PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2023-D27

PROVIDER –
Touro Infirmary

PROVIDER NO. –
19-0046

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators (J-5)

HEARING DATE –
July 21, 2022

YEARS –
Fiscal Year End December 31, 2010
Fiscal Year End December 31, 2011

CASE NOs. –
15-2265
16-0658

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ISSUE STATEMENT:

Whether the Medicare Contractor's adjustments to remove Full Time Equivalents ("FTEs") from the Graduate Medical Education ("GME") Cap for fiscal years ("FYs") 2010 and 2011 are proper?[1]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board" or "PRRB") finds that the Medicare Contractor's adjustments to remove a portion of the Intern and Resident ("I&R") FTE counts from the IME and GME caps that were used to calculate the GME and IME payments for FYs 2010 and 2011 were proper.

INTRODUCTION:

Touro Infirmary ("Touro" or "Provider") is an acute care hospital located in New Orleans, Louisiana, and was assigned Provider No. 19-0046.[2] Prior to 01/01/2010, Touro wholly owned the Touro Rehabilitation Center ("TRC"), a Medicare certified inpatient rehabilitation hospital ("IRF")[3] that operated under Provider No. 19-3034.[4] TRC, could be best described as a "hospital within a hospital," with Touro functioning as the host hospital.[5] The Provider made a change in its structure, through a multi-year process, that resulted in the transition of TRC's operations into Touro, and the transfer of TRC's rehabilitation beds into a distinct part unit ("DPU") of Touro.[6] This transitional event lies at the center of this appeal, as it leads to the question of whether, or not, Touro can *and* did, in fact, properly absorb TRC's I&R FTEs, as TRC is now a Medicare sub-provider of Touro, for purposes of the GME and IME payment.

The fiscal years at issue in this decision are FYs 2010 and 2011[7] and Touro's designated Medicare contractor[8] is WPS Government Health Administrators (the "Medicare Contractor"). On October 17, 2014, and July 7, 2015, the Medicare Contractor issued Touro a Notice of Program Reimbursement ("NPR") for FY 2010[9] and FY 2011,[10] respectively.

Touro timely appealed the NPRs for both FYs 2010 and 2011 to the Board, and it has met the jurisdictional requirements for a hearing. The Board conducted a live video hearing on July 21, 2022. Touro was represented by Gregory A. Brock, CPA of Greg Brock Consulting, Inc. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

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[1] Transcript ("Tr.") at 6.
[2] Medicare Contractor's Final Position Paper (hereafter, "Medicare Contractor's FPP") (Apr. 23, 2021) at 1.
[3] Provider's Final Position Paper (hereafter, "Provider's FPP") (Mar. 24, 2021) at 4, 7.
[4] *Id*. at 4.
[5] *Id*.
[6] *Id.* at 4, 7.
[7] Given the overlapping nature of the exhibits and position papers in these cases, all citations are to CN 15-2265, unless otherwise noted.
[8] 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.
[9] Exhibit (hereafter "Ex.") P-1.
[10] Ex. P-1 (for Case No. 16-0058) (April 12, 2021).

STATEMENT OF FACTS AND RELEVANT LAW:

Congress provided for payments to direct graduate medical education programs. Specifically, the Medicare program reimburses providers the costs of training intern and resident physicians which includes the direct costs of approved GME training programs.[11] Medicare also pays providers an additional payment known as the IME payment adjustment for the higher patient care costs of teaching hospitals relative to non-teaching hospitals.[12] Both the GME and IME payments are subject to a statutory cap, or base year determination, which is directly related to the number of I&R FTEs (the "FTE cap") used in these calculations. The FTE cap is used in subsequent year final determinations. For most hospitals, the FTE cap is the number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996.[13] However, beginning with discharges on October 1, 2005, CMS implemented an adjustment for teaching facilities that operate an IRF to compensate those facilities for the higher costs they incur in providing care to beneficiaries.[14] Furthermore, CMS set the FTE cap for IRFs that trained residents in their most recent cost reporting period ending on or before November 15, 2004.[15] These appeals concern the statutory FTE cap that Touro may report for purposes of the direct GME and IME payment calculations.[16]

An additional issue here is the effect of the termination of TRC's Medicare participation agreement/enrollment under Provider No. 19-3034.[17]

