PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2012-D24

PROVIDER -
Swedish American Hospital
Rockford, Illinois

Provider No.: 14-0228

vs.

INTERMEDIARY -
Wisconsin Physicians Service-
(formerly Mutual of Omaha Insurance Company)

DATE OF HEARING -
April 4, 2012

Cost Reporting Periods Ended -
May 31, 2004; May 31, 2005;
May 31, 2006; May 31, 2007

CASE NOs.: 07-0624; 08-0441;
08-2005 and 09-0768

INDEX

ISSUE:

Whether the Intermediary's adjustments reducing the 1996 base year IME/GME FTE[1] count for osteopathic and allopathic medicine interns and residents and their effect on the May 31, 2004 through May 31, 2007 FTE counts are correct.

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 under Title XVIII of the Social Security Act, as amended (Act), to provide health insurance to the aged and disabled. The Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare and Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to organizations known as fiscal intermediaries ("FIs") and Medicare Administrative Contractors ("MACs").[2] FIs and MACs determine payment amounts due the providers under Medicare law, regulation, and under interpretive guidelines published by CMS.[3]

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to the Medicare program.[4] The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement ("NPR").[5] 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.[6] Other relevant laws, regulations and related documents are presented as follows.

THE BALANCED BUDGET ACT OF 1997

In 1997, Congress enacted the Balanced Budget Act of 1997 ("BBA").[7] Among other things, BBA changed the way in which FTE residents were counted for purposes of calculating the IME adjustment and GME payments for teaching hospitals.

BBA capped the number of allopathic and osteopathic residents that a hospital could count for purposes of calculating the IME adjustment and GME payments. Specifically, BBA § 4623 provided that a hospital's total number of FTE residents in the fields of allopathic and

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[1] IME = Indirect Medical Education
GME = Graduate Medical Education
FTE = Full Time Equivalent

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

[3] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

[4] 42 C.F.R. § 413.20.

[5] 42 C.F.R. § 405.1803.

[6] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1839.

[7] Pub. L. No. 105-33, 111 Stat. 251 (1997).

osteopathic medicine in a hospital or nonhospital setting could not exceed the number of FTE residents with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996 ("FTE Resident Cap").[8] BBA § 4621(b)(1) also specified that, for the IME adjustment, the FTE resident cap applies to discharges occurring on or after October 1, 1997 and, for GME payments, the FTE resident cap applies to cost reporting periods beginning on or after October 1, 1997.[9] Furthermore, these BBA provisions provided the Secretary with rulemaking authority to implement the FTE resident caps.

August 29, 1997 Final Rule

In order to implement BBA §§ 4621(b)(1) and 4623, CMS promulgated regulations as part of the final rule for the hospital inpatient prospective payment system ("IPPS") for FY 1998 published on August 29, 1997 ("August 1997 Final Rule").[10]

For purposes of GME, the August 1997 Final Rule set forth the FTE resident cap at then 42 C.F.R. § 413.86(g)(4), which stated, in pertinent part, the following:

> For purposes of determining direct graduate medical education payment, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count for residents in allopathic and osteopathic medicine may not exceed the hospital's unweighted FTE count for these residents for the most recent cost reporting period ending on or before December 31, 1996.[11]

Consistent with BBA § 4621(b)(1), the August 1997 Final Rule also added the FTE resident cap for IME at then 42 C.F.R. § 412.105(f)(1)(iv), which read as follows:

> Effective for discharges occurring on or after October 1, 1997, the total number of full-time equivalent residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting that meets the criteria listed in paragraph (f)(1)(ii) of this section may not exceed the number of such full-time equivalent residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.[12]

In addition, as part of the August 1997 Final Rule, CMS promulgated 42 C.F.R. § 413.86(g)(6) and (7) to specify certain limited circumstances under which a hospital could adjust its FTE resident cap for direct GME upward after establishing a new medical residency training program, including a new program located in a rural area.[13]

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[8] Codified at 42 U.S.C. § 1395ww(h)(4)(F)-(H).
[9] Codified at 42 U.S.C. §§ 1395ww(d)(5)(B)(v)-(viii).
[10] 62 Fed. Reg. 45966 (Aug. 29, 1997). Unrelated corrections to the August 29, 1997 Final Rule were made at 62 Fed. Reg. 47237 (Sept. 8, 1997) and 62 Fed. Reg. 49049 (Sept. 18, 1997).
[11] 62 Fed. Reg. at 46034-46035.
[12] *Id.* at 46029.
[13] *Id.* at 46035.

