CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
JFK Medical Center **Provider** **vs.** **WPS Government Health Administrators** **Medicare Contractor**	**Cost Reporting Period Ending:** : June 30, 2012; June 30, 2013; June 30, 2014; June 30, 2015; and June 30, 2016 **Review of:** **PRRB Dec. No. 2023-D17** **Dated:** May 31, 2023

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 Medicare Administrative Contractor (MAC) submitted comments, requesting reversal of the Board's decision. The Provider also submitted comments requesting the Administrator's review and modification of the Board's Decision. The parties were notified of the Administrator's intention to review the Board's decision. Additional comments were received by the Provider asking the Administrator to reverse or modify the Board's Decision to confirm the Provider's cap calculations. The Centers for Medicare (CM) also submitted comments requesting that the Administrator reverse the Board's decision and affirm the determination by the MAC methodology for calculating the Provider's DGME and IME FTE resident caps for the new Internal Medicine program. 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 MAC correctly determined the Graduate Medical Education (GME) and Indirect Medical Education (IME) full-time equivalent (FTE) resident cap for the new Internal Medicine residents training program at JFK Medical Center (JFK or Provider) for the fiscal year (FY) 2012 through 2016 cost reporting periods.

The Provider, JFK established a new Internal Medicine Residency training program which was accredited for 66 training slots and had included West Palm Beach VA Medical Center (the VA) as a second "participating institution".[1] During the first three years of the program, certain residents spent part of their time training at the VA (referred to as "out-rotations"). The MAC adjusted JFK's GME and IME FTE

[1] The VA West Palm Beach Healthcare System is described as one of the leading health care systems serving Veterans in the VA Sunshine Health Care Network. https://www.va.gov/west-palm-beach-health-care/about-us/

caps to reflect the out-rotations at the VA. JFK challenged the methodology the MAC used in recognizing the out-rotations when calculating the Provider's GME and IME caps.

The Board held that the MAC calculated FTE resident caps for GME and IME for FYs 2012 through 2016 should be modified.[2] The Board ultimately concluded that the GME should be changed from 40.04 to 42.47 and the IME from 39.90 to 42.42 for the FY 2012 through 2015 cost reporting periods under appeal; and from 40.04 to 44.04 for GME and from 39.90 to 43.99 for IME for the FY 2016 cost reporting period. In reaching this determination, the Board compared the 2008 regulation to the 2012 revised regulation and concluded that the language materially changed and treated the out rotations differently. 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 and effective for new medical residency training programs established after October 1, 2012.

The MAC maintained that the 2012 revisions to 42 C.F.R. § 413.79(e)(1) are a clarification of the prior regulations that were in place during the initial three-year period of the program and should be followed when calculating the Provider's GME and IME caps for its new Internal Medicine Residency training program. In accordance with the 2012 revised regulation, the MAC adjusted JFK's GME and IME caps by removing the portion of the FTEs that rotated to the VA. This resulted in a GME cap of 40.04 and IME cap of 39.90. The MAC contends this method of calculating the Provider's FTE caps is appropriate even though the VA is not a Medicare certified acute-care hospital, and does not need to establish GME/IME FTE resident caps for the new program. The MAC argues that its method is supported by the regulations, and "accurately calculates overall FTE resident caps for the new resident training programs and appropriately allocates the caps to all hospitals that participated in the training" during the three-year growth period.

JFK disagreed that the 2012 revised regulation is a clarification of the 2008 regulation to the 2008 regulation and argued that the MAC's use of the revised regulation constitutes impermissible retroactive rulemaking. Instead, JFK maintained that the 2008 regulation requires an adjustment for out-rotations only if the provider's residents out-rotated for an entire program year (or years). The MAC did not dispute none of the out-rotations were for an entire year, and, therefore, JFK maintained there should be no adjustment to remove the partial year out-rotations to the VA. JFK stated that the caps should be calculated using the highest number of FTEs at JFK in any program year (PGY) during the third year of the program, with no consideration of any rotations to the VA because none of the residents spent an "entire year" at the VA (only partial years).As the calculated cap (shown below), considering only JFK's FTEs, is less than the approved slots for the program, JFK contended that 56.03 was the appropriate cap for the new program.

