Whether the formula for calculating the number of full-time equivalent (FTE) residents a hospital may count in a year for purposes of direct graduate medical education (DGME) reimbursement is unlawful?

1. **Facts**

The issue presented in this appeal is whether the formula at 42 CFR 413.79(c)(2)(iii) for calculating the number of full time equivalent (“FTE”) residents a hospital may count in a year for the purposes of direct graduate medical education reimbursement is unlawful insofar as it penalizes hospitals that train fellows (i.e., residents who are not in their initial residency period) while operating in excess of their FTE caps. The Provider maintains that this formula is unlawful and seeks relief in the form of an adjustment to its FTE count for its present, prior and penultimate years. However, the provider’s preliminary paper did not address the changes proposed to the regulation with the FFY 2023 Final Rule (Exhibit C-6).

The statement raises two questions to consider at the outset. One is more process/procedurally oriented. The second is on the merits as to whether the formula is in fact unlawful. The limit on residents that can be used in Direct Graduate Medical Education (DGME) payments is generally referred to as the Cap.

As presented in the issue statement, the Provider challenges a formula embedded in the DGME regulation. The Provider is not alleging that the MAC misapplied the formula or used incorrect inputs. That being the starting point, the PRRB lacks the authority to rewrite the formula and change the final weighted resident count as it is bound by 42 CFR 405.1867. **The Provider did not consider in its preliminary paper the impact of the FFY 2023 Final Rule.** Otherwise, an appropriate action would be to proceed under the Expedited Judicial Procedures in 42 CFR 405.1842. However, it is not the MAC’s role to initiate the EJR process.

As to the argument on the merits that the formula unfairly penalizes hospitals that train fellows, the MAC disagrees. The formula recognizes the statutory difference in the weighting or FTE count value for “fellows” as compared to residents in their initial residency period (IRPs). An IRP is considered a 1.0 FTE and a fellow as 0.5 or half. The higher the ratio of “fellows” to “IRPs”, the lesser is the “weighted” count. That is the simple mathematical application of Medicare law.

The Cap is a product of 42 U.S.C. 1395ww(h)(4)(F)(i):

**(F) Limitation on number of residents in allopathic and osteopathic medicine**

**For purposes of a cost reporting period 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 and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full time equivalent residents for the hospital’s most recent cost reporting ending on or before December 31, 1996.**

To neutrally restate the Cap law for allopathic and osteopathic physician trainees not in a rural area, the law can be fairly paraphrased as:

The total number of FTEs before application of weighting factors with respect to approved training program may not exceed the number of unweighted FTEs for the hospital’s most recent cost reporting period ending on or before Dec 31, 1996.

Key to the MAC analysis here is that the law did not say “the total number of FTEs allowed before application is equal to the number of unweighted FTEs in the base period.” Nevertheless, that is how the Providers want the law read. However, the weighting factors determined what the final FTE count was in the base year, so the actual weighting or mix of “fellows” and IRPs must be a factor in all future Cap years.

The weighting differences between fellows and IRPs is also a product of law and predates the imposition of the Cap. The law is at 42 USC 1395ww(h)(4)(C):

**In calculating the number of full time equivalent residents in an approved residency program…**

**(ii) for a resident who is in the residency period… the weighting factor is 1.00, …**

**(iv) for a resident who is not in the resident’s initial residency period… the weighting factor is .50**.

While (iv) above does not specifically use the term “fellow” it is understood that the reference is physicians seeking some specialized advance certification. They have completed an initial residency period.

The point is that the down-weighting of fellows as compared to IRPs is a product of statute. It was not a limitation on the Cap setting extra-legally added by CMS or its predecessor agency HCFA when the Cap was imposed. It was a factor in establishing allowable FTEs long before the implementation of the Cap.

A further factor affecting the FTE count in a post 1996 Cap year is the 3-year rolling average imposed by 42 USC 1395ww(h)(4)(G) (i);

**[T]he total number of full-time equivalent residents for determining a hospital’s graduate medical education payment shall equal the average of the actual full time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.**

The controlling regulations were promulgated as part of the FFY 1997 rule making process and designated as 42 CFR 413.86 (g)(4) and (5):

**(413.86(g)(4) 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. If the hospital’s number of residents exceeds the limit described in this paragraph (g), the hospital’s weighted FTE count (before application of the limit) 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.…**

The second sentence in the regulation quoted above contains the formula being challenged. The formula can be expressed in the following equation:

Current Year Unweighted 1996 FTE Cap

Allowable FTE Count = Unweighted Current Yr. FTE Count

x Weighted Current Yr. FTE Count

To calculate the allowable resident count and execute the formula, CMS has developed a cost report instruction (CMS Pub 15-2, Section 4034) and a cost report worksheet (Worksheet E-4). (See Exhibit C-3 for a sample Worksheet E-4 for the FYE in controversy). Providers are not arguing that the Worksheet E-4 conflicts with the regulation’s formula.

Next in play in the Provider’s FTE Count is the 3-year rolling average imposed by 42 CFR 413.86(g)(5)

**…For cost reporting periods beginning on or after October 1, 1998, the hospital’s weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods.**

There was a change in 42 CFR 413.86 effective for FFY 2001. In applying the weighted FTE count, there was a further mathematical step that separated primary care and OB/GYNE residents as a group from non-primary care residents. Later, in FFY 2004, 42 CFR 413.86 was re-designated as 42 CFR 413.79. Notwithstanding these actions, the operation of the formula under attack had not changed at the time of the NPRs.

Instead of focusing its arguments on the allowable resident count in the FYE in dispute, the Providers use simplified examples. The MAC will do the same. The examples the MAC will use come first from the Rule Making process.

