PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D11

PROVIDER –
Doctors Medical Center of Modesto
Modesto, California

Provider No.: 05-0464

vs.

INTERMEDIARY –
Wisconsin Physicians Service

DATE OF HEARING -
June 17, 2010

Cost Reporting Periods Ended -
May 31, 2001 through May 31, 2007

CASE NOs.: 09-0900, 06-1259, 07-0824, 09-0905, 09-0908, 09-0903 and 09-0904

INDEX

ISSUE:

Whether the Intermediary improperly eliminated all direct medical education and indirect medical education reimbursement for the Provider's family practice residency program for fiscal years ended May 31, 2001 through May 31, 2007.

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. *See* 42 U.S.C. §§ 1395 *et seq*. The Centers for Medicare & 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, regulation and interpretative guidelines published by CMS. *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. The cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. *See* 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). *See* 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. *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

Most short-term acute care hospitals are paid for services provided to Medicare patients under the hospital inpatient prospective payment system (IPPS). Under IPPS, inpatient operating costs are reimbursed based on a prospectively determined formula taking into account, among other things, national and regional operating costs. In addition, Congress has also provided for the direct costs of graduate medical education (GME) and the indirect costs of medical education (IME). *See* 42 U.S.C. § 1395ww(h) and 1395ww(d)(5)(B). The GME payment is for the direct costs of the training, such as salaries and fringe benefits for residents, and salaries attributable to teaching physician supervisory time. The IME payment is for the increased overhead costs that result from operating a teaching program, such as the costs resulting from the higher number of tests ordered by residents. 42 U.S.C. §§ 1395ww(h), 1395ww(d)(5)(B); *see also* 54 Fed. Reg. 40,286, 40,286- 40,321 (Sept. 29, 1989).

The Medicare GME payment is a hospital-specific amount calculated by multiplying the hospital's updated average per resident amount (APRA) by the actual number of the hospital's intern and resident full time equivalents (FTEs), and multiplying the product by the hospital's Medicare patient load. The total is apportioned between Part A and Part B of Medicare. *See* 42

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

C.F.R. § 413.86(d)(6).[2] Medicare IME payments are computed by applying a complex formula which utilizes the hospital's count of resident FTEs and the resident-to-bed ratio to the hospital's PPS payments. *See* 42 C.F.R. § 412.105.

For cost reporting periods commencing on or after October 1, 1997, Medicare law placed a limit on the number of FTEs a hospital could include in its FTE count for GME or IME payment purposes. 42 U.S.C. §§ 1395ww(d)(5)(B)(v), 1395ww(h)(4)(F). A hospital's unweighted FTE count (for Medicare reimbursement purposes) cannot exceed the hospital's unweighted count for its most recent cost reporting period ending on or before December 31, 1996. 42 C.F.R. §§ 412.105(f)(1)(iv); 413.86(g)(4). This limit is commonly known as the "FTE cap," and the FTE cap is hospital-specific.

If it trains residents in a "new medical residency program," a hospital can receive an adjustment to its FTE cap. 42 C.F.R. §§ 412.105(f)(1)(vii), 413.86(g)(6), 413.86(g)(13).[3] The Medicare GME regulation allows for the new program FTE cap increase, as follows:

> (6) If a hospital established a new medical residency training program as defined in paragraph (g)(13) of this section after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted as follows:
>
> (i) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending before December 31, 1996, and it establishes a new residency program on or after January 1, 1995, the hospital's unweighted FTE residency cap under paragraph (g)(4) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

42 C.F.R. § 413.86(g)(6). The regulation goes on to define new medical training residency program as "a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." 42 C.F.R. § 413.86(g)(13).

In December 1999 HCFA issued Program Memorandum Transmittal No. A-99-51. It states in relevant part:

> A. Definition of a New Medical Residency Training Program

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[2] All regulatory cites are to the 2002 version of the regulations unless otherwise noted. The GME regulations are currently at 42 C.F.R. §§ 413.75 to 413.83.

[3] Provider Supplement (PS) Exhibit PS-23 at 285, 295-96, 300.

> "New medical residency training program" is defined as a program "that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." 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 language does not mean that it is the first time that a particular hospital began training residents in a program on or after January 1, 1995, but the program was in existence at another hospital prior to January 1, 1995.
>
> The new residency program policy may be more easily explained as a two step process. First, determine if the hospital's residency training program qualifies as "new," meaning, it received initial accreditation by the appropriate accrediting body or began training residents on or after January 1, 1995. Second, determine whether or not the hospital had residents before January 1, 1995.[4]

When two hospitals merge, CMS has indicated that the surviving hospital's FTE cap should be the combined FTE caps for the two hospitals. CMS specifically stated that:

> We agree with commenters 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 or more (sic) 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.[5]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Doctors Medical Center of Modesto (DMC or the Provider), provider number 05-0464, is a 465-bed acute care hospital located in Modesto, California which was owned by Stanislaus County's Health Care Services.[6] Prior to 1997, the Provider did not have a graduate medical education program and hence its FTE cap was zero.[7] The Stanislaus County's Health Care System (County) also owned and operated, Stanislaus Medical Center (SMC), provider number 05-0183, and a psychiatric facility, Stanislaus Behavioral Health Center (SBHC), provider number 05-4088. SMC closed on November 30, 1997. In the Medicare tie-in Notice, there is no specific mention of beds added to DMC from SMC.[8] Prior to its closure, SMC had an Intern and

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[4] Exhibit PS-27 at 333-334.

[5] 63 Fed. Reg. 26318, 26329 (May 12, 1998) Exhibit PS-20 at 201; *see* similar statements at 63 Fed. Reg. 40954, 40997 (July 31, 1998) Exhibit P-S-20 at 228; and 71 Fed. Reg. 23996, 24111 (Apr. 25, 2006) Exhibit PS-20 at 247.

[6] As of November 30, 1997, DMC was owned and operated by Tenet Health System Hospitals, Inc. *See* Exhibit I-15.

[7] Exhibit I-5.

[8] Intermediary Position Paper at 8.

