PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2012-D16

PROVIDER -
Alegent Health - Immanuel Medical Center
Omaha, Nebraska

Provider No.: 28-0081

vs.

INTERMEDIARY –
Wisconsin Physicians Service

DATE OF HEARING
February 7, 2012

Cost Reporting Periods Ended -
June 30, 2004 and June 30, 2005

CASE Nos.: 07-0552; 07-2253

INDEX

ISSUE:

Were the Intermediary's adjustments to disallow the Provider's indirect medical education (IME) and direct graduate medical education (DGME) reimbursement for its graduate medical education activities correct?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due to a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended (Act),[1] to provide health insurance to the aged and disabled. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[2] determine payment amounts due the providers under Medicare law, regulations and under interpretive guidelines published by CMS.[3]

Cost reports are required from providers on an annual basis with reporting periods based on the provider's fiscal or accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs to be allocated to the Medicare program.[4] The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement (NPR).[5] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the receipt of the NPR.[6]

Since the inception of the Medicare program, Congress has authorized payment to hospitals for the direct cost of training physicians and that payment is referred to as Direct Graduate Medical Education (DGME). As part of the Social Security Amendments of 1983,[7] Congress established the prospective payment system and recognized that teaching hospitals incur indirect operating costs that would not be reimbursed under the prospective payment system or the DGME payment methodology.[8]

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[1] 42 U.S.C. Ch. 7, Subch. XVIII.

[2] FIs and MACs are hereinafter referred to as intermediaries.

[3] *See* §§ 1816 and 1874A of the Act, 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

[4] *See* 42 C.F.R. § 413.20

[5] 42 C.F.R. § 405.1803.

[6] *See* § 1878(a) of the Act, 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.

[7] Pub. L. 98-21, 97 Stat. 65 (1983).

[8] Social Security Amendments of 1983 § 601.

Specifically, § 601(e) of the Social Security Amendments of 1983 established, in pertinent part, § 1886(d)(5)(B) of the Act[9] to authorize an additional payment known as the Indirect Medical Education (IME) payment to hospitals with GME programs. The IME payment compensates teaching hospitals for higher-than-average operating costs, which are associated with the presence and intensity of residents' training in an institution but which neither includes nor can be specifically attributed to the cost of residents' instruction. The IME adjustment attempts to measure teaching intensity based on "the ratio of the hospital's full-time equivalent interns and residents to beds."[10] Thus, the IME adjustment payment amount is based, in part, upon the number of intern and resident FTEs participating in a provider's GME Program.

Prior to 1997, the Medicare program imposed no limit on the number of FTEs that a hospital could report for purposes of IME and DGME reimbursement. In 1997, Congress passed the Balanced Budget Act of 1997 (BBA)[11] and BBA § 4623 established a cap on the number of FTEs that a hospital may include in the IME/DGME calculation:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors . . . 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 of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[12]

Thus, BBA provided that a hospital's unweighted DGME FTE count cannot be greater that its unweighted FTE count for the cost reporting period ending on or before December 31, 1996 (the 1996 base year). BBA § 4621(b)(1) also required this FTE cap to be applied to the FTE counts used in the calculation of the IME payment.[13]

Finally, BBA § 4623 allowed hospitals in an "affiliated group" to aggregate and share their FTE caps as follows:

> The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the [FTE] limitation ... on an aggregate basis.[14]

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[9] 42 U.S.C. § 1395ww(d)(5)(B).

[10] § 1886(d)(5)(B)(ii) of the Act, 42 U.S.C. § 1395ww(d)(5)(B)(ii).

[11] Pub. L. No. 105-33, 111 Stat. 251 (1997).

[12] BBA § 4623, 111 Stat. at 477-478, was codified at § 1886(h)(4)(F) of the Act, 42 U.S.C. §1395ww(h)(4)(F). § 407 of the Balanced Budget Refinement Act of 1999 (BBRA), Pub. L. No. 106-113, 113 Stat. 1501, 1501A-373 (1999) made unrelated amendments and redesignated it as § 1886(h)(4)(F)(i) of the Act.

[13] BBA § 4621(b)(1) (codified as amended at § 1886(d)(5)(B)(v) of the Act, 42 U.S.C. §1395ww(d)(5)(B)(v)).

[14] BBA § 4623 (codified at § 1886(h)(4)(H)(ii), 42 U.S.C. §1395ww(h)(4)(H)(ii)).

