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|  | Whether the determination of Weighted Resident Full-Time Equivalents (FTE’s) for Direct Graduate Medical Education (DGME) is correct. |

A. Facts

The Medicare Administrative Contractor (MAC) issued a Revised Notice of Program Reimbursement (RNPR) to the Provider on July 28, 2022. (**Exhibit C-1**) The MAC’s Notice of Reopening of Cost Report, dated April 7, 2022, notified the Provider that the cost report was being reopened to review the 2018 Percent Reduction to Medicare Advantage (MA) Direct Graduate Medical Education (DGME) payments per Change Request 12596. (**Exhibit C-2**). On January 24, 2023, the Provider filed a timely appeal of the RNPR, which revised the 2018 MA DGME percent reduction on Worksheet E-4, Line 29.01, Column 2.01 from 7.00 percent to 4.12 percent in accordance with Change Request 12596, 42 C.F.R. § 413.76(d) and CMS Pub. 15-2, Section 4034. See **Exhibit C-3** for the final reopened adjustment report.

Based on the Provider’s issue statement, the Provider’s appeal centers around the Court’s finding in *Milton S. Hershey Medical Center v. Becerra*, No. 19-2680 (D.D.C. 2021) and the conforming changes enacted in the August 10, 2022, Federal Register which applies prospective and retroactive revisions to the method of calculating DGME payments to teaching hospitals when those hospitals’ weighted FTE counts exceed the DGME FTE cap.

The Provider’s appeal request states:

Bellevue protests and appeals the application of the prior version of CMS regulation 42 C.F.R. § 413.79(c)(2)(iii), with respect to the calculation of Bellevue’s weighted resident FTEs for FYE 2018, and asserts that the current version of that regulation should have been applied instead. As CMS described in the preamble to the proposed revised rule (87 Fed. Reg. 28108), this revision was in direct response to the Court’s finding in *Milton S. Hershey Medical Center, et al. v. Becerra*, Slip Op., 2021 WL 1966572 (D.D.C. May 17, 2021) that, under that prior version of the regulation, the “proportional reduction that CMS applied to the weighted FTE count when the weighted FTE count exceeded the FTE cap….impermissibly modified the weighting factors statutorily assigned to residents and fellows.” *Id*. at 28112-28113.

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On August 10, 2022, CMS “finalize[ed] the proposed policy and regulations text at 42 C.F.R. § 413.79(c)(2)(iii)…..” 87 Fed. Reg. 48780, 79072. CMS also reported at that time that “In response to comments, we are also making a conforming change to the regulations text at 42 C.F.R. § 413.79(d)(3) regarding application to the 3-year rolling average to state that for cost reporting periods beginning on or after October 1, 2001, the hospital’s weighted FTE counts for the preceding two cost reporting periods are calculated in accordance with the payment formula at § 413.79(c)(2)(iii).” *Id*. (**Exhibit C-4**.)

Congress recognized that various categories of expenses, including certain medical education expenses, are more appropriately reimbursed through separate payment methodologies. Specifically, Congress created an add-on to the Diagnosis Related Group (DRG) based inpatient Prospective Payment System (PPS) to address the added costs of being a teaching hospital, the indirect medical education (IME) adjustment, and a separate payment for direct graduate medical education (DGME) expenses. The Medicare statute requires the Secretary of Health and Human Services (Secretary) to reimburse hospitals for the Medicare share of the costs they directly incur when providing graduate medical education training programs for physicians. 42 U.S.C. § 1395ww(h). These costs include the salaries of teaching physicians and stipends paid to resident physicians. *See* S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965); H.R. No. 213, 89th Cong., 1st Sess. 32 (1965).

The Medicare statute sets forth a formula for computing a hospital's DGME payment in a given year. 42 U.S.C. § 1395ww(h). The statutory formula consists of three components: (1) the hospital's number of full-time equivalent (FTE) residents or "FTE count", (2) the hospital's average cost per resident (i.e.,the per resident amount, or PRA) and (3) the hospital's Medicare patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A beneficiaries. *Id.* The Secretary has implemented a regulation for calculating the number of FTEs that a hospital can count in a given year. In this appeal, the Provider does not dispute the actual unweighted or weighted FTE counts of its individual residents in the current, prior or penultimate years, but disputes the ***formula*** used to calculate the total allowable weighted FTEs in each year.