Resident GME program that was called the "Stanislaus Family Medicine Residency Program" (the Program).[9] It was originally accredited on March 26, 1975.[10]

SBHC also closed on November 30, 1997. A Medicare tie-in Notice from CMS[11] notes the following change when DMC took over the beds at SBHC and added them to DMC. It states:

> Effective November 30, 1997, Doctors Medical Center increased its beds from 392 to 462. The additional beds are located at 1501 Claus Road, Modesto, CA 95355. This location was previously the psychiatric unit of Stanislaus Medical Center (05-0183). Before becoming a unit, it was a free standing psychiatric hospital (Stanislaus Behavioral Health Center (Provider Number 05-4088).[12]

The Intermediary for both SMC and SBHC was Blue Cross of California. The Intermediary for the Provider was initially Aetna Life Insurance Company and then Mutual of Omaha starting in March 1997. The current Intermediary is Wisconsin Physicians Service (MAC).

In 1995, the Health Services Agency of Stanislaus County (County HSA) decided that it no longer wanted to be in the hospital business but instead wanted to put in place an alternative system that would continue to provide services to the community.[13] By open letter dated August 29, 1995, the County HSA put out a "request for information" (RIF) to any and all interested parties ". . . in developing a contemporary health care delivery system."[14]

On November 30, 1997, the County and Tenet Health System (Tenet) with and for the Provider, a wholly owned corporation of Tenet, entered into an Omnibus Agreement (OA).[15] The recitals of the OA include the following:

A. Tenet owns and operates Doctors Medical Center of Modesto, a general acute care hospital ("DMC").

B. County is obligated to provide health care services to certain classes of persons, and County has operated certain health care facilities including Stanislaus Medical Center, a general acute care hospital ("SMC") Stanislaus Behavioral Health Center, a psychiatric facility ("SBHC") and a network of local outpatient clinics (the "Clinics") for use in providing these services.

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[9] Exhibit I-11.

[10] *Id.*

[11] Exhibit I-22.

[12] *Id.*

[13] Exhibit I-14.

[14] *Id.*

[15] Exhibit PS-16.

C. The parties have determined that it is in their mutual best interest to collaborate in the provision of certain health care services so as to be better able to provide quality, cost effective health care services in Stanislaus County.
D. In connection with and in reliance upon the provisions of the overall transaction between the parties as set forth in this Omnibus Agreement, as of the Closing Date, the parties have entered into a Lease Agreement, Management Services Agreement, Affiliation Agreement, and Detention Facilities Subcontract (the "Other Transaction Agreements").
E. In consideration for the overall transaction, County will close SMC as of the Closing Date.

The nature of the Other Transaction Agreements are described in Section 1 of the OA as follows.

1.1 **The Lease.** County shall lease the land, buildings and furniture, fixtures and equipment used in the operation of SBHC to DMC with the intention that, on the Closing Date SBHC will become a distinct unit of DMC and operate and be licensed as a part of DMC. . . .
1.2 **The Management Services Agreement**. The County shall manage SBHC as a department of DMC and shall bear all economic risk for the financial performance of SBHC. . . .
1.3 **The Inpatient Hospital Services Agreement.** Subject to the contrary requirements of contracts with payor health plans or programs, mandates on enrollees or employer mandates to provide services to their employees at other designated facilities, DMC shall be the exclusive supplier of to County of all inpatient services required by County for the patients of the Clinics mostly at MediCal rates, emergency care and certain other free support functions for law enforcement and the coroner. DMC has agreed to provide certain free inpatient care and be paid for the balance at MediCal rates only for patients identified as eligible indigents by County. . . .
1.4 **The Affiliation Agreement.** County and DMC shall cooperate in the operation of the family practice residency program in affiliation with the University of California Davis medical school. County shall hire the residents at DMC expense in accordance with the mutually agreed upon annual Budget and staffing plans and DMC shall provide all inpatient facilities required for the program. County shall provide an opportunity for the residents to practice at the Clinics. The residency program shall be managed by a Graduate Medical Education Committee with representative from both County and DMC as well as others. . . .
1.5 Detention Facilities Subcontract Agreement. DMC shall subcontract with County to provide certain services provided by Stanislaus Medical Center to inmates under the Hospital Services Agreement for Medical Services in Stanislaus County Detention Facilities Agreement between County and California Forensic, dated July 1, 1997. . . .

Section 3 of the OA specifies the status of the County facilities after the Closing Date of the transactions as follows:

3.1 Stanislaus Medical Center. As a condition of and in reliance on the provisions of this Omnibus Agreement and the Other Transaction Agreements, County will cease the

operations of SMC as an acute care hospital. . . . Certain Clinic and ancillary services will continue to be located at SMC. . .

3.2 Stanislaus Behavioral Health Center. As of the Closing Date, SBHC will be leased by and operated under the acute care hospital license of DMC, under the management of County. . . .

3.3 County Clinics. Following the Closing Date, County shall continue to own, operate and manage the Clinics.

The Affiliation Agreement (AA) between the County HSA and the Provider refers to the residency program as follows:[16]

WHEREAS, HSA operates a Family Practice Residency affiliated with the University of California, Davis; and

WHEREAS, DMC maintains facilities which can be used to furnish clinical experience to trainees, DMC desires to have their facility so used; and

WHEREAS, it is in the mutual interest and benefit of the parties that trainees obtain a portion of their clinical experience at DMC's facilities.

Under the AA, the County HSA retains responsibilities for managing the Program.[17] It is responsible for working with DMC to establish educational goals, designating the HSA Managing Director and the Residency Program Director, assigning clinical faculty members to DMC for supervision, maintaining accreditation of the program, hiring all residents, and preparing the budget.[18] With respect to DMC, its obligations include establishing educational goals with the County HSA, maintaining adequate staff to meet the goals at its facility, paying all the costs up to the budgeted amount, maintaining its licensure, cooperating in the preparation of accreditation documents and permitting the inspection of its clinical and related facilities by those charges with the responsibility for accreditation of the program, and reporting performance issues with trainees or HSA faculty to the HSA Managing Director.[19] The AA states that the residents in the Program are employees of the County and will be assigned by the Residency Director to DMC.[20]

In a letter dated February 6, 1997, the Accreditation Council of the Graduate Medical Education Council (ACGMEC) sent a letter to the Director of the Program.[21] It stated that they had reviewed the information submitted regarding the residency in Family Practice, Stanislaus Medical Center Program, Stanislaus Medical Center, Modesto, CA, Program 1200511052, and

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[16] Exhibit PS-14 at 137.

