PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2017-D27

PROVIDER –
Rochester General Hospital

Provider No.: 33-0125

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

HEARING DATE –
June 8, 2016

Cost Reporting Periods Ended –
December 31, 2001; December 31, 2002

CASE NOs.: 05-0202 and 06-0933

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ISSUE STATEMENT

Whether the Provider is entitled to a temporary increase in its resident full time equivalent ("FTE") count due to the closing of one of the other three hospitals in a medical education training program.[1]

DECISION

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly disallowed the exception request for a temporary FTE cap increase for fiscal years ("FYs") 2001 and 2002 for Rochester General Hospital ("Rochester" or "Provider") in accordance with 42 C.F.R. § 413.86(g)(8).

INTRODUCTION

Rochester is a 475-bed acute care teaching hospital located in Rochester, New York. Rochester was one of four hospitals serving as a training site for residents participating in an internal medicine medical education program sponsored by Strong Memorial Hospital of the University of Rochester ("Strong"). The residents in the internal medicine training program rotated among the four hospitals, including Genesee Hospital ("Genesee"), which closed on May 10, 2001. Following Genesee's closure, Rochester sent a letter dated September 27, 2001 to its assigned Medicare contractor, National Government Services, Inc. ("Medicare Contractor"),[2] to request a temporary increase in the number of fulltime resident rotations for which it could be reimbursed by Medicare. The Medicare Contractor denied Rochester's request as untimely. Rochester appealed the Medicare Contractor's denial from its FY 2001 and 2002 Notices of Program Reimbursement ("NPR's") dated May 25, 2004 and November 3, 2005 respectively, and met the jurisdictional requirements for a Board hearing.

The Board held a hearing on June 8, 2016. Albert J. Lucas, Esq., of Calfee, Halter & Griswold, LLP represented Rochester. Joe Bauers, Esq., of Federal Specialized Services represented the Medicare Contractor.

STATEMENT OF THE FACTS

Rochester, Highland, and Genesee hospitals participated in a resident training program sponsored by Strong. The closure of Genesee necessitated the reassignment and transfer of residents training at Genesee to other hospitals.[3]

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[1] Transcript ("Tr.") at 6-7.
[2] Formerly known as Fiscal Intermediaries, CMS' payment and audit function under the Medicare program are now contracted to organizations known as Medicare Administrative Contractors. However, the term "intermediary" is still used in various statutes and regulations, and is interchangeable with the terms "Medicare Administrative Contractor" or "Medicare Contractor".
[3] Stipulations at ¶ 5.

By letter dated June 28, 2001, Strong, the training program operator, notified the Medicare Contractor of Genesee's closure and of the reassignment of residents to "Strong Memorial and Highland Hospitals" with specific increases in the caps for these two hospitals.[4] An attachment to this letter listed the relocated residents for Strong and Highland hospitals as well as specific FTEs for each of the hospitals for each of four years—2001 to 2005. Regarding Rochester (then known as "Via Health,"), the letter did not request a specific FTE cap increase for Rochester for these years, but the attachment listed the relocated residents assigned to Rochester identifying additional FTEs for each year. The letter which was signed by Strong's Senior Director for Finance stated that he would "like to set up a time to review this as well as an aggregate cap agreement between Strong Health and Via Health [*i.e.*, Rochester]."[5] In a subsequent letter dated September 27, 2001 and signed by Rochester's Senior Vice President, Rochester made a specific request for an FTE cap increase for each of the four years—2001 to 2005.[6] Rochester explains that it provided the necessary information regarding the cap increase to the Medicare Contractor as soon as it could, given that it was dependent upon university staff to obtain necessary demographic information needed to file the request to the Medicare Contractor.[7]

Nonetheless, Rochester argues that the Strong letter sufficiently informed the Medicare Contractor of Genesee's closure and "of the training rotations that would be re-assigned to Rochester General as a result…"[8] Rochester further argues that Strong was the operator of the training program and was solely responsible for assigning resident rotations and the distribution of the additional FTEs. As such, Rochester contends that Strong took responsibility for requesting the cap adjustment from the Medicare Contractor.[9] Additionally, Rochester argues that it provided an affiliation agreement to the Medicare Contractor which detailed the distribution of FTEs in the event that Genesee ceased its operations, but the Medicare Contractor rejected this agreement because it had been signed after Genesee ceased operating. [10]

