PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D10

PROVIDER –
Hackensack University Medical Center
Hackensack, New Jersey

Provider No.: 31-0001

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Riverbend Government Benefits
Administrator

DATE OF HEARING –
February 28, 2006

Cost Reporting Period Ended -
December 31, 1998

CASE NO.: 02-0363

INDEX

ISSUE:

Whether the Intermediary's adjustments to the Provider's direct graduate medical education and indirect medical education full-time equivalent counts were proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal 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). 42 C.F.R. §405.1803. 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Medicare reimburses teaching hospitals for their share of costs associated with direct graduate medical education (DGME) and indirect medical education (IME). 42 U.S.C. §1395ww(h); §1395ww(d)(5)(B). The Secretary pays providers an additional payment for DGME costs determined under regulations at 42 C.F.R. §413.86(d). The amount of the DGME payment varies depending on the number of full-time equivalent residents (FTEs) in the provider's residency training programs. The Secretary also pays providers an additional payment for IME determined under regulations at 42 C.F.R. §412.105. The amount of IME payment varies depending on the number of FTEs in the provider's residency programs.

In §§4621 and 4623 of the Balance Budget Act of 1997 (BBA), Pub. L. No. 105-33 (August 5, 1997), 42 U.S.C. §1395ww(h)(4)(F), the Secretary was directed to impose, with certain exceptions, caps on DGME and IME FTEs using 1996 as the base year. The FTE caps are effective for IME for discharges on or after October 1, 1997 and for DGME for cost reporting periods on or after October 1, 1997. See, 62 Fed. Reg. 45966, 46003 (for IME) and 46004 (for DGME) (Aug. 29, 1997) (Final Rule with comment period).

There are two exceptions to the FTE caps that are pertinent to the instant case. First, §4623 of the BBA allowed the Secretary to prescribe rules that allow institutions that are members of the same affiliated group (as defined by the Secretary) to elect to apply the FTE cap on an aggregate basis. The purpose of this provision was to provide hospitals flexibility in structuring rotations within a combined cap when they share residents. This change was effective October 1, 1997. 62 Fed. Reg. 45966, 46006-7 (Aug. 29, 1997). In the regulation at 42 C.F.R. §413.86(b) (1997), the Secretary defined an *affiliated group* as:

> two or more hospitals located in the same geographic wage area … in which individual residents work at each of the hospitals seeking to be treated as an affiliated group during the course of the approved program; or, if the hospitals are not located in the same geographic wage area, the hospitals are jointly listed as major participating institutions for one or more programs as that term is used in *Graduate Medical Education Directory*, 1997-1998.

The regulation at 42 C.F.R. §413.86(g)(4)(1997) provides in relevant part:

> [h]ospitals that are part of the same affiliated group may elect to apply the limit on an aggregate basis.

In subsequent regulations, 63 Fed. Reg. 26318 (May 12, 1998) (Final rule), the Secretary addressed comments concerning affiliation agreements and made modifications to the definition of affiliated group to permit affiliation between providers in contiguous areas and with common ownership. Id. at 26336-7. The preamble delineated detailed requirements for affiliation agreements. Id. at 26338-26341. It states, in relevant part, that:

> 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 specific time period, for residency training years and cost reporting periods subsequent to the period of the agreement. . . .
>
> 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 . . .

Id. at 26341.

No changes were made in the regulation in 1998 concerning requirements for affiliation agreements. CMS subsequently revised 42 C.F.R. §413.86(b)(2002), See, 67 Fed. Reg. 49982, 50069 (Aug. 1, 2002), to include a definition of an affiliation agreement consistent with the preamble language above.

The second exception is a temporary adjustment made to a hospital's FTE cap when that hospital takes on additional residents as a result of another hospital's closure. This issue was first addressed in response to a concern in the preamble to the regulation at 63 Fed. Reg. 26318, 26329-30 (May 12, 1998). It states in relevant part:

> For purposes of this final rule, we will allow for temporary adjustments to a hospital's FTE cap to reflect residents affected by a hospital closure. That is, we will allow an adjustment to a hospital's FTE cap if the hospital meets the following criteria: (1) During July 1996-June 1997 residency year the hospital assumed additional medical residents from a hospital that was closing; (2) The hospital added the residents with the intent of allowing them to complete their education program; and (3) The hospital that closed does not seek reimbursement for the residents. As stated above, the hospital's cap will be based solely on the statutory base year. Hospitals seeking an adjustment for this situation must document to their intermediary that an adjustment is warranted for this purpose and the length of time that the adjustment is needed.