The regulations governing direct graduate medical education payments have historically been located at 42 C.F.R. § 413.86.[15] On August 29, 1997, CMS issued a final rule to implement the BBA FTE cap at 42 C.F.R. § 413.86(g)(4).[16] In particular, § 413.86(g)(4) specified that "[h]ospitals that are part of the same affiliated group may elect to apply the [FTE] limit on an aggregate basis."[17] The final rule also included an initial definition for "affiliated group" located in 42 C.F.R. § 413.86(b).[18] However, on May 12, 1998, CMS issued a final rule to further implement the BBA FTE cap which amended the definition of "affiliated group." Following the May 12, 1998 final rule, § 413.86(b) defined "affiliated group" as follows:

> *Affiliated group* means—
> (1) Two or more hospitals located in the same urban or rural area ...or in contiguous areas if individual residents work at each of the hospitals during the course of the program; or
> (2) If the hospitals are not located in the same or a contiguous urban or rural area, the hospitals are jointly listed—
> (i) As the sponsor, primary clinical site or major participating institution for one or more of the programs as these terms are used in Graduate Medical Education Directory, 1997–1998; or
> (ii) As the sponsor or under ''affiliations and outside rotations'' for one or more programs in operation in Opportunities, Directory of Osteopathic Postdoctoral Education Programs.
> (3)The hospitals are under common ownership.[19]

Neither the August 29, 1997 nor May 12, 1998 final rules amended the regulations to specify how to make the § 413.86(g)(4) election to apply the FTE limit on an aggregate basis.[20] However, the preamble to the May 12, 1998 final rule did provide such guidance. It specified that this election must part of an "explicit agreement," *i.e.*, a written agreement:

> Hospitals that could qualify to be part of an affiliated group do not have to affiliate. As we describe in more detail below, for purposes of applying an aggregate cap hospitals *must affiliate by explicit agreement*. If a hospital does not affiliate, that

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[15] As part of the final rule published on August 12, 2004, CMS redesignated the then-existing § 413.83 governing payments for direct costs of GME into nine separate sections — 42 C.F.R. §§ 413.75 – 413.83. *See* 69 Fed. Reg. 48916, 49234-49238, 49254-49625 (Aug. 12, 2004).

[16] 62 Fed. Reg. 45966, 46006-46007, 46034-46035 (Aug. 29, 1997).

[17] *Id.* at 46035.

[18] 62 Fed. Reg at 46034.

[19] 63 Fed. Reg. at 26358 (emphasis in orginal) (amending 42 C.F.R. §413.86(b)).

[20] *Id.* at 46035.

> hospital will remain subject to a cap based on its FTE count in its most recent cost reporting period ending on or before December 31, 1996. The aggregate cap will only be applied for hospitals that elect to be part of an affiliated group.[21]

In addition, the May 12, 1998 preamble provided the following guidance on the timing and content of an affiliation agreement:

> As stated above, hospitals seeking to receive payments as an affiliated group must provide agreements specifying adjustments to FTE caps by July 1 of each year for the contemporaneous residency training year.
> In summary, we will apply the FTE caps for an affiliated group as follows:
> - Hospitals that qualify to be members of the same affiliated group for the current residency training year and elect an aggregate cap must provide an agreement to the fiscal intermediary and HCFA specifying the planned changes to individual hospital counts under an aggregate FTE cap by July 1 for the contemporaneous (or subsequent) residency training year.
> - Each agreement must be for a minimum of one year and may specify the adjustment to each respective hospital cap under an aggregate cap in the event the agreement terminates, dissolves or, if the agreement is for a specified time period, for residency training years and cost reporting periods subsequent to the period of the agreement. In the absence of an agreement on the FTE caps for each respective institution following the end of the agreement, each hospital's FTE cap will be the IME and direct GME FTE count from each hospital's cost reporting periods ending in 1996.
> - Each agreement must specify that any positive adjustment for one hospital must be offset by a negative adjustment for the other hospital of at least the same amount.
> - *The original agreements must be signed and dated by representatives of each respective hospital* that is a party to the agreement and that agreement must be provided to the hospital's fiscal intermediary with a copy to the HCFA. Copies of agreements that each hospital which is part of the original agreement has with other hospitals must also be attached.
> - Hospitals that provided an earlier agreement for planned changes in hospital FTE counts may provide a subsequent

[21] 63 Fed. Reg. at 26337 (emphasis added).

