, CMS implemented regulations at 42 CFR 413.75 through 413.83. The regulations, as a preliminary matter, requires proper documentation and identification of the residents, stating at 42 CFR 413.75 that:

> (d)Documentation requirements. To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.
> (1) The name and social security number of the resident.
> (2) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.
> (3) The dates the resident is assigned to the hospital and any hospital-based providers.
> (4) The dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any.
> (5) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation.

> (6) If the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of this section.
> (7) The name of the employer paying the resident's salary.

Further, 42 CFR 413.78, states that:

> §413.78 Direct GME payments. Determination of the total number of FTE residents. Subject to the weighting factors in §§ 413.79 and 413.80, and subject to the provisions of § 413.81, the count of FTE residents is determined as follows:
> (a) Residents in an approved program working in all areas of the hospital complex may be counted.
> (b) *No individual may be counted as more than one FTE. A hospital cannot claim the time spent by residents training at another hospital.* Except as provided in paragraphs (c), (d), and (e) of this section, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.(Emphasis added.)

Similarly, 42 CFR 412.105(f)(1)(2010) provides in defining full time equivalent, that:

> (ii) (A) Full-time equivalent status is based on the total time necessary to fill a residency slot. No individual may be counted as more than one full-time equivalent. If a resident is assigned to more than one hospital, the resident counts as a partial full-time equivalent based on the proportion of time worked in any areas of the hospital listed in paragraph (f)(1)(ii) of this section to the total time worked by the resident. A hospital cannot claim the time spent by residents training at another hospital. A part-time resident or one working in an area of the hospital other than those listed under paragraph (f)(1)(ii) of this section (such as a freestanding family practice center or an excluded hospital unit) would be counted as a partial full-time equivalent based on the proportion of time assigned to an area of the hospital listed in paragraph (f)(1)(ii) of this section, compared to the total time necessary to fill a full-time residency slot.

In the implementing regulations promulgated pursuant to notice and comment rulemaking in 1989, CMS explained that:

> 2. Determining Full-Time Equivalency (FTE) Section 1886(h)(4) of the Act bases payment for direct GME costs on a hospital's number of full-time equivalent (FTE) residents multiplied by a hospital-specific per resident amount. *Since our main concern in the counting of residents is that no individual be counted as more than one FTE, we did not propose to define a FTE based on a specific number of*

> *hours worked per week or per year.* Rather, we proposed that FTE status would be based on the total time necessary to fill a residency slot…. [2]

Towards that end, to ensure that all residents are properly counted and that no resident is counted as more than one FTE, CMS required that each hospital maintain and have available certain information for each resident whom it counts toward its number of FTEs at 52 CFR 413.75(d). Further, in the 1989 rulemaking, responding to comments, CMS stated:

> Comment: One commenter requested that we change our proposal to count a resident for only the hospital in which he or she spent the majority of the month to a prorated count between the hospitals.
> Response: We agree. We had originally believed that a monthly count would be significantly less burdensome than a daily or hourly count, or a count on any other basis. However, in order to attribute the count of a resident to the hospital in which the resident spent the majority of the month, sufficient documentation would be required so that prorating the resident across hospitals would probably not require that much additional time and effort. Therefore, we will instruct hospitals and fiscal intermediaries to apportion the time spent by each resident among the hospitals based on the number of days (or portions of days if necessary) worked at each facility. *It will be necessary for the hospital to maintain documentation acceptable to the fiscal intermediary to verify that no resident is counted as more than one FTE during the graduate medical education academic year, regardless of the number of hospitals in which he or she is providing services or the total number of hours of service provided.*
> Comment: Several commenters suggested that the problem of counting rotating residents would be best resolved by making all payments to the hospital that is the primary sponsor of the program. One commenter pointed out that, while some hospitals would not be paid for costs they incur for teaching and supervision of the residents, they would be adequately "repaid" by the services provided by residents to the patients at that hospital.
> Response: Section 1886(h)(2) of the Act requires that "The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount * * *." We do not believe that we have the authority to restrict the number of hospitals for which an approved FTE resident amount will be computed.[3]

CMS repeated this policy in the FFY 1991 Final Rule, stating that:

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[2] 54 Fed. Reg. 40286, 40291 (Sept 29, 1989) (Medicare Program; Changes in Payment Policy for Direct Graduate Medical Education Costs),

[3] 54 Fed. Reg. 40286 at 40303, (Sept. 29, 1989); see also 53 Fed. Reg. 36589, 36595 (Medicare Program; Changes in Payment Policy for Direct Graduate Medical Education Costs) (Sept. 21, 1988).