First, as JFK's program began in 2008, and the first three years of the program were completed by 2011, the Board found that C.F.R. § 413.79(e)(1) (2008) must be used to calculate the GME and IME caps for the new Internal Medicine training program at JFK. The Board contended that 2012 revised regulation, would not be applicable and it would be impermissible to retroactively apply the regulation to the program in dispute. However, that did not mean that the Board adopted the Provider's arguments as to the treatment

[2] The Board also considered that JFK, a Medicare-certified acute care hospital located in Atlantis, Florida merged, on April 1, 2016, with West Palm Hospital with JFK as the surviving entity. The Board considered that, while West Palm Hospital's FTE caps from its prior cost reports are to be partialized and incorporated into JFK's FTE cap for the FY 2016 cost reporting period. Therefore, for purposes of the decision, the Board considered it to be a part of JFK due to the 2016 merger, and referred to it accordingly.

of out-rotations. The Board, contrary to the Provider's arguments, interpreted the 2008 regulation to require out-rotations be calculated and excluded from the FTE cap. While the 2008 regulation states out-rotations to be "the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital," the Board interpreted that to mean collective rotations, or "full-time equivalents," of the "residents," in accordance with the Intern & Resident Information System (IRIS) reporting, not a single resident. The aggregate of the out- rotations (for the year) would result in FTEs that would be removed from the FTE total.

The Board concluded that the MAC was correct in adjusting JFK's GME and IME FTE caps for the inclusion of out-rotations and that doing so is consistent with the regulations in place at the time. However, the Board found that the 2008 regulation must be applied (not the 2012 regulation) and that the FTE caps were calculated improperly per the 2008 regulation. The Board further corrected the MAC's adjustment after evaluating 42 C.F.R. § 413.79(e)(2008) which states that: "the hospital's unweighted FTE resident cap . . . 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."

As noted in 42 C.F.R. § 413.79(e)(2008), "[t]he adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program." The Board interpreted this as a requirement to be applied to the full program, which includes rotations to both hospitals. As a result, when a program involves rotations to more than one hospital, the Board interpreted § 413.79(e) to apply to each "hospital" in the umbrella program since the regulation refers to a singular "hospital" and this program involves more than one hospital. Accordingly, the Board found that the VA must be factored in because to do otherwise would inappropriately shift costs from one hospital to another as well as from the VA program to the Medicare program in this situation. The regulation must be applied to all hospitals receiving rotations under the GME program regardless of whether they receive GME/IME reimbursement from the Medicare program. Ultimately, the Board directed the MAC to adjust the DGME and IME FTE resident caps to an amount higher than what the MAC had calculated, but less than what the Provider had calculated.

As a result of this interpretation, the Board disagreed with JFK that its new Internal Medicine training program resident cap should be 56.03 for GME and 55.84 for IME. Under JFK's methodology, the GME total cap for the program would be determined by adding the Provider's proposed 56.03 GME FTE cap to the similarly calculated VA GME cap of 31.0451 and, as shown above, it would be 87.07 FTEs. Thus, JFK's methodology would result in a GME total cap for the program that would clearly exceed the 66 accredited slots for this new program. Similarly, the Board disagreed with the MAC, which calculated the cap using the highest total FTEs for JFK and the VA collectively, in a single program year, and then allocates the FTEs by using the ratio of all rotations for the entire three years of the program. The Board found that using this method improperly results in an artificially low GME total cap under the 2008 regulation.

Accordingly, the Board found that each hospital's cap calculation must be determined separately and, if the aggregate result exceeds the total approved/accredited slots for the program, then there must be a proportional reduction pursuant to § 413.79(e)(1) to ensure the GME total cap does not exceed the total approved/accredited slots for the program. More specifically, each hospital's cap under the program must be determined using the PGY with the highest FTEs for that hospital. For JFK, the PGY with highest FTEs in the third year of the program is PGY-3. In contrast, for the VA, the PGY with the highest FTEs in the

third year of the program is PGY-2. This results in caps of 56.03 and 31.04 for JFK and the VA, respectively. As the resulting caps for JFK and the VA, in total, exceed the accredited/approved slots for the program, they are then allocated using the ratio of the calculated individual caps.

The Board recognized the merger of JFK and West Palm Hospital occurred on April 1, 2016, and thus, impacted three months (April – June) of the 2016 cost reporting period under appeal. The MAC's adjustments for FY 2016 reflected an add-on for both IME and GME caps of 1.57 FTEs which was agreed upon by the parties.