In accordance with 42 U.S.C. § 1395ww(h)(4)(F)(i) **(Exhibit C-5, pg. 4)**, for cost reporting periods “beginning on or after October 1, 1997, … the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital’s approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number … of such full time equivalent residents for the hospital’s most recent cost reporting period ending on or before December 31, 1996.”[[1]](#footnote-1) This is known as the hospital’s “FTE Cap.” If a hospital trains residents in excess of its cap, the difference will not be counted towards the hospital’s DGME payment for the year.

Next, in accordance with 42 U.S.C. § 1395ww(h)(4)(C), the number of FTE residents is calculated by applying a weighting factor. Residents who are in their initial residency period[[2]](#footnote-2) (IRP) are weighted as 1.0 FTE and residents who are over their IRP are weighted as 0.50 FTEs. Residents who are over their IRP are commonly referred to as “fellows.” The summation of a hospital’s residents, based on their IRP’s, is the hospital’s weighted FTE count.

Finally, for cost reporting periods beginning during fiscal years on or after October 1, 1997, the total number of FTEs for determining the DGME payment shall equal the average of the actual FTE resident counts for the cost reporting period and the preceding two cost reporting periods, i.e. “the rolling average.” 42 U.S.C. § 1395ww(h)(4)(G)(i). So in sum, a hospital’s current year FTE count, after applying the weighting factors and the FTE cap, is averaged with the corresponding FTE counts from the prior year (PY) and penultimate year (PPY). This result is the number of FTEs the hospital can claim for reimbursement in the current year.

The Provider contends that appealing its FYE 2018 DGME reimbursement from the last RNPR dated July 28, 2022, creates an open appeal that would qualify for the application of the policies and regulations adopted and expressly given retroactive effect in the August 10, 2022, Federal Register.

The MAC is challenging jurisdiction over the Provider’s appeal. The MAC contends that the single issue in dispute, Determination of Weighted Resident FTE’s for DGME, was beyond the scope of the RNPR, which was issued to correct the 2018 reduction to MA DGME payments per Change Request 12596, and thus there was no final determination for the Weighted Resident FTE’s for DGME in the subject RNPR. Even though the MAC contends the Board does not have jurisdiction over the appeal, the MAC will still address the Provider’s arguments in its preliminary position paper. The MAC contends that since the Provider is disputing the ***formula*** used to calculate the allowable FTEs and not the allowability of the actual FTEs, the MAC requests that it be able to file a supplemental position paper once clarification of final instructions from CMS is communicated.

B. Arguments

1. **The Allowable FTE Formula is Properly Promulgated**

In accordance with 42 U.S.C. § 1395ww(h)(4)(A), “The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time equivalent residents in an approved medical residency training program.” **(Exhibit C-5, pg. 3)** The Secretary established these rules at 42 C.F.R. § 413.79(c)(2)(iii) **(Exhibit C-6, pg. 3)**. Specifically, the regulation states,

If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section, the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

This regulation is the subject of the Provider’s dissatisfaction because the regulation further reduces a hospital’s weighted FTE count in cases in which a hospital trains residents above its cap level.[[3]](#footnote-3) Based on the regulation, the allowable FTE count is calculated as:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Allowable FTE Count | **=** | Unweighted FTE Cap Unweighted FTE Count | X | Weighted FTE Count |

The Provider does not agree that the ratio of the Unweighted 1996 DGME FTE Cap to the Unweighted current year total DGME FTEs should be applied to the current year Weighted DGME FTEs. The Provider contends that the regulation actively penalizes hospitals for training fellows above their cap. This “fellow penalty” is created because fellows are weighted as 0.50 FTEs and when the weighted FTE count is multiplied by the unweighted cap to current year FTE count ratio, the fellows 0.50 weight is further reduced. This “penalty” does not apply to residents that are within their IRPs because the weighted and unweighted FTE counts are the same. The Provider has found that as it continues to expand at a greater rate the number of residents enrolled in subspecialty programs (which in most cases are completed after the resident’s initial residency period), that its reimbursement related to DGME decreases.