> Based on these considerations, we are taking this opportunity to clarify that in determining the reasonable costs of GME included in the GME based period, the net costs incurred by a teaching hospital for services furnished by residents in other provider settings may be included in the hospital's allowable costs. However, in determining the total number of resident FTEs in both the GME base year *and in the payment year, only the time the resident spent at the teaching hospital will be counted*. This is because no resident may be counted as more than 1.0 FTE and the other hospital is required to include the portion of time the resident spent at its facility in its FTE count consistent with § 413.86(f).[4]

In the FFY 2003 final rule, CMS again addressed the matter that:

> 4. Rotating Residents to Other Hospitals. At existing § 413.86(f), we state, in part, that a hospital may count residents training in all areas of the hospital complex; no individual may be counted as more than one FTE; and, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as a partial FTE based on the proportion of time worked at the hospital to the total time worked (emphasis added). A similar policy exists at §§ 412.105(f)(1)(ii) and (iii) for purposes of counting resident FTEs for IME payment. Although these policies concerning the counting of the number of FTE residents for IME and direct GME payment purposes have been in effect since October 1985, we continue to receive questions about whether residents can be counted by a hospital for the time during which the resident is rotated to other hospitals. In the May 9, 2002 notice, we proposed clarifying that it is longstanding Medicare policy, based on language in both the regulations and the statute, to prohibit one hospital from claiming the FTEs training at another hospital for IME and direct GME payment. This policy applies even when the hospital that proposes to count the FTE resident(s) actually incurs the costs of training the residents(s) (such as salary and other training costs) at another hospital. First, section 1886(h)(4)(B) of the Act states that the rules governing the direct GME count of the number of FTE residents "shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital." In the September 4, 1990 Federal Register (55 FR 36064), we stated that "* * * regardless of which teaching hospital employs a resident who rotates among hospitals, each hospital would count the resident in proportion to the amount of time spent at its facility." Therefore, another hospital cannot count the time spent by residents training at another hospital. Only the hospital where the residents are actually training can count those FTEs for that portion of time. For example, if, during a cost reporting year, a resident spends 3 months training at Hospital A and 9 months training at Hospital B, Hospital A can only claim .25 FTE and Hospital B can only claim .75 FTE. Over the course of the entire cost reporting year, the resident would add up to 1.0 FTE.")

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[4] 55 Fed. Reg. 35990, 36065 (Sept. 4, 1990) (Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1991 Rates)

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> As we clarified in the proposed rule and also above, existing § 413.86(f) states, in part, that a hospital may count residents in all areas of the hospital complex; no individual may be counted as more than one FTE; and, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as a partial FTE based on the proportion of time worked at the hospital to the total time worked (emphasis added). A similar policy exists at §§ 412.105(f)(1)(ii) and (iii) for purposes of counting resident FTEs for IME payment. Thus, we believe our existing regulations are already very clear that hospitals cannot count resident rotations at other hospitals; indeed, the hospital can only count residents working "at the hospital". However, because we continue to receive many questions on this policy, even though it is a longstanding one, in this final rule we are revising §§ 413.86(f) and 412.105(f) to explicitly prohibit the counting of residents at other hospitals.[5]

In discussing the statutory basis for this rule that no individual may be counted as more than one FTE; and, if a resident spends time in more than one hospital, the resident counts as a partial FTE based on the proportion of time worked at the hospital to the total time worked, CMS again stated in the FFY 2003 Rule, that:

> In addition, section 1886(h)(4)(A) of the Act requires the Secretary to establish rules for the computation of FTE residents in an approved medical residency training program. Furthermore, at paragraph (B) of that section, the statute requires that the regulations take into account individuals who serve as residents simultaneously with more than one hospital. Therefore, we believe that the Secretary has the authority to allow a hospital to count only those residents actually training in that hospital. Even where the residents are training at other hospitals or foreign hospitals, it is not appropriate for the hospital to include those residents in its FTE count.[6]

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[5] 67 Fed. Reg. 49982, 50076-50078 (Aug. 1, 2002)(Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates)

[6] 67 Fed. Reg. 49982, 50076-50078 (Aug. 1, 2002); s*ee also* 71 Fed. Reg. 47870 (Aug. 18, 2006)(Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates)("In the existing regulations at §413.78(b) for direct GME payments, we specify that no individual may be counted as more than one FTE, and that a hospital cannot claim the time spent by residents training at another hospital. Therefore, if a resident spends time training in more than one hospital, the residents counts as a partial FTE based on the portion of time the resident trains at the hospital (and a nonhospital setting if the hospital meets the requirements of §413.78(e)) to the total time worked. (The same provisions apply to part-time residents as specified in § 413.78(b)). A similar policy exists at § 412.105(f)(1)(ii) and (iii) for purposes of counting FTE residents for IME payment purposes. As we have explained in previous Federal Register documents (55 FR 36064 and 67 FR 50077), these policies apply even when a hospital actually incurs the cost of training the resident(s) at another hospital(s). For example, during a cost reporting year, a full-time resident trains at Hospital A for 6 months and

The concern that a resident only be counted as no more than one FTE has also been raised by OIG.[7]

Consistent with the statutory mandates of section 1886(h)(4)(A) and (B) of the Act the language has stayed in place unaltered in the regulation. The language at section 1886(h)(4)(A) and (B) of the Act, when compared to section (H) did not carve out an exception with respect to the establishment of "new "program".