A. Legal Background

As part of the FY 2005 IPPS Final Rule, CMS promulgated 42 C.F.R. § 413.79(h) to address the temporary assignment of GME FTEs associated with residents displaced due to the closure of a hospital or hospital residency program. The relevant portion of this regulation pertains to the closure of a hospital as follows:

> (h) *Closure of hospital or hospital residency program*.
> (1) *Definitions*. For purposes of this section—
>
> (i) ***Closure of a hospital*** **means the hospital terminates its Medicare agreement under the provisions of § 489.52 of this chapter**.
>
> ****
>
> (2) *Closure of a hospital*. A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure if the hospital meets the following criteria:
> (i) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.

[11] 42 U.S.C. § 1395ww(h); 42 C.F.R. §§ 413.75 – 413.83.
[12] 42 U.S.C. § 1395ww(d)(5)(B); 42 C.F.R. § 412.105.
[13] 42 U.S.C. § 1395ww(h)(4)(F)(i); 42 U.S.C. § 1395ww(d)(5)(B)(v).
[14] 42 C.F.R. § 412.624(e)(4).
[15] 70 Fed. Reg. 47880, 47931 (Aug. 15, 2005).
[16] Provider's FPP at 10.
[17] Medicare Contractor's FPP at 6.

> (ii) No later than 60 days after the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.[18]

CMS promulgated a similar regulation for IME at 42 C.F.R. § 412.105(f)(1)(ix). Significantly, this regulation only provided for the *temporary* assignment of FTEs associated with displaced residents from a closed hospital. As a result, the GME and IME FTE resident caps associated with that closed hospital would, ultimately, be permanently retired or lost.[19]

In § 5506 of the Patient Protection and Affordable Care Act ("ACA"), Congress addressed this situation by revising 42 U.S.C. § 1395ww(h)(4)(H)(vi) to direct the Secretary to redistribute the FTE resident caps of *closed hospitals* for purposes of direct GME costs:

> (vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—
>
> (I) IN GENERAL.—Subject to the succeeding provisions of this clause, *the Secretary shall*, by regulation, *establish a process under which, in the case where a hospital* (other than a hospital described in clause (v)) with an approved medical residency program ***closes*** *on or after a date that is 2 years before the date of enactment of this clause*, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.
>
> (II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

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[18] (Bold and underline emphasis added and italics in original.)

[19] 75 Fed. Reg. 71800, 72212 (Nov. 24, 2010) (stating "Under existing regulations at § 413.79(h) for direct GME and § 412.105(f)(1)(ix) for IME, a hospital that is training FTE residents at or in excess of its FTE resident caps and takes in residents displaced by the closure of another teaching hospital may receive a temporary increase to its FTE residents caps so that it may receive direct GME and IME payment associated with those displaced FTE residents. However, those temporary FTE resident cap increases are associated with those specific displaced FTE residents, and the increases expire as those displaced residents complete their training program. *Thus, if a teaching hospital closes, its direct GME and IME FTE resident cap slots would be 'lost,'* ***because those cap slots are associated with a specific hospital's Medicare provider agreement, which would be retired upon the hospital's closure***." (Emphasis added).

> (aa) First, to hospitals located in the same core-based statistical area as, or a core- based statistical area contiguous to, the hospital that closed.
>
> (bb) Second, to hospitals located in the same State as the hospital that closed.
>
> (cc) Third, to hospitals located in the same region of the country as the hospital that closed.
>
> (dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).
>
> (III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.
>
> (IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).
>
> (V) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this clause.[20]

Section 5506 of the ACA also applies to the redistribution of IME FTE resident caps for closed hospitals.[21] In the final rule, published on November 24, 2010 ("2010 Final Rule"),[22] CMS implemented the ACA § 5506 redistribution of FTE resident slots of "closed hospitals." The 2010 Final Rule also implemented certain policy changes for the counting of FTE residents in determining payments to hospitals for direct GME and IME costs by promulgating the regulations at 42 C.F.R. § 413.79(d)(6) and (o) for direct GME and at § 412.105(f)(1)(ix)(B) for IME. More specifically, § 413.79(d)(6) and (o) state:

> (d) *Weighted FTE counts.*
>
> ****
>
> (6)(i) Subject to the provisions of paragraph (h) of this section, FTE residents who are displaced **by the closure of** either **another**

[20] Pub. Law. 111-148, §5506, 124 Stat. 119, 661-662 (2010) (italics, bold and underline added).
[21] ACA § 5506(b) (amending 42 U.S.C. § 1395ww(d)(5)(B)(v) to include reference to the newly-added § 1395ww(h)(4)(H)(vi)).
[22] 75 Fed. Reg. 71800 (Nov. 24, 2010).

