PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D13

PROVIDER –
Langley Porter Psychiatric Institute
San Francisco, California

Provider No.: 05-4144

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services - CA

DATE OF HEARING –
June 12, 2007

Cost Reporting Periods Ended -
June 30, 1999 and June 30, 2000

CASE NOs.: 02-0488 and 03-1001

INDEX

ISSUE:

Whether the Intermediary's determination of the Provider's direct graduate medical education (DGME) payment was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper 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. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(a).

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).

Section 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 Balanced Budget Act of 1997 (BBA-97) placed a limitation on resident FTEs for purposes of determining the DGME payment. 42 U.S.C. §1395ww(h)(4)(F)(i) states:

> . . . for purposes of a cost reporting period beginning on or after October 1, 1997, . . . the total number of full time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine may not exceed the number . . . of such full time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

The BBA-97 also allowed hospitals in an "affiliated group" to aggregate and reapportion their DGME FTE caps. "The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the [FTE] limitation on an aggregate basis." 42 U.S.C.§1395ww(h)(4)(H)(ii). The final rule implementing BBA-97 was published May 12, 1998 at 63 Fed. Reg. 26318 and defined an "affiliated group" as "(1) Two or more hospitals located in the same urban or…rural area or in contiguous areas if individual residents work at each of the hospitals during the course of the program; or…(3) The Hospitals are under common ownership." The preamble to the rule called for affiliated groups wishing to aggregate their FTEs to submit a written agreement to their fiscal intermediaries and to CMS. 63 Fed. Reg. 26341. The requirement was not included in the DGME regulations codified at 42 C.F.R.§413.86. In August 2002, CMS added a requirement for written affiliation agreement. 67 Fed. Reg. 49982, 50069 (August 1, 2002) amending 42 C.F.R. §413.86.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Langley Porter Psychiatric Institute (Provider) and the University of California - San Francisco Medical Center (UCSFMC) are adjacent health care facilities located in San Francisco, California. Both hospitals serve as teaching hospitals for the University of California, San Francisco. UCSFMC trains medical residents in a wide variety of specialties while the Provider trains psychiatric residents. In July 1993, the Provider's license was merged into that of UCSFMC and the two facilities commenced operations under a single California license under and the auspices of the Regents of the University of California. On November 1997, the Provider separated from UCSFMC to facilitate UCSFMC's merger with Stanford University Medical Center. The Provider was assigned its own Medicare Provider number as a free-standing psychiatric facility effective March 19, 1998.

BBA-97 capped the number of resident FTEs that a teaching hospital could count for DGME based upon its FTE count for the cost report period ending on or before December 31, 1996 (the 1996 base year). Since the Provider operated as a sub-provider of UCSFMC during its 1996 base year, only UCSFMC was assigned an FTE cap. UCSFMC's residents were capped at 539.37 which included 505.87 residents that trained at the UCSFMC and 33.5 residents that trained at the Provider. After the separation in 1997, National Government Services (Intermediary) continued to credit UCSFMC with the entire 1996 base year cap of 539.7 including the 33.5 residents that trained at the Provider. UCSFMC also claimed the entire cap of FTEs on its as-filed cost reports for fiscal year ended June 30, 1999 and 2000. On its as filed cost reports, the provider sought DGME payments for the residents that it trained after March 19, 1998 up to the number of FTEs training at the Provider during the 1996 base year (33.5). To this end the Provider claimed a 1996 base year cap of 33.5 FTEs. Although UCSFMC's cap included these residents because the Provider was a part of UCSFMC during 1996, UCSFMC could not claim the Provider's psychiatric residents after the split because they did not train them. As result, UCSFMC actual resident FTEs claimed were less than the 539.37 residents reflected in its 1996 base year FTE cap. The Intermediary disallowed the Provider's claim to a 1996 base year cap of 33.5 FTE even though they were credited to the UCSFMC cap because the parties had not filed a written affiliation agreement for the time period in question. The issue in this case involves the Provider's right to claim affiliated group status and thereby aggregate/reapportion its FTE cap with UCSFMC for DGME reimbursement purposes.