III. New Medical Residency Programs at 42 CFR 412.105(f)(1)(vii) and §§413.79(e)(1)

Congress, at section 1886(h)(4)(H) directed the treatment of medical programs established after July 1, 1995, with respect to the subparagraphs (F) and (G) that:

(H) Special rules for application of subparagraphs (F) and (G).-

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trains at Hospital B for 6 months. Hospital A is paying the salary and fringe benefits of the resident for the entire year. In this case, each hospital would only count 0.5 of an FTE at the most for that resident. Hospital A would not be able to count the entire FTE for that resident, regardless of the fact that it incurred all of the training costs for the resident during that training year."); (*See also* 83 Fed. Reg. 20164, 20545 (May 7, 2018)(Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates.) ("In accordance with § 413.78(b) for direct GME and § 412.105(f)(1)(iii)(A) for IME, no individual may be counted as more than one full-time equivalent (FTE). A hospital cannot claim the time spent by residents training at another hospital; if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as a partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.")

[7] 83 Fed. Reg. 20164, 20545 (FFY 2019 Proposed Rule)("In 1990, we established the [Intern and Resident Information System (IRIS)], under the authority of sections 1886(d)(5)(B) and 1886(h) of the Act, in order to facilitate proper counting of FTE residents by hospitals that rotate their FTE residents from one hospital or nonprovider setting to another. Teaching hospitals use the IRIS to collect and report information on residents training in approved residency programs. Section 413.24(f)(5)(i) requires teaching hospitals to submit the IRIS data along with their Medicare cost reports in order to have an acceptable cost report submission…..The need to verify and maintain the integrity of the IRIS data has been the subject of reviews by the Office of the Inspector General (OIG) over the years. An August 2014 OIG report cited the need for CMS to develop procedures to ensure that no resident is counted as more than one FTE in the calculation of Medicare GME payments (OIG Report No. A-02-13-01014, August 2014). More recently, a July 2017 OIG report recommended that procedures be developed to ensure that no resident is counted as more than one FTE in the calculation of Medicare GME payments (OIG Report No. A-02-15-01027, July 2017").

> (i) New facilities.—The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and subject to paragraphs (7) and (8),[8] 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.

Relevant to this case, the regulations at 42 C.F.R. §413.79(e)(1), states in part that:

> (1) If a hospital had no allopathic or osteopathic residents in its most recent cost
> reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (c) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.
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> (i) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital,

Regarding new programs, for the IME adjustment. 42 C.F.R. §412.105(f)(1)(vii) states that:

> If a hospital establishes a new medical residency training program, as defined in §413.79(l) of this subchapter, the hospital's full-time equivalent cap may be adjusted in accordance with the provisions of §§413.79(e)(1) through (e)(4) of this subchapter.

Under section 1886(h)(4)(H)(i) of the Act, as added by the BBA, the Secretary is required, consistent with the principles of establishing a limitation on the number of residents paid for by Medicare and the 3-year rolling average, to establish rules with respect to the counting of residents in medical residency training programs established on or after January 1, 1995. Such rules must give special consideration to facilities that meet the needs of underserved rural areas. Language in the Conference Report for the BBA indicates concern that there be proper flexibility to respond to changing needs given the sizeable number of hospitals that elect to initiate new (or terminate existing) training programs.

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[8] Section 1886(h) (7) and (8), respectively, address: 7) "Redistribution of unused resident positions" and 8) "Distribution of additional residency positions.'

Pursuant to the statute, in the August 29 1997 final rule with comment period, CMS established the following rules for applying the FTE limit and determining the FTE count for hospitals that established new medical residency training programs on or after January 1, 1995.[9] For purposes of this provision, a "program" would be considered newly established if it is accredited for the first time, including provisional accreditation, on or after January 1, 1995, by the appropriate accrediting body. The Secretary has broad authority to prescribe rules for counting residents in new programs, but the Conference Report for the BBA indicates concern that the aggregate number of FTE residents should not increase over current levels. Accordingly, we indicated that we would continue to monitor growth in the aggregate number of residency positions and may consider changes to the policies described below if there continues to be growth in the number of residency positions.

The regulations published on August 29, 1997 provide for adjustments to hospital FTE caps for hospitals that previously did not participate in GME training and hospitals that established new medical residency training programs on or after January 1, 1995 and on or before the August 5, 1997 enactment of the BBA.

For Hospitals with no residents prior to January 1, 1995, section 1886(h)(4)(H) of the Act allows the Secretary to prescribe special rules for the application of the FTE caps and 3-year averaging for medical residency training programs established on or after January 1, 1995. In the August 29, 1997 final rule with comment period (62 FR 46005), CMS provided a special rule for application of the FTE resident cap for hospitals which did not participate in GME training prior to January 1, 1995. Under this special rule, CMS allowed hospitals to establish their FTE cap based on the product of the number of first year residents participating in accredited GME training programs in the third year that the hospital received payment for GME and the minimum accredited length for the type of program.

