PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D7

PROVIDER -
Alegent Health - Immanuel Medical Center

Provider No.: 28-0081

vs.

INTERMEDIARY –
Wisconsin Physicians Service

DATE OF HEARING -
July 30, 2010

Cost Reporting Periods Ended -
June 30, 2000; June 30, 2001;
June 30, 2002 and June 30, 2003

CASE Nos.: 06-1709; 05-0627;
06-0192; 06-1710

INDEX

ISSUE:

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

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §1395 *et seq*. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulations and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to its intermediary showing the costs it incurred during the fiscal year and the proportion of those costs allocated to Medicare. 42 C.F.R. §413.20. The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 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 receipt of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835 (2008).

Since the inception of the Medicare program, Congress has authorized payment to hospitals for the direct cost of training physicians, that payment is referred to as Direct Graduate Medical Education (DGME). In 1983, Congress recognized that teaching hospitals also incur indirect operating costs that would not be reimbursed under the prospective payment system or by the DGME payment methodology and authorized an additional payment known as the Indirect Medical Education (IME) payment to hospitals with GME programs. 42 U.S.C. §1395ww(d)(5)(B). Specifically, the IME payment compensates teaching hospitals for higher-than-average operating costs that are associated with the presence and intensity of residents' training in an institution, but which cannot be specifically attributed to, and does not include, the cost of residents' instruction. The IME adjustment attempts to measure teaching intensity based on "the ratio of the hospital's full-time equivalent interns and residents to beds." Id. Thus, the IME adjustment payment amount is based, in part, upon the number of intern and resident FTEs participating in a provider's GME Program.

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

Prior to 1997, the Medicare program imposed no limit on the number of FTEs that a hospital could report for purposes of IME and DGME reimbursement. In 1997, Congress passed the Balanced Budget Act of 1997 (P.L. 105-33)[2] which imposed a cap on the number of FTEs that a hospital may include in the IME/DGME calculation. BBA 1997 stated that a hospital's un-weighted DGME FTE count cannot be greater that its un-weighted FTE count for the cost reporting period ending on or before December 31, 1996 (the 1996 base year).[3] Congress additionally applied this limit to the FTE counts used in the calculation of the IME payment.[4]

BBA 1997 also allowed hospitals in an "affiliated group" to aggregate and share their FTE caps as follows:

> The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the [FTE] limitation ...on an aggregate basis.[5]

On May 12, 1998, CMS issued its final rules implementing BBA 1997.[6] The final rule, in pertinent part, defined an affiliated group as:

> (1) Two or more hospitals located in the same urban or rural area ...or in contiguous areas if individuals residents work at each of the hospitals during the course of the program; or....
>
> (3)The hospitals are under common ownership.[7]

The final rule included within its regulatory preamble that affiliated groups wishing to affiliate and share their FTE caps would be required to submit a written affiliation agreement to their fiscal intermediaries and to HCFA.[8] The regulations implementing the final rule contained no specific requirement for a written agreement but, rather, provided that "[h]ospitals that are part of the same affiliated group may elect to apply the [FTE] limit on an aggregate basis."[9]

In August 2002, CMS amended the regulations to include a specific requirement for written agreements.[10] The regulations state in pertinent part:

> Affiliation *agreement* means a written, signed and dated agreement by responsible representatives of each respective hospital in an affiliated group...that specifies:

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[2]Hereinafter "BBA 1997".
[3] BBA 1997, P.L. 105-33, 111Stat. 251,477(codified as amended at 42 U.S.C. §1395ww(h)(4)(F)).
[4] 42 U.S.C. §1395ww(d)(5)(B)(v).
[5] 42 U.S.C. §1395ww(h)(4)(H)(ii).
[6] 63 Fed Reg. 26318 (May 12, 1998).
[7] 42 C.F.R. §413.86(b) (1998).
[8] 63 Fed. Reg. 26341
[9] 42 C.F.R. §413.86(g)(4)(1998).
[10] 67 Fed. Reg. 49982, 50069 (Aug. 1, 2002) amending 42 C.F.R. §§413.86(g)(7)(i), 413.86(b) (2002).

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

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

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

(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.

