PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2023-D17

PROVIDER–
JFK Medical Center

Provider No.: 10-0080

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

RECORD HEARING DATE –
April 14, 2021

Cost Reporting Periods Ending –
June 30, 2012, June 30, 2013, June 30, 2014, June 30, 2015, and June 30, 2016

Case Nos. – 15-1665, 16-2122, 18-1200, 19-0260, and 20-0452

INDEX

Page No.

Issue Statement 2
Decision 2
Introduction 2
Statement of the Facts 2
Discussion, Findings of Fact, and Conclusions of Law 5
Decision and Order 12

ISSUE STATEMENT:

Whether the Medicare Contractor correctly determined the Graduate Medical Education ("GME") and Indirect Medical Education ("IME") full-time equivalent ("FTE") resident caps 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 under appeal?[1]

DECISION:

After considering the Medicare law and regulations, the evidence admitted, and the parties' contentions, the Provider Reimbursement Review Board ("Board") finds the Medicare Contractor improperly calculated JFK's FTE resident caps for GME and IME for FYs 2012 through 2016, and that JFK's resident FTE caps should be modified as follows:

1. From 40.04 to 42.47 for GME and from 39.90 to 42.42 for IME for the FY 2012 through 2015 cost reporting periods under appeal; and

2. From 40.04 to 44.04 for GME and from 39.90 to 43.99 for IME for the FY 2016 cost reporting period under appeal.

INTRODUCTION:

JFK is a Medicare-certified acute care hospital located in Atlantis, Florida. On April 1, 2016, West Palm Hospital merged with the Provider. JFK was the surviving entity and continued its Medicare agreement as a participating provider.[2] Thus, while West Palm Hospital's FTE caps from its prior cost reports must be partialized and incorporated into JFK's FTE cap for the FY 2016 cost reporting period, the Board considers it to be a part of JFK due to the 2016 merger, and refers to it accordingly. JFK's designated Medicare contractor[3] is Wisconsin Physicians Service ("Medicare Contractor").

JFK started a new Internal Medicine resident training program on July 1, 2008. Under 42 C.F.R. § 413.79(e)(1), JFK had three years to establish the FTE caps for its new program. This three-year "cap-building" period ended June 30, 2011.[4] The Medicare Contractor did not calculate JFK's FTE caps until it audited the FY 2012 cost report.[5] The Provider disputes the methodology used by the Medicare Contractor in calculating the FTE cap.[6]

JFK timely appealed the Medicare Contractor's FTE cap determinations for FYs 2012 through 2015 to the Board, and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1840.

---

[1] Parties' Stipulations ("Stip.") at ¶ A.1 (Apr. 1, 2021).
[2] Provider's Final Position Paper ("Provider's FPP") at 2; Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 3.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Stip. at ¶ C.3-4.
[5] *Id.* at ¶ C.7.
[6] Provider's FPP at 3.

The Board held a live video hearing on April 14, 2021. Drew Marrocco, Esq. of Denton, US LLP represented JFK. Edward Lau, Esq. and Bernie Talbert, Esq., of Federal Specialized Services represented the Medicare Contractor.

STATEMENT OF THE FACTS:

JFK established a new medical education program on July 1, 2008.[7] Based on 42 C.F.R. § 413.79(e) (2008), the Provider had a three-year window in which to establish its permanent FTE caps. This regulation stated in pertinent part:

> (e) *New medical residency training programs*. If **a hospital** establishes **a new medical residency training program** as defined in paragraph (l) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (c) of this section may be adjusted as follows:
>
> (1) If **a hospital** had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it 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.[8]

On August 31, 2012, the Secretary revised 42 C.F.R. § 413.79(e)(1) to address resident rotations that are split between two hospitals. As a result of these revisions, the regulation read, in pertinent part:

---

[7] *Id.*

[8] (Bold and underline emphasis added.) Prior to August 11, 2004, 42 C.F.R. § 413.79(e) (2008) was located at 42 C.F.R. § 413.86(g)(6). 69 Fed. Reg. 48916, 49236-37 (Aug. 11, 2004). In turn, § 413.86(g)(6) was established as part of the final rules published on August 29, 1997 and May 12, 1998 and then last revised, in pertinent part, in the final rule published on July 30, 1999. 62 Fed. Reg. 45966, 46005-06, 46035 (Aug. 29, 1997); 63 Fed. Reg. 26318, 26333-34, 26358 (May 12, 1998); 64 Fed. Reg. 41490, 41542-43 (July 30, 1999).