> **hospital** or another hospital's program are added to the FTE count after applying the averaging rules in this paragraph (d), for the receiving hospital for the duration of the time that the displaced residents are training at the receiving hospital.
>
> (ii) If a hospital receives a permanent increase in its FTE resident cap under paragraph (o)(1) of this section **due to redistribution of slots from a closed hospital**, the displaced FTE residents that the hospital receives are added to the FTE count after applying the averaging rules only in the first cost reporting period in which the receiving hospital trains the displaced FTE residents. In subsequent cost reporting periods, the displaced FTE residents are included in the receiving hospital's rolling average calculation.
>
> ****
>
> (o) *Determination of an increase in the FTE resident cap due to slots redistributed from a closed hospital*. (1) Except in the case of the closure of the hospital with Medicare Provider Number 05-0578, **in the instance of a hospital closure, as defined at paragraph (h)(1)(i) of this section**, the FTE resident cap of the closed hospital would be redistributed, and a hospital that meets the requirements and qualifying criteria of [42 U.S.C. § 1395ww(h)(4)(H)(vi)] and implementing instructions issued by CMS, including submission of a timely application to CMS, may receive an increase in its FTE resident cap, as determined by CMS.
>
> (2)(i) Except in the case of the closure of the hospital with Medicare Provider Number 05–0578, in redistributing the FTE resident cap of a closed hospital, consideration shall be given to ensure that there is no duplication of FTE slots between FTE slots redistributed under this paragraph and temporary adjustments to FTE resident caps provider under paragraph (h)(2) of this section.
>
> (ii) The provisions of this paragraph (o) will not be applied in a manner that will require the reopening of settled cost reports, except where the provider has a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.[23]

CMS included the following discussion to explain what a "closed hospital" is for purposes of the ACA § 5506 FTE redistribution:

> 2. Definition of a "Closed Hospital"
>
> [42 U.S.C. § 1395ww(h)(4)(H)(vi)], as added by section 5506(a) of the Affordable Care Act, states that "the Secretary shall, by

[23] *Id.* at 72263-64 (bold and underline emphasis added and italics in original).

regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program *closes* on or after" March 23, 2008, the Secretary shall increase the FTE resident caps of other hospitals accordingly (emphasis added). Under existing regulations at §489.52 and §413.79(h), "closure of a hospital" means the hospital terminates its Medicare provider agreement. In the August 3, 2010 proposed rule (75 FR 46421 and 46422), we proposed to define a ''closed teaching hospital'' for purposes of section 5506 in a similar manner, but would also specify that the FTE resident cap slots of the hospital that closed no longer exist as part of any other hospital's permanent FTE resident cap. Thus, we proposed that this provision would not apply to hospitals that declare bankruptcy but are still participating under the same Medicare provider agreement, nor would it apply to teaching hospitals that remain open, but close one or more residency programs. It also would not apply to mergers, because in the case of a merger, the Medicare provider agreement of one hospital is **subsumed into the provider agreement of the surviving provider**; no provider agreement is retired, even if operations at one facility are scaled back or ceased.

However, we proposed that the proposed revised definition of hospital closure for purposes of implementing section 5506 *would* apply in the case of acquisitions, **where the new owner voluntarily terminates the Medicare provider agreement of the hospital it purchased** by rejecting assignment of the previous owners' provider agreement, thus abdicating the FTE resident cap slots associated with that provider agreement, even if the new owner will continue to operate the hospital exactly as it had been operated before the acquisition (that is, makes no changes to the bed size, infrastructure, services, and GME programs). We believe this is appropriate because section 5506 of the Affordable Care Act specifically addresses hospital "closure" and ensures preservation of the FTE cap slots within a community when a teaching hospital does "close," based on specified criteria for redistributing the slots from the closed hospital to increase the FTE caps for other hospitals. However, as we explain further below, it is possible for the new hospital formed in an acquisition **to receive preference** in receiving an increase to its FTE resident caps based on redistributed slots from the closed hospital that it acquired.