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

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Alegent Health – Immanuel Medical Center (Provider) is a non-profit, general acute care hospital that is located in Omaha, Nebraska. Prior to July 1998, Creighton University (Creighton) contracted with St. Joseph Regional Health Care System, LLC (St. Joseph – a Tenet Healthcare facility) to be the primary training site for its psychiatric residency training program. St. Joseph established an FTE cap of 145.39 for IME and 165.45 for DGME based upon its FYE 5/31/96 cost report.

On June 30, 1998, an academic affiliation agreement was executed between Creighton, St. Joseph and the Provider to expand opportunities for medical education through the addition of the Provider's facility for existing education programs. Although, St. Joseph ceased to be the primary training site of the psychiatric residency program, residents of the program continued to rotate through St. Joseph in addition to their rotations at the Provider.

Prior to this agreement, the Provider did not train residents and had no established base year FTE cap. In accordance with the academic affiliation agreement, the Provider claimed IME/DGME costs for 10 FTEs. Each year thereafter, the Provider filed its cost

report claiming IME and DGME reimbursement based upon its understanding that its affiliation agreement to form an affiliated group with St. Joseph to elect to share FTE Cap, filed on June 30, 1998, was in effect through June 30, 2001. In addition, St. Joseph entered into an affiliation agreement exclusively with other Tenet facilities effective July 1, 1999 to share the IME/DGME FTE caps and the cost reports filed by St. Joseph reflected the base year FTE caps identified in the respective Tenet affiliation agreements but not the resident FTEs claimed by the Provider.

During the audit of the Provider's cost reports from FYE June 30, 1999 (i.e. the first year of the residency program at the Provider) through June 30, 2002, the Intermediary reviewed the academic affiliation agreement[11] and made a determination that it adequately documented the Provider as a part of an affiliated group to share the FTE Cap for IME/DGME reimbursement purposes.[12] However, the Intermediary also had determined the psychiatric residency program was a new program and allowed reimbursement on this basis, through June 30, 2001.[13]

It was not until the audit of the Provider's FYE June 30, 2003 Medicare cost report, which occurred in 2005, that the Intermediary made a determination that the affiliation agreement was insufficient because it did not contain explicit or specific language about the assignment or sharing of St. Joseph's IME & DGME FTE Caps. The Intermediary issued an original NPR dated April 14, 2006 for FY 2003, disallowing all IME and DGME reimbursement claimed by the Provider. In addition, the Intermediary reopened the NPRs for the Provider's FYEs 6/30/00, 6/30/01 and 6/30/02 and made adjustments disallowing most of the IME and DGME payments for those years.[14] The reopenings made no adjustments to the actual FTE counts for each fiscal year but determined that the Provider's base year FTE Cap was zero.

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

PROVIDER'S CONTENTIONS:

The Provider argues that it met the requirements of an affiliated group under the version of 42 C.F.R. §413.86, in effect as of July 1, 1998. The Provider contends that those regulations established only two criteria to share FTE caps as an affiliated group: 1) The hospitals had to meet the definition of an affiliated group, (i.e., "two or more hospitals

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

[12] Exhibits PC-12 at p. 18 (6/30/99); PC-13 at p. 12 (6/30/00) and PC-15 at p.2 (6/30/01); *See also* Transcript at 137-139.

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

[14] Exhibit PC-17.

located in the same urban or rural area... if individual residents work at each of the hospitals during the course of the program."[15]) and; 2) hospitals that were part of the same affiliated group had to "elect to apply the [FTE] limit on an aggregate basis."[16] The Provider argues that the Provider and St. Joseph were located within the same geographic area and operated under a shared rotational assignment.[17] Further, the Provider and St. Joseph made a formal election to form an affiliated group and share St. Joseph's FTE caps[18] and conveyed a copy of its academic affiliation agreement to HCFA and the Intermediary.[19]

The Provider also argues that the Preamble to the May, 1998 Federal Register states:

> This means that we would apply a cap to the group as a whole, and the cap for the group would equal the sum of the individual caps for all hospitals that are a part of the affiliated group...That is the aggregate cap under the August 29, 1997, final rule with comment period would be the combined individual caps of each hospital that elects to be a part of an affiliated group.[20]

The Preamble continues:

> An agreement between two hospitals does not mean only those hospitals are an affiliated group, if those hospitals also have agreements with other hospitals. Rather, the affiliated group includes the original two hospitals that have an agreement and every hospital that has an agreement with any of those hospitals.