Id. at 26330.

The preamble states that the rules are applicable to cost reporting periods beginning on or after October 1, 1997. Id. at 26327. No change in the regulation was proposed in 1998; however, CMS revised 42 C.F.R. §413.86(g)(8)(1999) to include the following language:

> 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.
> (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.

The question in this case is to whether the Provider is entitled to relief from its FTE caps under either of the two exceptions noted above as well as the extent of that relief.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Hackensack University Medical Center (the Provider) is a 568-bed, acute care facility located in Hackensack, New Jersey. During its fiscal year ended (FYE) December 31, 1998, the Provider claimed reimbursement for DGME and IME costs that were subject to FTE caps. As a result of the closure of an unrelated hospital, United Hospital (United) in February 1997, residents training at United were re-assigned to other providers in the area to complete their training. Under an agreement signed with the remaining hospitals in the area that provided residency training, the Provider agreed to be responsible for training 12 additional resident slots previously trained at United. Exhibit I-9. Therefore, the Provider sought to raise its FTE cap by 12 FTEs. Riverside Government Benefits Administrator (the Intermediary) did not allow a permanent adjustment to the Provider's FTE cap for the 12 FTEs but in a revised Notice of Program Reimbursement dated November 24, 2003 did allow a temporary adjustment to the number of FTEs claimed by the Provider for residents it accommodated from United in FY 1998.

The Provider timely appealed the adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1831-405.1841.

The residents at issue in this case were employed by the University of Medicine and Dentistry of New Jersey (University). The residents were assigned to training programs at various hospitals in the area, including the Provider, depending on the needs of the residents. They were generally assigned to rotate at more than one hospital during each academic year and during the years needed to complete their training. Each academic year begins on July 1 and ends on June 30. Although the University paid the residents, each of the training hospitals was responsible for reimbursing the University for the residents that trained at their facilities.

In February 1997, United declared bankruptcy and permanently closed its doors. At that time, United had 49.5 resident FTEs rotating through its facility that were part of the program being run by the University. After United closed, the residents were reassigned to four other area hospitals, including University Hospital, to complete their training. The other area hospitals were Morristown Memorial Hospital, St. Michael's Medical Center and the Provider. Also, after the closure of United, the University and the remaining hospitals reached a written agreement entitled "Agreement for an Aggregate Count of Residency Positions (henceforth, referred to as affiliation agreement)." See, Exhibit P-19. The agreement specifies the number of residents that were at all hospitals participating in the University residency program as of December 31, 1996. It notes that due to the financial condition at United, the costs of 49.5 of the 85 residents at United as of December 31, 1996 were being borne by the University. When United closed on

February 22, 1997,[1] the agreement states that "[i]t was agreed to reallocate those 49.5 [University] positions to the [remaining hospitals]." The Provider was allocated 12 of the 49.5 positions. The agreement further indicates the total number of positions each remaining hospital will have following the reallocation and notes that there has been no increase in the number of FTEs in the University program at its affiliated hospitals.

The agreement is signed by the University and the remaining affiliated hospitals but not by any representative of United. The agreement is undated and, according to testimony at the hearing, Tr. at 147, was not entered into until June of 1998, after United had closed. Tr. at 104.

In its claim for DGME and IME reimbursement, the Provider included the number of FTEs it was entitled to under the DGME and IME caps plus 12 FTEs for the displaced United residents. On July 14, 1998, the Intermediary requested guidance from CMS concerning low to handle this issue for the Provider and the other affected providers. In a letter dated December 15, 1998, Exhibit I-8, CMS indicated that:

> The regulations allow for a temporary adjustment to the FTE cap for a hospital which assumed additional residents during the 1996-1997 resident year from a hospital which closed. The hospital must have trained the additional resident with the intent of allowing the residents to complete their program and the hospital which closed can no longer seek reimbursement for those residents. If the hospitals which are training the residents who were formerly at United Hospital meet these criteria, they may receive an adjustment to their FTE caps for those residents.