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[9] The August 1997 rule at 42 CFR 413.86(g)(6) states: "If a hospital established a new medical residency training program as defined in this paragraph (g) after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted as follows:
"(i) If a hospital had no residents before January 1, 1995, and it establishes a new medical residency training program on or after that date, the hospital's unweighted FTE resident cap under paragraph (g)(4) of this section may be adjusted based on the product of the number of first year residents in the program in the third year of the program's existence and the number of years in which residents are expected to complete that program based on the minimum accredited length for the type of program. For these hospitals, the cap will only be adjusted based on the first program (or programs, if established simultaneously) beginning on or after January 1, 1995. The cap will not be revised for programs subsequently established." 62 Fed. Reg. 45966, 46035 (August 29, 1997) (Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates)

CMS first published a final on May 12, 1998,[10] which proposed the following language to address section 1886(h) :

> (6) * * *
> (i) If a hospital had no residents before January 1, 1995, and it establishes a new medical residency training program on or after that date, the hospital's unweighted FTE resident cap under paragraph (g)(4) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the programs based on the minimum accredited length for the type of program. For these hospitals the cap will only be adjusted for the programs established on or after January 1, 1995. Except for rural hospitals, the cap will not be revised for new programs established after the 3 years. Only rural hospitals that qualify for an adjustment to its FTE cap under this paragraph are permitted to be part of the same affiliated group for purposes of an aggregate FTE limit.

In response to commenters, CMS subsequently addressed the addition of language to the regulation in the final rule in July 30, 1999 addressing how to treat residents when they spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital during the first 3 years of the new residency program, stating that:

> b. Sections 413.86(g)(6)(i) and 413.86(g)(6)(ii) specify that the adjustment to the cap is also based on the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program. *We proposed to add language to clarify how to account for situations in which the residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital.* In this situation, the adjustment to the FTE cap is based on the number of years the residents are training at each hospital, not the minimum accredited length for the type of program. If we were to use the minimum accredited length for the program in this case, the total adjustment to the cap for both hospitals might exceed the total accredited slots available to the hospitals participating in the program. In the May 12, 1998 final rule (63 FR 26334), we specified that the adjustment to the FTE cap may not exceed the number of accredited resident slots available.[11]

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[10] 63 Fed. Reg. 26318, 26358 (May 12, 1998))(Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates).

[11] 64 Fed. Reg. 41490, 41542 (July 30, 1999).("(6) If a hospital establishes a new medical residency training program as defined in paragraph (g)(9) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted as follows: (i) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident

The language corresponding to this pronouncement was set forth in the regulation at 42 CFR 413.86(g)(6)(i)(A)(now 42 CFR 413.79(e)(1)(i), which states that:

> If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital." [12]

This provision was eventually redesignated as 42 CFR 413.79(e)(1)(i) for the cost years at issue. In the July 30, 1999 *Federal Register* final rule preamble, CMS also specifically addressed commenters questions on how to account for situations when residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital during the first three years of the new residency program and when residents rotate to multiple sites in a single program year. CMS stated:

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cap under paragraph (g)(4) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program(s), the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(C) Except for rural hospitals, the cap will not be adjusted for new programs established more than 3 years after the first program begins training residents.

(D) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is not permitted to be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(E) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is permitted to be part of an affiliated group for purposes of establishing an aggregate FTE cap

[12] 64 Fed. Reg. 41490, 41543.

> Comment: We received several comments on our clarification on how to account for situations when residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital (or hospitals) during the first 3 years of the new residency program. We stated that, in this situation, the adjustment to the FTE cap is based on the number of years the residents are training at each hospital, not the minimum accredited length of the program. One commenter asked us to clarify the adjustment to the cap in situations where the residents rotate to multiple sites in a single program year during the first 3 years of a new residency program -that is, the residents rotate to other hospitals partial years. Another commenter requested that we give examples of how to calculate the FTE cap adjustment in these situations.
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> Response: In situations where residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital during the first 3 years of the new residency program, each hospital that trains the residents receives an adjustment to its cap based on the product of the highest number of residents in any program years during the third year of the first program's existence and the number of years that the residents are training at each respective hospital. In situations where the residents spend partial years at different hospitals during the first 3 years of the new residency program, each hospital that trains the residents receives an adjustment to its cap based on [the] product of the highest number of residents in any program year during the third year of the first program's existence and the minimum accredited length of the program.

In addition, the July 30, 1999 *Federal Register* final rule preamble language, discussing residents training for partial years at multiple hospitals, clarified that the regulations at 42 C.F.R. § 413.86(g)(6)(i)(1999) (now 413.79(e)(1)) states the requirement that a new teaching hospital's cap is adjusted and that: "The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program."[13]

Relevant to the Provider's challenge in this case, 42 C.F.R. §413.79(e)(2012) was modified in 2012,[14] due to CMS' decision to extend the "growing period" for a new medical residency program to five years.[15] In revising the language to account for the new growing period, CMS also explained certain effective dates relating to those changes:

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[13] 64 Fed. Reg. 41490, 41542 (July 30, 1999).