The sections concludes:

> If the combined FTE counts for the individual hospitals that are members of the same affiliated group do not exceed the aggregate cap, we will pay each hospital on its hospital specific cap.[21]

The Provider contends that the language of the Preamble makes clear that, since the Provider and St. Joseph created an affiliated group and elected to apply their FTE limit on an aggregate basis, the FTE caps for the affiliated group must be applied in the aggregate, with each hospital receiving payment based upon its hospital specific FTE count. The Provider contends further that St. Joseph was also a part of the Tenet hospitals affiliated group[22] and, accordingly, the aggregate cap would include all of the hospitals in the Tenet affiliated group plus the provider. The Provider concludes that since the aggregate FTE

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[15] 42 C.F.R. §413.86(b)(1) (1998).
[16] 42 C.F.R. §413.86(g)(4) (1998).
[17] Exhibit PC-9 at 2.
[18] Exhibits PC-1, PC-2 and PC-3.
[19] Exhibits PC-4 and PC-6.
[20] 63 Fed. Reg. 26318, 26338 (May 12, 1998).
[21] Id. at 26341as corrected at 63 Fed. Reg. 40997 (July 31,1998).
[22] Exhibit PC-10, at pp.16-17.

caps of the Tenet hospitals group plus the Provider were not exceeded by the actual count of the Tenet Hospital group plus the Provider, the Provider is entitled to be reimbursed for its IME/DGME based on its actual FTE count.

The Provider also argues that the CMS regulations requiring a written affiliation agreement are unenforceable under the Paper Work Reduction Act (PRA).[23] The PRA imposes significant limitations on a federal agency's ability to collect information and states:

> [a]n agency shall not conduct or sponsor the collection of information unless in advance of the adoption or revision of the collection of information –
>
> (1) the agency has –
> (A) conducted the review established under section 3506(c)(1);
> (B) evaluated the public comments received under section 3506(c)(2);
> (C) submitted to the Director [of OMB][24] the certification required under section 3506(C)(3) ...and
> (D) published a notice in the Federal Register...
>
> (2) the Director has approved the proposed collection of information or approval has been inferred, under the provisions of this section; and
>
> (3) the agency has obtained from the Director a control number to be displayed upon collection of information.[25]

The Provider contends that CMS made significant changes to the provisions governing affiliated groups in both the proposed and final rules for the inpatient prospective payment system for FY 2003 by specifically including a regulatory requirement that providers submit information to CMS before being permitted to share FTE caps.[26] CMS did not solicit comments relative to affiliated groups nor was an OMB control number requested or obtained. The Agency's failure to comply with the PRA makes CMS' requirement for a written affiliation agreement unenforceable under the public protection provision of the PRA. The provision provides that "[n]otwithstanding any other provision of law," a party may not "be subject to any penalty for failing to comply with a collection of information" imposed by a federal agency that fails to obtain the required approval from OMB.[27] Further the legislative history of the statute states that any "[i]nformation collection requests" that fail to obtain the required approval "are to be considered 'bootleg' requests and may be ignored by the public."[28]

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[23] 44U.S.C. §3501 *et. seq.*
[24] Office of Management & Budget.
[25] 44 U.S.C. §3507(a).
[26] 67 Fed. Reg. at 31403, 31504-31505 (May 9, 2002); 67 Fed. Reg. at 49,982, 50069 (Aug. 1, 2002)
[27] 44 U.S.C.§3512.
[28] Rep. No. 96-930 at 52 (1980).

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that the Provider failed to satisfy the requirement for a written agreement required by the Preamble to May 12, 1998 Federal Register which states that "[f]or purposes of applying an aggregate cap hospitals must affiliate by explicit agreement..."[29] The Section requires:

> "[E]ach agreement must specify the adjustments to each hospital's FTE counts from the cost reporting period ending during calendar year 1996 for purposes of applying the aggregate cap for the period of the agreement. The agreements must specify the adjustment to the IME and DGME FTE counts separately since hospitals are subject to two different FTE counts for each respective cap. Since medical residency training programs generally follow a July 1 to June 30 residency training year, each agreement should specify adjustments to FTE counts on a 12-month basis from June 1 to June 30 of each year."[30]
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> * * * *
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> "Hospitals that qualify to be members of the same affiliated group for the current residency training year and elect an aggregate cap must provide an agreement to the fiscal intermediary and HCFA specifying the planned changes to individual hospital counts under an aggregate FTE cap by July 1 for the contemporaneous (or subsequent) residency training year.
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> Each agreement must be for a minimum of one year and may specify the adjustment to each respective hospital cap under an aggregate cap...
>
> 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 party to the agreement and that agreement must be provided to the hospital's fiscal intermediary with a copy to the HCFA...
>
> Hospitals that provided an earlier agreement for planned changes in hospital FTE counts may provide a subsequent agreement on June 30 of each year modifying the agreement for applying the individual hospital caps under an aggregate FTE cap. [31]

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[29] 63 Fed. Reg. 26337 (May 12, 1998).
[30] Id., at 26338.
[31] Id., at 26341.

The Intermediary contends that the above language of the Federal Register provides clear guidelines relative to the requirements of an affiliation agreement including the identification of the parties, the term of the agreement, total FTE caps for each hospital as well as the breakdown of counts between IME and DGME and the manner in which the aggregate cap will be distributed among members of the affiliated group. The Intermediary argues that the Provider's academic affiliation[32] provides no mention of the sharing or assignment of FTE nor does it identify the sharing methodologies among the agreement's participants. Further, St. Joseph filed its cost report for the same period claiming its entire FTE cap and it appears therefore that St. Joseph never intended to share its FTE cap. The Intermediary asserts the agreement is inadequate to satisfy the requirements of the Federal Register or establish the intent of the parties to share their FTE cap and in the absence of such an agreement, the Provider may not participate in the proration of the aggregate cap with St. Joseph. The Provider's program must rely upon its own base year FTE cap which the Intermediary has determined to be zero.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

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

Congress created the requirement for an FTE cap in the Balanced Budget Act of 1997, Public Law 105-33. Section 4623 of the BBA amended section 1886(h)(4) of the Social Security Act, 42 U.S.C. § 1395ww(h)(4), to add subsection (F). The same legislation also included new subsection (G), which required the Secretary to "prescribe rules . . . in the case of medical residency training programs established on or after January 1, 1995." The Conference Report which accompanied the bill demonstrates Congressional awareness that "there are a sizeable number of hospitals that elect to initiate such programs (as well as terminate such programs) over time," and its concern that "within the principles of the cap there is proper flexibility to respond to such changing needs . . . ." House Conf. Report No. 105-217, 105th Cong., 1st Sess. 821-22 (July 30, 1997), *reprinted at* 1997 U.S. Code Cong. & Admin. News 176, 442-43.

The Intermediary asserts that the provider is a new medical residency training program under the regulations at 42 C.F.R. §413.86(g)(6) (1997) states:

> If a hospital established a new medical residency training program as defined in paragraph (g)(13) after January 1, 1995, the hospital's

[32] Exhibit I-3.

> FTE cap described under paragraph (g)(4) of this section may be adjusted...

In 1997, 42 C.F.R. §413.86 (g)(7) defined a new medical residency training program as:

> A medical residency training program that receives initial accreditation by the appropriate accrediting body on or after July 1, 1995.[33]

In 1998, the language of the regulation was changed to read:

> A new medical residency training program that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995. [34]

The change to the regulation defining a new medical residency program was published in the Federal Register, Vol. 63, No. 91, Tuesday, May 12, 1998. The Secretary responded to commentors who questioned the advisability of just using the accreditation date for determination of a new medical residency program. Commentors noted that programs may not be able to get up and running for some time after the accreditation letter is issued. In revising the definition of a new medical residency program, the Secretary stated at page 26332:

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

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

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[33] Transcript, p. 117.
[34] Exhibit I-5.

residents in a program on or after January 1, 1995, but the program was in existence at another hospital prior to January 1, 1995 [35]..."