The Provider appealed the Intermediary's adjustment to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 – 405.1841. The Provider was represented by Ronald S. Connelly, Esquire of Powers, Pyles, Sutter & Verville, P.C. The Intermediary was represented by Bernard M. Talbert, Esquire of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that during the periods at issue both the Provider and USFMC were under the common ownership of the Regents of the University of California, were located in the same area and had residents who worked at both hospitals during the course of their training. Accordingly, the Provider argues that it met the definition of affiliated group found at 42 C.F.R. §413.86(b). The Provider argues further that the regulation in effect in 1999 did not require a written agreement to elect an affiliation. That requirement was not published until 2002, and the Administrative Procedures Act prohibits its retroactive application.

INTERMEDIARY'S CONTENTIONS:

The Intermediary acknowledges that the Provider and UCSFMC meet the definition of an affiliated group. However, the entire resident-FTE cap (539.37) belonged to UCSFMC. The cap included 33.5 residents who had trained at the Provider during the 1996 base year. The Intermediary contends that the Provider had an FTE cap of zero. Therefore, in

order for the Provider to receive GME reimbursement, both the Provider and UCSFMC would have had to enter into an affiliation in which UCSFMC agreed to share its established cap with the Provider. UCSFMC had to agree to claim less than its established resident FTE cap and to have that reduction redistributed the Provider. No such agreement was in place during the period in issue. The Intermediary acknowledges that the requirement for a written agreement does not appear in the regulations until 2002 but argues that it appeared in the Preamble in Fed. Reg. at 46,006 (08/29/97). The Intermediary argues that case law[1] supports the application of preamble language not found in regulation and, accordingly, contends that the Provider may not apportion the cap without an agreement.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of Medicare law and guidelines, the parties' contentions and the evidence presented at the hearing, finds and concludes that the Intermediary's adjustment reducing the Provider's 1996 base year cap to zero was proper.

The single issue in this case is whether the Provider's right to claim affiliated group status is supported by an election. The controlling regulation for this issue appears at 42 C.F.R. §413.86(g)(4). The regulations state in pertinent part:

> For purposes of determining direct graduate medical education payment, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count for residents in allopathic and osteopathic medicine may not exceed the hospital's unweighted FTE count for these residents for the most recent cost reporting period ending on or before December 31, 1996… Hospitals that are part of the same affiliated group may elect to apply the limit on an aggregate basis….

The Provider operated as a sub-provider unit of UCSFMC during the 1996 GME base year and the FTE cap was established for the institution as a whole and was not apportioned in any way between the residents training in the acute care hospital and those training in the psychiatric sub-unit. Once the Provider ceased operating under UCSFMC's license on November 1, 1997, the Provider, as a free-standing hospital, had a resident FTE cap of zero. Accordingly, the only way for the Provider to obtain GME reimbursement was by meeting the requirements of the controlling regulations regarding affiliated groups and electing to have their FTE caps applied on an aggregate basis.

It is undisputed that the Provider and UCSFMC met the definition of an affiliated group found at 42 C.F.R. §413.86(b)(1) thru (3). However, the Board majority finds that an election was not made by both hospitals to apply the FTE cap on an aggregate basis.

While CMS set out in the Preamble proposed detailed instructions regarding how to prepare a written affiliation agreement to elect to apply the FTE cap on an aggregate

[1] *Parkview Medical associates v. Shalala*, 158F.3d 146, DC CIR, 1998; *Methodist Hospital of Sacramento v. Shalala*, 38 F.3d 1225, DC Cir., 1994.

basis, the Board majority finds that the Provider and UCSFMC failed to make the election in any form, thereby making the question moot whether specific requirements for a written agreement in the Preamble must be met.

The Board searched the record for evidence of an election, or even an understanding implicit in the parties dealings, as to how the FTEs would be handled following the organizational split. This search included a further post hearing inquiry to the parties to clarify what appeared to be a conflict in the evidence. Specifically, the evidence showed that in the year following the split, UCSFMC did not claim the full 539.37 FTE cap established when the parties were part of the same organization. However, the number claimed by UCSFMC was 517.76, not 505.87 that would have been the net of the FTE cap minus the 33.5 FTEs trained by the Provider. The Provider clarified that discrepancy in a post hearing submission requested by the Board. It explained that UCSFMC continued to claim the full FTE *cap*, including the 33.5 FTEs trained by the Provider, although the University never benefited from the higher cap by increasing the number of residents it trained. The lower cap claimed was due solely to other adjustments unrelated to the 33.5 FTEs in dispute here. With this clarification, the evidence is clear that there was never an election; that is, an agreement or understanding in any form between the parties to allocate FTEs.