[14] 77 Fed. Reg. 53258, 53416 - 53422 (Aug. 31, 2012) (Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes).

[15] 77 Fed. Reg. 53258, 53417 -18.("We also proposed to revise the regulations at § 413.79(e)(1)(i) that discuss the methodology used to calculate a qualifying teaching hospital's cap adjustment for a new residency training program if residents training in the new program are rotating to more than one hospital during the 5-year window. We proposed to revise the regulations to specify that, in calculating the cap adjustment for each new program started within

In summary, we proposed to revise the regulations at § 413.79(e)(1) for the purposes of direct GME and, by reference, § 412.105(f)(1)(vii) for purposes of IME to state that if a hospital begins training residents in a new program for the first time on or after October 1, 2012, that hospital's caps may be adjusted based on the product of the highest number of FTE residents training in any program year during the fifth academic year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The cap would be applied beginning with the sixth academic year of the first new program. We also proposed conforming changes throughout paragraph (e)(1) of § 413.79 to correspond with the proposed change to increase the length of the cap-building period from 3 to 5 years. In addition, we proposed to change the regulation text at § 413.79(e)(1)(i) to reflect a methodology to calculate a qualifying teaching hospital's cap adjustment if the residents in the new training program are training at more than one hospital. We proposed that these changes would be effective for a hospital that begins training residents for the first time on or after October 1, 2012. Lastly, we proposed to make a clarification to the existing regulation text at § 413.79(e)(1)(i) to insert the missing phrase "and the number of years in which residents are expected to complete the program

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the 5-year window, we would look at the highest total number of FTE residents training in any program year during the fifth academic year of the first new program's existence at all participating hospitals to which these residents rotate and multiply that highest FTE resident count by the number of years in which residents are expected to complete the program, based on the minimum accredited length of the specific program. Furthermore, we proposed that, for each new program started within the 5-year window, we would take that product and multiply it by each hospital's ratio of the number of FTE residents in that new program training over the course of the 5-year period at each hospital to the total number FTE residents training in that new program at all participating hospitals over the course of the 5 years. We believed it was appropriate to propose to apportion the overall FTE cap among the hospitals participating in training residents in the new program based on the percentage of FTE residents each hospital trained over the course of the entire 5-year period, rather than the percentage of FTE residents each hospital trained only during the fifth academic year, because the trend of training over the entire 5 years may reflect more completely the patterns in the training in years subsequent to the fifth academic year. Otherwise, a hospital's FTE cap adjustment, which is permanent, may reflect too heavily the share of training time solely in the fifth academic year, which may or may not be beneficial to the hospital. We noted that a hospital's cap adjustment could differ, depending on whether we look only at the fifth academic year of the first new program or look at every available year (up to 5 years) for which training occurred to calculate each hospital's share of the aggregate cap for a specific program.")

based on the minimum accredited length for the type of program." This change is consistent with our past, current, and proposed policy.[16]

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Because we are finalizing the methodology as proposed, we refer readers to the examples provided in the proposed rule and also included earlier in this preamble for further guidance. We agree with the commenters who suggested that we replace the phrase "an entire program year (or years)" at 42 CFR 413.79(e)(1)(i) with the phrase "portions of a program year (or years)" and, therefore, are amending this regulation text to include this change. We also are amending the regulation text at 42 CFR 413.79(e)(1)(i) to more clearly describe that an individual hospital's cap adjustment for a new program that rotates residents to more than one hospital is based on the product of three factors, which are described earlier in this paragraph. Furthermore, in this final rule, we are making minor revisions to the regulation text at 42 CFR 413.79(e)(2) through (e)(4) for purposes of maintaining consistency throughout 42 CFR 413.79(e).[17]

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In summary, we are finalizing our proposal to increase the cap-building period from 3 years to 5 years. We also are finalizing the proposed methodology used to calculate a cap adjustment for an individual hospital if a new program rotates residents 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. In addition, we are making minor revisions to the regulation text at 42 CFR 413.79(e)(2) through (e)(4) for purposes of maintaining consistency throughout 42 CFR 413.79(e) .[18]

The final rule in 2012 thus read as follows:

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[16] 77 Fed. Reg. 53258, 53420.

[17] 77 Fed. Reg. 53258, 53422.

[18] 77 Fed. Reg. 53258, 53423-24.

> (1) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012, the hospital's unweighted FTE resident cap under paragraph (c) of this section may be adjusted for new residency training programs based on the sum of the products of the highest number of FTE residents in any program year during the third year of the first new program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program. If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins training residents in a new medical residency training program(s) for the first time on or after October 1, 2012, the hospital's unweighted FTE resident cap of this section may be adjusted for new residency training programs based on the sum of the products of the highest number of FTE residents in any program year during the fifth year of the first new program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.
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> (ii) If a hospital begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012, and if the residents are spending portions of a program year (or years) at one hospital and the remainder of the program at another hospital(s), the adjustment to each qualifying hospital's cap for a new medical residency training program(s) is equal to the sum of the products of the highest number of FTE residents in any program year during the third year of the first new program's existence and 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 the number of years the residents are training at each respective hospital….