[17] *Id.*

[18] *Id.* at 137-138, Section I, Subsections A, B, C, G, H, I and J.

[19] *Id.* at 139-140, Section II, Subsections A, B, C, E, F and H.

[20] *Id.* at 140 and 142, Sections III.A and IV.A

[21] Exhibit I-32.

Medical Center Program, Stanislaus Medical Center, Modesto, CA, Program 1200511052, and that based on that information, they accredited the program as follows:

> Status: Continued Full Accreditation
> Length of Training: 3
> Approximate date of next site visit: January 2000.[22]

With respect to DMC it stated, "Doctors Medical Center has been added to the program listing because the duration of resident assignments to that hospital is sufficient to qualify for inclusion. The new listing will be Stanislaus Medical Center Program, Stanislaus Medical Center, Doctors Medical Center, Modesto, CA."[23]

As noted in the stipulations below, the Provider initially believed that the 1997 transaction with the County constituted a merger and claimed GME and IME reimbursement for the Program pursuant to the cost reporting principles for mergers by carrying over the SMC APRA.[24] The Intermediary, however, rejected that a merger had occurred and instead treated the Program as a new medical residency training program under 42 C.F.R. § 413.86(g)(6) with a lower, newly created, Provider-specific APRA.[25] For the next eight years, the Provider, in accordance with the Intermediary's adjustment, claimed GME and IME costs pursuant to the guidelines for new medical residency programs. For FYE 2000, the Provider appealed the Intermediary's calculation of the number of allowable FTE residents under the new program rules and under an administrative resolution, the Program was audited and was determined to be a new program.[26] However, CMS and the Intermediary subsequently questioned whether the Provider qualified for the new residency training program and issued notices of reopening for FYE 2002 through 2005 with regard to the GME/IME issue. On January 20, 21, and 23, 2009, the Intermediary issued revised NPRs for each of the appeal years (except FYE 5/31/07) recouping all previous IME and GME payments. On October 8, 2008, the Intermediary issued an original NPR for FYE 5/31/07 eliminating previous GME and IME payments. On February 19, 2009, the Provider timely appealed the GME/IME issue for each of the fiscal years.

The basis of the CMS and Intermediary determination is stated in a letter from the CMS Deputy Administrator dated January 15, 2009.[27] It states:

> For purposes of determining direct GME and IME payments, sections 1886(h)(4)(F) and 1886(d)(5)(B)(v) of the Social Security Act established a cap on the number of full-time equivalent (FTE) residents the hospital may count based on the number of FTE residents it was training in its most recent cost reporting period ending on or before December 31, 1996

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[22] *Id.*

[23] *Id.*

[24] Provider Fiscal Year Ended (FYE) 5/31/1998 cost report. Exhibit PS-28 at 340.

[25] Exhibit PS-28 at 341.

[26] Exhibit PS-32.

[27] Exhibit I-7.

(1996 cap). Stanislaus Medical Center (SMC), a county owned hospital, operated a family practice residency program for many years. Under the law, SMC was permitted to count residents in its family practice program on or after October 1, 1997, only up to its 1996 cap.

In November 1997, the inpatient acute portion of SMC closed, and its Medicare provider number was retired. Doctor's Medical Center of Modesto (DMC), owned by Tenet Health Care Corporation, which was not a teaching hospital in 1996 and therefore has FTE resident caps of zero, took over the family practice residency program from SMC. Since that time, DMC began counting the FTE residents in the family practice program and has received IME and direct GME associated with the family practice program. However, the counting of these FTE residents and the associated IME and direct GME payments are not in accordance with our regulations.

Under Federal regulations at 42 CFR Section 413.79(c)(1), a hospital that had no allopathic or osteopathic residents in 1996 may become a teaching hospital, and may receive an adjustment to its FTE resident cap of zero if it establishes one or more new medical residency training programs. However, the family practice program at DMC cannot be considered a new program because it was continuously in operation throughout the transition of the program from SMC to DMC.

The parties executed a joint stipulation, filed on May 19, 2010,[28] that states the following:

1. SMC permanently closed its doors as of November 30, 1997, and at the same time SMC voluntarily terminated its Medicare provider agreement and Medicare provider number.
2. The Provider's GME and IME FTE caps, based on its FYE 5/31/96 cost report, were each zero (0.00).
3. Originally, because the Provider believed that a November 30, 1997 transaction between the Provider and SMC constituted a merger, it claimed GME and IME reimbursement on its as-filed FYE 5/31/98 cost report pursuant to the cost reporting principles for mergers by, in part, carrying over and using SMC's GME APRA.
4. The Intermediary did not accept the merger approach and instead treated the residency program at the Provider as a new medical residency training program under 42 C.F.R. section 413.86(g)(6) with a lower, newly created, Provider-specific APRA.
5. For its FYEs 5/31/99 and forward, the Provider complied with the Intermediary's adjustment and accordingly claimed and received GME and IME payments associated with its residency program pursuant to the cost reporting guidelines for "new medical residency programs."

[28] Exhibit PS-44.

6. For FYE 5/31/2000, the Provider appealed the Intermediary's calculation of the number of allowable FTE residents in light of the "new program" rules. The appeal resulted in an Administrative Resolution in which the Provider's residency program was treated as a new program.
7. Since, ultimately, the Provider was reimbursed GME and IME under the new program rules (and not as if the Provider and SMC merged), SMC's base year 1996 resident FTE cap for GME and IME purposes has not been used by the Provider since SMC closed its doors.

The parties also jointly stipulated on July 23, 2010 that the decision reached with regard to Case Numbers 06-1259 and 07-0824 for FYE 5/31/02 and 5/31/03 should apply to the other five years pending on the same issue.[29]

The Provider was represented by Jon P. Neustadter, Esquire, of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by Stacy Hayes, Specialist Cost Report Appeals, of Wisconsin Physicians Service.

PARTIES' CONTENTIONS:

The Provider contends that its residency program is entitled to previously claimed GME and IME payments because the 1997 agreements and transactions between the Provider and the County constituted a merger for GME and IME purposes and/or the program was a new program. The Provider also contends that after a decade of being affirmatively informed by the Intermediary that its program constituted a new program, the recoupment of GME and IME payments would be inequitable and not merited by any relevant change in law or regulation.