It is undisputed that the Provider trained the residents and incurred the costs of training those residents during the cost reporting years at issue. Nevertheless, the Board is bound by the controlling regulation that requires an election and, accordingly, the Board majority finds that the Provider failed to meet the requirements of the regulation that would have secured reimbursement for these costs.

DECISION AND ORDER:

The Provider failed to meet the requirements of the 42 C.F.R. §413.86(g)(4). The Intermediary's adjustments reducing the Provider's direct graduate medical education reimbursement were proper.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes (Dissenting)
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: March 6, 2009

Dissenting Opinion of Yvette C. Hayes

I respectfully dissent with the Board majority's findings that:

> "[there was] no evidence that an election in any form was made by both hospitals to apply the FTE cap on an aggregated basis."

Section 4623 of the BBA added section 1886(h)(4) (F) of the Act to establish a limit on the number of allopathic and osteopathic residents that a hospital can include in its full time equivalent (FTE) count for direct GME payment. The purpose of this section was to limit the growth in the number of FTEs reimbursed by the Medicare program.

42 U.S.C. §1395ww(h)(4)(F) entitled Limitation on number of residents in allopathic and osteopathic medicine, in relevant part states:

> (i) In general. Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, subject to paragraph (7), the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

Section 1886(h)(4)(H)(ii) of the Act permits but does not require 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 resident limit on an aggregate basis. The purpose of this provision was to permit a group of providers who are sharing residents as part of the same approved program to reapportion aggregated FTE caps amongst these providers to best determine how training can be provided and reimbursement shared among the affiliated group members.

42 U.S.C. §1395ww(h)(4)(H) entitled Special rules for application of subparagraphs (F) and (G), in relevant part states:

> (ii) Aggregation. The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis.

Pursuant to the broad authority conferred by the statute, CMS established the criteria to define "affiliated group" and implemented these special rules effective with cost reporting periods beginning on or after October 1, 1997 in conjunction with the FTE limit provisions. See 62 Fed. Reg. 46006-46007 (August 29, 1997).

It is undisputed that the Provider (Langley Porter) and UCSFMC met the definition of an "affiliated group" pursuant to 42 C.F.R. §413.86(b) (1998) which states:

Affiliated group means –

(1) Two or more hospitals located in the same urban or rural area (as those terms are defined in §412.62(f) of this subchapter) or in contiguous areas if individuals work at each of the hospitals during the course of the program; or

(2) If the hospitals are not located in the same or contiguous urban or rural area, the hospitals are jointly listed-

(i) As the sponsor, primary clinical site or major participating institution for one or more of the programs as these terms are used in *Graduate Medical Education Directory, 1997-1998*; or

(ii) As the sponsor or under "affiliations and outside rotations" for one or more programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs*.

(3) The hospitals are under common ownership.

63 FR 26358 (May 12, 1998)

It is also undisputed that the regulation found at 42 C.F.R. §413.86(g)(4) is controlling which states:

> For purposes of determining graduate medical education payment, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count for residents in allopathic and osteopathic medicine may not exceed the hospital's unweighted FTE count for these residents for the most recent cost reporting period ending on or before December 31, 1996
>
> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, exceeds the limit described in this paragraph (g), the hospital's weighted FTE count (before application of the limit) will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996

Hospitals that are part of the same affiliated group may elect to apply the limit on an aggregated basis.

The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (g)(4) based on the equivalent of a 12-month cost reporting period.

(Emphasis added)

The above regulation, in effect during the years under appeal, did not require a written agreement to elect to apply the FTE limit (cap) on an aggregated basis as part of an affiliation. No such requirement existed until new paragraph §413.86(g)(7) was added in 2002 (effective as of October 1, 2002), that in pertinent part states:

(i) Each hospital in the affiliated group must submit the affiliation agreement, as defined under paragraph (b) of this section, to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the affiliation agreement will be in effect.

67 FR 50120 (August 1, 2002) (Emphasis added)

42 C.F.R. §413.86(b) Definitions.(2002) provides in relevant part:

* * * *

Affiliation agreement means a written, signed, and dated agreement by responsible representatives of each respective hospital in an affiliated group, as defined in this section, that specifies—

(1) The term of the agreement (which, at a minimum is one year), beginning on July 1 of the year;

(2) Each participating hospital's direct and indirect GME FTE caps in effect prior to the affiliation:

(3) The total adjustment to each hospital's FTE caps in each year that the affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to one hospital's direct and indirect FTE caps that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount;

(4) The adjustment to each participating hospitals' FTE counts resulting from the FTE resident's (or residents') participation in a shared rotational arrangement at each hospital participating in the affiliated

> group for each year the affiliation agreement is in effect. This adjustment to each participating hospital's FTE count is also reflected in the total adjustment to each hospital's FTE caps (in accordance with paragraph (3) of this definition); and
>
> (5) The names of the participating hospitals and their Medicare provider numbers.