> (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 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. . . .
>
> (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. . . .[9]

The August 31, 2012 changes were effective October 1, 2012.[10]

JFK's new Internal Medicine Residency training program was accredited for 66 training slots and has two "participating institutions": JFK and West Palm Beach VA Medical Center ("the VA").[11] During the first three years of the program, some residents spent part of their time training at the VA (referred to as "out-rotations").[12] The Medicare Contractor adjusted JFK's GME and IME FTE caps to reflect the out-rotations at the VA. JFK is challenging how the Medicare Contractor handled the out-rotations when calculating the Provider's GME and IME caps.[13]

---

[9] 77 Fed. Reg. 53416-24, 53680-81 (Aug. 31, 2012).

[10] *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.").

[11] Exhibit ("Ex.") P-27 (ACGME Accreditation letter dated Oct. 29, 2007).

[12] Tr. at 11; Medicare Contractor's FPP at 10; Stip. at ¶ C.1.

[13] Provider's Post-Hearing Brief at 3 (June 14, 2021).

JFK believes that the Medicare Contractor improperly calculated its GME and IME caps using the methodology in the 2012 regulations instead of the methodology in the regulations that were in effect during the three years ending June 30, 2011.[14]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

The Medicare Contractor contends that the 2012 revisions to § 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 are to be followed when calculating the Provider's GME and IME caps for its new Internal Medicine Residency training program.[15] Using the 2012 revised regulation as a guide, the Medicare Contractor 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.[16] The Medicare Contractor 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 Medicare Contractor 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.[17]

JFK disagrees that the 2012 revised regulation is a "clarification' of the 2008 regulation (the "Old Rule") and argues that the Medicare Contractor's use of the revised regulation constitutes impermissible retroactive rulemaking.[18] JFK maintains that the 2008 regulation is clear that an adjustment for out-rotations applies *only if* the provider's residents out-rotated for an entire program year (or years).[19] Because the Medicare Contractor does not contend that any of its out-rotations were for an entire year, JFK believes there should be no adjustment to remove the out-rotations.[20]

The Board compared the 2008 regulation to the 2012 revised regulation and finds that the language did materially change and would appear to treat out-rotations differently. Specifically, the 2008 regulation discusses out-rotations and states, in part, "if the residents are spending *an entire* program year or years . . . ."[21] The 2012 revised regulation modified this section stating "if the residents are spending *portions* of a program year (or years)".[22] However, as explained in detail below, the Board finds the 2012 revised regulation clarifies how out-rotations are handled in the calculation of the GME/IME FTE caps for new medical residency training programs established after October 1, 2012. The Board further finds that the 2012 regulation does not retroactively change the application and interpretation of the 2008 regulation.

JFK's program began in 2008, and the first three years of the program were completed by 2011. Therefore, the Board finds that C.F.R. § 413.79(e)(1) (2008) must be used to calculate the GME

[14] *Id.* at 1-3.
[15] Medicare Contractor's FPP at 17-18.
[16] Stip. at ¶ C.7.d.
[17] Medicare Contractor's FPP at 16-17.
[18] Provider's Post-Hearing Brief at 2.
[19] Provider's FPP at 15, 17.
[20] Provider's Post-Hearing Brief at 21-22.
[21] 42 C.F.R. § 413.79(e)(2008).
[22] 42 C.F.R. § 413.79(e)(2012).

and IME caps for the new Internal Medicine training program at JFK. The 2012 revised regulation, would *not* be applicable and it would be impermissible to retroactively apply the regulation to the program in dispute. Notwithstanding, the Board interprets 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 *resident**s*** are spending an *entire* program year (or years) at one hospital and the remainder of the *program* at another hospital," the Board interprets 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 would result in FTEs that would be removed from the FTE total. The Board notes that during the hearing, Board Member Smith and the Provider's witness had the following exchange:

MR. SMITH:	. . . are there any rotations . . . required at either of those hospitals? . . . Is it possible a resident could spend all 3 years at one hospital or are there required rotations that they see at both places?
THE WITNESS:	No, sir. They could all spend their time at just one of those facilities.
MR. SMITH:	Are there any residents that have done that?
THE WITNESS:	No, sir.[23]

The Board finds that the testimony of the Provider's witness is inconsistent and implies that rotations to the VA are not required. Contrary to the witness' suggestion, the record clearly shows that, in practice, ***all*** residents rotate to the VA at one or more times during the 3 years of the program[24] and the Program Accreditation identifies both hospitals as "Participating Institutions."[25]

JFK states 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).[26] As the calculated cap (shown below), considering only JFK's FTEs, is less than the approved slots for the program, JFK contends that 56.03 is the appropriate cap for the new program.