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By specifying that ''the FTE resident cap slots of the hospital that closed no longer exist as part of any other hospital's permanent FTE resident caps'' in the August 3, 2010 proposed rule (75 FR 46422), we proposed to emphasize that if slots were permanently

> transferred to another provider and they continue to exist, section 5506 would not apply. An example of such a situation would be a merger wherein the Medicare provider agreement of one hospital is subsumed into the provider agreement of the surviving provider. In this example, no provider agreement is terminated, and the FTE resident caps also would be subsumed permanently into the provider agreement of the surviving provider. Thus, the purpose of section 5506 is to ensure that slots that are not already part of another hospital's permanent cap are not lost, but rather will be redistributed to qualifying hospitals.
>
> The second commenter's understanding of our proposal regarding acquisitions is correct. We do include acquisitions in a case in which the new owner terminates the provider agreement of the hospital it purchased in the definition of hospital closure because, in this case, a Medicare provider agreement is terminated, thus releasing the FTE resident cap slots associated with that provider agreement.[24]

Consistent with ACA § 5506, CMS established an application process for hospitals to apply to CMS to receive an increase in FTE caps based on slots from "closed hospitals."[25] The 2010 Final Rule also provided an application process for redistribution of the FTE slots associated with hospitals that had closed between March 23, 2008 and August 3, 2010:

> *Comment*: One commenter stated that because hospitals interested in applying for resident cap slots under this provision must be put on notice of all slots that will be available through the closed hospital resident slot preservation program, CMS would accomplish this most effectively by publishing in the final rule a list of all hospitals that closed on or after March 23, 2008. In publishing this list, the commenter suggested that CMS also indicate how many cap slots are available from the hospital's 1996 cap versus how many cap slots are available from the section 422 redistribution program. . . . .
>
> *Response*: We agree with the commenter's request and **have included at the end of this section a list of teaching hospital closures on or after March 23, 2008 through August 3, 2010, along with their 1996 FTE caps and section 422 caps as applicable**. . . .
>
> After consideration of the public comments we received, in this final rule, we are establishing the application deadline for receipt

[24] *Id.* at 72213-14.
[25] *Id.* at 72215.

> of slots from hospitals that closed between March 23, 2008 through August 3, 2010, as April 1, 2011.[26]

Significantly, the "List of Teaching Hospitals That Have Closed On or After March 23, 2008 and Before August 3, 2010" included TRC (Provider No. 19-3034), in CBSA 35380, with a termination date of December 31, 2009 and listed DGME and IME caps of 3.20 and 2.99, respectively, for redistribution.[27]

The Medicare application form to request redistribution of FTE slots from a closed/terminated hospital specifies that the highest level of priority is for "hospitals located in the same core-based statistical area (CBSA) as, or in a CBSA contiguous to, the hospital that closed."[28] The application form further specifies that the "Ranking Criterion One" is whether "[t]he applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, possibly the same program director, and possibly the same (or many of the same) teaching staff)."[29] Similarly, "Ranking Criterion Three" concerns whether "[t]he applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training . . . ."[30]

Finally, in the 2010 Final Rule, CMS noted that "the fact that Congress included this language clearly means that Congress intended for our determination with regard to FTE resident cap redistributions under [42 U.S.C. § 1395ww(h)(4)(H)(vi)] as added by [§] 5506(a) to be final, and not subject to appeal."[31] Accordingly, CMS stated that "we do not believe it would be appropriate to allow hospitals (or CMS) to appeal determinations concerning the FTE cap redistributions under [42 U.S.C. § 1395ww(h)(4)(H)(vi)]."[32]

B. Factual Background

Touro requests a reversal of the Medicare Contractor's adjustments removing 2.99 FTEs from its GME cap[33] and sub-provider IME base year cap.[34] These adjustments were made to both its FYE December 31, 2010 and December 31, 2011 cost reports. Touro explains that prior to January 1, 2010, TRC operated its rehabilitation beds on the Touro campus and that Touro (a) acted as the

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[26] *Id.* at 72215-16.
[27] *Id.* at 72230.
[28] *Id.* at 72235.
[29] *Id.* While not applicable here, the "Ranking Criterion Two" is similar and concerned whether the applying hospital had an Medicare GME affiliation agreement with the closed hospital before it closed under which the applying had received slots from the closed hospital.
[30] *Id.* at 72236.
[31] *Id*. at 72230.
[32] *Id.*
[33] Reported on Worksheet E-3, Part IV, Line 3.01 of each cost report under appeal. *See* CN 15-2265, Provider's FPP at 7; *See also* CN 16-0658, Provider's FPP at 7.
[34] Reported on Worksheet E-3, Part I, Line 1.35 of each cost report under appeal. *See* CN 15-2265, Provider's FPP at 7; *See also* CN 16-0658, Provider's FPP at 7.