The Provider asserts that the County's RFI[30] sought bids for the consolidation and continuation of all of the key functions and operations of SMC. The Provider claims that the four agreements it reached with the County (the Inpatient Hospital Services Agreement (IHSA), the AA, the Interim Agreement Regarding Personnel (IARP) and the OA) constituted a merger of SMC's enterprises and patient care obligations into the Provider. The Provider asserts that there is no definition or guidance concerning a merger for GME or IME purposes. While acknowledging that SMC was a non-distinct enterprise of the County and could not be a part of a traditional merger under California law,[31] the transaction was a merger under other definitions of the term. These general definitions focus on combining and consolidating the merging parties' activities and interests and assignment of rights to and assumption of obligations by the surviving entity. In this regard, the key portions of SMC's operations were to be continued under the IHSA, such as the County's obligation to provide care to the medically indigent adults under California law. In addition, the Provider also assumed the County's commitment related to inmate services, coroner's office services, pre-incarceration treatment, pre-commitment screening, bio-hazardous

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[29] Case Numbers 09-0900, 09-0903, 09-0904, 09-0905 and 09-0908 for FYE 5/31/04 through 5/31/07.

[30] Exhibit PS-12.

[31] Provider Supplemental Position paper at 19, n. 12.

waste disposal and forensic cooperation.[32] Also, under the IHSA, the Provider continued medical training activities and the residency program.[33] Under the IHSA, the Provider was required to provide emergency and obstetric services and maintain its qualification to provide Medicare and Medi-Cal services to the community, including emergency and obstetric services.[34]

The Provider asserts that other key functions were merged into its operations. For example, SBHC continued as a distinct part hospital-based unit of the Provider, with management support by the County.[35] Also, the family residency training program previously operated by SMC in conjunction with the University of California, Davis was merged into the Provider's operations.[36] Finally, SMC employees were transitioned to the Provider's operation pursuant to the Interim Agreement Regarding Personnel (IARP), which supported the orderly transition of SMC employees and services.[37]

The Provider notes that the term merger can be "used to denote various arrangements by which two corporations become united in interest."[38] The Provider indicates that per the 1997 transaction, the County as the owner of SMC, continued to provide input into the combined operations, just as shareholders of a disappearing corporation retain rights after a typical merger. Examples include the following:

- The County was granted the right to appoint one member of the Provider's local governing body[39]
- The County continued management rights with respect to the SBHC[40]
- The Provider and County were required to work jointly in connection with the Program[41]
- The Provider and County were required to coordinate regarding admissions, utilization review and quality management policies and certain regulatory reports[42] and

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[32] Exhibit PS-13 at 124-125.

[33] *Id.* at 125, Sections 7.4 and 7.5.

[34] *Id.* at 118-120, 126 and 129-130; Sections 1.1, 1.6, 1.7, 8.2, 8.3 and 11.

[35] Exhibit PS -16 at 172-173; OA, Sections 1.1, 1.2 and 3.2.

[36] Exhibit PS-13 at 125; IHSA, Section 7.4 and Exhibit PS-14, AA.

[37] Exhibit PS-15.

[38] Fletcher Cyc. Corp. § 7041, Exhibit PS-35 at 402.

[39] Exhibit PS-16 at 173; OA, Section 5.

[40] *Id.* at 172-173; OA, Sections 1.2 and 3.2.

[41] Exhibit PS-14 at 137-140; AA, articles I and II.

[42] Exhibit PS-13 at 123; IHSA, Section 4.

- The Provider and County agreed to work together to develop a fully integrated delivery system for capitated coverage for Medicare, Medi-Cal and indigent residents of the County[43]

The Provider also states that other factors contained in the 1997 transaction indicate transferred rights and obligations associated with a merger. Those include:

- The Provider leased the land, building, furniture, etc. used in the operation of SBHC and SBHC became a distinct part hospital-based unit of the Provider[44]
- Employees of SMC were transitioned to the Provider[45]
- Key contractual rights and responsibilities associated with SMC were transferred to the Provider such as medical services to inmates, services to the coroner's office pre-incarceration treatment, pre-commitment screening, biohazard waste disposal and forensic cooperation,
- The Provider assumed the responsibility for training residents and became their primary training site, and
- The Provider assumed the SMC and County obligation for medically indigent adults, medical records maintenance, maintaining emergency obstetrics and inpatient hospital services for covered patients and maintaining the ability to provide Medicare and Medi-Cal services in the community

The Provider asserts that consistent with common merger definitions, after SMC ceased to exist, its activities, functions, rights and obligations were integrated into and continued by the Provider. Accordingly, the Provider should be able to continue the Residency Program with a merged SMC/Provider FTE cap and SMC's GME APRA.

The Provider notes that the Intermediary initially determined that it was entitled to receive IME and GME reimbursement as a new medical residency program. The Provider agrees with that determination because it undertook, for the first time after January 1, 1995, the responsibility of being the primary teaching hospital and being listed as such, for the first time in 1997, on the ACGME accreditation for the residency program.[46]

The Provider points out that a residency program is a "new medical residency training program" for Medicare purposes if the program "receives initial accreditation by the appropriate accrediting body **or** begins training residents on or after January 1, 1995." 42 C.F.R. § 413.86(g)(13) (emphasis added). The Provider maintains that the use of the "or" in the regulation establishes that meeting either one of the requirements is sufficient to qualify as "new." Section 413.86(g)(6) further supports the notion that the new program analysis focuses on whether and when the hospital had previously reported residents in its 1996 cost report. For example, 42 C.F.R. § 413.86(g)(6)(i), referring to the availability of a new program FTE cap adjustment, states "[if] **a hospital** had no allopathic or osteopathic residents in its most recent

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[43] Exhibit PS-16 at 173; OA, Section 4.

[44] Id. at 171; OA, Section 1.1.

[45] Exhibit PS-15 at 118-119; Interim Agreement Regarding Personnel, Section 1.0-1.7.

[46] Exhibit PS-19.

cost reporting period ending on or before December 31, 1996, **and it establishes** a new medical residency training program on or after January 1, 1995 . . ." (emphasis added).

The Provider asserts that at the time of the November 1997 transaction, there was no guidance on what constituted a "new medical residency program," or what documentation was required. Guidance in the preamble to the regulation,[47] merely indicated that documentation should be provided to the fiscal intermediary and manifested an intent by CMS to have those determinations made by the fiscal intermediary.