Based on my review, I find the statute and regulations do not specifically address, or allow for a process to address, the application of the resident FTE cap where hospitals unravel a merger after December 31, 1996 (the base period) and only one of the hospitals gets to retain its same provider number and participation agreement. In this instance, you have to look to Congress' intent, under Section 4623 of BBA'97, which was to limit the growth in the number of FTEs reimbursed by the Medicare program to 1996 levels. The purpose of this new provision was not to cease to reimburse or make payments for GME costs incurred by a well-established (or existing) approved medical residency training programs, as what has occurred in this instant case.

The 1998 Final Rule preamble only spoke to situations where two hospitals merged subsequent to 1996 base year period. See 63 FR 26330, which states in pertinent part:

> Response: We agree with the comments that when there is a merger, the cap for the hospital should reflect the base year FTE counts for the hospitals that merged. . . . For purposes of this final rule, where two 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.

But the question of how a provider should demonstrate that it has elected to apply its resident FTE cap on an aggregated basis remains to be answered.

The Board majority's decision did not speak to what type of evidence would be acceptable or necessary to support the Provider's contentions that such an election had been made. However, the Intermediary argued that for the Provider to receive direct GME reimbursement, a formal written affiliation agreement must have been entered into by both the Provider and UCSFMC and filed with the Intermediary.

Again, it is undisputed that the Provider did not enter into any such affiliated agreement. The Intermediary acknowledges and concedes that the requirement for a written agreement does not appear in the regulations until 2002 but argues that the Preamble to the Federal Register at 46,006 (8/29/97) and again at 26,338 (5/12/98) discussed the need for such an agreement. The Intermediary also argued that case law supports the application of Preamble language not found in the regulation. Although not bound by the Preamble, the Board has afforded it some weight in that the Provider was put on notice that "draft" instructions or guidance were under development of what such an agreement would entail.

Recognizing the Intermediary's preference for a written agreement that addresses this reassignment is one thing but dictating that it conform to a 2002 regulation, regarding GME affiliation agreements that did not exist at the time the cost report was filed, is a retroactive application and contrary to the Administrative Procedure Act. Until such time that a specified manner for making such an election was dictated in the regulations (in 2002), there is nothing to preclude the Provider from making this "election" by claiming a resident FTE cap amount on its as-filed cost report, as long as there is a corresponding reduction in resident FTE cap for UCSFMC.

Contrary to the Board majority, I find evidence in the record that UCSFMC claimed an amount less than its established resident FTE cap of 539.37[2], which could be indicative of its intention to "share" the cap with Langley Porter as part of an affiliated group.[3] UCSFMC reported a resident FTE cap amount of 517.76 FTEs on its FY 99 Cost Report[4]. This represents a decrease of 21.61 FTEs from the resident FTE cap of 539.37 FTEs assigned to UCSFMC's Medicare Provider Number 05-0454.

Although, there is still a difference of 13.57 FTEs (34.98[5] FTEs verses 21.61 FTEs) between what was claimed by Langley Porter on its cost report and the reduction in UCSFMC's resident FTE Cap, the necessary adjustments can be made to ensure the amounts net to zero by allowing the Provider to only claim up to the amount of the reduction and to ensure the combined total resident FTE cap does not exceed 539.37 FTEs.

There is additional evidence in the record of USCFMC's intention to "share" its resident FTE cap with Langley Porter. In the Declaration of Charlotte Canari, Director of Reimbursement Services for UCSFMC[6], it states in relevant part that:

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[2]See Provider Exhibit P-21 at 3. The number of unweighted FTE residents allowed by Medicare for the UCSFMC in FY 1996 is 539.37 for DGME…

[3] Although it recognized that UCSFMC's cap changed from 539.37 to 517.76, the Provider acknowledges that it has never conclusively determined why. Therefore, the Provider is not claiming that UCSFMC reduced its FTE cap on its as-filed cost reports during the corresponding periods, but rather that UCSFMC viewed the portion of its FTE cap attributable to residents training at the Provider as properly belong to the Provider and never benefited from the Provider's portion of the FTE cap because UCSFMC's FTE count was at least 33.5 FTEs (actual- FY99- 41.36 FTEs) below the FTE cap. See, the Provider's Response to Board Questions letter dated December 24, 2008. No response provided by the Intermediary.