The Provider contends that the Secretary’s formula is in violation of the Medicare statute, as interpreted by both the *Hershey* court and most recently by CMS in the August 10, 2022, Final Rule. However, the statute does not include a specific methodology for computing the DGME payments, except that the DGME payments should be made based on a 3-year rolling average count of weighted residents. The statute specifically says, “The Secretary shall establish rules … for the computation of the number of full-time-equivalent residents in an approved medical residency training program.” 42 U.S.C. § 1395ww(h)(4)(A) **(Exhibit C-5, pg. 3)** The Secretary did just that when s/he promulgated 42 C.F.R. § 413.86(g)(4)(iii) on October 1, 1999.[[4]](#footnote-4) Therefore, the MAC contends that the Secretary’s formula was based on a permissible construction of the statute.

1. **The Board is Bound by 42 C.F.R. § 405.1867**

The Board does not have the authority to grant relief to the Provider because it is bound by the regulation at 42 C.F.R. § 405.1867, which states,[[5]](#footnote-5)

In exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS. (**Exhibit C-7**)

The regulation at 42 C.F.R. § 413.79(c)(2)(iii) was finalized in the Federal Register at 66 FR 39893-39896 on August 1, 2001 **(Exhibit C-8, pp. 2-5)**. The Federal Register states,

3. Determining the 3-Year Rolling Average for Direct GME Payments (§ 413.86(g)(4) and (g)(5))

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The new methodology is effective for cost reporting periods beginning on or after October 1, 2001. The methodology for determining a hospital’s direct GME payment is as follows:

*Step 1.* Determine that the hospital’s total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital’s FTE cap for these residents in accordance with § 413.86(g)(4). If the hospital’s total unweighted FTE count in a cost reporting period exceeds its cap, the hospital’s weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The proportional reduction is calculated *for primary care and obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:

(FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)

plus

(FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).

Add the two products to determine the hospital’s reduced cap. (Emphasis added.)

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Whether the proposed methodology results in a payment difference for a hospital is dependent upon whether or not the number and mix (primary care and nonprimary care) of FTEs changes in a 3-year period. If the number and mix of FTEs does not change in a 3-year period, there would be no difference in a direct GME payment amount derived using the proposed methodology versus the existing methodology.

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If the number and mix of FTEs varies from year to year, there will be a difference in the results of the two methodologies. In some instances the existing methodology would result in a higher payment, and in other instances the proposed methodology would result in a higher payment.

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In a scenario where a hospital makes larger reductions to the number of FTEs, the proposed methodology may be more beneficial.

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We proposed to revise § 413.86(g)(4) to specify that, effective for cost reporting periods beginning on or after October 1, 2001, if the hospital’s total unweighted FTE count in a cost reporting period exceeds its cap, the hospital’s weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. We also proposed to revise § 413.86(g)(5) to specify that, effective for cost reporting periods beginning on or after October 1, 2001, the direct GME payment will be calculated using two separate rolling averages, one for primary care and obstetrics and gynecology residents and one for nonprimary care residents.

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*Response:* The proposed new methodology would *replace* the existing rolling average methodology effective for cost reporting periods beginning on or after October 1, 2001 (the effective date of this final rule). Hospitals training both primary care and nonprimary care residents would determine two separate rolling average counts; one for primary care and one for nonprimary residents.

*Comment:* One commenter stated: ‘‘although the new rolling average methodology is difficult and complex, its impact on GME programs is far from clear.’’ The commenter asked how much change in resident number and mix is necessary before this new methodology has an effect on payment, and stated that more examples would be helpful in determining this effect. The commenter also expressed hope that, if this change is finalized, we will revisit this issue after implementation and fully examine and analyze its impact on teaching program payment.