> agreement on June 30 of each year modifying the agreement for applying the individual hospital caps under an aggregate FTE cap.[22]

In a final rule published on August 1, 2002, CMS amended 42 C.F.R. § 413.86(b) to add a definition for "affiliation agreement."[23] In the preamble to the August 1, 2002 final rule, CMS explained that it added the definition "to clarify in regulations the requirements for participating in an affiliated group" and noted that "[m]ost of these requirements are explicitly derived from the policy explained in the August 29, 1997 and May 12, 1998 final rules."[24] As a result of this amendment, § 413.86(b) defined "affiliation agreement" as follows:

> *Affiliation agreement* means a written, signed and dated agreement by responsible representatives of each respective hospital in an affiliated group…that specifies:
>
> (1) The term of the agreement (which, at a minimum is one year), beginning on July 1 of a year;
>
> (2) Each participating hospital's direct and indirect GME FTE caps in effect prior to the affiliation;
>
> (3) The total adjustment to each hospital's FTE caps in each year that the affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to one hospital's direct and indirect FTE caps that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount;
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> (4) The adjustment to each participating hospitals' FTE counts resulting from the FTE resident's (or residents') participation in a shared rotational arrangement at each hospital participating in the affiliated group for each year the affiliation agreement is in effect. This adjustment to each participating hospital's FTE count is also reflected in the total adjustment to each hospital's FTE caps (in accordance with paragraph (3) of this definition); and
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> (5) The names of the participating hospitals and their Medicare provider numbers.[25]

The issue in this case involves the interpretation of the regulations at 42 C.F.R. § 413.86 for the proper accounting of FTEs in the DGME/IME calculations.

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[22] 63 Fed. Reg. at 26341 (emphasis added).

[23] 67 Fed. Reg. 49982, 50119 (Aug. 1, 2002) (amending 42 C.F.R. §§ 413.86(b)).

[24] 67 Fed. Reg. at 50069.

[25] 67 Fed. Reg. at 50119 (emphasis in original).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Alegent Health – Immanuel Medical Center (Provider) is a non-profit, general acute care hospital that is located in Omaha, Nebraska. This case concerns the Provider's cost reports for the fiscal years ending (FYEs) June 30, 2004 and June 30, 2005.

Prior to July 1998, Creighton University (Creighton) contracted with St. Joseph Regional Health Care System, LLC (St. Joseph – a Tenet Healthcare facility) to be the primary training site for its psychiatric residency training program. St. Joseph established an FTE cap of 145.39 for IME and 165.45 for DGME based upon its cost report for FYE May 31, 1996.

On June 30, 1998, Creighton, St. Joseph, and the Provider executed and entered into an affiliation agreement to expand opportunities for medical education through the addition of the Provider's facility to Creighton's then-existing residency training programs.[26] Prior to the June 30, 1998 affiliation agreement, the Provider did not train residents and had no established base year FTE cap.[27] The affiliation agreement was for a term of three years that could be "renewed thereafter by the parties in writing for additional three year terms."[28] As a result of the affiliation agreement, St. Joseph ceased to be the primary training site of the psychiatric residency program but residents of the program continued to rotate through St. Joseph in addition to their rotations at the Provider.[29]

By the letter dated June 25, 1998, a representative of Arthur Andersen requested on behalf of St. Joseph and the Provider that CMS treat St. Joseph and the Provider "as an 'affiliated group' for purposes of direct graduate medical education and indirect medical education residency caps effective July 1, 1998."[30] By letter dated June 30, 1998, a representative of Alegent Health sent CMS a copy of the June 30, 1998 affiliation agreement that had inadvertently excluded from the June 25, 1998 letter.[31]

In addition to the affiliation agreement, Creighton, Creighton Health Care, Inc., St. Joseph, and the Provider executed and entered into a separate general academic affiliation agreement on July 24, 1998 for the Psychiatric Residency Program with the intent "to form an alliance among the parties . . . to provide for strong academic affiliations and to improve the quality and cost effectiveness of patient care across Alegent and CSJ [*i.e.*, St.

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[26] Exhibit P-4, subtab PC-5.

[27] *See* Exhibit P-1 at 95-98 (transcript from related PRRB case nos. 05-0627, 06-0192, 06-1709, and 06-1710).

[28] Exhibit P-4, subtab PC-5 at 1.

[29] *See* Exhibit P-4, subtabs PC-1 at ¶ 3, PC-2 at ¶¶ 3-4, and PC-3 at ¶¶ 3-4.

[30] Exhibit P-4, subtab PC-4.

[31] Exhibit P-4, subtabs PC-5 and PC-6.

Joseph] consistent with the faith-based philosophies they maintain."[32] Among other things, the agreement incorporated by reference the June 30, 1998 affiliation agreement.[33]

In accordance with the June 30, 1998 affiliation agreement, the Provider claimed IME/DGME costs for 10 FTEs on its cost report for FYE June 30, 1999. Each fiscal year thereafter, the Provider filed its cost report claiming IME and DGME reimbursement based upon its understanding that its affiliation agreement to form an affiliated group with St. Joseph was in effect through the Provider FYE June 30, 2001.