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 with respect to FTE residents that trained at one hospital for less than an entire program year. The MAC explained that to determine a new program cap, you only need to take the Provider's highest FTE count in any given year of the program in the third year that it had trained and multiply it by the number of program years. The MAC further noted that there was no need to include other participants' FTE counts or to prorate based on the ratio of residents trained by each participant to the gross aggregate total of all residents trained. The MAC noted that it took the sum of all of the participants' highest FTE count in any given PGY in the third year of the new program's existence and multiplied that by the minimum number of years for which the program was accredited. Then the MAC prorated the FTE amount among all hospital participants based on the ratio of residents trained by each hospital participant to the total of all residents trained. The MAC argued that the Board correctly concluded that the MAC was correct in adjusting JFK's GME and IME FTE caps for the inclusion of away-rotations at the VA and that doing so is consistent with the regulations in place at the time.

However, the MAC disagreed with the Board's calculation in consideration of the rotations to the VA hospital. The MAC argued that the Board's application and interpretation of the applicable 2008 regulations and contended that the MAC had calculated the new program FTE caps properly per the application 2008 regulations. The MAC noted that the methodology the Board implemented for the calculation and apportionment of the new program FTE failed to consider and factor the "number of years the residents are training at each respective hospital" as called for in the applicable regulations at 42 C.F.R. §413.79(e)(1)(i). The MAC concluded that its methodology factors in the number of years the residents are in training at each respective hospital, the program length of 3 years and the apportionment percentages for JFK and the VA hospital of 60.62 percent and 39.38 percent. It argued that the MAC's methodology is logically sound and is the method, which is prescribed in the applicable 2008 regulations, and more closely approximates the apportionment percentages. In summary, the MAC agreed with the Board's finding that the out rotations at the VA Hospital must be factored into the determination of the new program caps, however, it disagreed with the Board's method of calculating the FTE count for the Provider. The MAC requested that the Administrator reverse the Board's decision and confirm the MAC's adjustment.

CM commented and noted that main issue of concern in the instant case, is whether the calculation of the FTE Resident Caps at JFK Medical Center should account for rotations at other hospitals, and whether the 2008 or the 2012 version of the regulations applies. CM agreed with the Board's interpretation of the 2008 regulation that out-rotations must be excluded from the cap calculation, in accordance with IRIS and cost reporting requirements. CM argued that this is consistent with the relevant *Federal Register* preamble discussions which explained the regulations text in effect in 2008 (64 Fed.Reg. 41518-20, July 30, 1999).

In addition, CM pointed out that under administrative law, preambles published through notice and comment can comprise binding rules.

CM pointed out that, specifically, the July 30, 1999 IPPS *Federal Register* (64 Fed. Reg. 41518-20) provided the most relevant discussion of the regulations text to which the Board and Provider referred. CM noted that it was not until the FY 2013 IPPS rulemaking, as finalized in the August 31, 2012 preamble language and regulations text at §413.79(e). As a result, the policy, examples, rationale, and methodology prescribed in the August 31, 2012 *Federal Register* represents a clarification of previous policy and not a new policy, with regard to the proper way to calculate the overall FTE cap adjustments among multiple teaching hospitals training residents in a new program. CM argued that the approach applied by the MAC to look "collectively" at the PGYs at all hospitals combined in a given year was consistently followed by CMS when applying the 2008 regulations, whereas no final agency decision embraced the approach adopted by the Board that the highest FTE count in a PGY should be identified individually for each hospital.

CM concluded that the Board and the Provider were incorrect to assert that the 2012 regulations are a change in policy from the 2008 regulations, and the Board was also incorrect that the highest PGY must be identified at each hospital separately rather than collectively. Thus, CM agreed with the MAC's methodology for calculating the Provider's DGME and IME FTE resident caps and recommended that the Administrator reserves the Board's findings and affirm that the DGME FTE resident cap is 40/04, and IME FTE resident cap is 39.90 for the years under appeal.