*Response:* As we explained in the proposed rule, whether the new methodology results in a payment difference for a hospital is dependent upon whether or not the ratio of primary care to nonprimary care FTEs changes in a 3-year period. If the ratio of the FTEs does not change over the 3-year period, there would be no difference in a direct GME payment amount derived using the new methodology versus the existing methodology. In particular, there would be an increase in direct GME payment under the revised methodology, where a hospital’s proportion of primary care residents to nonprimary care residents over the last 3 years is higher than the hospital’s proportion of primary care residents to nonprimary care residents in the current year. As this new rolling average methodology is implemented, we intend to evaluate hospitals’ direct GME payments to further analyze the impact of using this methodology. (Emphasis added)

Based on 42 C.F.R. § 405.1867, the Board must comply with the published regulation at 42 C.F.R. § 413.79 and as a result, the Board does not have the authority to revise the ***formula*** used to calculate the allowable FTEs. Reference the Board’s decisions in *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, PRRB Dec. No. 2017-D11, dated March 27, 2017, and *Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, PRRB Dec. No. 2017-D12, dated March 28, 2017.

The MAC contends that the Provider's reopened cost report correctly calculated the ratio of the Unweighted 1996 DGME FTE Cap to the Unweighted Current Year DGME FTEs, and then correctly applied this ratio to the Current Year Weighted DGME FTE Count to determine the current year allowable FTEs in accordance with the August 1, 2001, Final Rule.

The MAC does note that changes to DGME policies are in process. After reviewing the statutory language regarding the direct GME full-time equivalent (FTE) cap and the court’s opinion in *Milton S. Hershey Medical Center v. Becerra*, No. 19-2680 (D.D.C. 2021)**(Exhibit C-9**), a Final Rule was issued in 87 FR 49065-49072 (August 10, 2022) (**Exhibit C-10**), which finalized a modified policy to be applied prospectively for all teaching hospitals, as well as retrospectively for certain provider and cost years. The modified policy addresses situations for applying the FTE cap when a hospital’s weighted FTE count is greater than its DGME FTE cap but would not reduce the weighting factor of residents that are beyond their initial residency period to an amount less than 0.50. Specifically, for cost reporting periods beginning on or after October 1, 2001, if the hospital’s unweighted number of FTE residents exceeds the FTE cap, and the number of weighted FTE residents also exceed that FTE cap, the respective primary care and obstetrics and gynecology weighted FTE counts and other weighted FTE counts are adjusted to make the total weighted FTE count equal the FTE cap. If the number of weighted FTE residents does not exceed that FTE cap, the allowable weighted FTE count for direct GME payment is the actual weighted FTE count. Before proceeding with resolution of this issue, the MAC is awaiting final clarifications of instructions from CMS.

1. **The Issue Appealed is Beyond the Scope of the Final Determination in the Revised Notice of Program Reimbursement**

The MAC is challenging jurisdiction over the Provider’s appeal of the RNPR dated July 28, 2022. The Notice of Reopening of Cost Report, dated April 7, 2022, notified the Provider that the cost report was being reopened to review the 2018 Percent Reduction to Medicare Advantage (MA) Direct Graduate Medical Education (DGME) payments per Change Request 12596. **(Exhibit C-2).** The MAC revised the 2018 MA DGME percent reduction on Worksheet E-4, Line 29.01, Column 2.01 from 7.00 percent to 4.12 percent in accordance with Change Request 12596 (**Exhibit C-11**), 42 C.F.R. § 413.76(d), and CMS Pub. 15-2, Section 4034.The RNPR did not include adjustments for the weighted FTE counts for DGME and thus the MAC contends there was no MAC final determination made for the issue appealed.

As discussed above, the issue on appeal in the present case is whether the MAC has properly calculated the Weighted Resident FTEs for DGME in accordance with the Court Ruling in *Milton S. Hershey Medical Center v. Becerra*, No. 19-2680 (D.D.C. 2021) (**Exhibit C-9**) which was promulgated in the August 10, 2022, Federal Register (**Exhibit C-10**).