In addition, St. Joseph entered into an affiliation agreement exclusively with other Tenet facilities effective July 1, 1999 to share the IME/DGME FTE cap (the July 1, 1999 Tenet affiliation agreement).[34] The Provider was not aware of the July 1, 1999 Tenet affiliation agreement prior to this appeal and the cost reports filed by St. Joseph reflected the base year FTE caps identified in the respective Tenet affiliation agreements but not the resident FTEs claimed by the Provider.[35]

During the audit of the Provider's cost reports from FYE June 30, 1999 (*i.e.* the first year of the residency program at the Provider) through June 30, 2002, the Intermediary reviewed the affiliation agreement[36] and made a determination that it adequately documented the Provider as a part of an affiliated group to share the FTE cap for IME/DGME reimbursement purposes.[37] However, the Intermediary also determined the psychiatric residency program was a "new program" and allowed reimbursement on this basis through the Provider's FYE June 30, 2001.[38]

It was not until 2005 when the Intermediary audited the Provider's Medicare cost report for FYE June 30, 2003 that the Intermediary made a determination that the psychiatric residency program was not a "new program" and that the affiliation agreement was insufficient because it did not contain explicit or specific language about the assignment or sharing of St. Joseph's IME & DGME FTE cap.[39] The Intermediary issued an original NPR dated April 14, 2006 for FYE June 30, 2003, disallowing all IME and DGME reimbursement claimed by the Provider. In addition, the Intermediary reopened the NPRs for the Provider's FYEs June 30, 2000, June 30, 2001, and June 30, 2002 and made

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[32] Exhibit P-4, subtab PC-30 at 1.

[33] *Id.*

[34] *See* Exhibit P-1 at 48 -49, 81-82,

[35] *See* Exhibit P-1 at 48-49, 81-81, 145.

[36] It is the Provider's assertion that although this document is titled as an academic affiliation agreement, it was known by all parties that it was an affiliation agreement entered into for the purpose of sharing the FTE Caps. These agreements are also referred to by the Provider as Medicare GME Affiliation Agreements. *See* Provider's Consolidated Position Paper, Volume I at 7, fn 9.

[37] Exhibit P-4, subtabs PC-12 at 18 (FYE 6/30/99), PC-13 at 12 (FYE 6/30/00), and PC-15 at 2 (FYE 6/30/01). *See also* Exhibit P-1 at 137-139.

[38] Per Provider's witness testimony, during the audit of FY 2002, the Intermediary determined its psychiatric residency program was not a new program. Exhibit P-1 at 117-122.

[39] *See* Provider's Consolidated Position Paper at 14-16; Exhibit P-4, subtab PC-17.

similar adjustments disallowing most of the IME and DGME payments for those years.[40] The reopenings made no adjustments to the actual FTE counts for each fiscal year but determined that the Provider's base year FTE cap was zero. Consistent with the FYE June 30, 2003 finding, the Intermediary continued to adjust the Provider's base year FTE cap to zero for the FYEs June 30, 2004 and June 30, 2005 which is the subject of this record hearing.[41]

The Provider appealed the denial of FYEs June 30, 2004 and June 30, 2005 to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 to 405.1841. The Provider was represented by Joanne B. Erde, P.A., of Duane Morris LLP. The Intermediary was represented by Byron Lamprecht of Wisconsin Physicians Service.

PROVIDER'S CONTENTIONS:

The Provider contends that the June 30, 1998 affiliation agreement executed by Creighton, St. Joseph, and the Provider met the requirements of an affiliated group as delineated in the version of 42 C.F.R. § 413.86 in effect on June 30, 1998 and that this affiliation agreement continued in effect through FYEs June 30, 2004 and June 30, 2005 which are the fiscal years at issue. In particular, the Provider asserts that the then-existing regulations established only two criteria in order to share FTE caps as an affiliated group: (1) The hospitals had to meet the definition of an "affiliated group" (*i.e.*, "two or more hospitals located in the same urban or rural area... if individual residents work at each of the hospitals during the course of the program"[42]); and (2) each hospital in an affiliated group had to "elect to apply the [FTE] limit on an aggregate basis" for such affiliated group.[43]

The Provider maintains that it met these two criteria because: (1) the Provider and St. Joseph were located within the same geographic area and operated under a shared rotational assignment;[44] and (2) the Provider and St. Joseph made a formal election to form an affiliated group and share St. Joseph's FTE caps[45] and conveyed a copy of its written affiliation agreement to CMS and the Intermediary.[46] In support of its position, the Provider cites to the following excerpts from the the preamble to the May, 1998 final rule:

> This means that we would apply a cap to the group as a whole, and the cap for the group would equal the sum of the individual caps for all

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[40] Exhibit P-4, subtab PC-17.