CMS also indicated that members of an affiliated group are permitted to reallocate their aggregate FTEs under the 1996 FTE cap but that the agreement must meet the requirements specified in the preamble to the regulations at 63 Fed. Reg. 26341 (May 12, 1998). CMS pointed out that the affiliation agreement is not signed by United and therefore, the affiliated group cannot include United's residents in the aggregate cap. Id.

The Intermediary calculated a temporary adjustment for the Provider of 4.74 FTEs for IME and 4.38 FTEs for DGME. The Intermediary arrived at the amounts based on the following audit steps.

1. Verified that the Provider's 1998 FTE amount exceeded the 1996 base year cap amount.
2. Reviewed the DGME/IME audit workpapers of United for FYE 2/17/97. Exhibit I-11.
3. Compared the interns and residents names from the February 1997 rotation schedule from United to the Provider's 1998 rotations schedules.

[1] The date that United Hospital closed is cited by the Provider as February 22, 1997 while the Intermediary's position paper at page 6 cites a closure date of February 19, 997.

4. Accumulated a list of the matching names that resulted in 4.74 FTEs for IME and 4.38 FTEs for DGME purposes. Exhibit I-12.
5. Issued a revised NPR on November 24, 2003.

See, Intermediary Position Paper at 9 and 10.

Initially, the Intermediary only counted residents at United in February of 1997 who subsequently rotated through the Provider in FY 1998 as temporarily displaced. Tr. at 330-331. The Intermediary modified its position to include residents at United in both January and February who subsequently rotated through the Provider in FY 1998 as having been displaced. The Intermediary also proposed allowing an adjustment for these residents in FY 1999 as well. Tr. at 328, 356.

The Provider seeks to count all 12 residency slots it agreed to accept under the affiliation agreement. In the alternative, the Provider proposes using a different method of counting the number of residents considered displaced than that used by the Intermediary. Using its method, the Provider claims an additional 6.5312 FTEs for DGME and 6.1712 FTEs for IME. Even if the Intermediary's methodology of using only January and February is sustained, the Provider indicates that the Intermediary's calculation is understated by 2.4068 weighted FTEs for DGME and 2.9918 FTEs for IME.[2]

The Provider was represented by Robert L. Roth, Esquire, and Michael Paddock, Esquire, of Crowell & Moring LLP. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider asserts that it is entitled to a permanent adjustment to its FTE cap because it has and will accommodate training for 12 additional FTE slots for residents who can no longer be trained at United. The Provider points out that the preamble to the regulation states that hospitals that are members of the same "affiliated group" may "elect to apply the[ir] caps on an aggregate basis." 63 Fed. Reg. at 26329. It further states that these hospitals may "by mutual agreement, adjust each respective hospital's FTE cap under an aggregate FTE cap." Id. This section of the preamble concludes as follows: "If the combined FTE count for the individual hospitals that are members of the same affiliated group do not exceed the aggregate cap, we will pay each hospital based on its FTE cap as adjusted per agreements." Id.

"Affiliated group" is defined in the preamble as hospitals "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." 63 Fed. Reg. at 26358, codified at 42 C.F.R. §413.86(b)(1). The Provider asserts that the hospitals that formalized the affiliation agreement[3] in this case

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[2] See, Provider's Post Hearing Brief at 16, n 26 and Exhibit P-66. The documentation supporting the Provider's claim is not in the record.

[3] The Provider refers to this agreement as "Reallocation Agreement." See, Provider Exhibit P-19.

met the definition for affiliated group and provided the agreement to the Intermediary on June 30, 1998. Tr. at 90-91 and 306.

The Provider disagrees with the Intermediary's position that the affiliation agreement is invalid because it was not signed by United. The Provider indicates that when the agreement was signed the only guidance was the preamble and the August 29, 1997 final rule with comment period. Although the preamble contained a reference to a signature requirement, 63 Fed. Reg. at 26340, it did not address how that requirement should be applied where one of the hospitals has closed. The Provider notes that the signature requirement was not codified in the regulation until 2002, and the Intermediary cannot rely upon it for this earlier time period. See, 42 C.F.R. §413.86(b) (2002).

The Provider also disagrees with the Intermediary's argument that the reallocation of FTEs violates the purpose of the BBA of 1997 which was to impose caps on FTEs. The Provider argues that the BBA permits affiliation agreements as long as any positive adjustment is offset by a negative adjustment for another hospital of at least the same amount. The Provider observes that the 12 FTE slot increase at its facility is offset by a 12 FTE slot decrease at United.