"host hospital"; (b) wholly owned TRC; and (c) both Touro and TRC operated under the same tax ID number for Internal Revenue Service purposes. Ultimately, Touro claims that TRC was "merged" into Touro and denies the Medicare Contractor's position that TRC was "closed" or terminated.[35]

In support of its position that TRC was merged rather than terminated, Touro asserts "there was no disruption of services to patients and there was no change in the teaching program during that transition [the change in its hospital structure]."[36] Touro describes the change as a "conversion."[37] Furthermore, Touro's "planning documents describe the event as a "conversion" of beds from TRC to TI,"[38] for the purpose of addressing the challenge that TRC faced because it "receives roughly 50% less in Medicaid rehabilitation reimbursement than other rehabilitation facilities in Louisiana, which has resulted in ongoing TRC losses for Medicaid patients on a cost and contribution basis. This lower rate can be traced to TRC being PPS-exempt (versus a distinct part unit ("DPU"))."[39] As a result, Touro *planned* to convert 51 of TRC's 63 rehabilitation licensed beds from TRC's license to Touro's license, as a DPU to be billed under Touro's general acute Medicare provider number, *leaving 12 beds to remain under TRC's license*.[40] As part of the planned conversion, Touro's "reimbursement staff attempted to get clarification on cost reporting questions specific to graduate medical education" [41] in an email sent to WPS and dated February 8, 2010.[42] Touro's email described TRC as Provider Number 19-3034 and stated that TRC "ceased operation as of 12/31/09."[43] Touro did not mention a "merger" in its email, nor did it provide support showing that Touro had followed-up on WPS' recommendation on whom to contact for GME CAP assistance. Finally, Touro's email to WPS came after it had already notified WPS on January 27, 2010, that it was "voluntarily terminating its Medicare Enrollment."[44] As such, it is clear that the "planning documents" did not describe what *actually* occurred (the conversion of all 63 beds from TRC to Touro) since TRC (including both the TRC license and its Medicare participation agreement) ceased to exist.[45]

Touro also claims that, since both Touro and TRC were under one ownership, "there was no need for a "'sales or merger' agreement to define the transition of TRC into [Touro]." [46] Touro states "[t]here was no closure of beds, nor was there a closure of the teaching program."[47] However, it is undisputed that: (1) by letter dated January 27, 2010, TRC stated it was "voluntarily terminating its Medicare Enrollment" and such "termination is for the Touro Rehabilitation Center, Provider

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[35] Provider's FPP at 7.
[36] *Id.*
[37] *Id.* at 9.
[38] *Id.*
[39] Ex. P-3 at 2.
[40] *Id.*
[41] Provider's FPP at 9.
[42] Ex. P-4 at 2.
[43] *Id.*
[44] Ex. C-4 at 3.
[45] Tr. at 77-78 ("MR. SMITH: So what was planned and what happened aren't exactly the same thing, I fear. MR. BROCK: Likely the specifics and the timing of the units may have changed. Yes, I would agree with that. MR. SMITH: I would say not just those issues, but if you went from planning to having two licenses still with 51 and 12 beds, and you went to having one license 53, that's kind of a major change. You're killing a provider. You're terminating -- closing a provider (laughs). The beds remaining wouldn't have done that. Correct? MR. BROCK: Correct.").
[46] Provider's FPP at 7.
[47] *Id.*

#19-3034 only";[48] and (2) because of that request, the Medicare program terminated TRC's Provider #19-3034.[49]