[41] This case is a continuation of PRRB Dec. No. 2012-D7 (Jan. 20, 2012) which included the FYEs June 30, 2000 through June 30, 2003. The parties have included relevant evidence from that case in this record including the transcript at Exhibit P-1.

[42] 63 Fed. Reg. at 26358 (amending the definition of affiliated group at 42 C.F.R. §413.86(b)).

[43] 42 C.F.R. §413.86(g)(4) (Oct. 1, 1997 edition).

[44] *See* Exhibit P-4, subtab PC-9 at 2.

[45] *See* Exhibit P-4, subtabs PC-1, PC-2, and PC-3.

[46] Exhibit P-4, subtabs PC-4 , PC-5, and PC-6.

> hospitals that are a part of the affiliated group... That is the aggregate cap under the August 29, 1997, final rule with comment period would be the combined individual caps of each hospital that elects to be a part of an affiliated group.[47]
>
> * * *
>
> An agreement between two hospitals does not mean only those hospitals are an affiliated group, if those hospitals also have agreements with other hospitals. Rather, the affiliated group includes the original two hospitals that have an agreement and every hospital that has an agreement with any of those hospitals.[48]
>
> * * *
>
> If the combined FTE counts for the individual hospitals that are members of the same affiliated group do not exceed the aggregate cap, we will pay each hospital on its hospital specific cap.[49]

Specifically, the Provider asserts that the above preamble language supports its position that the FTE caps for the affiliated group must be applied in the aggregate with each hospital receiving payment based upon its hospital specific FTE count because the Provider and St. Joseph created an affiliated group and elected to apply their FTE limit on an aggregate basis. The Provider further notes that St. Joseph also was a part of the Tenet hospitals affiliated group pursuant to the July 1, 1999 Tenet affiliation agreement and maintains that the aggregate cap for St. Joseph and the Provider that was created under the June 30, 1998 affiliation agreement would include all of the hospitals in the Tenet affiliated group plus the Provider.[50] The Provider concludes that the Provider is entitled to be reimbursed for its IME/DGME based on its actual FTE count for such FYEs because the aggregate FTE caps of the Tenet hospitals group plus the Provider during FYEs June 30, 2004 and June 30, 2005 were not exceeded by the actual count of the Tenet Hospital group plus the Provider.

In the alternative, the Provider contends that it is entitled to equitable relief based on its reliance on the Intermediary's characterization of the Provider as a new program for IME and DGME as late as the Provider's FYE June 30, 2005.[51] The Provider maintains that either the Medicare program must be estopped from denying reimbursement for the Provider's failure to have a written affiliation agreement for FYEs subsequent to its FYE June 30, 2001, or the deadline for the Provider to file an affiliation agreement for the fiscal years at issue must be extended pursuant to the doctrine of equitable tolling. Finally, the Provider maintains that the Intermediary reversed in error its prior determination that the Psychiatric Residency Program was a new program.

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[47] 63 Fed. Reg. 26318, 26338 (May 12, 1998).

[48] *Id.* at 26338 (May 12, 1998).

[49] *Id.* at 26341as corrected at 63 Fed. Reg. 40997 (July 31, 1998).

[50] Provider's Consolidated Position Paper at 37-38.

[51] *See* Provider's Consolidated Position Paper at 44, fn 22 and Exhibit P-4, subtab PC-11.

Finally, the Provider contends that the regulations requiring a written affiliation agreement[52] are unenforceable under the Paperwork Reduction Act (PRA).[53] The PRA imposes significant limitations on a federal agency's ability to collect information and states:

> An agency shall not conduct or sponsor the collection of information unless in advance of the adoption or revision of the collection of information –
>
> (1) the agency has –
> (A) conducted the review established under section 3506(c)(1);
> (B) evaluated the public comments received under section 3506(c)(2);
> (C) submitted to the Director [of OMB][54] the certification required under section 3506(C)(3), the proposed collection of information, copies of pertinent statutory authority, regulations, and other related materials as the Director may specify; and
> (D) published a notice in the Federal Register…;
> (2) the Director has approved the proposed collection of information or approval has been inferred, under the provisions of this section; and
> (3) the agency has obtained from the Director a control number to be displayed upon collection of information.[55]

The Provider maintains that CMS made significant changes to the provisions governing affiliated groups in both the proposed and final rules for the inpatient prospective payment system for FY 2003 by specifically including a regulatory requirement that providers submit information to CMS before being permitted to share FTE caps.[56] The Provider further maintains that CMS did not solicit comments relative to affiliated groups and that CMS did not request or obtain an OMB control number even though one was required. The Provider concludes that CMS' failure to comply with the PRA makes CMS' requirement for a written affiliation agreement unenforceable under the public protection provision of the PRA. In this regard, the Provider notes that the PRA provides that "[n]otwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information that is subject to this subchapter [*i.e.*, the PRA]."[57]

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[52] 42 C.F.R. 413.86(b) and (g)(7)(i)(2002).