The RNPR, issued July 28, 2022, adjusted the 2018 reduction to MA DGME payments per Change Request 12596. Change Request 12596, issued on February 4, 2022, corrected the calendar year (CY) 2018 percent reduction to direct GME MA payments that were updated per Change Request 11642, issued December 14, 2020. (*See* **Exhibit C-11** for Change Request 12596 and **Exhibit C-12** for Change Request 11642)

Change Request 11642 states:

Section 541 of the Balanced Budget Refinement Act (BBRA) of 1999 (P.L. 106-113), and section 512 of the Benefits Improvement and Protection Act (BIPA), (P.L. 106-554), instituted Medicare+Choice nursing and allied health payments for portions of cost reporting periods occurring on or after January 1, 2000. CMS last provided instructions to the Medicare Administrative Contractors (MACs) on May 23, 2003, in the form of Transmittal A-03-043, CR 2692, for the purpose of making the Calendar Year (CY) 2001 nursing and allied health Medicare+Choice payments. This CR provides MACs with instructions on how to compute and/or reconcile these payments for CYs 2002 through 2018, as applicable.

(**Exhibit C-12**, **pg. 3**)

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In conjunction with the additional payments for nursing and allied health programs, the BBRA provided that payments that are made to teaching hospitals for costs of direct GME associated with services to MA enrollees will be reduced by an estimated percentage in each CY. Specifically, the law provides that the estimated reductions in MA direct GME payments must equal the estimated total additional MA nursing and allied health education payments.

(See Attachment A for these amounts). Accordingly for portions of cost reporting periods occurring in a calendar year, all hospitals that receive MA direct GME payments (including those that do not receive additional nursing and allied health payments under the BIPA provision) will have these payments reduced by the percent reduction stated in Attachment A. (This percent reduction occurs on CMS-2552-96 lines 6.05 and 6.08 of Worksheet E-3 Part IV, and CMS-2552-10, line 30, of Worksheet E-4).

(**Exhibit C-12, pg. 7**)

Attachment A of Change Request 11642 reflects the percent reduction to MA DGME payments for CY 2018 as 7.00 percent. (**Exhibit C-12, pg. 15**)

Change Request 12596, issued February 4, 2022, states:

Change Request 11642 (Transmittal 10315, originally issued August 21, 2020 as updated most recently by Transmittal 10520, issued December 14, 2020) provided instructions to MACs for computing calendar year (CY) 2002 through 2018 nursing and allied health education Medicare Advantage (N&AH MA) payments to qualifying hospitals, along with the applicable CY percent reduction to be made to a teaching hospital’s direct GME MA payment. Change Request 11642 included Attachment A, which contained the applicable N&AH factors and direct GME MA percent reductions for CYs 2002 through 2018. We have found that the direct GME MA percent reduction included in Attachment A for CY 2018 of 7.00 percent is incorrect. The purpose of this Change Request is to revise the CY 2018 percent reduction to direct GME MA payments to 4.12 percent. All other amounts in Attachment A for CY 2018 and other years remain unchanged.

(**Exhibit C-11, pg. 3**)

The regulations at 42 C.F.R. § 405.1835(a) provide details on the right to a hearing, stating in part:

1. Right to hearing on final contractor determination. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if –
2. The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. *Exception*: If a final contractor determination is reopened under § 405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§ 405.1887(d), 405.1889(b), and the “Exception” in § 405.1873(c)(2)(i)).
3. The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
4. Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

(**Exhibit C-13**) (emphasis added)

Under 42 U.S.C. § 1395oo(a)(1)(A)(i), any provider which has filed a cost report within the time specified may obtain a hearing by the Board if such provider:

is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished . . .

(**Exhibit C-14**)

The regulations at 42 C.F.R. § 405.1889 provide further details on the right to a hearing pursuant to a RNPR. Specifically, 42 C.F.R. § 405.1889 states:

(a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

(**Exhibit C-15**) (emphasis added)

Further, as addressed in the regulations at 42 C.F.R. § 405.1887(d):

(d) A reopening by itself does not extend appeal rights. Any matter that is reconsidered during the course of a reopening, but is not revised, is not within the proper scope of an appeal of a revised determination or decision (as described in § 405.1889 of this subpart).