Notwithstanding, Touro argues that the transition of TRC beds into Touro as an excluded subunit was a "merger by CMS Definition"[50] pursuant to the Medicare Program Integrity Manual, CMS Pub. 100-08 ("MPIM"), Ch. 10, § 5.5.2. Touro further alleges that "[t]he provider agreement for TRC was *automatically* assigned to [Touro]," and that TRC and Touro "took *no action* to terminate the provider agreement as part of the merger event."[51] Accordingly, Touro asserts that the resident FTE cap for the two Providers should have been combined as the hospitals were merged.[52] Touro recognizes that the 2010 Final Rule implemented ACA § 5506 and specifically named TRC as a closed teaching program;[53] however, Touro claims that this Final Rule was "incorrect" in its characterization of TRC having been "a closed program."[54]

The Medicare Contractor explains that it removed the FTE cap Touro "reported for its IRF sub-unit"[55] citing its workpapers L-2 and L-2.1, included as Exhibit C-3. The Medicare Contractor states "[t]he [P]rovider's IRF sub-unit was a ***new*** provider effective January 1, 2010;" and, thus, "[t]he [P]rovider could not have trained residents prior to November 15, 2004, in its IRF sub-unit."[56]

The Medicare Contractor counters that Touro attempted to *transfer* the FTE caps from the terminated IRF (*i.e.,* TRC) to both its IRF sub-unit and the acute hospital for GME and IME payments.[57] The Medicare Contractor's position is that Touro is prohibited from using the FTE cap from another provider that terminated its Medicare agreement (*i.e*., TRC); and that the nature of the transaction between Touro and TRC was ***not*** a "merger" which, if it had been, may have permitted the absorption of the FTE cap from one provider to another.[58]

DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW:

ACA § 5506 sets forth the requirement that GME and IME FTE resident caps from closed hospitals be redistributed. CMS promulgated regulations at 42 C.F.R. § 413.79 to implement this requirement. In this regard, § 413.79 (h)(1) defines the term "*[c]losure of hospital*" to mean that a "hospital terminates its Medicare agreement under the provisions of § [42 C.F.R. §] 489.52 of this chapter" which states, in pertinent part:

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[48] *See* Ex. C-4 at 3.
[49] Tr. at 43 (Touro's witness acknowledging that TRC's provider number was terminated). *See also* Ex. C-4.
[50] Provider's FPP at 7.
[51] *Id.*.
[52] *Id.*
[53] 75 Fed. Reg. at 72230. This final rule includes a chart entitled "List of Teaching Hospitals That have Closed On or After March 23, 2008 and Before August 3, 2010" which identified "Touro Rehabilitation Center" under Provider No 19-3034 being terminated on December 31, 2009.
[54] Provider's FPP at 8.
[55] Medicare Contractor's FPP at 7.
[56] *Id.*
[57] *Id*.
[58] *Id.* at 7-12.

> **§ 489.52 Termination by the provider.**
>
> (a) *Notice to CMS*. (1) A provider that wishes to terminate its agreement, except for a SNF as specified in paragraph (a)(2) of this section, must send CMS written notice of its intention in accordance with paragraph (a)(3) of this section.
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> ****
>
> (3) The notice may state the intended date of termination which must be the first day of the month.
>
> (b) *Termination date*. (1) If the notice does not specify a date, or the date is not acceptable to CMS, CMS may set a date that will not be more than 6 months from the date on the provider's notice of intent.
>
> ****
>
> (c) *Public notice*. (1) The provider must give notice to the public at least 15 days before the effective date of termination.
>
> (2) The notice must be published in one or more local newspapers and must—
>
> (i) Specify the termination date; and
>
> (ii) Explain to what extent services may continue after that date, in accordance with the exceptions set forth in § 489.55.

The record before the Board clearly demonstrates that TRC's termination of its Medicare participation agreement is a "closure of hospital" as defined in § 413.79(h)(1). By letter dated January 27, 2010, TRC submitted its request to "voluntarily terminat[e] its Medicare Enrollment" related to its Provider No. 19-3034.[59] With the January 27, 2010 letter, TRC enclosed an 855A application that contains the following actions taken by TRC:

1. Checked the box stating "You are **voluntarily terminating** your Medicare enrollment" but left unchecked the box stating "Your organization has taken part in an **Acquisition** or **Merger**" and the box stating "Your organization has **Consolidated** with another organization"[60]; and

2. Confirmed that the Provider Number 19-3034 is the "Medicare Identification Number that is [being] terminated" and that January 1, 2010 is the "Effective Date of Termination."[61]