[53] Pub. L. No. 104-13, 109 Stat. 163 (1995) (codified at 44 U.S.C. Chap. 35, Subch. I).

[54] Office of Management & Budget.

[55] 44 U.S.C. § 3507(a).

[56] *See* 67 Fed. Reg. 31403, 31504-31505 (May 9, 2002); 67 Fed. Reg. 49,982, 50069 (Aug. 1, 2002).

[57] 44 U.S.C. § 3512. Similarly, the legislative history of the statute states that any "[i]nformation collection requests" that fail to obtain the required approval "are to be considered 'bootleg' requests and may be ignored by the public." Rep. No. 96-930 at 52 (1980).

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the June 30, 1998 affiliation agreement[58] does not satisfy the requirements for an affiliation agreement and, as a result, is invalid.[59] The Intermediary maintains that CMS gave definitive guidance on the requirements for a proper affiliation agreement in preamble to the May 12, 1998 final rule and that these requirements covered such items as identification of the parties, the term of the agreement, the total FTE cap for each hospital prior to entering the affiliation agreement (including the breakdown of counts between IME and DGME), and the manner in which the resulting aggregate cap will be distributed among the members of the affiliated group.[60] The Intermediary maintains that the Provider's affiliation agreement does not meet these requirements because it neither mentions the sharing or assignment of FTEs nor identifies the sharing methodologies among the agreement's participants.[61] Further, the Intermediary asserts that the letters sent by Arthur Andersen and the Provider to CMS contemporaneous with the execution of the June 30, 1998 affiliation agreement did not cure these deficiencies because these letters were not signed by each respective hospital/party to the June 30, 1998 affiliation agreement.[62]

Next, the Intermediary points out that the St. Joseph affiliation agreements for the fiscal years in question do not name the Provider as an affiliate and the Provider is not a signatory to these affiliation agreements. Moreover, the affiliation agreements specifically preclude any provider that is not named as an affiliate in the affiliation agreements from otherwise being an affiliate because such agreements provide: "[n]one of the Affiliates has entered into an affiliation agreement for aggregations of resident limits with another hospital."[63] However, the St. Joseph affiliation agreement for the fiscal year ending June 30, 2006 which is the FYE immediately following the two fiscal years at issue clearly lists the Provider as part of that affiliation agreement. [64]

Finally, the Intermediary notes that St. Joseph filed its cost report for the same period at issue claiming its entire FTE cap.[65] As a result, the Intermediary asserts that St. Joseph never intended to share its FTE cap during the period at issue.

In summary, the Intermediary asserts that the agreement is inadequate to satisfy the requirements of the preamble to the May 12, 1998 final rule or establish the intent of the parties to share their FTE cap and in the absence of such an agreement. As a result, the Intermediary asserts that the Provider may not participate in the proration of the

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[58] Exhibit I-1, subtab I-3.

[59] Intermediary Consolidated Final Position Paper at 6.

[60] *Id.* at 9.

[61] *Id.* at 9-10.

[62] *Id.* at 10.

[63] Exhibit I-4.

[64] Intermediary Consolidated Final Position Paper at 10-11.

[65] Intermediary Consolidated Final Position Paper at 11; Exhibit I-1, subtab I-2.

aggregate cap with St. Joseph. Rather, the Provider's program must rely upon its own base year FTE cap which the Intermediary has determined to be zero.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered Medicare law and guidelines, the parties' contentions, and the evidence presented. Set forth below are the Boards findings and conclusions.

The issue presented for the Board's consideration required an examination of the statute and regulations supporting competing arguments advanced by the parties. The Intermediary asserts that the Provider failed to "elect" to apply the FTE resident limitation (cap) on an aggregate basis and, therefore, did not satisfy the conditions described under the statutory and regulatory provisions. The Provider contends that it met the requirements of an affiliation agreement and is properly entitled to aggregate FTE caps with St. Joseph.