The Provider also disagrees with the method that the Intermediary used to calculate the temporary adjustment. The Provider argues that the temporary adjustment should apply to residents affected by the closure. The Provider does not believe that the residents at United, at the time it closed in January and/or February, were the only affected residents. The Provider points out that residents rotate among several hospitals, so any resident who rotated through United in academic year 1996-1997 and/or was scheduled to rotate through United in academic year 1996-1997 should be considered "affected by the closure" because it was expected by all parties that these residents would rotate back through United in later years. The Provider indicates that it had adequate documentation in the record to support its list of affected residents including sign-in and sign-out sheets for virtually all residents. Provider's Post Hearing Brief at 32.

The Intermediary asserts that the Provider is entitled to a temporary adjustment due to the United closing but that there is no basis to grant the Provider a permanent or renewable adjustment to its FTE cap. The affiliation agreement presented by the Provider does not meet the requirements for an acceptable affiliation agreement under the regulations because it was not signed and dated by a representative of each hospital that was a party to the affiliated group.

With respect to the affiliation agreement, the Intermediary notes that the Provider claims to be part of an affiliated group under 42 C.F.R. §413.86 and, therefore, is able to claim some of United's FTEs under its "affiliation agreement." The Intermediary states that the document the Provider presented cannot be an affiliation agreement between United, the Provider and the other hospitals because it was executed after United closed. It cannot reflect the overall number of capped FTEs to be allocated among the hospitals because United no longer had any FTEs to share with any of the other hospitals and no ongoing relationship with the Provider or the others in the "affiliated group."

The need for an ongoing relationship and the ability to actually serve residents in medical residency programs is supported by the plain wording of the regulation in effect at the time. The regulation at 42 C.F.R. §413.86 defines an affiliated group as two or more hospitals in the same or contiguous area if "individual residents work at each of the hospitals during the course of the program. . . ." The following commentary in the preamble to the regulation supports this view:

> Hospitals that no longer have a relationship for training residents do no meet the criteria for being members of the same affiliated group even if those hospitals jointly participated in residency programs in the past. The criteria for being members of the same affiliated group are intended to recognize that hospitals which have a relationship for training residents need flexibility in those arrangements under an aggregate FTE cap. If hospitals no longer have a relationship for training residents, we do not believe there is the same need for flexibility.

63 Fed. Reg. 26330 (May 12, 1998).

The Intermediary contends that a closed hospital does not have any responsibility for training residents or any ongoing relationship with the Provider or others in the "affiliated group;" therefore, United cannot be a member of an affiliated group.

The Intermediary asserts that language in the preamble at 63 Fed. Reg. 26330 (May 12, 1998) permitting temporary adjustments to the FTE caps when a hospital closed should only extend to individual residents who were displaced from United when it closed in February 1997,[4] even though it ultimately allowed residents in both January and February. These residents were subsequently accommodated by the Provider and other hospitals where they completed their residency training in the 1996-1997 academic year. Residents not enrolled in a residency training program at United in February 1997 were not displaced simply because they were not participating in any program at United at that time. The Intermediary points out that the temporary adjustment is for displaced residents not slots that are no longer available.

Finally, the Intermediary contends that the residents at United in January and February were certainly displaced; however, the use of schedules and house staff lists to determine who would have been displaced in the remaining portion of academic year 1996-1997 and subsequent periods cannot be relied upon because they are changing all the time. Intermediary's Post Hearing Brief at 10; Tr. at 279. Moreover, the house staff listings "don't reflect [the] actual rotations of residents." Id.

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[4] The Intermediary modified its adjustment to consider residents at United in both January and February of 1997. The Intermediary indicates that it added January for settlement purposes but maintains that only the residents at United when it closed in February 1997 were displaced. Intermediary Post Hearing Brief, Proposed Decision at 4, n.1.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

The Board finds that the agreement entered into by the Provider and other hospitals to reallocate the number of residents trained at each hospital after the closing of United does not meet the definition of an "affiliation agreement" under the regulation. The Board agrees with the Intermediary that it is appropriate to grant the Provider only a temporary adjustment to its cap to the extent it accommodated residents who were displaced by the closure of United. Finally, the Board finds undeterminable which residents would be affected during the remainder of the 1996-1997 academic year or during the Provider's 1998 fiscal year, which is calendar year 1998. Therefore, the methodology used by the Intermediary to determine the temporary adjustment to the Provider's resident cap is sustained.