The Provider commented challenging the calculation methodology the MAC used in establishing JFK's DGME and IME caps in the Provider's FY 2012 cost reporting period, asserting that the formula used by the MAC improperly decreased its DGME cap from 56.03 to 40.04 FTEs and its IME cap from 55.84 to 39.90 FTEs. It argued that the MAC improperly disregarded the cap-setting regulation that was in effect throughout JFK's three-year cap-building period and in 2011, when JFK's cap-building period ended (the "Old Rule"), and instead adjusted JFK's FTE caps by retroactively applying a cap-calculation methodology that took effect prospectively-only as of October 1, 2012 (the "New Rule"), even though JFK's cap-building period closed more than a year before that methodology's effective date. The Provider also argued that based on the administrative record, the Board and the MAC miscalculated JFK's FTE caps. It alleged that the Board was required to apply the Old Rule, and instead, devised its own cap-calculation methodology that is materially different from the Old Rule's cap calculation formula, improperly applying its own interpretation of a purported "clarification" to the Old Rule formula that CMS adopted with impermissible retroactive effect as of October 1, 2012.

The Provider claimed that the Board was required to calculate the Provider's FTE caps based on the highest number of new-program residents training at JFK in any program year (PGY) class during the third year of JFK's cap-building period. It noted that under the Old Rule, out-rotations were accounted for only if the residents are spending an entire program year at one hospital and the remainder of the program at another hospital. The Provider argued that the Board's calculations are not supported by the plain text of the Old Rule, which must be applied as written, as it is unambiguous. Moreover, the Board found that the language with respect to out rotations "materially changed" between the Old Rule and the New Rule, and appeared to treat out-rotations differently. The Provider argued that despite acknowledging a material change in the regulatory language with respect to the cap-calculation treatment of programs with entire-year versus partial-year rotations, the Board concluded that the Old Rule and the

New Rule should be interpreted identically to apply the apportionment methodology to calculate the caps.

The Provider further noted that notwithstanding that the VA is not eligible to receive Medicare GME reimbursement nor FTE caps, and thus would not be expected to share in available cap slots with respect to the Program, the Board found that the VA must be factored in when calculating the caps because to do otherwise would inappropriately shift costs from one hospital to another, as well as from the VA program to the Medicare program in this case. However, the Provider argued that the Board's cost-shifting concern is misplaced because awarding the Provider all of the FTE cap slots to which it is entitled under the Old Rule would not shift costs from the VA program to the Medicare program insofar as JFK would receive FTE caps based solely on its own GME training costs actually borne by JFK for training conducted at JFK. The Provider further argued that the Board's apportionment cap-calculation methodology does not appear anywhere in the plain language of the Old Rule or in contemporaneous CMS guidance concerning the Old Rule. The Board read an apportionment methodology into the Old Rule that is completely unsupported by the plain language of the Old Rule. The Provider contended that it then applied that apportionment methodology to training in Year Three as opposed to considering all three years of the cap-building period as the MAC did. This ultimately resulted in the Board's calculations being a modest upward adjustment of JFK's caps from those the MAC calculated. The Provider argued that the Administrator should reverse, modify, vacate the Board's Decision, or remand the case to the Board to a component of CMS, or to the MAC for recalculation of the Provider's caps in accordance with the Old Rule.

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, [3] 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 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

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

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.—
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> (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.

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:
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> (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 C.F.R. §413.75 through §413.83. The regulations, as a preliminary matter, requires proper documentation and identification of the residents, stating at 42 C.F.R. §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 C.F.R. §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 C.F.R. §412.105(f)(1) 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….[4]

[4] 54 Fed. Reg. 40286, 40291 (Sept 29, 1989) (Medicare Program; Changes in Payment Policy for Direct Graduate Medical Education Costs),

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 42 C.F.R. §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.[5]

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

> 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).[6]

[5] 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).
[6] 55 Fed. Reg. 35990, 36065 (Sept. 4, 1990) (Medicare Program; Changes to the Inpatient Hospital

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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> 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.[7]

Prospective Payment System and Fiscal Year 1991 Rates).

[7] 67 Fed. Reg. 49982, 50076-50078 (Aug. 1, 2002)(Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates).

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.[8]

Further, the concern that a resident only be counted as no more than one FTE and that documentation to account for out-rotations to other providers, has also been raised by OIG. CMS reviewed this principle in the FFY 2019 rule that:

> 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

[8] 67 Fed. Reg. 49982, 50076-50078 (Aug. 1, 2002); *see 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 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.")

> 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).[9] 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") [10].[11]

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 regarding the principle of ensuring that no resident is counted as more than one, with respect to the establishment of "new "program".