In 1997, Congress created the requirement for an FTE cap in BBA § 4623 by amending section 1886(h)(4) of the Act[66] to add new subsections (F), (G), and (H). The new subsection (F) created the FTE cap and the new subsection (G) required, among other things, the Secretary to "prescribe rules . . . in the case of medical residency training programs established on or after January 1, 1995." The following excerpt from the Conference Report which accompanied the bill demonstrates Congressional awareness of the need for certain "proper flexibility" within the application of the FTE cap:

> The Conferees understand that there are a sizeable number of hospitals that elect to initiate such programs (as well as terminate such programs) over time and the Conferees are concerned that within the principles of the cap that there is proper flexibility to respond to such changing needs, including the period of time such programs would be permitted to receive an increase in payments before a cap was applied.[67]

Beginning with FYE June 30, 1999, the Intermediary initially treated the Provider as a new medical residency training program. The regulations at 42 C.F.R. § 413.86(g)(6) in effect during federal fiscal year 1997 provided, in pertinent part:

> 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
> . . . .

In the final rule published on August 29, 1997, CMS promulgated the following definition of a new medical residency training program at 42 C.F.R. § 413.86 (g)(7):

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[66] 42 U.S.C. § 1395ww(h)(4).

[67] House Conf. Report No. 105-217, 105th Cong., 1st Sess. 821-22 (July 30, 1997), *reprinted at* 1997 U.S. Code Cong. & Admin. News 176, 442-43.

> [A] medical residency training program that receives initial accreditation by the appropriate accrediting body on or after July 1, 1995.[68]

In the final rule published on May 12, 1998, CMS expanded this definition in response to concerns of commenters who questioned the advisability of just using the accreditation date for determination of a new medical residency program. In particular, commenters noted that programs may not be able to get up and running for some time after the accreditation letter is issued. The following excerpt provides CMS' response to these concerns:

> We recognize that hospitals that either received accreditation for a new medical residency training program or began training residents in the new program may have expended substantial resources during the accreditation process. We also recognize that hospitals usually do not begin training residents immediately upon receiving an accreditation letter. For these reasons, we believe it appropriate to consider a medical residency training program to be newly established if the program received initial accreditation or began training residents on or after January 1, 1995. We are modifying the regulation accordingly.[69]

As a result, CMS expanded the definition of a new medical residency training program at 42 C.F.R. § 413.86 (g)(7) so that it read:

> [A] medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.[70]

However, even under this expanded definition of a new medical residency program, the Board finds that the Provider's initial participation in the University of Nebraska Psychiatric residency program after January 1, 1995 does not constitute a new medical residency training program. The Provider did not establish the program, but rather the Provider began participating in a then-existing residency program. CMS addressed the facts presented by Alegent Health – Immanuel Medical Centers participation in the existing program in the preamble to the July 30, 1999 final rule. CMS explained that the phrase "begins training residents on or after January 1, 1995" means that the program may have been accredited by the appropriate accrediting body prior to January 1, 1995 but that the program did not begin training until January 1, 1995 or afterwards. CMS goes on to explain that "the language does not mean that it is the first time a particular

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[68] 62 Fed. Reg. at 46034-46035.

[69] 63 Fed. Reg. at 26332.

[70] 63 Fed. Reg. 26318, 26358 (May 12, 1998).

hospital began training residents in a program on or after January 1, 1995, but the program was in existence at another hospital prior to January 1, 1995."[71]

Based on the above analysis, the Board concludes that the Provider did not establish a new medical residency training program after January 1, 1995. Rather, the Provider became a new training site for then-existing medical residency training programs established and operated by Creighton University/University of Nebraska.

The Provider contends that it met the requirements of an affiliated group under 42 C.F.R. § 413.86, in effect as of July 1, 1998. The regulations established only two criteria to share FTE caps as an affiliated group: (1) The hospitals had to meet the definition of an affiliated group, (*i.e.*, "two or more hospitals located in the same urban or rural area ... or in contiguous areas if individual residents work at each of the hospitals during the course of the program"[72]); and (2) hospitals that were part of the same affiliated group had to "elect to apply the [FTE] limit on an aggregate basis."[73] The Board finds that the preamble to the May 12, 1998 final rule established specific requirements governing the content and form of an affiliation agreement, including that it must be in writing, signed by each of the affiliates, and last for a term of one year or more and that, in 2002, these requirements were incorporated into regulations at 42 C.F.R. § 413.86.

The Board examined the Provider's agreements and submissions in conjunction with the requirements of the affiliation agreements as delineated in the preamble to the May 12, 1998 final rule and later incorporated into regulations at 42 C.F.R. § 413.86(b). The Board finds that the Provider had in fact executed an affiliation agreement on June 30, 1998 that spoke directly to an affiliation for purposes of supporting up to 10 residents.[74] That agreement was signed by the parties and was forwarded to HCFA under a cover letter that made specific request for treatment as an affiliated group for "purposes of the direct graduate medical education and indirect medical residency caps effective July 1, 1998."[75] The Board finds that the Provider's intent was clear and that their collective submissions qualify the parties as an affiliated group during the three year term specified in the affiliation agreement (*i.e.*, July 1, 1998 through June 30, 2001).[76]

However, the Board also finds that the affiliation agreement lapsed on June 30, 2001 because the parties did not extend or renew the affiliation agreement beyond the three-year term specified in the affiliation agreement. Both the preamble to the May 12, 1998 final rule[77] and subsequent regulations finalized in 2002[78] made a written agreement

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[71] 64 Fed. Reg. 41490, 41519 (July 30, 1999).