Furthermore, the August 1997 Final Rule also granted affiliated groups the ability to aggregate their FTEs for purposes of the FTE resident cap for direct GME. Specifically, as promulgated under the August 1997 Final Rule, 42 C.F.R. § 413.86(g)(4) stated:

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

The following definition of the term "affiliated group" was promulgated at 42 C.F.R. § 413.86(b):

> *Affiliated group* means two or more hospitals located in the same geographic wage area (as that term is used under part 412 of this subchapter for the prospective payment system) in which individual residents work at each of the hospitals seeking to be treated as an affiliated group during the course of the approved program; or, if the hospitals are not located in the same geographic wage area, the hospitals are jointly listed as major participating institutions for one or more programs as that term is used in *Graduate Medical Education Directory, 1997-1998.*[14]

May 12, 1998 Final Rule

In the IPPS Final Rule for FY 1999 published on May 12, 1998 ("May 1998 Final Rule"),[15] CMS responded to comments on the direct GME and IME provisions of the August 1997 Final Rule. CMS also made various revisions to 42 C.F.R. § 413.86 for direct GME. In particular, CMS revised the definition of an "affiliated group" at 42 C.F.R. § 413.86(b) so that it read as follows:

> *Affiliated group* means–
> (1) Two or more hospitals located in the same urban or rural area (as those terms are defined in §412.62(f) of this subchapter) or in contiguous areas if individual residents work at each of the hospitals during the course of the program; or
>
> (2) If the hospitals are not located in the same or a contiguous urban or rural area, the hospitals are jointly listed–
>
> (i) As the sponsor, primary clinical site or major participating institution for one or more of the programs as these terms are used in *Graduate Medical Education Directory, 1997-1998*; or
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> (ii) As the sponsor or under "affiliations and outside rotations" for one or more programs in operation in *Opportunities,*

[14] *Id.* at 46034.
[15] 63 Fed. Reg. 26318 (May 12, 1998).

Directory of Osteopathic Postdoctoral Education Programs.

(3) The hospitals are under common ownership.[16]

In addition, as part of the May 1998 Final Rule, CMS promulgated 42 C.F.R. § 412.105(f)(1)(vi) to state the following with respect to affiliated groups for IME purposes:

> Hospitals that are part of the same affiliated group (as described in §413.86(b)) may elect to apply the limit at paragraph (f)(i)(iv) of this section on an aggregate basis.[17]

In the preamble to the May 1998 Final Rule, CMS described the conditions under which two or more hospitals must enter into an agreement to aggregate their FTEs as an affiliated group. Specifically, CMS stated:

> In summary, we will apply the FTE caps for an affiliated group as follows:
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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 [affiliation] 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.
> - Each agreement must be made for a minimum of one year and may specify the adjustment to each respective hospital cap under an aggregate cap in the event the agreement terminates, dissolves or, if the agreement is for a specified time period, for residency training years and cost reporting periods subsequent to the period of the agreement. In the absence of an agreement on the FTE caps for each respective institution following the end of the agreement, each hospital's FTE cap will be the IME and direct GME FTE count from each hospital's cost reporting periods ending in 1996.
> - Each agreement must specify that any positive adjustment for one hospital must be offset by a negative adjustment for the other hospital of at least the same amount.
> - The original agreements must be signed and dated by representatives of each respective hospital that is a party to the agreement and that agreement must be provided to the hospital's fiscal intermediary with a copy to the HCFA. Copies of agreement that each hospital which is part of the

[16] *Id.* at 26358.
[17] *Id.* at 26357.

> original agreement has with other hospitals must also be attached.
> - 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.
>
> 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 based on its hospital specific FTE count. 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 based on its FTE cap as adjusted per agreements.[18]

Finally, in the preamble to the May 1998 Final Rule, CMS also addressed a scenario where a hospital began training additional residents after its cost reporting period ending during 1996 because another hospital closed or discontinued its teaching programs during the July 1996 through June 1997 residency year. Specifically, CMS stated the following with respect to that scenario:

> Similar to the situation of a merger, we agree that, when a hospital takes on residents because another hospital closes or discontinues its program, a temporary adjustment to the [FTE resident] cap is appropriate and consistent with the base year system. In these situations, residents may have partially completed a medical residency training program and would be unable to complete their training without a residency position at another hospital. We believe that it is appropriate to allow temporary adjustments to the FTE caps for a hospital that provides residency positions to medical residents who have partially completed a residency training program at a hospital which closed.
>
> For purposes of this final rule we will allow for temporary adjustment to a hospital's FTE cap to reflect residents affected by a hospital closure. That is, we will allow an adjustment to a hospital's FTE cap if the hospital meets the following criteria: (1) During the July 1996-June 1997 residency year the hospital assumed additional medical residents from a hospital that was closing; (2) The hospital added the residents with the intent of allowing them to complete their education program; and (3) The hospital that closed does not seek reimbursement for the residents. As stated above, this adjustment will be temporary to allow Medicare payment for those residents from the closed hospital.