[59] Ex. C-4 at 3.
[60] *Id.* at 4.
[61] *Id.*

Thus, consistent with § 413.79(h)(1), TRC "terminate[d] its Medicare agreement under the provisions of § [42 C.F.R. §] 489.52."[62]

The Board disagrees with Touro's position, as it relates to TRC's GME cap, that a merger occurred wherein "the TRC provider agreement was subsumed into the [Touro] provider agreement."[63] As demonstrated above, TRC clearly and *voluntarily* terminated its Medicare participation agreement and, as a result, that agreement did not (and could not) merge into Touro's Medicare participation agreement. Moreover, regardless of whether an *organizational* or corporate merger occurred, it does not change the fact that Touro's action terminated TRC's Medicare participation agreement (and also terminated TRC's licensure).

Furthermore, the occurrence of an organizational merger of one organization with another, does not automatically mean that a merger *of the Medicare participation agreements* occurred. The Medicare Program classifies a provider merger as a change in ownership pursuant to 42 C.F.R. § 489.18, which states:

> (a) *What constitutes change of ownership*— . . . .
>
> (3) *Corporation*. **The merger of the provider corporation into another corporation**, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.[64]

The MPIM, Chapter 15, section 15.7.7.1.1 (*eff.* 07/02/12) defines a merger as follows:

> Acquisition/Merger – In general, this occurs when two or more Medicare-enrolled entities combine, leaving only one remaining CCN number and provider agreement. For instance, Entity A and Entity B are both enrolled in Medicare, each with its own CCN number and provider agreement. The two entities decide to merge. Entity B's CCN number and provider agreement will be eliminated (leaving only Entity A's CCN number and provider agreement).
>
> If the acquisition results in an existing provider having new owners but keeping its existing provider number, the applicant should check the CHOW box in section 1A of the *Form* CMS-855A.
>
> Unlike the new owner in a Chow or consolidation, the new owner in an acquisition/merger need not complete the entire *Form* CMS-855A. This is because the new owner is already enrolled in Medicare. As such, the provider being acquired should be reported

[62] 42 C.F.R. § 413.79(h)(1).
[63] Provider's FPP at 9.
[64] (Emphasis added.)

> as a practice location in section 4 of the new owner's *Form* CMS-855A.[65]

A provider who is planning a merger *must* notify CMS in writing, and "the existing provider agreement will automatically be assigned to the new owner."[66] Here, TRC did *not* have its provider agreement reassigned to Touro but rather, *of its own volition*, requested that it be terminated.

In support of this finding, the Board notes that the Final Rule for the FY 1998 Inpatient Prospective Payment Systems addressed the treatment of FTE caps of merged hospitals specifically, stating:

> …when there is a merger, the cap for the hospital should reflect the base year FTE counts for the hospitals that merged. This is consistent with the principle of limiting payments based on the base year specified in the statute. Also, in implementing the COBRA 1985 provision establishing a hospital-specific per resident amount in the situation of a merger, we have calculated the revised per resident amount for the merged hospital using an FTE weighted average of each of the respective hospital's per resident amount which is part of the merger. We believe that it would be appropriate to address the FTE caps using the same principle. For purposes of this final rule, where two or more or more hospitals merge after each hospital's cost reporting period ending during FY 1996, the merged hospital's FTE cap will be an aggregation of the FTE cap for each hospital participating in the merger. We are modifying § 413.86(g)(6) to reflect this change.[67]

Similarly, the per resident amount for merged hospitals is addressed at 42 C.F.R. 413.77(h)(2014), and provides:

> Hospital mergers. Effective for cost reporting periods beginning on or after October 1, 2006, when multiple hospitals merge, a primary care and obstetrics and gynecology weighted average per resident amount and a nonprimary care weighted average per resident amount is calculated, if applicable, for the surviving hospital, using FTE resident data and per resident amount data from the most recently settled cost reports of the respective hospitals prior to the merger.