The Medicare statute authorizes the Secretary to prescribe rules which allow institutions that are members of the same affiliated group (as defined by the Secretary) to elect to apply the DGME and IME limits on an aggregate basis. 42 U.S.C. §1395ww(h)(4)(H)(ii). The purpose of the provision is to provide hospitals flexibility in structuring rotations within a combined cap when they share residents. Under this authority, the Secretary issued a final rule with comment period defining affiliated groups. 62 Fed. Reg. 45966 (August 29, 1997) (Effective date of October 1, 1997) (See, comments at 46006-7 and rule at 46034) Exhibit P-45. The provisions of the regulation provide as follows.

> *Affiliated group* means two or more hospitals located in the same geographic wage area . . . in which individual residents work at each of the hospitals seeking to be treated as an affiliated group during the course of the approved program; or, if the hospitals are not located in the same geographic wage area, the hospitals are jointly listed as major participating institutions for one or more programs as that term is used in *Graduate Medical Education Directory, 1997-1998*.

42 C.F.R. §413.86(b) (1997).

The regulation was modified in a final rule. 63 Fed. Reg. 26318 (May 12, 1998) Exhibit P-46. The modification referenced affiliated groups in the IME regulation at 42 C.F.R. §412.105(a)(1) and (f)(vi) and expanded the definition of affiliated groups in the DGME regulation at 42 C.F.R. §413.86(b) to include rural areas, contiguous areas, programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs* and commonly owned hospitals. Id. at 26358. The Secretary subsequently modified the regulation to specify requirements for affiliation agreements. 42 C.F.R. §413.86(b) (2002).

The Provider contends that a "renewable" increase in a provider's cap is allowed under the regulation where hospitals are part of an "affiliated group" that agrees to shift residents while keeping the aggregate number of FTEs among the hospitals unchanged. The Provider points out that the regulations in 1998 did not define an "affiliation agreement." The Provider asserts that it was not until 2002 that CMS revised the regulation to define an affiliation agreement as requiring written signatures for each hospital. The Provider argues that this was a new definition or requirement that was not effective until October 1, 2000. The Provider maintains that it met the requirements for an affiliation agreement under the regulations in effect at the time it was signed. The Intermediary asserts that the affiliation agreement is not valid under the regulation existing at the time, 42 C.F.R. §413.86(b) (1997), which defines an affiliated group as two or more hospitals in the same contiguous areas where "individual residents work at each of the hospitals" during the course of the program. The Intermediary contends that since United was closed, it no longer had any FTEs to share and no on-going relationship with any of the members of the affiliated group.

The Board agrees with the Intermediary that the initial definition of an affiliated group in the regulation requires that "individual residents work at each of the hospitals seeking to be treated as an affiliated group during the course of the approved program." Id. The Board finds that United was closed at the time of the agreement and could not have entered into an agreement with the other hospitals. In addition, the Board finds that it is not possible for individual residents to work at each of the hospitals in the affiliated group when one of the hospitals (United) no longer existed. The Board finds that the Provider cannot claim to be part of an affiliated group with United for purposes of reallocating its FTEs on a permanent or renewable basis.

The Board notes that the initial regulation did not provide for a temporary adjustment due to the closure of another hospital. However, in the preamble to the final rule, 63 Fed. Reg. 26330 (May 12, 1998) Exhibit P-46, CMS agreed that when a hospital takes on residents because another hospital closes or discontinues its program, a temporary adjustment to the cap is appropriate and indicated that the rule would be effective from October 1, 1997. The Intermediary agreed to temporarily adjust the Provider's cap due to the closure of United; however, the parties disagree on the amount of the temporary adjustment that should be permitted.

Neither the preamble nor the regulatory provision specifies a method for determining the temporary impact of a closed hospital except it recognizes individual residents as opposed to residency training slots. See, 63 Fed. Reg. at 26330. In a simple example, where there are just two hospitals and residents did not rotate between hospitals, all of the residents from the closed hospital would have to be accommodated at the remaining hospital for the remainder of the academic year and subsequent academic years until they completed their training. The problem in this case is that residents do not receive all of their academic training at a single hospital during a particular academic year or at a single hospital during the several academic years they need to complete their training. Tr. at 29 – 31, 78. Instead, they rotate among the various hospitals that offer training opportunities throughout each academic year and over the several academic years they spend in

training depending on the needs of the residents and the availability of the residency programs at the hospitals.