---

[23] Tr. at 131.

[24] Ex. C-2 at 28-49. This Exhibit reflects JFK's IRIS data, by program year and individual resident rotations. Only 2 PGY3 residents reflect 0 FTE spent at the VA during the year, and both residents only spent part of the year in the program in total (one was a single month and the other was 4 months (both at 46)). All other residents reflect FTEs at both the VA and JFK.

[25] The Board notes that the program accreditation (Ex. P-27) clearly identifies *both* hospitals as "Participating Institution(s)." The agency which provides this accreditation, per the letter, is the Accreditation Council for Graduate Medical Education (AGCME). Their public website is noted on the letterhead as www.acgme.org. Consistent with this Exhibit, the Board takes administrative notice that the ACGME website under "Institution and Program finder" describes the specific JFK program (1401131535, as identified on Ex. P-27) as consisting of "Required Rotations" at both hospitals are "Required Rotations" and that residents spend 20 months rotating at JFK (5/6/9 in PGY1/2/3, respectively) and 16 months rotating at the VA (7/6/3) in a 3-year program (36 months).

[26] Provider's Post-Hearing Brief at 28.

JFK GME Residents in PGY-3/Program Year 3	18.6765[27]
Multiplied by Program Length	3.0000
Calculated Cap	56.0295
Approved Program Slots	66.0000[28]
Excess Over Approved Slots	(-9.9705)

However, the Provider's interpretation is excessively restrictive/narrow and improperly fails to account for the VA rotations. Indeed, the Provider fails to properly apply its interpretation to its own partial rotations at JFK. For example, if a resident spent a consecutive period of 14 months on an out-rotation, this would mean the resident definitely spent a year (12 months) on the out-rotation, plus another 2 months. Would the Provider then argue that only 1 year would be counted, as it was an entire year, but the 2 months would be ignored, as the regulation says "entire program year or years?" Similarly, the Board notes that JFK had 30.13 resident FTEs in Year 1, 35.03 resident FTEs in Year 2, and 39.90 resident FTEs in Year 3 for GME.[29] In each of those years, based on the fact that there are "partial FTEs" (*i.e.*, the FTE counts are not "xx.00"), *it must be assumed the residents did* ***not*** *spend entire program years at JFK, either*.[30] In fact, the term "FTE" stands for "full-time equivalent." The FTEs reported on the CMS-mandated IRIS file are based upon calculated total FTEs, using the time spent by all residents at the facility for the applicable year. As such, 18.00 FTEs could reflect 18 residents at the facility for the full program year, or 36 residents at the facility for 6 months each. In all cases, CMS requires the reporting of total FTEs, as calculated by the IRIS, which calculates FTEs using the combined time spent by all residents at the facility in the cost reporting year. The Board finds it likely that CMS revised § 413.79(e)(1) in 2012 to address the ambiguity of "partial-year rotations" and as such, clarified its intent in the determination of caps for new programs. Moreover, as described below, the Board finds that the VA must be accounted for in the GME cap calculation because it is part of "the program."

The Medicare Contractor argues that, under the regulation, the proper calculation is to identify the highest number of combined residents in any PGY year in the third year of the program and multiply it by 3 (the length of the program in years).[31] The Medicare Contractor's calculation is shown below:

---

[27] Stip. at ¶ C.6, Table 1.
[28] *Id.* at ¶ C.1.
[29] *Id*. at ¶ C.6, Table 1.
[30] This raises obvious concerns about how extremely small partial year rotations at JFK would be handled. Would a 1-month rotation at JFK followed by an 11-month rotation at the VA result in JFK getting credit for the full 12 months? Similarly, if the VA was a Medicare participating hospital, the Provider's methodology would result in more residents being allocated to each hospital than the program total slots. As shown above, the Provider's methodology provides a GME cap of 56.03 FTEs for JFK. A similar calculation for the VA would provide a GME cap of 31.04 FTEs for the VA (highest GME FTEs in year 3 = 10.348 multiplied by the program length of 3 years). The total GME cap for the entire program would then be 87.07 FTEs (56.03 + 31.04). This exceeds the approved 66 slots per the program approval, as stipulated by both parties (Stip. at ¶ C.1).
[31] Stip. at ¶ C.7.