The Provider indicates that the Program Memorandum Transmittal No. A-99-51, dated December 1999, well after the first year that the Provider reported residents advised that the regulatory language "does not mean that it is the first time a particular hospital began training residents in a program on or after January 1, 1995."[48] The Provider asserts that this position goes against the Congressional intent to compensate teaching hospitals using a hospital specific approach. The Provider indicates that it claimed no GME or IME FTEs on any cost report until FYE May 31, 1998 and was not recognized as a primary teaching institution by ACGME until 1997 and as such, qualifies as not having had residents before January 1, 1995.

The Provider notes that language in the preamble supports its claim to qualify under the regulation. HCFA commented, "[w]e recognize that hospitals that . . . began training residents in the new program . . ." and further, "[a] hospital seeking to qualify as a new program must provide documentation to the intermediary indicating the date a program received accreditation **and/or** the date the residents begin training for the hospital to receive an adjustment to its FTE cap."[49] (emphasis added) The Provider notes that in 1997, after January 1, 1995, ACGME accredited it for the first time as the new principal training site. Indeed, after reviewing its FYE May 31, 1998 cost report, the Intermediary revised the Provider's FTE count to reflect the Residency Program's status as a "new program."[50] The Provider further notes that the Intermediary's determination was confirmed in the joint Administrative Resolution. The Provider and the Intermediary agreed that the FYE May 31, 2000 cost report, which was submitted to and accepted by the Board is the second 'full' period for intern and residents and falls within the three year transition period ***as a new provider program***."[51] The Provider notes that the Intermediary had carefully considered all aspects of the nature of the Provider's Residency Program, as shown by its expressed rejection of the Provider's use of SMC's GME APRA (based on a merger) and affirmative issuance of a new, Provider-specific APRA.[52] The Provider would have been given a new APRA only if it qualified for GME payments using a new FTE cap.

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[47] 63 Fed. Reg. 26318, 26336 (May 12, 1998), Exhibit PS-20 at 208.

[48] Exhibit PS-27 at 333-34.

[49] 63 Fed. Reg. at 26332 (May 12, 1998), Exhibit PS-20 at 204.

[50] Provider's as-filed FYE 05/31/98 worksheet E-3, Part IV (PS-28 at 340 and Line 3.02 of Intermediary's audited worksheet E-3, Part IV for the Provider's FYE 5/31/98, Exhibit PS-28 at 341.

[51] Exhibit PS-32 (emphasis added).

[52] Exhibits PS-28 at 340-41 and PS-30 (2000 and 2005 APRA notices).

The Provider also indicated that recent CMS clarifications concerning which programs qualify as new programs for purposes of an adjustment to the FTE cap[53] may be applicable to the facts in this case. The Provider points out that CMS clarified that an accrediting body's determination that a program is new is not controlling on whether a program is in fact new, as opposed to being an existing program that transfers to a new site.[54] The Provider indicates that CMS noted that an important consideration in granting new program FTE cap adjustments is that the "aggregate number of FTE residents should be held to the 'current' levels at the time the [FTE cap statute] was enacted."[55] CMS expressed concern that allowing a new program FTE cap when a program merely relocates from one hospital to another could lead to an increase in the aggregate number of FTE residents if both hospitals continued to operate.[56] CMS clarified that an important factor in granting new program status is whether a residency program has transitioned from another hospital that "actually closes (that is, its Medicare provider agreement and its FTE caps are retired and not used by another hospital) . . ."[57] Thus, CMS is less concerned about the transition of a program from a closed hospital to another hospital because "there would be no threat of duplicative FTE slots relating to the same program [and] [r]ather, the national aggregate FTE cap would remain approximately the same."[58] CMS stated that "a program originated from a hospital that closed, where no other hospital retained the FTE caps, suggests that **it would be appropriate to consider the program to be new** for purposes of establishing IME and direct GME FTE caps."[59] (emphasis added). And that this is the case even though "there are significant similarities between the program in terms of the program director, teaching staff, or residents . . . ."[60]

The Provider notes that the residency program in this case originated at SMC, which closed its doors and voluntarily terminated its provider agreement and provider number.[61] CMS' determination that the program was not new because it was "continuously in operation throughout the transition of the program from SMC to [the Provider]" did not give any weight to the new important factor regarding closed hospitals. In this case, SMC closed and its FTE cap ceased to exist and there is no danger of duplicative FTE caps or an increase in the aggregate FTEs.

The Provider also asserts that it should retain its IME and GME payments based on various equitable grounds.[62] For more than 10 years, the Provider reasonably relied on the Intermediary's multiple affirmative representations that it was properly claiming GME and IME

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[53] 74 Fed. Reg. 43754 (Aug. 27, 2009), Exhibit PS-43.

[54] *Id.* at 43909.

[55] *Id.*

[56] *Id.* at 43910.

[57] *Id.* at 43914.

[58] *Id.*

[59] *Id.*

[60] *Id.*

[61] Exhibit PS-44.

[62] Provider's Supplemental Position Paper at 33-44.

payments for its Residency Program and thus had reasonable and settled expectations regarding those GME and IME payments. If CMS or the Intermediary had timely determined that the Provider was bound to its 1996 FTE cap of zero, the Provider could have sought other relief.

The Intermediary contends that the Provider was not a teaching hospital in the 1996 cap year and thus, its cap was zero. The 1996 cap that existed at SMC could not have been transferred to the Provider because the program was not new and there was no merger between the Provider and SMC that would have allowed transfer of the cap to the Provider. Also, the Provider and SMC also did not have any affiliation agreement with each other that would have allowed them to share the cap. As a result, the Intermediary was required to recover all payments for GME and IME.