III. New Medical Residency Programs at 42 C.F.R. §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).-
>
> (i) New facilities.—The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and subject to paragraphs (7) and (8),[12] 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)(2008), states in part that:

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[9] https://oig.hhs.gov/oas/reports/region2/21301014.pdf (Specifically, finding that 26 hospitals claimed residents for the same period as more than 1 full-time equivalent on cost reports covering fiscal years 2009 and 2010.)

[10] https://oig.hhs.gov/oas/reports/region2/21501027.pdf (Medicare cost reports covering FYs 2012 and 2013, 65 hospitals in California and Hawaii claimed GME reimbursement for residents who were claimed by more than one hospital within MAC Jurisdiction E for the same period and whose total FTE count exceeded one.)

[11] 83 Fed. Reg. 20164, 20545 (FFY 2019 Proposed Rule).

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

> (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.
>
> (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…(Emphasis added.)

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.

Pursuant to the statute (and prior to the implementation of the 2008 version of 42 CFR 413.79(e)), 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.[13] For purposes of this provision, a "program" would be considered

[13] The August 1997 rule at 42 C.F.R. §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)

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, CMS indicated that it would continue to monitor growth in the aggregate number of residency positions and may consider changes to the policies if there continued to be growth in the number of residency positions.[14]

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 Fed. Reg. 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.

CMS first published a final on May 12, 1998,[15] which proposed the following language to address changes to 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 on July 30, 1999 specifically, how to treat residents when they spend an entire program year (or

[14] 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.

[15] 63 Fed. Reg. 26318, 26358 (May 12, 1998))(Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates).

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.[16]

[16] 64 Fed. Reg. 41490, 41518; see Id. at 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 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

Unique to the formation of the new cap and a less frequent occurrence is where a resident spends the entire program year at one hospital during the three-year period used to establish the cap. This situation is different from the common occurring and previously addressed situation where residents rotate to multiple sites in a program year. CMS explained:

> 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 for partial years. Another commenter requested that we give examples of how to calculate the FTE cap adjustment in these situations.
>
> 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 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 response to the second commenter's request, the following are some examples as to how to calculate the adjustment to the FTE cap for a new residency program in situations where residents spend an entire program year (or years) at one hospital and the remaining year (or years) at another hospital during the first 3 years of the program. In addition, we are including an example where residents spend partial years at different hospitals during the first 3 years of the new residency program:
>
> Example 1
> Assume Hospital A has 10 residents in a new internal medicine residency program. These 10 residents are trained at Hospital A for 2 years of the program. In the third year of the program, 5 of the 10 residents are rotated to Hospital B for training.
> Hospital A would receive an adjustment to its cap of 10 FTE (5 residents * 2 years).
> Hospital B would receive an adjustment to its cap of 5 FTE (5 residents * 1 year).
>
> Example 2
> Assume Hospital A has the following residents training in its new internal medicine residency program:
> Year 1-10 new program year (PGY1 1) residents

Year 2—Hospital A rotates the 10 (now PGY 2) residents from Year 1 to Hospital B for training for 1 year and Hospital A also accepts 8 (PGY 1) new residents.
Year 3—The 10 (now PGY 3) residents who rotated to Hospital B in Year 2 return to Hospital A. Hospital A accepts 9 new (PGY 2) residents and also rotates the 8 (PGY 2) residents from Year 2 to Hospital B for training for 1 year. Thus, in the third year of the program, Hospital A has 10 (PGY 3) residents and 9 (PGY 1) residents and Hospital B has 8 (PGY 2) residents.
Hospital A would receive an FTE cap adjustment of 20 FTE (10 residents * 2 years).
Hospital B would receive an FTE cap adjustment of 8 FTE (8 residents * 1 year).
1 PGY = Program Year

Example 3
Assume Hospital A has 10 residents in a new internal medicine program for one half of each of the three residency program years. Hospital B trains the 10 residents for the other half of each of the three residency years.
Hospital A would receive an FTE cap adjustment of 15 FTEs (10 residents * .5 FTE * 3 years).
Hospital B would receive an FTE cap adjustment of 15 FTEs (10 residents * .5 FTE * 3 years).
Both Hospital A and Hospital B train a total of 5 FTE residents each residency program year (.5 of 10 residents each year) and this number is multiplied by the minimum accredited length of the residency program (3 years for internal medicine).[17]

In addition,

Comment: One commenter suggested that only the hospital or hospitals that have received the accreditation for the new residency program should receive the adjustment to the FTE cap or caps.