Finally, Rochester also argues that the September 27, 2001 letter provided sufficient information, summarizing the additional training rotations expected to be incurred by each hospital as a result of the Genesee closure. Based on this communication with the Medicare Contractor, Rochester maintains that it complied with the notice requirements and cites *Mercy Catholic Med. Ctr. v. Thompson* 380 F. 3d 142 (3rd Cir. 2004) to argue that the Medicare Contractor inappropriately rejected counting the additional FTEs based on a "technicality."[11]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Federal law at 42 U.S.C. §§1395ww(h)(4)(F) and 1395ww(d)(5) limits payment for the direct graduate medical education ("DGME") and indirect medical education ("IME") costs of a hospital that trains residents by placing a "cap" on the number of residents' FTEs that a hospital

[4] Provider's Supplemental Position Paper, Provider Exhibit P-5
[5] *Id.*
[6] *Id.*, at Provider Exhibit P-6; Medicare Contractor Exhibit I-7.
[7] Provider's Final Position Paper at 6.
[8] Provider's Supplemental Position Paper at 9.
[9] Tr. at 59-60.
[10] Tr. at 54:5-17. *See also* Provider's Supplemental Position Paper, Provider Exhibit P-10.
[11] Provider's Post-hearing Brief at 8.

may claim on its cost report.[12] A hospital may receive a temporary adjustment to this number, referred to as a "temporary cap increase exception," where a hospital takes on additional residents as a result of another hospital's closure where "closure" means "the hospital terminates its Medicare agreement under the provisions of [42 C.F.R.] § 489.52."[13] However, a hospital may receive this temporary adjustment to its FTE cap to reflect the additional residents only if the hospital meets the following criteria delineated in 42 C.F.R. § 413.86(g)(8)(ii) (2001):

> (A) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.
> (B) *No later than 60 days after the hospital begins to train the residents*, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.[14]

Rochester states that it met the above-cited regulatory requirements for a temporary increase to its FTE cap. Specifically, Rochester maintains that the June 28, 2001 Strong letter was a sufficient request for temporary cap increase, that letter was submitted to the Medicare Contractor within 60 days after it began training the re-assigned residents, and that the attachment to the letter identified the residents who came from the closed hospital.[15]

Based on its review of the record, the Board finds that Rochester did not timely request a cap adjustment as required by 42 C.F.R. § 413.86(g)(8)(ii). The evidence in the record indicates that the June 28, 2001 letter was submitted by Strong and did not specifically request a cap adjustment for Rochester. Rather, the letter indicated that there would be a subsequent conversation about Rochester's cap adjustment. Further, the letter did not specify the length of time that the cap extension would be needed. Although the attachment apparently listed the transferred residents, this list did not include the number of additional FTEs being requested by Rochester.[16] Thus, due to the specific fact pattern established in this case, the Board cannot find that the Strong letter met the full set of requirements in § 413.86(g)(8)(ii) in order for it to qualify as an acceptable and timely request for a temporary cap increase for Rochester. While Rochester's subsequent letter dated September 27, 2001 may have met these requirements, the letter was not submitted within the 60-day period mandated by regulation. Therefore, the Board concludes that Rochester did not timely comply with the regulatory requirements to receive a temporary cap adjustment.

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[12] *See also* 42 C.F.R. §§ 412.105(f)(1)(iv), 413.79(c)(2)(i).
[13] 42 CFR § 413.86(g)(8) (2001). This regulation was amended and recodified at 42 CFR § 413.79(h) in 2004. *See* 69 Fed. Reg. 48916, 49158 (Aug 11, 2004).
[14] (Emphasis added.)
[15] 42 C.F.R. § 413.86(g)(8)(ii).
[16] Provider's Supplemental Position Paper, Exhibit P-5 at 13-20, and Provider Exhibit P-6 at 2-6.

DECISION

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Board finds that the Medicare Contractor properly disallowed the request for a Temporary Cap Increase Exception for FYs 2001 and 2002 for Rochester in accordance with 42 C.F.R. § 413.86(g)(8).

BOARD MEMBERS PARTICIPATING

L. Sue Andersen, Esq.
Clayton Nix, Esq.
Charlotte Benson, CPA
John Ahern, MBA, CHFP
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FOR THE BOARD

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: September 19, 2017