[18] *Id.* at 26341.

> After this period, the hospital's cap will be based solely on the statutory base year. Hospitals seeking an adjustment for this situation must document to their intermediary that an adjustment is warranted for this purpose and the length of time that the adjustment is needed.[19]

However, CMS did not specifically incorporate these requirements into regulation in 1998 at then 42 C.F.R. §§ 413.86 or 412.105 for a hospital to adjust its FTE resident caps when it temporarily assumed additional residents due to another hospital closing or discontinuing its teaching program.

AUGUST 1, 2001 FINAL RULE

In the IPPS Final Rule for FY 2002 published on August 1, 2001 (August 2001 Final Rule),[20] CMS revised 42 C.F.R. § 413.86(g)(8) to establish provisions for a hospital to temporarily adjust its FTE resident cap when a hospital assumes the training of additional residents because another hospital closed its residency teaching program. Specifically, the August 2001 Final Rule revised § 413.86(g)(8) to specify that, if a hospital that closes its residency training program agrees to temporarily reduce its FTE resident cap according to the criteria specified in § 413.86(g)(8)(i)(B) and (g)(8)(iii)(B), another hospital could receive a temporary adjustment to its FTE resident cap for direct GME to reflect residents added because of the closure of the residency training program if the criteria at then 42 C.F.R. § 413.86(g)(8) are met.[21] CMS incorporated similar provisions, in the August 2001 Final Rule, for IME at then 42 C.F.R. § 412.105(f)(1)(ix). CMS stated that the foregoing adjustment provisions would only be applicable to cost reporting periods (for direct GME) and discharges (for IME) beginning on or after October 1, 2001.[22]

August 1, 2002 Final Rule

In the IPPS Final Rule for FY 2003 published on August 1, 2002 (August 2002 Final Rule),[23] CMS sought to clarify the requirements for hospitals participating in an affiliated group. Specifically, the August 2002 Final Rule revised the definition of the term "affiliation agreement" at 42 C.F.R. § 413.86(b).[24] In addition, the August 2002 Final Rule revised 42 C.F.R. §§ 413.86(g)(4)(iv) and 413.86(g)(7) to clarify the requirements for a hospital to receive a temporary adjustment to its FTE resident cap for direct GME through an affiliation agreement.[25] CMS incorporated similar provisions at 42 C.F.R. § 412.105(f)(1)(vi) for purposes of the FTE resident cap for IME.[26]

In the August 2002 Final Rule, the Secretary also made a change in policy pertaining to the FTE resident cap adjustments and the termination of affiliation agreements. CMS recognized that, in

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[19] *Id.* at 26330.
[20] 66 Fed. Reg. 39828 (Aug. 1, 2001).
[21] *Id.* at 39937-39938.
[22] *Id.* at 39933-39934.
[23] 67 Fed. Reg. 49982 (Aug. 1, 2002).
[24] *Id.* at 50119.
[25] *Id.* at 50120.
[26] *Id.* at 50112.

the preamble to the May 1998 Final Rule, CMS stated the following policy for affiliation agreements:

> Each agreement must also specify the adjustment to each respective hospital cap in the event the agreement terminates, dissolves, or, if the agreement is for a specified time period, for residency training years and cost reporting periods subsequent to the period of the agreement for purposes of applying the FTE cap on an aggregate basis.[27]

In the preamble to the August 2002 Final Rule, CMS articulated the reason for revising this policy, in part, as follows:

> [E]xisting policy allows affiliated hospitals to redistribute their FTE caps (within the limits of the aggregate FTE caps) upon the termination of the affiliation agreement in order to enable hospitals by agreement to more closely reflect the realities of the residency rotational arrangement. However, we proposed to change this policy because we believed that it was susceptible to abusive practices such as the formation of affiliation agreements solely for the purposes of obtaining permanent adjustments to FTE caps.[28]

In addition, in the preamble, CMS described how its policy change is consistent with statutory provisions addressing FTE resident caps and Congressional intent.[29] Thus, in the August 2002 Final Rule, CMS revised C.F.R. §§ 413.86(g) and 412.105(f) to specify that, when an affiliation agreement terminates, the FTE resident cap of each hospital in the affiliated group will revert back to the individual hospital's pre-affiliation FTE resident cap.[30]

CMS's change in policy was applied prospectively to terminations of affiliation agreements that terminated on or after October 1, 2002.[31]

MMA Redistribution of Unused FTEs

While the Medicare program makes GME payments and IME adjustments taking into account a hospital's FTE resident caps, Congress recognized that some hospitals were training allopathic and osteopathic residents in excess of their FTE resident caps. Congress also recognized that other hospitals had reduced their resident counts to some level below their FTE resident caps. Therefore, in § 422 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA),[32] Congress added 42 U.S.C. § 1395ww(h)(7), as described below, to provide for

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[27] *Id.* at 50070 (quoting 63 Fed. Reg. at 26339).
[28] *Id.* 50075.
[29] *Id.*
[30] *Id.* at 50112 and 50119-50120 (promulgating 42 C.F.R. §§ 412.105(f)(1)(vi) and 413.86 (g)(7)(v) respectively).
[31] *Id.* at 50076.
[32] Pub. L. No. 108-173, 117 Stat. 2066, 2284-2287 (2003).

the one-time redistribution of "unused" FTE resident positions in the fields of allopathic and osteopathic medicine.