With respect to a merger, the Intermediary states that a merger did not occur between the Provider and SMC, where the residency program was based. The Intermediary points out that SMC simply closed on November 30, 1997, but that the County continued to own and operate the facility for its clinics. The Intermediary notes that no merger was reported to CMS for DMC and SMC and there is no evidence that the surviving entity assumed assets and liabilities of the previous two provider operators. Only a lease of the free-standing SBMC by DMC actually occurred. The Intermediary also indicates that the Provider acknowledged that SMC closed, its provider number was terminated and there was no approved merger between DMC and SMC or any other provider so its FTEs disappeared.[63]

With respect to the residency program at DMC being considered new, the Intermediary points out that the regulation at 42 C.F.R. § 413.86(g)(13) defines a new medical residency training program as a medical residency that "receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." While the Intermediary initially allowed the Provider to claim GME and IME payments for the program transferred from SMC to DMC, CMS' regulations[64]clarify that the phrase, "or begins training residents on or after January 1, 1995," specifically applies to programs which were provisionally certified prior to January 1, 1995, but with a start-up date after January 1, 1995. It states that the regulation:

> [c]urrently defines a new medical residency training program as 'a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.' We did not propose to revise the language of the regulations text because we believe the existing language is sufficient in that it conveys the important point that a program must be "initially" accredited *for the first time* as new by the accrediting body. The supporting factors that we have provided for determining whether a program is to be considered as new by CMS further clarify and support the concept of "initial' accreditation.[65]

Thus, the concept of initial accreditation is not overridden by the factors that may be considered to determine if a program "might be" considered new. CMS addresses what could be considered new only if the program receives initial accreditation.

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[63] Hearing Transcript (Tr.) at 22 and 23.

[64] 74 Fed. Reg. 43754, 43909 (Aug. 27, 2009); Exhibit PS-43.

[65] *Id.* at 43916

In this case the Provider did not obtain "initial' accreditation after assuming the old program. It only submitted documentation that the program from SMC continued.[66]

Additional language from CMS' clarification clearly indicates that a transfer of an existing program does not qualify for an FTE increase. It states:

> [t]he closure of one program and the movement of the program director, faculty, and residents to another hospital are indicative of the relocation of an existing program for which no FTE cap increase is warranted. [67]

And also,

> Furthermore, the focus of the clarification in the proposed rule was *not* that a hospital may close a program and fill those vacant slots with residents from another specialty, which, by itself, is acceptable, but rather, it was to address the point that an FTE cap increase should only be awarded to a hospital for starting a genuinely new program, not one that was merely transferred from another hospital.[68]

The Intermediary points out that the only other circumstance where a program can be moved and an increase in the CAP achieved would be through a temporary increase as explained in 42 C.F.R. § 413.86(g)(9). This regulation describes a "closed hospital" with "displaced residents." The Provider in this case is training residents from SMC that closed November 30, 1997. SMC surrendered its Medicare provider contract and provider number as indicated in the tie-in notice.[69]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

If a hospital's FTE cap prior to December 31, 1996 was zero, there are two methods by which its FTE cap could be increased above zero for cost reporting periods beginning on or after October 1, 1997. First, FTE caps could be increased because of a hospital's new residency program; and second, because of a merger of hospitals, which results in a combination of their FTE caps and GME APRA.[70]

The Board finds that the facts in this case do not support a determination that the Provider's Program is either a new residency program or that there was a merger between SMC and the Provider.

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[66] Exhibit I-11.

[67] 74 Fed. Reg. 43754, 43913 (Aug. 27, 2009); Exhibit PS-43.

[68] *Id.* at 43915.

[69] Exhibit I-22.

[70] *See* n. 5, *supra.*

New Residency Program

A hospital can receive an adjustment to its FTE cap if it trains residents in a "new medical residency program."[71] The Medicare GME regulation allows for the new program FTE cap increase, as follows:

> (6) If a hospital establishes a new medical residency training program **as defined in paragraph (g)(13)** of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted as follows:
>
> > (i) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (g)(4) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

42 C.F.R. § 413.86(g)(6)(2002) (emphasis added).

The regulation goes on to define a new medical residency training program as:

> a medical residency that receives **initial** accreditation by the appropriate accrediting body **or** begins training residents on or after January 1, 1995.

42 C.F.R. § 413.86(g)(13)(2002) (emphasis added).

The Board notes that the text of the regulation does not define what was meant by "initial accreditation" and that the language "or begins training of residents on or after January 1, 1995" is unclear as to whether a provider can qualify as new merely by beginning training of residents on or after January 1, 1995. The Board notes, however, that CMS provided explanations concerning the meaning of these provisions in the preamble language at the time the regulations were initially promulgated.

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[71] 42 C.F.R. §§ 412.105(f)(1)(vii), 413.86(g)(6), 413.86(g)(13). (Exhibit PS-23 at 285, 295-96, 300).

In the preamble language of the Final Rule with Comments, 62 Fed. Reg. 45966, 46006 (Aug. 29, 1997), the Board notes that CMS stated the following with regarding what it meant by the term "initial accreditation."

> [W]e are establishing the following rules for applying the FTE limit and determining the FTE count for the hospitals that established new medical residency programs on or after January 1, 1995. For purposes of this provision, a "program" will be considered newly established if it is accredited **for the first time**, including provisional accreditation on or after January 1, 1995 by the appropriate accrediting body.

Id. (Emphasis added).

With respect to the Provider's argument that the "or" in the regulation allows the Provider to qualify by merely starting to train on or after January 1, 1995, the Board notes that in the initial version of the regulation at 62 Fed. Reg. 45966, 46035 (August 29, 1997), CMS' definition of 42 C.F.R. § 413.86(g)(7), (subsequently modified and redesignated 42 C.F.R. § 413.86(g)(13), did not contain the phrase "or began training residents" and merely stated the following.

> (7) For purposes of paragraph (g) of this section, *new medical residency program* means a medical residency program that receives initial accreditation by the appropriate accrediting body on or after July 1, 1995.

Responding to concerns from commenters, CMS proposed changes to the regulation that added the phrase "or began training residents" and explained the reasons for those changes in a Final Rule at 63 Fed. Reg. 26318, 26331 (May 12, 1998). It states as follows:

> Comment: . . . Some commenters suggested that the new program definition be based on the date the residents begin training rather than the date of an accreditation letter. These commenters noted that the majority of programs starting July 1, 1995, received their accreditation letters prior to January 1, 1995, and would not qualify as new programs. . . .
>
> Response: . . . As the comments reflect, establishing a newly accredited medical residency training program can be a costly and time consuming process. 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 is 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.(Emphasis added).