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

The Provider argues that it met the requirements of an affiliated group under the version of 42 C.F.R. §413.86, in effect as of July 1, 1998. The regulations established only two criteria to share FTE caps as an affiliated group: 1) The hospitals had to meet the definition of an affiliated group, (i.e., "two or more hospitals located in the same urban or rural area... if individual residents work at each of the hospitals during the course of the program."[36]) and; 2) hospitals that were part of the same affiliated group had to "elect to apply the [FTE] limit on an aggregate basis."[37] The Board's finds that standards requiring both the need for an agreement and its content were included in the Federal Register dated May 12, 1998 that announced the final rule. The Federal Register states:

> In summary, we will apply the FTE caps for affiliated groups as follows:
>
> - Hospitals that qualify to be members of the same affiliated group for the current residency training year and elect an aggregate cap must provide an agreement to the fiscal intermediary and HCFA specifying the planned changes to individual hospital counts under an aggregate FTE cap by July 1 for the contemporaneous (or subsequent year) residency training year.
>
> - Each agreement must be for a minimum of one year and may specify the adjustment to each respective hospital cap under an aggregate cap...
>
> - 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 party to the agreement and that agreement must be provided to the hospital's fiscal intermediary with a copy to the HCFA...)
>
> - Hospitals that provided an earlier agreement for planned changes in hospital FTE counts may provide a subsequent agreement on June 30 of each year modifying the agreement for applying the individual hospital caps under an aggregate FTE cap. [38]

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[35] Exhibit I-8, page 41519.
[36] 42 C.F.R. §413.86(b)(1) (1998).
[37] 42 C.F.R. §413.86(g)(4) (1998).
[38] 63 Fed. Reg. 26318, at 26341 (May 12, 1998).

The Board examined the Provider's agreements and submissions in conjunction with the requirements of the Federal Register. The Board finds that the Provider had in fact executed an agreement that spoke directly to an affiliation for purposes of supporting up to 10 residents.[39] The agreement was signed by the parties and was forwarded to HCFA under a cover letter that made specific request for treatment as an affiliated group for "purposes of the direct graduate medical education and indirect medical residency caps effective July 1, 1998.'[40] The Board believes that the Provider's intent was clear and that their collective submissions qualify the parties as an affiliated group for the three year period stated in the agreement.[41] The Board concludes therefore, that for fiscal years 2000 and 2001, the Provider satisfied the requirements for an affiliated group and may aggregate its FTE caps.

The Board finds that the agreement lapsed without renewal in 2001. Both the Federal Register[42] and the regulations[43] in effect at that time made a written agreement necessary to qualify as an affiliated group. It is undisputed that no agreement was in place for fiscal periods 2002 and 2003 and, accordingly, the Board concludes that Provider does not qualify for treatment as an affiliated group for those time periods. The Provider may not share FTE caps with St. Joseph for those periods.

The Board also examined the Provider's claim that the requirement for an agreement in writing is violative of the APA. BBA-97 was implemented through Section 1886 (h)(F)(i) of the Social Security Act ("the ACT"). Section 1886(h)(4)(H)(ii) of the Act gives the Secretary broad authority to prescribe rules under which to allow institutions to elect to apply the FTE limit on an aggregate basis. Further, Section 1886(h)(4)(H)(iii) authorizes the Secretary to collect such data from the entities that operate the residency programs as the Secretary considers necessary to ensure proper application of the limitation. The Secretary properly promulgated regulatory provisions addressing the proper application of the FTE cap in the final rule issued via the Federal Register dated August 19, 1997.[44] The Secretary responded to comments received on that register in the May 12, 1998 Federal Register.[45] The Board concludes that the Secretary's actions are consistent with his authority under the statute and do not constitute a violation of the APA.

The Board also notes that the Provider sought equitable remedies from the Board under the doctrines of equitable estoppel and equitable tolling. Remedies based on equity are beyond the scope of the Board's authority and consequently the Board reaches no conclusions relative to these arguments.

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[39] Exhibit PC-5, P.3, ¶ V.
[40] Exhibits PC-4 and PC-6.
[41] Exhibit PC-5, P.1 ¶III.
[42] 67 Fed. Reg.50068, 50069 (August 1, 2002).
[43] 43 CFR §413.86
[44] Exhibit I-5.
[45] Id.

DECISION AND ORDER

The Provider did not establish a new medical residency training program. Rather the Provider became a new training site for existing medical residency training programs.

For Fiscal years 2000 and 2001, the Provider satisfied the requirements for an affiliated group and may aggregate its FTE caps.

For fiscal years 2002 and 2003, the provider did not satisfy the requirements for treatment as an affiliated group and may not aggregate its caps for those periods.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, CPA
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FOR THE BOARD:

Michael Harty
Chairman

DATE: JAN 20 2012