[4] The reported amount is the same on the "as-filed" cost report and the "finalized" or audited cost report. See Worksheet E-3, Part IV, line 3.01 entitled: Unweighted Resident FTE count for Allopathic & Osteopathic programs for CR Periods ending on or before Dec. 31, 1996 and line 3.04 entitled: FTE Adjustment Cap. See Intermediary's Exhibit I-8. (provided on the date of hearing)

[5] See Provider Exhibit P-24. The source is identified as the FY'96 resident rotation schedules showing FTE count of 34.98 before weighting 5th year resident by 0.5 FTE (33.55 FTEs after adjustment).

[6] See Provider Exhibit P-11.

- UCSFMC's base year unweighted DGME cap included 33.5 FTEs that trained at Langley Porting in fiscal year 1996

- In fiscal periods ending 8/31/99, 3/31/00, 6/30/00 and 6/30/01, UCSFMC did not include in its count of FTEs the residents who rotated to Langley Porter during those years

- UCSFMC does not object to Langley Porter claiming and receiving DGME reimbursement for 33.5 FTEs under UCSFMC's DGME FTE cap….

- On June 28, 2001, UCSFMC & Langley Porter entered into a written affiliation agreement, which was filed with CMS. UCSFMC views this written agreement as a continuation of an affiliation agreement that has existed in practice as long as I [Ms. Canari] have had a relationship with UCSFMC.[7]

Furthermore, in a letter dated April 23, 2003, the former CMS Administrator, Thomas A Scully in response to a letter from the Provider's U.S. House representative provided the following guidance:[8]

> . . .[I]f UCSF and Langley Porter can demonstrate that they met the requirements to be treated as an affiliated group, and that the number of residents training at both hospitals did not exceed the aggregate cap for the period of July 1, 1998 through June 30, 2001, we would allow Langley Porter to count all the time the residents spent training at Langley Porter for purposes of receiving GME reimbursement for that time period.

This guidance was communicated again by a representative from CMS in a telephone conference held on September 1, 2004 stating that CMS would permit Langley Porter to claim DGME FTEs on its cost reports for fiscal years ending 6/30/99, 6/30/00, and 6/30/01, so long as the combined FTEs claimed by UCSFMC and Langley Porter did not exceed UCSFMC's cap.[9]

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[7] Id. In the same declaration, Ms. Canari indicated she has worked for UCSFMC since before November 1997.

[8] See Provider Exhibit P-9.

[9] See Provider Exhibit P-11 at 3.

COMPARISON CHART:

Description	UCSFMC	Langley Porter
Assigned resident FTE Cap	539.37	00.00
Reassigned FTE Cap[10]	505.87	33.50
Cap Amount Claimed on the CR[11]	517.76	34.98
Current Year FTE Count[12]:		
FY 1999- Per As-Filed CR	476.40	34.00
- Per NPR	369.26	26.12
FY 2000-Per As-Filed CR	N/A[13]	29.01
-Per NPR	N/A[14]	00.00[15]

Another question involves whether or not a resident FTE cap was established for Langley Porter.

Langley Porter was a separate and distinct facility (located adjacent to the UCSFMC campus) granted hospital-based status from July 1, 1995 through March 18, 1998 as a sub-provider of UCSFMC and included within its Medicare Provider Number.

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[10] Per Provider Exhibit P-21. See UCSF-LPPI Medicare Aggregate FTE Cap Agreement dated June 28, 2001.

[11] Unweighted resident FTE Count for [Cost Report] Periods Ending on/after December 31, 1996 on Worksheet E-3, Line 3.01. See Intermediary's Exhibit I-8 for UCSFMC and Provider's Exhibit P-23 for Langley Porter. Note: Even with the reduced FTE Cap of 517.76, UCSFMC's FY 1999 Unweighted resident FTE count was significantly below its cap both at the time of filing by 41.36 FTEs and after audit by 148.5 FTEs.

[12] Id. Unweighted resident FTE Count for Current Year on Worksheet E-3, Line 3.05.

[13] Not Available. Information was not provided in the record.