Additional circumstances further complicate the matter. As noted above, residents are scheduled to make rotations at various hospitals before the start of an academic year, July 1, through June 30, and a schedule was prepared that indicates which resident were to rotate through the programs at United during academic year 1996-1997. The first problem is that despite the existence of a residency schedule for the academic year, testimony indicates that the schedules frequently change, so that the Intermediary requires additional documentation such as sign-in and sign-out sheets to determine where resident training actually occurs. Tr. 278-280. The second problem is that even if one were certain who was to be trained at United for the remainder of the academic year and discerned where they received their training instead, there were no schedules presented for where any of the residents were to receive their training in academic year 1997-1998 or thereafter. The Provider is seeking an adjustment to its limits for its fiscal year 1998, which runs from January 1, 1998 to December 31, 1998, and subsequent years; however, there are no schedules past June 30, 1997 on which to base such an estimate.

Both the Intermediary and the Provider have proposed methods to determine which residents were "displaced" from United and to allow a temporary adjustment to the Provider's cap if these displaced residents were subsequently trained at the Provider's facility. Initially, the Intermediary looked at residents that were at United when it closed in February 1997. It assumed that these specific residents were directly affected by the closure and had to be trained for the remainder of the academic year at another facility. In addition, it assumed that these residents would have to complete the remaining years of their residency training at other hospitals. Under the Intermediary's method, any hospital that trained these residents in subsequent time periods would be granted a temporary adjustment to its FTE caps. The Intermediary subsequently expanded its method to allow any residents at United in both January and February of 1997 to be considered displaced. Using this broader definition, the Intermediary ultimately adjusted the Provider's FTE caps by 4.38 for DGME and 4.74 for IME purposes for the FYE 12/31/98. The Board notes that the Intermediary's methodology does not account for some of the unique circumstances pertaining to University residents. While it is clear that residents at United in February of 1997 when it closed had to be re-assigned to other training sites, it is not clear whether these residents were scheduled to continue their residency training at United for the rest of the academic year or subsequent academic years. The same is true with respect to residents at United in January of 1997. They may not have been scheduled to receive any additional training at United for the remainder of the academic year or thereafter. In addition, this method does not provide for residents not at United in January or February, but who were scheduled to rotate to United after it closed and who had to receive training elsewhere. While the Board is critical of the Intermediary's methodology, it recognizes that relying on the rotation schedules, which are subject to frequent changes, may not be a better solution, especially since there were no rotation schedules presented beyond academic year 1996-97.

The Provider proposes to count as displaced all residents who rotated at United during the entire academic 1996-1997, up until it closed in February 1997 and those who were scheduled to rotate through United after its closure for the remainder of the academic year 1996-1997. However, the Provider's methodology suffers from the same problems as the Intermediary's proposal. Residents in the earlier period of the academic year may not have been scheduled for additional training at United after February 1997, and residents scheduled for rotations after its closure may not have rotated to United because of scheduling changes. And again, there are no rotation schedules included in the record beyond the 1996-1997 academic year to even attempt to determine where these residents may have been trained.

Because rotation schedules are subject to frequent changes and the lack of any basis for determining which residents may have rotated through United in the remainder of the 1996-1997 and subsequent academic years, the Board finds that the Intermediary's methodology is the most adequate solution for determining which residents were displaced by the closure of United. The decision to limit the number of residents affected to residents training at United in both January and February of 1997 is reasonable as it represents residents that were directly impacted by the closure. The Board does not find sufficient evidence in the record to indicate that residents who rotated through United earlier in the academic year were displaced. The Board also finds the Intermediary's position to continue the adjustment for displaced United residents beyond the 1996-1997 academic year is reasonable. The Board finds that there is insufficient documentation to support an alternative methodology; therefore, the Intermediary's methodology is affirmed.

DECISION AND ORDER:

The Provider is entitled to a temporary adjustment to its DGME and IME FTE caps in fiscal year 1998. The Intermediary's methodology used to determine the number of residents affected by United's closure is reasonable and is affirmed.

Board Members Participating:

Suzanne Cochran, Esquire
Elaine Crews Powell, CPA
Anjali Mulchandani-West, CPA
Yvette C. Hayes

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: December 3, 2007