In summary, regarding the limitation or cap on FTEs, under §1886(h)(4)(H)(i) 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 § 1886(d)(5)(B)(v) of the Act, a similar limit or cap 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 statutory cap. Section 1886(h)(4)(H)(i) of the Act also requires CMS to establish rules for calculating the direct GME caps of teaching hospitals training residents in new programs established on or after January 1, 1995. Under §1886(d)(5)(B)(vii) of the Act, these rules also apply to the establishment of a hospital's IME cap. CMS implemented

these statutory requirements in the August 29, 1997 *Federal Register*,[19] the May 12, 1998 *Federal Register*[20] and in the July 31, 1999 *Federal Register*.[21]

Generally, under existing regulations at 42 C.F.R. § 413.79(e)(1) (for DGME) and 42 C.F.R. § 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 residency 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 product of the highest number of FTE residents in any program year during the third year of the first new program, for all new residency training programs established during that 3-year period, and the minimum accredited length for each type of program.[22] 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.[23] 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.[24]

IV. Findings and Conclusions of Law

The Provider is a Medicare-certified short-term acute care hospital located in Wayne, Michigan. The Provider established a new family medicine residents training program on July 1, 2004. The program was approved by the Accreditation Council for Graduate Medical Education (ACGME) for 30 positions. Under 42 C.F.R. § 413.79(e)(1)(2007),[25] the Provider's three-year window, for establishing its FTE resident caps based on the new family medicine residency program ended June 30, 2007. During the first three years of the program, some residents spent part of their time training at two other hospitals, Beaumont Hospital-Dearborn and Beaumont Hospital-Trenton. In calculating the FTE resident caps of the Provider, the MAC apportioned the caps based on the percentage of time spent training at each of the three hospitals. The Provider challenged the methodology the MAC used to account for the out-rotations to the other hospitals when calculating the Provider's direct graduate medical education (DGME) and indirect medical education (IME) caps. Specifically, the Provider argued that the MAC improperly calculated its DGME and IME caps using the methodology in the 2012 regulations instead of the methodology in the regulations that were in effect during the three years ending June 30, 2007. According to the Provider, the resident "out-rotation" adjustment, when residents are training for the portion of a year in another hospital, does not apply under the 2007 regulations. The Provider argued that the MAC applied the wrong version of 42 C.F.R. § 413.79(e)(1) when calculating its DGME and IME caps for its new family medicine residents training program. The Provider contends that the regulation at 42 C.F.R. §413.79(e)(1), effective October 1, 2007, governs the MAC's

[19] 62 Fed. Reg. 45966, 46005 (August 29, 1997);
[20] 63 Fed. Reg. 26318, 26333 (May 12, 1998).
[21] 64 Fed. Reg. 41490, 41518 (July 30, 1999).
[22] 42 C.F.R. § 413.79(e)(1)(2007).
[23] *Id.*
[24] 42 C.F.R. § 413.79(e)(1)(iii)(2007).
[25] CMS revised parts of the regulations at 42 C.F.R. § 413.79(e)(1) in 2012.

computation of the FTE caps at issue, instead of the regulation at 42 C.F.R. § 413.79(e)(1), effective May 11, 2012, and that the regulation at 42 C.F.R. § 413.79(e)(1), effective October 1, 2007, does not require an adjustment for "out-rotations."

As noted above, the regulations at 42 C.F.R. § 413.79(e)(1)(2007), states in part that:

> (1) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (c) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.
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> (i) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

CMS revisited the regulation because of the extension of the growth period, at 42 C.F.R. § 413.79(e)(1)(ii) (2012), reads as follows;

> (e) New medical residency training programs.
> If a hospital establishes a new medical residency training program as defined in paragraph (l) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (c) of this section may be adjusted as follows:
> (1) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012, the hospital's unweighted FTE resident cap under paragraph (c) of this section may be adjusted for new residency training programs based on the sum of the products of the highest number of FTE residents in any program year during the third year of the first new program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program. If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins training residents in a new medical residency training program(s) for the first time on or after October 1, 2012, the hospital's

> unweighted FTE resident cap under paragraph (c) of this section may be adjusted for new residency training programs based on the sum of the products of the highest number of FTE residents in any program year during the fifth year of the first new program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.
> (i) If a hospital begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012, and if the residents are spending portions of a program year (or years) at one hospital and the remainder of the program at another hospital(s), the adjustment to each qualifying hospital's cap for a new medical residency training program(s) is equal to the sum of the products of the highest number of FTE residents in any program year during the third year of the first new program's existence and 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 the number of years the residents are training at each respective hospital. If a hospital begins training residents in a new medical residency training program(s) for the first time on or after October 1, 2012, and if the residents are spending portions of a program (or years) at one hospital and the remainder of the program at another hospital(s), the adjustment to each qualifying hospital's cap for new residency training program (s) is equal to the sum of the products of three factors (limited to the number of accredited slots for each program):
> (A) 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 the program rotate; (B) The number of years in which residents are expected to complete the program, based on the minimum accredited length for each type of program.
> (C) 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.

