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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.

We have been made aware of some instances where an urban hospital may incur all the training costs of residents while those residents train at a rural hospital, because the rural hospital may not have the resources or infrastructure to claim those costs and FTEs on a Medicare cost report. However, even in this scenario, the urban hospital is precluded from claiming any FTEs for the proportion of time spent in training at that rural hospital, or at any other hospital.

We note, however, that, consistent with the statutory provisions of section 1886(d)(5)(B)(iv) of the Act for IME payment and section 1886(h)(4)(E) of the Act for direct GME payment, a hospital may count the time residents spend training in a *nonhospital* setting if the hospital complies with the regulatory criteria at §413.86(f)(4).

Comment: One commenter agreed that our clarification on the prohibition against a hospital counting residents training at other hospitals is one that is "longstanding Medicare policy, based on language in both the regulations and the statute." As such, this commenter recommended that we amend our regulations to include this clarification as part of §413.86(f)(2), "rather than remain as a footnote to longstanding Medicare policy."

Response: 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.

As we stated above, and also in the proposed rule, we are aware of some scenarios where one hospital incurs the residency training costs of residents training at other hospitals. However, even in this scenario, the hospital incurring the costs of the residents at the other hospitals is precluded from claiming any FTEs for the proportion of time spent in training at the other hospitals.

Comment: One commenter stated that CMS should consider allowing hospitals to enter into agreements that would permit one hospital to claim the resident FTE time worked at another hospital as long as the hospital claiming the resident time is incurring "all or substantially all" of the training costs at the other hospitals, similar to the regulations specified at existing §413.86(f)(4) for nonhospital sites.

Another commenter stated that it disagrees with our clarification concerning the situation where a teaching hospital cannot count resident rotations to nonteaching hospitals, even when the teaching hospital incurs "all or substantially all" of the costs and the rotation is part of the accredited program. One commenter requested that it be allowed to count the "round time" at another hospital. One commenter requested clarification on whether our policy that prohibits a hospital from counting residents rotating to other hospitals applies to the situation where residents rotate to hospitals not participating in Medicare, such as State-operated psychiatric facilities and hospitals located in foreign countries.

Response: We do not believe that it is consistent with the requirements at sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act to expand the policy at §413.86(f)(4) concerning counting residents in nonhospital settings to allow hospitals to count residents training at other hospitals even if the hospitals seeking to count the residents incur "all or substantially all" of the costs. In fact, it is only because the statute has specifically provided for counting residents training at nonhospital sites that it is appropriate to include any resident not training at the hospital in the hospital's FTE count.

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. Further, although the commenter refers to rotations occurring at "nonteaching" hospitals, we note that by virtue of the fact that residents are rotating and training at a hospital, the hospital is, by definition, a teaching hospital. In fact, each Medicare-participating hospital at which the residents are rotating over the course of the program year should be completing the direct GME and IME (if applicable) worksheets of the Medicare cost report in order to claim and receive Medicare payment for their respective portions of the FTE training time, regardless of whether the hospital incurs any costs for training those residents. Accordingly, we are not adopting the policy change suggested in these comments.