JFK GME Residents in PGY-3/Program Year 3	18.6765[32]
VA GME Residents in PGY-3/Program Year 3	3.3385[33]
Total GME Residents in PGY-3/Program Year 3	22.0150
Multiplied by Program Length	3.0000
Calculated Cap	66.0450

The Medicare Contractor then apportioned this cap between the training hospitals based on the ratio of training time at each of the facilities over all 3 years of the program. This calculation is shown below:

	JFK	VA	Total
GME Residents Year 1	30.1309[34]	18.7796[35]	48.9105
GME Residents Year 2	35.0295[36]	25.9274[37]	60.9569
GME Residents Year 3	39.8967[38]	23.5360[39]	63.4327
Total GME Residents	105.0571	68.2430	173.3001
Percent to total	60.62%	39.38%	100.00%
Apportioned Slots	40.04	26.01	66.05

In making this allocation, the Medicare Contractor alleges that it is irrelevant that the VA training partner does not receive Medicare GME/IME payments, as it is still a participating institution, and that the lack of Medicare GME/IME payments does not affect the integrity of the calculation.[40]

The Board concludes that the Medicare Contractor 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 finds the 2008 regulation must be applied (not the 2012 regulation) and that the FTE caps were calculated improperly per the 2008 regulation. As noted in 42 C.F.R. § 413.79(e)(2008):

> 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.[41]

[32] *Id*. at ¶ C.6, Table 1.
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] Medicare Contractor's Post-Hearing Brief at 21 (June 10, 2021).
[41] (Italics emphasis added.)

The parties stipulate, and the Board agrees, that the highest number of residents for JFK in any program year, during the third year of the Internal Medicine training program was in the PGY3, with 18.6765 FTEs for GME and 18.6123 for IME.[42] For the VA, the parties stipulate, and the Board agrees, that the highest number of residents in any program year, during the third year of the Internal Medicine training program was in the PGY-2, with 10.348 FTEs for both IME and GME.[43] These amounts are then multiplied by 3, resulting in FTE caps which must not exceed the accredited slots, in accordance with 42 C.F.R. § 413.79(e)(2008). JFK argues that, since the VA does not participate in the Medicare program and does not file a cost report using an FTE cap, the caps, as calculated below, for both JFK and the VA do not exceed the 66 accredited slots. While the individual hospitals' calculated caps do not exceed 66 slots, the total caps for the entire program do, as shown below, for both GME and IME.

	JFK GME	VA GME	Total PGM
Highest FTEs in Year 3	18.6765[44]	10.3480[45]	
Multiplied by Program Length	3	3	
Calculated Cap	56.0295	31.0440	87.0735

	JFK IME	VA IME	
Highest FTEs in Year 3	18.6123[46]	10.3480[47]	
Multiplied by Program Length	3	3	
Calculated Cap	55.8369	31.0440	86.8809

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 interprets 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 interprets § 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 finds 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.[48] In other words, in order to prevent inappropriate shifting of costs, 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.[49]

---

[42] Stip. at ¶ C.7.a.
[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] *Id.*
[48] *See* 42 C.F.R. §§ 413.5(a) (specifying that "costs attributable to other patients of the institution are not to be borne by the program"), 413.9(a) (specifying that "[r]easonable cost includes all necessary and proper costs *incurred* in furnishing the services….").
[49] The Medicare Contractor is correct that VA hospitals participate in the Medicare Program. *See, e.g.,* 42 C.F.R. § 424.518(a)(1)(viii) (noting that VA hospitals applying for participation in the Medicare program are assigned a low risk for purposes of the screen level being apply to an enrollment application (e.g., initial and revalidation application); CMS State Operations Manual, CMS Pub. 100-07, § 3102 (rev. May 21, 2004) (listing VA hospitals among "[c]ertain kinds of hospitals [that] are paid under special provisions and are never subject to [I]PPS").

As a result of this interpretation, the Board disagrees with JFK that its new Internal Medicine training program resident cap should be 56.03 for GME and 55.84 for IME.[50] 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 31.04[51] 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 disagrees with the Medicare Contractor, which calculates the cap using the highest total FTE's 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 3 years of the program. The Board finds that using this method improperly results in an artificially low GME total cap under the 2008 regulation. The 2008 regulation at § 413.79(e)(1)(i) refers to "each hospital[]" relative to "the program":

> 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 <u>each</u> 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.[52]

Accordingly, the Board finds 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)[53] 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*. Here, *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, as shown below:

	JFK	VA	Total
Calculated GME Cap	56.0295	31.0440	87.0735
% to total	64.35%	35.65%	100.00%
Alloc. of GME Appr. Slots	42.47	23.53	66.00

	JFK	VA	Total
Calculated IME Cap	55.8369	31.0440	86.8809
Percent to total	64.27%	35.73%	100.00%
Alloc. Of IME Appr. Slots	42.42	23.58	66.00

[50] This is the amount calculated by the Provider. *See* Provider's Post-Hearing Brief at 10-11.
[51] The IME amount would be immaterially different and therefore will not be discussed, but will be calculated as part of the decision, using the same methodology as discussed for GME.
[52] (Italics and underline emphasis added.)
[53] 42 C.F.R. § 413.79(e)(1) states in pertinent part: "The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program."