CMS provided further clarification in its Final Rule, 64 Fed Reg. 41490, 41519 (July 30, 1999) in response to commenter concerns. It states as follows:

> Comment: Several commenters expressed concern about our definition of "new medical residency training program" for purposes of determining the FTE cap adjustment under Sec. 413.86(g). . . . Another commenter suggested we have interpreted "new residency program" to be simply a new site for a residency program that may have been in existence at other clinical sites in the past.
>
> Response: Under the existing Sec. 413.86(g)(7) (proposed to be redesignated as Sec. 413.86(g)(9)), we define "new medical residency training program" to be a program "that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." **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 language does not mean that it is the first time a particular hospital began training residents in a program on or after January 1, 1995, but the program was in existence at another hospital prior to January 1, 1995, as the commenter suggests.** (Emphasis added).

The Board finds that the preamble language clearly indicates that CMS, from the beginning, intended the word "initial" to mean only residency programs that were accredited "for the first time." Furthermore, the Board finds that the purpose of including the phrase "or begins training residents" in the later version of the regulations was to allow programs to be considered new, even if they were accredited before January 1, 1995 but did not begin training residents until on or after January 1, 1995. CMS clearly stated that this language was not intended to mean that it was the first time a particular hospital began training but that the program was in existence at another hospital prior to January 1, 1995.

The Board notes that the record contains the ACGME Accreditation Program Information concerning the Program.[72] Under Accreditation and General Information it states that the original accreditation date of the program was March 26, 1975.[73] The Board further notes that under the AA between the Provider and the Health Service Agency (a health system operated by

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[72] Exhibit I-11.

[73] *Id.*

the County) it states that the "HSA operates the Family Practice Residency affiliated with the University of California, Davis," that "DMC maintains facilities which can be used to furnish clinical experience to trainees," and "it is in their mutual interest and benefit of the parties that trainees obtain a portion of their clinical experience at DMC's facilities."[74] Under the responsibilities of the HSA, they continue to select the Managing and Residency Program Directors, assign appropriate clinical faculty to DMC, maintain the accreditation of the program, hire the residents, and submit a budget.[75] The Provider's responsibilities include maintaining staff and facilities for the educational goals of the program, paying all the costs in the budget, and cooperating in the preparation of accreditation documents and permitting inspection by the accrediting agency.[76] Based on the AA, it is clear that the Program is not a new medical residency program that was accredited "for the first time," but the continuation of the same medical residency with the Provider replacing the role previously served by SMC. The Board further notes that the accreditation of the Provider by the ACGME in its letter dated February 6, 1997,[77] clearly states that it is granting "Continued Full Accreditation" of the existing program and that "Doctor's Medical Center has been added to the program listing because the duration of resident assignments to that hospital is sufficient to qualify for inclusion." The Board therefore finds that the Provider did not receive an initial accreditation of the Program, instead, it was the first time that the Provider began training residents in the Program on or after January 1, 1995, but that the Program was in existence at another hospital prior to January 1, 1995.

The Board also considered the Provider's argument that CMS' recent clarification of the regulation[78] lends additional support to its position that the Program should be considered new. Even though CMS noted that allowing a new program FTE cap when a program merely relocates from one hospital to another could lead to an increase in the aggregate number of FTE residents if both hospitals continue to operate, it recognized that if the "program originated from a hospital that closed, where no other hospital retained the FTE caps, suggests that it would be appropriate to consider the program to be new for purposes of establishing IME and direct GME FTE caps."[79] The Provider indicates that with the closure of SMC, there is no issue of exceeding the FTE cap and therefore, it is appropriate to consider the Program to be new even though there are significant similarities between the program at SMC and the Provider's program. The Intermediary indicates that the clarification provided did not change the definition of new residency program that required "initial accreditation," namely, that the program was accredited "for the first time." The Intermediary notes that only if this requirement is met can CMS consider the other factors in determining whether the program is truly new.

The Board notes that CMS stated the following in its recent clarification.

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[74] Exhibit PS-14 at 137, AA Witnesseth Section.

[75] *Id.* at 137-138, AA Section I, Subsections B, C, G, H, and J.

[76] *Id.* at 137-138, Section II, Subsections B, C and F.

[77] Exhibit I-32.

[78] 74 Fed. Reg. 43754 (Aug. 27, 2009).

[79] *Id. at* 43914.

> [W]e have suggested in discussions in our previous rules, rather than relying solely on the accrediting body's characterization of whether a program is new, we continue to believe it is appropriate that CMS require a hospital to evaluate whether a particular program is a newly established one for Medicare GME purposes by considering whether a program was initially accredited ``for the first time,'' and is not a program that existed previously at another hospital. In evaluating whether a program is truly new, as opposed to an existing program that is relocated to a new site, it is important to consider not only the characterization by the accrediting body, but also supporting factors such as (but not limited to) whether there are new program directors, new teaching staff, and whether there are only new residents training in the program(s) at the different site. In determining whether a particular program is a newly established one, it may also be necessary to consider factors such as the relationship between hospitals (for example, common ownership or a shared medical school or teaching relationship) and the degree to which the hospital with the original program continues to operate its own program in the same specialty. (Although this discussion of new programs is framed in the context of a hospital operating a program, we note that many programs are operated or sponsored by schools of medicine or other nonhospital entities.) This section is intended to address all GME programs that were previously accredited at one operating entity, and that entity ceases to operate the program, but the program is then opened and operated at another entity, even if it is accredited as a new program at the second entity. Such a program may not be treated as new at the second entity.)[80] (Emphasis added)

The Board finds that the purpose of the clarification was to indicate that CMS will not defer to the accrediting agency's characterization of the program as "new" or "initial" but instead will rely on its previous interpretation of the rule that the accreditation of the program had to be "for the first time" and was not a program that existed previously at another hospital. The Board further notes that even though CMS granted additional flexibility in considering a program to be new, if an accredited program transferred from a hospital that closed and the FTEs were not utilized by any other hospital, it did not change the requirement that there be an initial accreditation for the program. Because the Program in this case was initially accredited in 1975 at SMC and continued under the AA with the Provider assuming SMC's responsibility to become the principal training site for the Program, it cannot qualify as new even though SMC closed and its FTEs can't be utilized by another provider. The Board notes that this determination is consistent with the determination in CMS' letter.[81]

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[80] *Id.* at 43909.

[81] Exhibit I-7.