In general, a hospital's "reference resident level" is its resident level for the most recent cost reporting period ending on or before September 30, 2002, for which a cost report has been settled (or, if not, submitted).[33] Specifically, § 1395ww(h)(7)(A) provided for a hospital's FTE resident cap to be reduced if its "reference resident level" was less than the otherwise applicable resident limit (FTE resident cap). The reduction was equal to 75 percent of the difference between the hospital's otherwise applicable FTE resident cap and its reference resident level.[34]

Section 1395ww(h)(7)(B)(i) authorizes the Secretary to increase the otherwise applicable FTE resident cap for certain qualifying hospitals for portions of cost reporting periods occurring on or after July 1, 2005, by a number not to exceed the estimated aggregate reduction in FTE resident caps for all hospitals under § 1395ww(h)(7)(A). However, § 1395ww(h)(7)(B)(iv) imposes a limit on redistributions by specifying that a single hospital cannot receive an increase in its FTE resident caps of more than 25 FTEs.

In determining which hospitals would receive FTE resident cap increases, § 1395ww(h)(7)(B)(ii) and (iii) directed the Secretary to: (1) take into account the demonstrated likelihood of a hospital filling the additional positions within the first 3 cost reporting periods beginning on or after July 1, 2005; and (2) to distribute resident slots in an established priority order: first, to programs in hospitals located in rural areas; second, to hospitals located in urban areas that are not large urban areas; and third, to other hospitals in a State where there is no other residency training program for a particular specialty in the State.

To implement MMA § 422, CMS promulgated regulations and issued related guidance on the one-time FTE redistribution process.[35] Hospitals seeking to obtain additional FTEs under this one-time FTE redistribution process had to apply to CMS by December 15, 2004.[36]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Swedish American Hospital ("Provider") was an acute care hospital complex located in Rockford, Illinois. Wisconsin Physicians Service[37] ("Intermediary") was the Provider's Medicare fiscal intermediary. The Provider and Intermediary have agreed that the position papers and exhibits found in Case Number 07-0624 will be used as the record for deciding all

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[33] *See* 42 U.S.C. § 1395ww(h)(7)(A)(ii)(I). Under certain circumstances and upon a timely request, a teaching hospital's cost reporting period that includes July 1, 2003 could be used for determining the "reference resident level." *See* 42 U.S.C. § 1395ww(h)(7)(A)(ii)(II).

[34] 42 U.S.C. § 1395ww(h)(7)(A)(i)(I).

[35] *See, e.g.*, 69 Fed. Reg. 48916 (Aug. 11, 2004); 69 Fed. Reg. 69536 (Nov. 30, 2004); CMS Pub. 100-20, Transmittal No. 77 (April 30, 2004); CMS Pub. 100-20, Transmittal No. 87 (May 26, 2004); CMS Pub. 100-20, Transmittal No. 92 (July 2, 2004); CMS Pub. 100-20, Transmittal No. 127 (Dec. 3, 2004).

[36] *See* 69 Fed. Reg. at 69536 (Nov. 30, 2004); 69 Fed. Reg. at 49115-49116 (excerpt at Intermediary Exhibit I-17). However, if a hospital's resident level was audited for purposes of 42 U.S.C. § 1395ww(h)(7)(A), a hospital's application for additional FTEs had to be received by CMS on or before May 1, 2005.

[37] Formerly Mutual of Omaha.

four cases in this appeal and all references to exhibits in this decision can be found in the record of Case Number 07-0624 unless specifically noted.