[14] UCSFMC had two (2) shortened cost reporting periods which ended in FY 2000. A seven (7) month period from September 1, 1999 through March 31, 2000 and a three (3) month period from April 1, 2000 through June 31, 2000. The "FTE caps" reflected in these reports were reduced or adjusted for the short periods (and include FTEs for Mt Zion Medical Center – San Francisco), for a combined total of 476.51 FTEs (325.53 + 150.98) and the "current year FTE count" for a combined total of 357.07 FTEs (249.57 + 107.50). Per a copy of the Intermediary's work paper for FYE 3/31/2000, the *full* FTE cap attributable to UCSFMC was 517.76. See Provider Exhibit P-30.

[15] Per Intermediary's audit adjustment, all GME related data was eliminated pending reopening for FTE audit.

After Langley Porter ceased operating under a combined hospital license with UCSFMC on November 1, 1997, the Provider obtained certification as a freestanding hospital effective March 19, 1998 and was issued new Medicare Provider No. 05-4144.[16] No resident FTE cap was assigned to the new Medicare Provider number at the time, although the Intermediary was aware that Langley Porter was a teaching hospital.

If Langley Port did not have an assigned resident FTE cap, because it was considered a new provider of services operating a new medical residency training program, then no cap would apply in its first 3 years of operations (for a period of years equal to the minimum accredited length of each new program).

This scenario was addressed in the 1998 Preamble[17] as follows:

> *Hospitals with no residents prior to January 1, 1995*. . . . In the August 29, 1997 final rule with comment period (62 FR 46005), we provided a special rule for hospitals which did not participate in GME training prior to 1/1/95. Under this special rule, we allowed hospitals to establish their FTE cap based on the product of the number of first year residents participating in accredited GME training programs in the third year that the hospital received payment for GME and the minimum accredited length for the type of program.

In this case, the Provider is not operating a new medical residency training program as defined at 413.86(g)(7) (1997).

If Langley Port did not have an assigned resident FTE cap, because it was considered a new provider of services participating in an existing medical residency training program, then its cap would be established as part of an affiliation; as addressed in the 1998 Preamble below:

> Comment: Some commenters stated that hospitals that did not receive GME payments prior to January 1, 1995, and subsequently become teaching hospitals by affiliating with an existing training program, should be eligible for GME payments if they incur substantially all of the costs of the resident training and the overall number of residents does not increase. . . .
>
> Response: Under §413.86(g)(4), hospitals that are part of the same affiliated group may elect to apply the FTE cap under section 1886(h)(F) on an aggregate basis. If a hospital that did not receive direct or indirect GME payment prior to January 1, 1995, qualifies to be part of the same affiliated group with another hospital that participates in residency training, these hospitals can, by mutual agreement, provide for adjustments to each respective hospital's FTE cap under an aggregate cap for the affiliated hospitals. . . .
>
> Id.

[16] See Provider Exhibit P-4.
[17] 63 FR 26332 (5/12/98).

It is undisputed that residents were participating in a medical residency training program at Langley Porter during the 1996 base year period and that the residents' FTEs were assigned to the Medicare provider number (UCSFMC) in existence at the time. It is for this reason that I find a FTE resident cap amount was established for Langley Porter that should be reported by the Provider as its FTE cap amount.

A change in hospital status (e.g. from freestanding to hospital-based or visa versa), that results in a change in the Medicare Provider number the facility is assigned to, does not alter which facility actually trained the residents. Regardless of provider number assignment, the only way Langley Porter's 1996 FTE Cap would be zero is that the hospital did not train any residents during that period. If any residents were trained then the cap should be some number other than zero.

The portion of the resident FTE cap amount claimed by each entity should be identified and verified to ensure that the Medicare program only reimburses the hospitals up to the 1996 FTE cap amount established. The hospitals should be allowed to separate out the combined FTE count for the base period, as mutually agreed, for their respective hospital.

I conclude that:

- the Provider did in fact exercise its right (elect) to affiliated group status by making a claim on its as filed cost report (including a FTE Cap amount of 34.98 FTEs), in conjunction with UCSFMC reporting a reduction to its assigned resident FTE cap amount; and

- that there was no requirement this election be evidenced in the form of a written affiliation agreement and filed with the Intermediary; and alternatively,

- the Provider should be allowed to claim the portion of the 1996 base year FTE resident cap assigned to UCSFMC's Medicare provider number for residents trained at Langley Porter Psychiatry Hospital to properly reflect which hospital provided (and continues to provide) the training and therefore should receive the reimbursement for direct GME costs incurred.

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Yvette C. Hayes