Merger of DMC and SMC

The Board notes that CMS has indicated that when hospitals merge it is appropriate for the surviving hospital's FTE cap to be the combined FTE caps for the hospitals that merged.[82]

Even though the Provider and SMC, a County run hospital, could not technically merge under California law, the Provider indicates that the transaction amounted to a merger. The Intermediary indicates that the transactions between DMC and the County did not meet the definition of a merger under Medicare rules. There was no combining of DMC and SMC under California state law and DMC did not acquire the assets or liabilities of SMC. Instead, SMC was closed but continued to be owned and operated by the County for its Clinics, no merger was reported to CMS for DMC and SMC and there is no evidence that the surviving entity assumed the assets and liabilities of SMC.

The Board notes that when there is a change of ownership of a provider such as a merger, the provider is required to notify CMS.[83] There is no specific guidance for what constitutes a merger under the GME/IME rules, however, there is a definition of a merger for purposes of a change in ownership at CMS Pub. 15-1 § 1500.3. It states the following:

> Merger. – The merger of the provider under the corporation laws of a State into another corporation, resulting in the surviving corporation acquiring the assets and liabilities of the provider corporation.

The Board finds that the evidence in the record indicates that the Provider did not merge with SMC under California law and did not acquire either the assets or liabilities of SMC. The Board notes that the Provider indicated that SMC was a non-distinct enterprise of the County, which would not have been permitted to be part of a traditional, statutory merger with the Provider under California law.[84] The record also indicates that the County closed SMC and its associated Medicare provider number and agreement were terminated.[85] Rather than merge, the Provider and the County entered into a series of agreements in which the Provider agreed to render services that the former SMC had provided. However, the Provider did not assume the assets or liabilities of SMC. In addition, the Board notes that the Provider did not take steps to report to CMS that it had merged with SMC. Even the Provider's own financial reports did not indicate that a merger between the Provider and SMC had taken place.

The OA between the Provider and the County does not indicate that the parties are merging.[86] Instead, the agreement states that the "County is obligated to provide health care services to certain classes of persons" and the County has operated SMC and SBHC and a network of outpatient clinics to provide those services but that "the parties have determined that it is in their

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[82] *See* n. 5, *supra.*

[83] 42 C.F.R. § 489.18(b), Exhibit I-23.

[84] Provider's Supplemental Position Paper at 19, n. 12.

[85] Stipulation 1, Exhibit PS-44.

[86] Exhibit PS-16, OA.

mutual best interest to collaborate in the provision of certain health services" in the County.[87] (emphasis added) The parties entered into a number of additional agreements to provide those services, and "in consideration for entering into the transaction, the County will close SMC."[88] (emphasis added)

With respect to the IHSA, the Provider agrees to be the exclusive supplier to the County of all inpatient services required by the County for the patients of the Clinics (that the County will continue to operate) mostly at MediCal rates, emergency care and certain other free support functions for law enforcement and the coroner.[89] However, the County continues to pay for inpatient services provided to these recipients.[90] Rather than merge with DMC, the agreement states that the "County will cease the operations of Stanislaus Medical Center as an acute care hospital in reliance on the availability of services to be provided by DMC under this [Inpatient] Hospital Services Agreement."[91] In addition, the agreement between the parties is for a long but limited period of twenty years and may be terminated under certain conditions.[92]

Likewise, under the Detention Facilities Subcontract Agreement (DFSA), the County indicates that it "is a party to an agreement for Medical Services in Stanislaus County Detention Facilities ("Detention Agreement") with California Forensic Medical group ("CFMG")" and "desires to subcontract the provision of certain services related to hospitalization to DMC."[93] This agreement does not merge the Provider and SMC but merely substitutes DMC as the source of the services previously provided by SMC. Again, the County is obligated to provide and pay for the services and the Provider has contracted with the County to be the source of those services and accept payment from the County.[94]

The Board also notes that the 1998 Annual Report of Tenet Health Care Corporation does not mention any merger between the Provider and any other hospital in either Modesto or Stanislaus County, even though other mergers within Tenet's organization are reported.[95] In addition, in the Form HCFA-339, submitted by the Provider for FYE May 31, 1998, no change in ownership is reported.[96]

In summary, the Board finds there is no evidence that the Provider and SMC merged under California law or that the Provider as the surviving corporation acquired the assets or liabilities

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[87] *Id.*, Recitals B and C.

[88] *Id.*, Recitals D and E.

[89] Exhibit PS-13 at 119; IHSA, Section 1.3, Exhibit PS-13.

[90] *Id.*, at 122 Section 3.4.

[91] *Id.*, at 118 Recital D.

[92] *Id.*, at 127 Section 9.

[93] Exhibit I-19 at 1; DFSA, Recitals A and B.

[94] *Id.*, Sections 1 and 2.

[95] Exhibit I-27 at 6-7.

[96] Exhibit I-28 at 2.

of SMC. Instead, the agreement provided that the County close SMC and SMC's provider number was terminated. The agreements do not specify that the Provider will assume the assets or liabilities of SMC but merely contractually obligates it to offer certain services previously provided by the County through SMC at DMC. At the same, time the contracts require that the County continues to pay the Provider for the delivery of those services.[97]

Finally, the Board notes that the Provider presented a number of equitable reasons to support its contention that it should retain its GME payments. The Board notes, however, that it is an administrative forum that does not have general equitable powers and therefore, has not considered the Provider's equitable arguments.

DECISION AND ORDER:

The Board finds that the Intermediary properly eliminated all direct medical education and indirect medical education payments for the Provider's family practice residency program for fiscal years ended May 31, 2001 through May 31, 2007. The Intermediary's adjustments to recover GME and IME payments are affirmed.

BOARD MEMBERS PARTICIPATING:

Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.
Michael W. Harty

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: FEB 2 4 2012

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[97] Although not directly related to the merger of the Provider with SMC, it is also clear that the Provider also did not merge with SBHC. With respect to SHBC, the Provider leased the land, building, furniture and equipment used in the operation of SBHC from the County and agreed to obtain all necessary and appropriate licenses to operate SHBC as a distinct part of its hospital. However, under a separate agreement, the County, not the Provider, continued to manage SBHC as a department in DMC and agreed to bear all the economic risk for its financial performance. *See* Facility Lease Agreement, Exhibit I-16 and Facility All Risk Management Agreement, Section F, Exhibit I-17.