The Board compared the text of 42 C.F.R. §413.79(e)(2007) with the text of 42 C.F.R. §413.79(e)(2012), and concluded that the methodology in the 2012 regulation was not a clarification of CMS policy, but rather a change to the way rotations to other hospitals are handled in the calculation of the FTE resident caps for new medical residency training programs. The Board concluded that since residents only spent portions of the year at the other hospitals (not an entire year), the MAC incorrectly adjusted the Provider's DGME and IME FTE caps for out-rotations.

The Administrator does not agree. The regulatory text at issue in the 2007 regulation only addresses the situation, with respect to the three year cap determining period, on how to count residents rotating through year-long programs at other hospitals. The language is not all inclusive (for example, the text does not state "*only if* the residents are spending an entire

program year (or years) at one hospital and the remainder of the program at another hospital,….") and the preamble specifically explained that this was being added to explain that particular situation, while the preamble conjointly discussed the residents that rotated to other hospitals for only a portion of the year.

The calculation of the cap also cannot be read to nullify the statutory mandates of section 1886(h)(2) and section 1886(h)(4)(B) of Act as implemented in the regulation as to counting FTEs: that a resident cannot be counted as more than one FTE and that a hospital cannot count time spent by residents at another hospital. The regulations at 42 C.F.R. §412.105(f)(1)(iii) for IME and §413.78(b) for DGME state that a resident cannot be counted as more than one FTE and a hospital cannot claim the time spent by residents training at another hospital. In addition, in both the 2007 and the 2012 version of the regulations at 42 C.F.R. §413.79(e), there is a requirement that "the adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program."

The Board and the Provider are incorrect to concluded that the 2012 regulations are a change in policy from the 2007 regulations (with the exception of the actual change in the new program growth window from 3 years to 5 years, effective October 1, 2012), and the Board is also incorrect in finding that the 2007 and 2012 regulations treat out-rotations differently regarding full year out-rotations versus partial year out-rotations. CMS specifically addressed rotations to other hospitals for both whole years and partial year out-rotations in the July 30, 1999 *Federal Register* final rule preamble. The method used to address partial year rotations is clearly consistent with the statute with respect to counting FTEs when there is an "out-rotation" as Congress has required. That CMS specifically addressed how entire year rotations should be counted, is consistent with the fact that the cap determination is a three year picture of the new medical residency.

The Provider cited to several sections of the proposed 2012 rule preamble to demonstrate that the regulation purpose was to apply to new teaching programs that began training residents on or after 10/1/2012. *See* 77 Fed. Reg. 27976 at 279880-279881 (May 11, 2012). ("We are proposing that this change would apply to new teaching hospitals that begin training residents in new programs for the first time on or after October 12, 2012.") Further, the Provider asserted that CMS stated that the change in methodology regarding residents training at more than one hospital applied only to teaching programs commencing on or after October 1, 2012: "In addition, we are proposing to change the regulation text at§ 413.79(e)(l)(i) to reflect a methodology to calculate a new teaching hospital's cap adjustment if the residents in the new training program are training at more than one hospital. We are proposing that these changes would be effective for a hospital that begins training residents for the first time on or after October 1, 2012." (77 Fed. Reg. 27976 at 27980-27981).These statements, the Provider contended, should end the inquiry. However, as noted by the foregoing citations when viewed in actual context of the discussion of the effective dates in the preamble of the final rule and the plain text of the 2012 regulation at 42 CFR 413.79(e)(1)(i) is without support. The Provider's claim that the exclusion of time spent training at other hospitals is intended to be effective only for a hospital that first begins training residents on or after October 1, 2012 does not address the plain text of the 2012 rule for that category of hospitals. The Provider's comments overlook the

fact that the cited effective date references to 42 CFR 413.79(e)(1)(i) are to changes made with respect to the five year growth period, which is discussed in the same paragraph (i) section of the regulation. A further review of the preamble to the 2012 final rule as to effective dates, as noted above, does not show that the October 1, 2012 effective date was being applied to the pre-five year growth policy (i.e., where a hospital begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012). Instead, when viewed in context, the same paragraph (i) addresses both the pre-five year and five year policy, to which the October 1, 2012 effective date applies to the latter.

In addition to such a October 1, 2012 effective date as not being consistent with past policy and section 1886(h) (among other things), such an effective date of October 1, 2012, would not be legally and consistently implementable for hospitals in the category where "a hospital begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012." Pragmatically, the clarifying language is specifically included in the regulation for this category of hospitals and would not make sense operationally, if it were effective October 1, 2012.