The Intermediary made final determinations on the Provider's Medicare cost reports for the fiscal years ending (FYEs) May 31, 2004, May 31, 2005, May 31, 2006 and May 31, 2007.[38] As part of these determinations, the Intermediary adjusted the IME/GME FTE cap to reflect the interns and residents FTEs at the hospital during the Provider's May 31, 1996 base year cost reporting period. The Provider filed timely requests for hearing before the Board as indicated below:

FYE	Date of Intermediary Determination	Date Hearing Request Filed	GME/IME FTE Cap Audit Adjustment Numbers	Provider's Estimated Reimbursement Impact
5-31-04	9-22-06	1-09-07	21 and 29	$968,059
5-31-05	9-21-07	12-26-07	23 and 28	$933,800
5-31-06	2-22-08	5-23-08	38	$822,972
5-31-07	10-29-08	1-28-09	23 and 27	$1,028,253

The Provider participated with the University of Illinois, College of Medicine at Rockford ("University") in the Family Practice Residency Program ("FPR Program"). An agreement between the Provider and University was in effect for the audit of the Provider's base year ending May 31, 1996.[39] The Intermediary established a cap of 12.38 FTE residents for the IME program and 15.05 FTE residents for the GME program.[40]

During this same period of time, Saint Anthony Medical Center (St. Anthony), another hospital located in Rockford, Illinois, similarly had an agreement with the University concerning the FPR Program. The Intermediary audited St. Anthony's FTE base year ending September 30, 1996 and established a cap of 6.42 FTE residents for the IME program and 8.42 FTE residents for GME program.[41] St. Anthony's resident rotation schedules and IRIS reports for FYE September 30, 1996[42] reflect this resident count. St. Anthony did not claim any FTEs for training interns and residents after its FYE September 30, 1996 cost report. In addition, St. Anthony is not listed as a participant in the FPR Program in the *ACGME Directory* after the 1995-1996 academic year.[43]

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[38] The Provider claimed the FTEs in controversy as protested amounts in FYEs May 31, 2004, May 31, 2005, May 31, 2006, and May 31, 2007. *See* Provider's Request for Appeal (Case Nos. 07-0624, 08-0441, 08-2005, and 09-0768).

[39] *See* Intermediary Exhibit I-1.

[40] *See* Intermediary Exhibit I-2.

[41] *See* Intermediary Exhibit I-3.

[42] *See* Intermediary Exhibit I-20.

[43] *See* Intermediary Exhibit I-26.

St. Anthony and the Provider did not have an affiliated group agreement. In June of 1996, St. Anthony withdrew from the FPR Program. The Provider absorbed the residents that were a part of the St. Anthony program. It is these St. Anthony residents and their related FTE cap and count that are at the core of this appeal.

The Provider was represented by Charles F. MacKelvie, Esq., of Krieg DeVault LLP. The Intermediary was represented by Byron Lamprecht of Wisconsin Physicians Service.

PROVIDER'S CONTENTIONS:

The Provider believes that, in an earlier case involving FYEs prior to those at issue in this case,[44] "the PRRB, the Secretary and the Court misapplied the relevant law and failed to adhere to the standards on whether the Secretary's decision was correct in light of the . . . BBA . . . Conference Committee Report on affiliation and whether the Intermediary's/PRRB's/Secretary's final decisions were arbitrary, capricious and contrary to both law and facts." [45] In particular, the Provider asserts that the Secretary ignored Congress' intent under BBA that in some circumstances, the Secretary should permit an aggregate limit of GME/IME resident slots rather than a per facility limit.[46]

The Provider argues that St. Anthony could not possibly have been able to affiliate with the Provider at any time subsequent to July 1, 1996 because, in June 1996, St. Anthony resigned as a sponsoring institution with ACGME and did not retain the FTE slots.[47] Further, the Provider asserts that it was administratively unfeasible to enter into an affiliation agreement with other hospitals to increase the number of aggregate slots subsequent to December 31, 1996.[48]

The Provider asserts that the portions of the county it is located in and two neighboring counties are "Medically Underserved Areas containing Medically Underserved Populations." As such the Provider argues that the Secretary was required to provide special consideration to programs established to serve rural undeserved areas pursuant to 42 U.S.C. § 1395ww(h)(4)(H)(i) as added by BBA § 4623.[49]

The Provider argues that it was training all of St. Anthony's residents by September 30, 1996 and that the Intermediary should have adjusted St Anthony's and the Provider's 1996 FTE cap to account for the residents that were shifted from St. Anthony to the Provider.[50] Further, the Provider asserts that there were a significant number of unused resident slots in the U.S. notwithstanding the FTE caps and that it "did not assume OSF St. Anthony's resident slots but merely claimed the number of residents on its costs reports that the U of I-Rockford's [FPR] Program was accredited for."[51]

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[44] *See Swedish Amer. Hosp. v. Sebelius*, 773 F.Supp.2d 1 (D.D.C. 2011), *aff'g* PRRB Decision No. 2008-D45 (Sept. 30, 2008), *Administrator declined review* (Nov. 17, 2008).
[45] Provider's Supplemental Final Position Paper at 2.
[46] *See id.*
[47] *See id.* at 4, 8-9.
[48] *See id.* at 9.
[49] *See id.* at 10.
[50] *See id.* at 11.
[51] *See id.* at 13.