Comment: Several commenters were concerned about our provision on the adjustment to the FTE cap during the first 3 years of a new residency program, as specified in proposed §413.86(g)(6)(i)(B). One commenter stated that it seemed inconsistent to refer to "adjusting the cap" during these years when the cap is not actually adjusted until the third year. Another commenter suggested that, when looking at the number of residents training at the hospital during the first 3 years for purposes of deciding the cap adjustment in those 3 years, the FTE count for cost reporting purposes should be based on the number of residents for which the hospital has oversight and the time worked in locations within or outside the hospital complex to which they rotate.

Response: Section 413.86(g)(6)(i)(B) contains the provision that explains how a hospital is to adjust its FTE cap during the first 3 years of establishing a new residency program—the hospital's cap may be adjusted during each of the first 3 years using the actual number of residents participating in the new program. The "number of residents participating in the new program" means the number of residents actually training at that hospital. It does not

[17] 64 Fed. Reg. 41519-41520.

> mean the number of residents within the "oversight" of the hospital, which could include the time residents spend at other types of facilities during their training; it only includes the time the residents spend training at the actual hospital site.
>
> When a hospital establishes a new residency program, the hospital's 1996 FTE cap for the first 3 years is adjusted. Thus, the 1996 FTE cap is also receiving an adjustment during those 3 years.[18]

CMS also specifically addressed a comment that argued only the accredited hospital should receive the adjustment to the FTE cap:

> Comment: One commenter suggested that only the hospital or hospitals that have received the accreditation for the new residency program should receive the adjustment to the FTE cap or caps.
>
> Response: While Medicare will provide GME payment to a hospital for training a resident only if that resident is participating in an accredited program, it is irrelevant whether the accreditation for the program belongs to the hospital currently training the residents or some other entity. Thus, we disagree with the commenter's suggestion to allow only hospitals that received the new residency program accreditation to receive a new residency program adjustment.[19]

The language corresponding to this pronouncement was set forth in the regulation at 42 C.F.R. §413.86(g)(6)(i)(A)(now 42 C.F.R. §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."[20]

This provision was eventually redesignated as 42 C.F.R. §413.79(e)(1)(i) for the cost years at issue.

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."[21]

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[18] 64 Fed. at 41520.(This again underlines the treatment of FTEs and would most certainly not allow for the inclusion of time spent at other hospitals and not under the oversight of the hospital at issue.)

[19] 64 Fed. Reg. at 41520

[20] 64 Fed. Reg. 41490, 41543.

[21] 64 Fed. Reg. 41490, 41542 (July 30, 1999).

Relevant to the Provider's challenge in this case, 42 C.F.R. §413.79(e)(2012) was modified in 2012,[22] due to CMS' decision to extend the "growing period" for a new medical residency program from three to five years.[23] In revising the language to account for the new growing period, CMS also explained certain effective dates relating to those changes:

> 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

[22] 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).

[23] 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 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.")

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.[ ][24] 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 based on the minimum accredited length for the type of program." This change is consistent with our past, current, and proposed policy.[25]

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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 C.F.R. §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 C.F.R. §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 C.F.R. § 413.79(e)(2) through (e)(4) for purposes of maintaining consistency throughout 42 C.F.R. §413.79(e). [26]

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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

[24] The Board decision at n.10 references only part of this preamble and only quoted: "*Id*. at 53420 (stating: "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."). See also id. at 53421 (stating: "We believe it is appropriate that the policies included in this final rule will be effective with the start date of the next fiscal year, in this case, October 1, 2012.")."

[25] 77 Fed. Reg. 53258, 53420.

[26] 77 Fed. Reg. 53258, 53422.

are making minor revisions to the regulation text at 42 C.F.R. § 413.79(e)(2) through (e)(4) for purposes of maintaining consistency throughout 42 C.F.R. §413.79(e).[27]

The final rule in 2012 thus read 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 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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> (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….

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

[27] 77 Fed. Reg. 53258, 53423-24.