In sum, CMS had discussed in the preamble and implemented this policy as early as 1999 in specifically calculating new program caps. This policy is consistent with the statutory and regulatory mandates regarding the counting of FTEs which were set forth at the establishment of IPPS, section 1886(d), and section 1886(h) of the Act. Thus, CMS reasonably considered that this text modification in 2012 as a clarification of existing and mandated policy where a hospital begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012.

In this case, the total allowed cap amounts for DGME and IME respectively is 30. The Provider argued that it should receive DGME and IME caps of 29.28, which is the product of 9.76 Program Year 1 - FTE residents (the highest number of residents in any program year during the third year of the first program's existence), and 3 years (the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program, which is 3 years for family medicine). The Administrator finds that, if the Provider is allowed to take 29.28 as its own DGME and IME FTE resident caps, the Provider is taking more than it legal share of the 30 accredited positions.[26] In addition, it is counting time residents spent

[26] The Administrator notes that the other two participating hospitals in Dearborn and Trenton already had FTE resident caps established based on residents in their most recent cost reporting periods ending on or before December 31, 1996, and therefore, are not permitted to receive additional FTE resident cap adjustments for participating in a new program. Nevertheless, the rules for counting FTEs generally applies and the methodology for apportioning the cap based on training time spent at each hospital (consistent with the rules for counting FTEs) must be followed to be in accord with the statute and to ensure that the overall cap does not exceed the number of accredited positions; that a resident does not count for more than one FTE; and that the hospital does not count time a resident spends training at another hospital.

at other hospital training and, over all, resulting in a resident as counting as more than one FTE. The application of the cap (and the status of other hospital's caps where a resident is training) does not change how FTEs are counted as a starting point. Only by accounting for the time spent at each hospital respectively, by multiplying the overall cap adjustment of 29.28 by the percentage of time spent at each hospital over 3 years, can the Medicare Program be assured that the limit of 30 accredited positions is not exceeded, that a resident is not counted as more than one FTE and that the Hospital is not counting time a resident spent training at other hospitals. In this case, the record shows that 81.87 percent of the DGME training time and 81.54 percent of the IME training time was spent at the Providers. This resulted in a DGME FTE resident cap of 23.96 and an IME cap of 23.87.[27]

Accordingly, the Administrator finds that MAC was correct in adjusting the Provider's DGME and IME FTE caps to account for out-rotations. The Administrator finds that the methodology utilized by the MAC to make its calculations was consistent with Medicare law, the regulations and program instructions, and resulted in an accurate and equitable means to distribute the

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Because of these FTE rules CMS had to specifically carve out and legally support a special rule for certain hospitals at 64 Fed. Reg. 41490, 41521 (July 30, 1999)(Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2000 Rates.)
("4. Adjustment to GME Caps for Certain Hospitals to Account for Residents in New Medical Residency Training Programs. Section 4623 of the BBA amended section 1886(h) of the Act to provide for "special rules" in applying FTE caps for medical residency training programs established on or after January 1, 1995. In the August 29, 1997 and May 12, 1998 final rules (62 FR 46002 and 63 FR 26327), we implemented special rules to account for residents in new medical residency training programs. We proposed to implement another special rule to permit an adjustment to the FTE cap for a hospital if the entire facility was under construction prior to August 5, 1997 (the date of enactment of the BBA) and if the hospital sponsored a new medical residency training program but the residents were temporarily trained at another hospital.
Under current policies, if a new medical residency training program was established on or after January 1, 1995, a hospital may receive an adjustment to its FTE cap to account for residents in the new program. If the residents in the new program begin training in one hospital and are subsequently "transferred" to another hospital, the second hospital would not receive an adjustment to its FTE cap; *if we made an adjustment for the second hospital, then two hospitals would receive an adjustment for the same resident*. We believe, however, that an adjustment for the second hospital might be appropriate in certain limited circumstances. If the second hospital sponsored a new medical residency training program but the residents in the new program temporarily trained at the first hospital because the second hospital was still being built, then we believe it would be appropriate to permit an adjustment for the second hospital. Otherwise, the second hospital's FTE cap would be zero, and the hospital would not receive any GME or IME payments.") Conversely, for the rule at issue in this case, as residents are not to be counted as more than one FTE as a general rule, CMS did not create a special rule (assuming arguendo it could even legally do so) to allow hospitals to claim residents time spent for a portion of the year in another hospital, nor create an exception when the other hospital could not receive the benefit of an adjustment to its cap.

[27] *See*, Comparison of MAC and Provider FTE Caps Computation.

allowable FTE caps. The Administrator finds that considering all three years of the cap-building period in calculating the Provider's cap adjustment is appropriate, as it provides a more complete picture of the actual rotations that will be part of the approved residency training program as opposed to just taking into account what is happening in the new program during the final year of the cap building period, (as the Provider would have the Medicare program do), which may not accurately reflect the hospitals' plans for dividing rotations among participating hospitals which may fluctuate from year to year.

In sum, when the record and law is viewed in its totality the Administrator finds that the MAC's determinations were appropriate, and that the Provider is not entitled to the higher DGME/IME FTE resident caps.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 6/21/2018

/s/
Demetrios L. Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services