The Provider asserts the Intermediary gave explicit approval for the Provider to increase its 1996 FTE caps for GME/IME slots for the Provider's 1999-2003 fiscal years.[52]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the GME/IME FTE caps were applied as established pursuant to BBA. The Intermediary argues that there is no regulation that would allow St. Anthony's FTE cap and count to be permanently transferred to the Provider regardless of any agreements between the Provider and St. Anthony. The regulatory provisions at 42 C.F.R. § 413.86(g)(4) became effective October 1, 1997, which is after the June 30, 1996 closure of St. Anthony and it cannot be applied retroactively to this situation.[53]

The Provider could not have been part of an affiliated group since residents did not rotate to other hospitals after October 1, 1997. In situations where hospitals no longer have a relationship for training residents and do not meet the criteria for being a member of an affiliated group, CMS allows the FTE cap based on 1996 FTE counts. When a relationship is terminated, the FTE cap for each hospital reverts back to its respective 1996 FTE count. The Intermediary notes that St. Anthony continues to be a Medicare participating provider even though it discontinued its GME/IME education program. The Intermediary asserts that St. Anthony could reinstate or create a new GME/IME education program and use its established FTE cap.[54]

The Provider did not ask to be part of an affiliated group as required by the May 1998 Final Rule. Since St. Anthony did not terminate its participation in the Medicare program, it could have reinstated its residency training program or affiliated with other hospitals. Furthermore, the regulation that addresses the temporary transfer of FTE caps, 42 C.F.R. § 413.86(g)(8)(ii)(B), became effective October 1, 2001 and, as a result, it does not apply to this case. In addition, the Provider never requested a temporary adjustment of its FTE resident caps nor could it have received such an adjustment.[55]

The Provider's allegations that the Intermediary had advised it that the proposed arrangement was allowable in principle are unfounded. The Provider has no evidence that: (1) the Intermediary granted explicit approval for a "composite base year FTE count"; (2) a lack of an adjustment in prior periods can be construed to mean explicit approval; or (3) the Intermediary purposely waited until the time frame had elapsed for the Provider to request a redistribution of additional GME FTEs.[56]

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, parties' contentions and evidence submitted, the Board finds and concludes that the Intermediary properly reduced the Provider's 1996 base year FTE resident IME/GME counts for osteopathic and allopathic medicine.[57] In examining the facts in this

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[52] *See id.* at 11; Provider Exhibit P-52 at 8.
[53] *See* Intermediary Final Position Paper at 13-14.
[54] *See id.* at 17-20.
[55] *See id.* at 19-20.
[56] *See id.* at 21-22.
[57] The Board's findings are consistent with the Board's decision for this same Provider addressing FYEs in previous years. *See Swedish Amer. Hosp. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2008-D45 (Sept. 30, 2008),

case, the Board finds that the Provider did not meet any of the various requirements of the Medicare regulations that would have allowed it to include St. Anthony's IME/GME FTE cap and count in its totals.

AFFILIATED GROUP

The August 1997 Final Rule provided for affiliation agreements among parties and the related allocation of FTEs to the members of the affiliated group. The Board notes that the Provider, St. Anthony, and the Board of Trustees of the University of Illinois entered into an affiliation agreement with an execution date of March 15, 1991.[58] The affiliation agreement was limited to the FPR Program.

Several years later, on February 13, 1995, the administrator/CEO of St. Anthony notified the University[59] that its participation in the FPR Program would cease on or about June 30, 1996. This notice complied with the terms of the March 15, 1991 affiliation agreement.

The University and the Provider executed a new affiliation agreement that was effective July 1, 1996.[60] There was no other party to the new agreement. This new agreement made no allowance for another hospital's residents or caps to be shared.

Finally, the Provider has conceded that St. Anthony could not possibly have been able to affiliate with the Provider at any time subsequent to July 1, 1996. Once St. Anthony resigned as a sponsoring institution with ACGME, it could not hold any FTE slots. Therefore, in reviewing these documents as well as the record as a whole, the Board finds no evidence that would allow St. Anthony's IME/GME FTE cap and count to be included with the Provider's count based upon an affiliation agreement during the time at issue pursuant to the applicable regulations.