(**Exhibit C-16**)

These regulations make it clear, and the Board has confirmed in prior decisions, that a provider can only appeal items that are specifically adjusted from a RNPR.[[6]](#footnote-6) The 9th Circuit reached a similar conclusion in *Anaheim Memorial Hospital v. Shalala*, 130 F.3d 845 (9th Cir. 1997):

If Anaheim were allowed to treat the entire [routine cost limits] as a single, giant issue, a change in the way the RCL is applied to any single cost item would open the entire schedule to challenge. This would defeat the purpose of the statute of limitations on challenges to the initial NPR. See 42 U.S.C. § 1395oo(a), (b); 42 C.F.R. § 405.1841(b); French Hospital, 89 F.3d at 1420 (“[A]llowing a provider to appeal any issue in a revised NPR would nullify the 180-day deadline for appealing the initial NPR.”). Like the litigant in French Hospital, Anaheim has already had the opportunity to appeal the CDCA [national average of covered days of care] factor and chose not to do to. Id. at 1422. Anaheim may not use a reopening of its cost report on an unrelated issue as a back door to walk through the statute of limitations on its appeal of the CDCA factor.[[7]](#footnote-7)

More recently, the Board in *San Francisco General Hospital,[[8]](#footnote-8)* found it lacked jurisdiction where the specific issue on appeal was not adjusted in the RNPR. The provider in *San Francisco General Hospital* appealed from a revised cost report that had been reopened in response to a request for SSI realignment. The Board found:

[T]hat it does not have jurisdiction over the Accuracy of CMS Developed SSI Ratio and the DSH Inclusion of Medicare Part C Days in the SSI Ratio issues for San Francisco General Hospital that were appealed from the March 12, 2019 *revised* NPR. The Board finds that the Provider’s revised NPR did not adjust either issue. Adjustment Nos. 4 and 6 on the Provider’s audit adjustment report related to the revised NPR were to revise the SSI percentage and DSH percentage based on the latest CMS letter of SSI percentage realignment which were based on the Provider’s request to CMS. This realigned SSI percentage only adjusted the total number of SSI days from being calculated based on the federal fiscal year to being calculated based on the cost reporting fiscal year. Neither the flaws and inaccuracies of the CMS matching process, nor the question regarding the inclusion of Part C days in the SSI fraction were part of the cost report revision.

Accordingly, the scope of the RNPR adjustments at issue in this appeal was limited to the payment reduction of the MA DGME payments in accordance with Change Request 12596. The weighting of FTE’s for DGME was not identified for revision in CR 12596 and a review of the respective adjustment report confirms that the specific item on appeal was neither addressed nor specifically adjusted. Accordingly, there was no final determination for the weighting of FTE counts in the DGME payments at issue and the RNPR falls outside the scope of this appeal.

C. Conclusion

The MAC requests that the Board dismiss the Provider’s appeal in accordance with 42 C.F.R. § 405.1887(d) and 42 C.F.R. § 405.1889. The Provider takes its appeal from an RNPR, which did not include a final determination regarding the specific item at issue – i.e., Determination of Weighted Resident FTE’s for DGME. Therefore, the RNPR challenged falls outside the scope of the issue appealed. Further, as the Provider is disputing the ***formula*** used to calculate the allowable FTEs and not the allowability of the actual FTEs, in the event the Board determines that it has jurisdiction over this appeal, the MAC requests additional time for clarification of final instructions from CMS to be communicated.

IV. LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

Law:

42 U.S.C. § 1395oo(a)(1)(A)(i) Provider Reimbursement Review Board;42 U.S.C. § 1395ww(h) Payments to hospitals for inpatient hospital services-Payments for Direct Graduate Medical Education Costs;Pub. L. 105-33, § 4623 The Balanced Budget Act of 1997

Regulations:

42 C.F.R. § 413.76(d) Direct GME payments: Calculation of payments for GME costs;42 C.F.R. § 413.79(c)(2)(iii) formerly 42 C.F.R. § 413.86(g)(4)(iii) Direct GME payments: Determination of the weighted number of FTE residents;42 C.F.R. § 405.1835(a) Right to Board hearing: contents of, and adding issues to, hearing request42 C.F.R. § 405.1867 Scope of Board’s legal authority42 C.F.R. § 405.1887(d) Notice of reopening: effect of reopening;42 C.F.R. § 405.1889 Effect of a revision: issue-specific nature of appeals of revised determinations and decisions