The Board finds the Medicare Contractor's adjustments to remove FTEs from Touro's GME Cap were proper. As Touro noted, the 2010 Final Rule clarified that ACA § 5506 "would not apply to mergers, because in the case of a merger, the Medicare provider agreement of one hospital is

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[65] *See* Ex. C-5.
[66] 42 C.F.R. § 489.18(b) and (c).
[67] 63 FR 26318, 26329 (May 12, 1998).

subsumed into the provider agreement of the surviving provider."[68] However, the evidence provided does not demonstrate that TRC's Medicare participation agreement was merged into Touro's Medicare participation agreement (*i.e*, that the TRC Medicare participation agreement, with its associated liabilities, was subsumed into Touro's Medicare participation agreement). Rather, the evidence indicates that TRC was closed *as it terminated its Medicare participation agreement/enrollment* through the submission of a CMS Form 855-A. Indeed, TRC specifically requested the termination of its Medicare participation agreement in the CMS Form 855-A and the cover letter to this request confirmed that "[t]he provider is voluntarily terminating its Medicare Enrollment . . . . for the Touro Rehabilitation Center, Provider # 19-3034 only."[69] Within the included CMS Form 855-A, Section 1: Basic Information, TRC indicated it was terminating its Medicare enrollment *effective January 1, 2010*.[70] TRC had the option of indicating the reason for filing the Form 855-A was that its "organization has taken part in an acquisition or merger" with Touro.[71] However, TRC did not make this election.

42 C.F.R. § 489.18(b) required Touro to notify CMS, in writing, if it was contemplating a "change of ownership" such as a merger (as defined in § 489.18(a)). There is no evidence or testimony that CMS was provided such written notice. Although Touro submitted a "planning" document which summarizes a planned conversion of 51 beds of the total 63 beds from TRC to Touro at Exhibit P-3, this document does not satisfy the requirement of 42 C.F.R. § 489.18(b) and, regardless, could not provide notice of a "merger" since this document did not describe what *actually* occurred. Indeed, as discussed *supra*, the "planning" document did not describe a merger, since two corporations were not being merged and, further, what was planned was not even a merger of two organizations, since the "planning" document would have left TRC operational with its bed size reduced to 12 beds. While the Provider argues that the change in operations between TRC and Touro "does not fall cleanly into either a merger or a closure,"[72] the evidence and testimony support a finding that this was a closure, pursuant to Medicare program regulations and guidance, *as it relates to the GME/IME FTE cap determinations*.[73]

Finally, the Board rejects Touro's allegation that the 2010 Final Rule which implemented ACA § 5506 incorrectly named TRC as a closed teaching program.[74] As discussed *infra*, TRC terminated its Medicare participation agreement and, thus, was a closed facility and the associated IME and GME caps were permanently lost. Consistent with that closure, the 2010 Final Rule notified the provider community of the redistribution of the TRC FTE slots to other hospitals consistent with ACA § 5506. Touro had an opportunity to apply and request those slots be assigned to it; however, it apparently forewent that opportunity.[75] Pursuant to ACA § 5506, TRC's FTE caps have been redistributed, pursuant to the process authorized by 42 U.S.C. § 1395ww(h)(4)(H)(vi). That redistribution is not reviewable, pursuant to 42 U.S.C. § 1395ww(h)(7)(E), which states in pertinent part:

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[68] Provider's FPP at 8.
[69] Ex. C-4.
[70] *Id.*
[71] *Id.*
[72] Provider's Supplemental Responsive Brief (Case No. 16-0658) (May 12, 2021) at 3.
[73] In other contexts, it might not be considered a "closure" of an organization; however, for purposes of the GME/IME FTE cap determinations, it is. This is borne out in the ACA § 5506 redistributions discussed *infra*.
[74] *See supra.* notes 53-54 and accompanying text.
[75] Indeed, under the criteria governing the redistribution process, Touro would have had a high priority as it is located in the same area as TRC and appears to have taken on TRC's residency program.

> **(E) Judicial review**
>
> There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise, with respect to determinations made under this paragraph, paragraph (8), or paragraph (4)(H)(vi).[76]

Accordingly, even if the Board were to agree with Touro, the Board would be precluded by § 1395ww(h)(7)(E) from clawing back those redistributed FTEs.

Based on the above findings, the Board finds that the Medicare Contractor's adjustments to remove FTEs from the Provider's IME and GME Caps were proper.

DECISION AND ORDER:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor's adjustments to remove FTEs from the Provider's IME and GME Caps were proper.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

8/15/2023

X Clayton J. Nix

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

[76] (Emphasis in original.)