REDISTRIBUTION OF UNUSED IME/GME RESIDENTS FTE CAP

The Provider has argued that it was injured by the Intermediary's inappropriate guidance, and as a result, it missed an opportunity to receive additional FTEs as part of the one-time redistribution of unused FTEs specified in MMA § 422.[61] The Provider contends that, as a result of the Intermediary's guidance, it missed the December 15, 2004 regulatory deadline to apply for additional FTEs as part of the one-time FTE redistribution process for the purpose of increasing its IME/GME FTE cap. The Board is sympathetic to the Provider's plight. However, pursuant to 42 C.F.R. § 405.1867, in exercising its legal authority, the Board must comply with the Act, regulations, and CMS rulings. The Provider has conceded that it missed the regulatory deadline to apply for additional FTEs as part of the one-time FTE redistribution process specified in MMA § 422. This regulatory deadline is located in 42 C.F.R. § 413.70(c)(4) (2004) and requires "the hospital [to] submit an application to CMS within the timeframe specified by CMS." Consistent

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Administrator declined review (Nov. 17, 2008), *aff'd*, *Swedish American Hospital v. Sebelius*, 773 F.Supp.2d. 1 (D.D.C. 2011), and *denying reconsideration*, Civ. Action No. 08-2046(RMU), 2012 WL 640796 (D.D.C. Feb. 29, 2012).

[58] *See* Provider Exhibit 40.

[59] *See* Provider Exhibit 29.

[60] *See* Provider Exhibit 38.

[61] *See* Provider Exhibit P-52 at 9, 13-14.

with § 413.70(c)(4), CMS set the regulatory deadline for December 1, 2004 and later extended this regulatory deadline to December 15, 2004 as published in the final rules dated August 11, 2004 and November 30, 2004 respectively. The Board is bound by this regulatory deadline and cannot grant the relief the Provider seeks from this regulation.

RURAL FACILITIES SERVING MEDICALLY UNDERSERVED

The Provider asserts it is located in "Medically Underserved Areas containing Medically Underserved Populations." As such the Provider argues the Secretary was required to provide special consideration to programs established to serve rural undeserved areas. The Board finds that 42 U.S.C. § 1395ww(h)(4)(H)(i) entitled "NEW FACILITIES" and as added by BBA § 4623 does allow for special consideration of "facilities that meet the needs of underserved rural areas" and that such special consideration is limited to "new facilities" which serve "underserved rural areas."

However, the Board agrees with District Court's finding in the previous year appeal that the Provider was neither a "new program" nor a rural facility. Specifically, the District Court stated:

> Next, the plaintiff argues that Rockford, Illinois, the location of SAH, is a rural area, mandating the defendant's "special consideration." Pl.'s Mot. for Recons. at 8–9. To support its argument, the plaintiff asserts that there is no "contra evidence in the record that portions of Rockford, Illinois, Winnebago, Boone and Ogle Counties, Illinois were not (and are not) rural areas in 1997." *Id.* at 9. The plaintiff further argues that SAH "participate[d] in a [University of Illinois] Family Practice Rural Tracking Program in rural Ogle County, [Illinois]." *Id.*
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> [T]he plaintiff nonetheless misconstrues both the facts and the regulations. The defendant may indeed give special consideration to rural hospitals under 42 C.F.R. § 413.86(g)(6)(iii) and adjust the FTE reimbursement cap upwards if a hospital creates "additional new programs *but not [if it] expan[ds] ... existing or previously existing programs.*" 42 C.F.R. § 413.86(g)(6)(iii) (emphasis added). A "new program" is defined as "a new 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. § 413.79(l). Here, the plaintiff's program began in the 1970's, *see* Pl.'s Mot. for Summ. J. at 1, rendering it an existing program—not a new program—and therefore the defendant was not required to give the plaintiff special consideration as a rural hospital.
>
> Additionally, the relevant question is not whether SAH and the University of Illinois define themselves as a "rural" area, as the plaintiff contends, but whether the regulations define the location of SAH as such. 42 C.F.R. § 412.62(f)(iii). The regulations in place during 1997 define Rockford as part of a "metropolitan statistical area" or an "urban area." *See* 61

> Fed.Reg. 46166, 46261 (Aug. 30, 1996) (noting that Rockford, Boone, Ogle, and Winnebago, Illinois are part of the same metropolitan statistical area); 42 C.F.R. § 412.62(f)(ii)-(A) (stating that "[t]he term urban area means ... [a] Metropolitan Statistical Area"); *see also Heartland Reg'l Med. Ctr. v. Leavitt,* 511 F.Supp.2d 46, 54 (D.D.C.2007) *aff'd sub nom. Heartland Reg'l Med. Ctr. v. Sebelius,* 566 F.3d 193 (D.C.Cir.2009) (stating that "this court has already held that the [Metropolitan Statistical Area]-based definition of urban area was not contrary to [the] statutory authority [of the defendant]"). Thus, by definition, Rockford could not have been considered a "rural area" during 1997. 42 C.F.R. § 412.62(f)(iii) (stating that "[t]he term rural area means any area outside an urban area"). Accordingly, the plaintiff fails to present any reason for this court to provide relief upon reconsideration, and the court denies the plaintiff's motion.[62]

The Board believes that the District Court's finding applies equally to the Provider's argument in this case. As a result, the Board finds that the Provider is not entitled to additional IME/GME FTEs as a "new facility" that meets the needs of "underserved rural areas."