Federal Registers:

66 FR 39893-39896 August 1, 2001;87 FR 49065-49072 August 10, 2022

Program Instructions:

CMS Pub. 15-2, Section 4034;Worksheet E-4 – Direct Graduate Medical Education and ESRD Outpatient Direct Medical Education Costs

Case Law:

*Anaheim Memorial Hospital v. Shalala*, 130 F.3d 845 (9th Cir. 1997);*Milton S. Hershey Medical Center v. Becerra,* No. 19-2680 (D.D.C. 2021)

Other:

Transmittal 10520, Change Request 11642 Updates to Nursing and Allied Health Education Medicare Advantage Payment Policies;Transmittal 11248, Change Request 12596 Nursing and Allied Health Medicare Advantage Payment – Revision to CY 2018;*University Health System (UHS),* PRRB Case No. 11-0056, PRRB Jurisdictional Decision (May 9, 2012);*Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, PRRB Dec. No. 2017-D11 (March 27, 2017);*Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, PRRB Dec. No. 2017-D12 (March 28, 2017);*San Francisco General Hospital*,PRRB Case No. 19-2550, PRRB Jurisdictional Decision (April 15, 2020)

V. EXHIBITS

C-1 Revised Notice of Program Reimbursement

C-2 Notice of Reopening of Cost Report dated April 7, 2022

C-3 Reopening Audit Adjustment Report

C-4 Provider’s Issue Statement from Appeal Request dated January 24, 2023

C-5 42 U.S.C. § 1395ww(h)

C-6 42 C.F.R. § 413.79

C-7 42 C.F.R. § 405.1867

C-8 66 FR 39893-39896 (August 1, 2001)

C-9 *Milton S. Hershey Medical Center v. Becerra,* No. 19-2680 (D.D.C. 2021)

C-10 87 FR 49065-49072 (August 10, 2022)

C-11 Transmittal 11248, Change Request 12596

C-12 Transmittal 10520, Change Request 11642

C-13 42 C.F.R. § 405.1835

C-14 42 U.S.C. § 1395oo

C-15 42 C.F.R. § 405.1889

C-16 42 C.F.R. § 405.1887

C-17 *University Health System (UHS)*, PRRB Case No. 11-0056, PRRB Jurisdictional Decision (May 9, 2012)

C-18 *Anaheim Memorial Hospital v. Shalala*, 130 F.3d 845 (9th Cir. 1997)

C-19 *San Francisco General Hospital*, PRRB Case No. 19-2550, PRRB Jurisdictional Decision (April 15, 2020)

1. *See* also The Balanced Budget Act of 1997, Pub. L. 105-33, § 4623, 111 Stat. 251, 477-78 (1997) [↑](#footnote-ref-1)
2. Initial residency period means the period of time it takes to become Board certified in a specialty. The initial residency period is determined at the time the resident first enters the residency training program and shall not exceed five years, unless otherwise specified. 42 U.S.C. § 1395ww(h)(5)(F) and (h)(5)(G)(i). [↑](#footnote-ref-2)
3. This regulation only applies when a hospital reports residents in excess of its cap level. If the unweighted FTE count is less than or equal to the cap, the weighted FTEs are not reduced. [↑](#footnote-ref-3)
4. 42 C.F.R. § 413.86(g)(4)(iii) was redesignated as 42 C.F.R. § 413.79(c)(2)(iii) in 2004. [↑](#footnote-ref-4)
5. As of 10/1/2022. [↑](#footnote-ref-5)
6. *See* *University Health System (UHS),* PRRB Case No. 11-0056, PRRB Jurisdictional Decision (May 9, 2012) at **Exhibit C-17**. [↑](#footnote-ref-6)
7. *See* *Anaheim Memorial Hospital v. Shalala*, 130 F.3d 845 (9th Cir. 1997) at **Exhibit C-18**. [↑](#footnote-ref-7)
8. *See* *San Francisco General Hospital*,PRRB Case No. 19-2550, PRRB Jurisdictional Decision (April 15, 2020) at **Exhibit C-19***.* [↑](#footnote-ref-8)