[72] 63 Fed. Reg. at 26358 (amending the definition of affiliated group at 42 C.F.R. §413.86(b)).

[73] 42 C.F.R. §413.86(g)(4) (Oct. 1, 1997 edition).

[74] Exhibit P-4, subtab PC-5 at 3, Section V.

[75] Exhibit P-4, subtabs PC-4, PC-5, and PC-6.

[76] Exhibit P-4, subtab PC-5 at 1, Section III.

[77] 63 Fed. Reg. at 26341.

[78] 67 Fed. Reg. 49982, 50069-50071, 50119-50120 (Aug. 1, 2002) (amending 42 C.F.R. §413.86 to specify, among other things, a definition for affiliation agreement in subsection (b) and when a hospital may receive a temporary adjustment to its FTE cap in paragraph (g)(7)).

necessary to qualify as an affiliated group. It is undisputed that no written agreement was in place for fiscal years 2002 through 2005. Accordingly, the Board concludes that Provider does not qualify for treatment as an affiliated group for the periods in this appeal — FYEs June 30, 2004 and June 30, 2005. The Provider may not share FTE caps with St. Joseph for those periods.

The Board also notes that the Provider sought equitable remedies from the Board under the doctrines of equitable estoppel and equitable tolling. Remedies based on equity are beyond the scope of the Board's authority and consequently the Board reaches no conclusions relative to these arguments. The Provider refers to several cases in support of its equity arguments.[79] The equity finding in every case is awarded under the authority of the federal court and not under authority granted this Board. The Board's authority can be found in 42 C.F.R. § 405.1867 which states:

> In exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

Since the Provider failed to meet the regulatory requirements for an affiliated group pursuant to 42 C.F.R. § 413.86, as described above, the Board is bound to find against the Provider in this case.

Finally, the Board also examined the Provider's claim that the requirement for a written affiliation agreement as delineated in 42 C.F.R. § 413.86 is violative of the PRA. In BBA, Congress established the FTE cap through the promulgation of § 1886 (h)(4)(F) and (H) of the Act and specifically gave the Secretary broad authority in § 1886(h)(4)(H)(ii) to prescribe rules under which to allow institutions to elect to apply the FTE limit on an aggregate basis. Further, § 1886(h)(4)(H)(iii) authorizes the Secretary to collect such data from the entities that operate the residency programs as the Secretary considers necessary to ensure proper application of the limitation. The Secretary properly promulgated regulatory provisions addressing the proper application of the FTE cap as part of notice and comment processes that resulted in the final rules published on August 29, 1997,[80] May 12, 1998[81], and August 1, 2002.[82] Since the Provider failed to meet the regulatory requirements for an affiliated group pursuant to 42

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[79] *See Auburn Reg. Med. Ctr. v. Sebelius,* 642 F.3d 1145 (D.C. Cir. 2011), *Heckler v. Community Health Servs.*, 467 U.S. 51 (1984), *Swedish Am. Hosp. v. Sebelius,* 773 F. Supp. 2d 1 (D.D.C. 2011), *Bradford Hosp. v. Shalala,* 108 F. Supp. 2d 473 (W.D. Pa. 2000).

[80] 62 Fed. Reg. 45966 (Aug. 29, 1997).

[81] 63 Fed. Reg. 26318 (May 12, 1998).

[82] 67 Fed. Reg. 49982 (Aug. 1, 2002).

C.F.R. § 413.86, as described above, the Board pursuant to 42 C.F.R. § 405.1867 is bound to find against the Provider in this case.

DECISION AND ORDER:

The Provider did not establish a new medical residency training program. Rather, the Provider became a new training site for existing medical residency training programs. Further, the Provider did not satisfy the regulatory requirements in 42 C.F.R. § 413.86 for treatment as an affiliated group and, as a result, may not aggregate its caps for fiscal years ending June 30, 2004 and June 30, 2005. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, CPA
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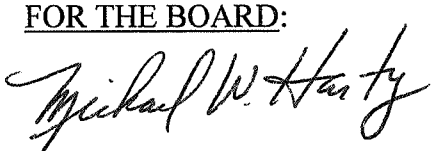
FOR THE BOARD:



Michael W. Harty
Chairman

DATE: JUN 15 2012