TEMPORARY CAP ADJUSTMENT FOR CLOSED PROGRAMS:

The Board notes that the prior District Court decision remanded the question of whether the Provider met the "Temporary Cap Increase Exception" found in the May 1998 Final Rule;[63] 42 C.F.R. § 413.86(g)(8)(1999); 42 C.F.R. §§ 413.86(g)(8) and 412.105(f)(1)(ix) (2001); and the August 2001 Final Rule.[64] Therefore, the Board will address this issue for purposes of this case.

The "Temporary Cap Increase Exception" is allowed in order to assist displaced residents to complete their education program.[65] The Board finds the displaced residents were in a three year program.[66] As a result, the temporary cap increase to assist the residents complete their education, if applicable, would have applied to the residency years ended June 30, 1997 through June 30, 1999 for any residents that the Provider absorbed as of September 30, 1996. As these fiscal years are prior to the periods at issue in this appeal, the Board finds that the "Temporary Cap Increase Exception" provides no legal basis to increase the Provider's FTE cap.

In addition, the Board finds the "Temporary Cap Increase Exception" promulgated as part of the May 1998 Final Rule[67] only applied to residents that were displaced through the closure of a hospital. The May 1998 version of the Temporary Cap Increase Exception was in effect from June 1998 through September 30, 2001. The Board finds it is uncontested that St. Anthony's did not close its hospital but only the residency training program. The regulation applicable to this period defines a closure as follows: "(iii) For purposes of paragraph (g)(8) of this section, 'closure' means

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[62] *See Swedish Amer. Hosp.,* 2012 WL 640796 at *5.
[63] 63 Fed. Reg. at 26330.
[64] 66 Fed. Reg. at 39899-39901. *See Swedish Amer. Hosp.,* 773 F.Supp.2d. at 14.
[65] *See* 63 Fed. Reg. at 26330; 42 C.F.R. § 413.86(g)(8)(1999); 42 C.F.R. §§ 413.86(g)(8) and 412.105(f)(1)(ix) (2001); 66 Fed. Reg. at 39899-901.
[66] *See* Intermediary Exhibit I-1.
[67] *See* 63 Fed. Reg. at 26318, 26330; 64 Fed. Reg. at 41490, 41522; 42 C.F.R. § 413.86(g)(8)(1999).

the hospital terminates its Medicare agreement under the provisions of § 489.52 of this chapter."[68] The Board finds the Provider does not qualify under the May 1998 version of Temporary Cap Increase Exception because St. Anthony's closure of its residency training program does not meet the hospital "closure" requirement for the period prior to October 1, 2001.

The August 2001 Final Rule expanded the "Temporary Cap Increase Exception" for closure of another hospital's program, without the requirement that the hospital itself be closed.[69] This benefit was effective for direct GME for cost reporting periods beginning on or after October 1, 2001 and for IME with discharges beginning on or after October 1, 2001.[70] The Board finds this August 2001 change in the regulation is not applicable because any of the displaced residents would have completed their training prior to October 1, 2001.

Based on the above, the Board finds the "Temporary Cap Increase Exception" does not apply to the Provider for the years under appeal in this case.

OTHER ALLEGATIONS

The Provider alleges that the Intermediary misled it into believing that St. Anthony's FTE cap count could be included in the Provider's count. Even if this allegation were true, the Board's authority is bound by the application of the Medicare regulations as they relate to evidence presented by the parties.[71]

Although the Provider presented a preponderance of evidence to document its takeover of St. Anthony's residency training program and these documents were informative and show the history and relationships of the parties, the Board finds none of this evidence relevant. The Board is bound by the Medicare law relative to how the FTE resident count for the 1996 base year should be reflected and reported for each hospital. The Board finds that the Provider's FTE resident cap should reflect only its 1996 FTE resident count, and that St. Anthony's 1996 FTE count remains assigned to it upon the termination of its relationship with the Provider and the University on June 30, 1996.

DECISION AND ORDER:

The Intermediary properly applied and used the 1996 base year IME/GME FTE cap for the Provider only. The Intermediary's adjustments are affirmed.

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[68] 42 C.F.R. § 413.86(g)(8)(iii)(1999).

[69] *See* 66 Fed Reg. at 39899-39901.

[70] *See* 66 Fed Reg. 39899-39901. *See also* 42 C.F.R. §§ 413.86(g)(8), 412.105(f)(1)(ix) (2001).

[71] The Board notes the District Court's finding in prior years appealed by this Provider held that the Secretary "cannot be estopped from recovering Medicare funds provided to the plaintiff [Provider] based on erroneous advice provided by the fiscal intermediary." *See Swedish Amer. Hosp.*, 773 F.Supp.2d. at 8.

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