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*, [28] the May 12, 1998 *Federal Register* [29] and in the July 31, 1999 *Federal Register*.[30]

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]

I. Findings and Conclusions of Law

The Provider is a Medicare-certified acute care hospital located in Atlantis, Florida. The Provider established a new Internal Medicine resident training program on July 1, 2008. The Provider's new Internal Medicine Residency training program was approved by the Accreditation Council for Graduate Medical Education (ACGME) for 66 positions and had two participating institutions, JFK and West Palm Beach VA Medical Center (the VA). During the first three years of the program, some residents spent part of their time training at the VA (referred to as "out-rotations"). Under 42 C.F.R. § 413.79(e)(1), the Provider's three-year window, for establishing its FTE resident caps for its new program ended June 30, 2011. The MAC calculated JFK's FTE caps when it audited the FY 2012 cost report. The Provider disputes the methodology used by the MAC in calculating the FTE caps in its appeal of FYs 2012 through 2016.

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 applied the incorrect regulation when adjusting the Provider's DGME and IME FTE caps for out-rotations.

The Administrator finds that the regulatory text at issue in the 2008 regulation only addresses the situation, with respect to the three-year cap determining period, on how to count residents rotating through years(s)-long programs at other hospitals. The language is not all inclusive and does not, by specifically addressing

[28] 62 Fed. Reg. 45966, 46005 (August 29, 1997).
[29] 63 Fed. Reg. 26318, 26333 (May 12, 1998).
[30] 64 Fed. Reg. 41490, 41518 (July 30, 1999).

one situation ("if", a conditional)), exclude the proper treatment of partial year out rotations through the three-year period consistent with the law. The preamble specifically explained that this was being added to explain the (less typical situation) where residents rotate through year(s) long programs during the three-year period. The preamble also discussed the treatment of residents (in the more typical situation often addressed by CMS) that rotated to other hospitals for only a portion of the year.[31] The Provider's reading is not supported by any of the contemporaneous and historical *Federal Registers*. The Provider's interpretation (that out rotations are not recognized except for full year rotations) would appear to be a significant change in policy and contrary to the law on how FTEs are counted.

The regulation setting forth the calculation of the cap 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 computation of the cap in this case is consistent with the statutory requirements of 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. Paragraph (B) of that section requires that the regulations take into account individuals who serve as residents simultaneously with more than one hospital. CMS has reasonably required a hospital to count only those residents training in that 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 (including a hospital such as the VA).

The Board and the Provider were incorrect to concluded that the 2012 regulation is a change in policy from the 2008 regulations (with the exception of the actual change in the new program growth window from 3 years to 5 years, effective October 1, 2012).[32] 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 in the three-year picture of the new medical residency, does not negate that out rotation are to also be recognized. The Provider's methodology is counter to the statute and provides them a windfall, amplified by its attempt to argue that, not only are out rotations not to be considered, but a special rule should be applied when the participating hospital is a VA hospital.

In addition, the MAC's methodology which considers collectively the PGYs at all hospitals combined in a given year has been consistently been followed by CMS when applying the 2008 year regulation as later clarified in the 2012 regulation.[33] The MAC's calculation properly identified the highest number of combined residents in any PGY year in the third year of the program and multiply it by the length of the

[31] As CM recognized in n.1 of its comments, courts have recognized the binding effect and the informative contemporaneous evidence of the agency's meaning of published preamble language subject to notice and comment.

[32] The defects in the Provider's arguments, accurately and illustratively pointed out by the Board, are applicable whether one considers the 2008 regulatory text or the prior preamble text and 2012 regulatory clarification controlling in this case.

[33] CM also points out logical inconsistencies of the Board's approach in an example in its comments.

program in years (three years). CMS properly examines all training occurring during the third year of the program's existence, examines the highest number of FTEs in any PGY at all hospitals collectively and then allocates the aggregate cap based on the amount of training occurring at all hospitals over the entire three years, not just the final third year.

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 and published in the *Federal Register* that the text modification in 2012 was a clarification of existing and consistent with the statute, 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.

Accordingly, the Administrator finds that MAC was correct in adjusting the Provider's DGME and IME FTE caps to account for out-rotations and used the correct methodology to determine the cap. 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 allowable FTE caps. The Administrator finds that considering all three years of the cap-building period in calculating the Provider's cap adjustment within the context of both hospitals, collectively, is appropriate, as it provides a more complete picture of the actual rotations that will be part of the approved residency training program.

In sum, when the record and law is viewed in its totality the Administrator finds that the MAC's determinations were correct and that the Provider is not entitled to either the higher DGME/IME FTE resident caps for which it argues, or the final FTE resident caps determined by the Board.

DECISION

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

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

Date: July 24, 2023

/s/
Jonathan Blum
Principal Deputy Administrator
Centers for Medicare & Medicaid Services