The Board notes that the above interpretation of the 2008 regulation is consistent with ensuring that there is no inappropriate cost shifting as highlighted by the following factors:

1. The intent of setting the GME cap based on each hospital's portion of the overall GME program which usually consists of three PGYs;

2. CMS uses the third year of a new program since the program is expected to be "fully running," since in the third year it would be expected to be training residents in each of the three PGYs;

3. If the new program rotates to multiple hospitals, each hospital (through design and nature of the rotations and the new program) may always have more rotations in one year versus another, and it is likely each hospital's share of the total FTEs during a PGY will vary by PGYs 1, 2, and 3 (*e.g.*, the nature of the rotations at one hospital may be more suited for PGY-2 while the nature of the rotations at another hospital are more suited for PGY-3).[54]

Accordingly, the Board finds that JFK's resident FTE caps should be modified from 40.04 to 42.47 for GME and from 39.90 to 42.42 for IME for the FY 2012 through 2015 cost reporting periods under appeal.

As mentioned above, the merger of JFK and West Palm Hospital occurred on April 1, 2016, and thus, only had an effect on 3 months (April – June) of the 2016 cost reporting period under appeal. The Board notes that the Parties stipulated as follows:

> Effective as of April 1, 2016, JFK merged with another hospital, JFK-North Medical Center, Medicare provider number 10-0234. JFK's FTE caps were adjusted prospectively as a result of the merger. The Provider's FYE 2012 cap calculation issue being litigated in these consolidated appeals does not impact that subsequent merger-related FTE cap adjustment or impair any arguments or appeal rights the Provider may have in connection with the same.[55]

The Medicare Contractor's adjustments for FY 2016 reflect an add-on for both IME and GME caps of 1.57 FTEs, which is described in Audit Adjustment No. 42/Ref. 42 as "[t]o properly report New Program Add-on FTE caps to include prorated amounts from merged provider 10-0234."[56] The Board further identified that JFK requested that the caps be adjusted for both IME and DME for the FY 2016 cost report to reflect an additional 1.57 FTEs, as a prorated amount of the total

---

[54] To highlight this, the Board raises the hypothetical where, in PGY 1, all rotations are to Hospital A; in PGY 2, all rotations are at Hospital B; and in PGY 3, all rotations are at Hospital C. Under the Medicare Contractor's reading of the 2008 regulation, two hospitals would receive a cap of 0 and one hospital would receive a cap based only on its own FTEs during a PGY because it happened to have the most FTEs during that PGY, relative to the other hospitals. This hypothetical situation highlights how the Medicare Contractor's interpretation of the 2008 regulation would result in inappropriate cost shifting.

[55] Stip. at ¶ C.13.

[56] Ex. P-5 at Audit Adjustment Report page 17.

FTE cap of 6.32 FTEs for the newly merged provider under Prov No. 10-0234.[57] The Parties are in agreement upon the merged provider cap increase of 1.57 FTEs for both IME and GME for the FY 2016 cost reporting period. As such, the Board finds that JFK's resident FTE caps should be adjusted for FY 2016 to reflect 44.04 (42.47 + 1.57) for GME and 43.99 (42.42 + 1.57) for IME.[58]

DECISION AND ORDER:

After considering the Medicare law and regulations, the evidence admitted, and the parties' contentions, the Board finds the Medicare Contractor incorrectly calculated the FTE resident caps for GME and IME for FYs 2012 through 2016, and that JFK's resident FTE caps should be modified as follows:

1. From 40.04 to 42.47 for GME and from 39.90 to 42.42 for IME for the FY 2012 through 2015 cost reporting periods under appeal; and

2. From 40.04 to 44.04 for GME and from 39.90 to 43.99 for IME for the FY 2016 cost reporting period under appeal.

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

5/31/2023

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[57] Provider's FPP at 7.

[58] The Board notes, *for informational purposes only*, that the caps for FY 2017 and onward would be 48.79 (42.47 + 6.32) for GME and 48.74 (42.42 + 6.32) for IME, reflecting the full year of the merged facility's cap.