On June 7, 2023, the MAC conferred with the provider regarding the FFY 2023 Final Rule’s change to the regulations at 42 C.F.R. § 413.79(c)(2)(iii) and 42 C.F.R. § 413.79(d)(3). The Provider agrees that the implementation following the updated regulation may result in the administrative resolution of these cases.

1. **Arguments**
2. **Regulation Prior to FFY 2023 Final Rule**

On August 29, 1997 at 62 FR 45966 the HEALTH CARE FINANCING ADMINISTRATION (HCFA) published a final rule with comment period in part to implement the DGME Cap recently enacted in the Balanced Budget Act of 1997. It is in the preamble where the issue is first developed. (Exhibit C-4). In 2001, the agency name changed to CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS). Appropriate following references will be to CMS.

The discussion of the Cap application starts at 62 FR 46004

**(1) Counting Residents based on a 3- year average (413.86(g)(5))**

**Section 1886(h) of the Acts added by section 4623 of Public Law 105-33, provides that for the hospital’s first cost reporting period beginning on or after October 1, 1997, the hospital’s weighted FTE count for payment purposes equals the average of the weighted FTE count for that cost reporting period and the preceding cost reporting period. For cost reporting periods beginning on or after October 1, 1998, section 1886(h)(4)(G) of the act requires that hospitals’ direct medical education weighted FTE count for payment purposes equals the average of the actual weighted FTE count for payment purposes equal the average of the actual weighted FTE count for the payment year cost reporting period and the preceding 2 cost reporting periods. This provides incentives for hospitals to reduce the number of residents in training by phasing in the associated reduction in payment over a 3-year period. We are revising 413.86(g)(5) accordingly.**

**For cost reporting periods beginning on or after October 1, 1997, we will determine the hospital’s direct GME payments as follows:**

The preamble goes on to identify four steps to determine the final total Medicare DGME payments. Step one, which is the step at issue, is to determine the 3 year weighted rolling average. Steps two, three and four which are described starting in the left column at 62 FR 46005 in the exhibit are not part of the dispute.

The point of the debate is starting to emerge in step one. Once the 3-year rolling weighted average is calculated, what is it compared against? The Providers argument taken down to its basics, is if the 3-year rolling weighted average exceeds the unweighted base year count, it should be paid based on that unweighted base year count. What that argument ignores is the hospital’s base year experience.

Consider three different hospitals that have an unweighted count of 100. The first has all IRPs, the second has 80 IRPs and 20 fellows, and the third has 50 IRPs and 50 fellows. The weighted FTE counts will be 100, 90 and 75. The Provider wants to ignore a hospital’s base year weighting outcome as irrelevant in determining its DGME FTE allowance once the Cap was in place. That is not justified by the statutory design or the regulation’s application.

Starting at the bottom of the first column at 62 FR 46005, an example is given for a hypothetical provider that illustrates the base year (1996), calculates the weighted FTE count for 1997, 1998 and 1999 and then modifies the 1998 calculation to apply the formula being challenged.

**The following example illustrates determination of direct GME payment under the rolling average methodology:**

**Assume a hospital cost reporting period ending December 31, 1996 (beginning January 1, 1996) had 100 unweighted residents and 90 weighted FTE residents. The hospital’s FTE Cap is 100 unweighted residents.**

As a starting point although not expressly stated, given 100 unweighted residents, 90 weighted residents and the weighting of 1.0 for and IRP and 0.5 for a fellow, the distribution in the base year had to be 80 IRPs and 20 fellows. (80 x 1.0 + 20 x 0.5) = 90. Therefore, its DGME payment in the base year (1996) would have been based on 90 FTEs. The weighted count is as important as the unweighted count. The two values worked in concert when a particular hospital’s Cap was set in its 1996 base year.

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| **FY** | **Residents in IRP** |  |  | **IRP Weighting** |  | **Fellows** |  | **Fellows Weighting** |  | **Weighted FTE Count** | **Unweighted FTE Count** | **% of IRPs to Total** |
| 1996 | 80.00 80.00 | X |  | 1.00 | + | 20.00 | X | 0.50 | **=** | 90.00 | 100.00 | 80.0% |

The dispute begins here. It is true that the hospital’s allowable FTE count can never exceed 100. The Provider implicitly argues that if the unweighted count exceeds 100 in a future year, then 100 FTEs is the payment multiplier. The Provider’s unstated argument is that the base year mix of IRPs and fellows is irrelevant for future years with the Cap in play. The MAC responds that weighted base year experience is an inseparable part of future year FTE counts.

The preamble continues **(in bold)**,with MAC annotations following:

**Step one. In its cost reporting period beginning January 1, 1997, it had 100 unweighted residents and 90 weighted residents.**

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| **FY** | **Residents in IRP** |  | **IRP Weighting** |  | **Fellows** |  | **Fellows Weighting** |  | **Weighted FTE Count** | **Unweighted FTE Count** | **% of IRPs to Total** |
| 1997 | 80.00 | X | 1.00 | + | 20.00 | X | 0.50 | **=** | 90.00 | 100.00 | 80.0% |

In this example, there was no change from the base year residents in the penultimate year.

**The hospital had 90 unweighted residents and 85 weighted residents for its cost reporting period beginning January 1, 1998.**

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| **FY** | **Residents in IRP** |  | **IRP Weighting** |  | **Fellows** |  | **Fellows Weighting** |  | **Weighted FTE Count** | **Unweighted FTE Count** | **% of IRPs to Total** |
| 1998 | 80.00 | X | 1.00 | + | 10.00 | X | 0.50 | **=** | 85.00 | 90.00 | 88.9% |

In the prior year, using the counts given, the IRPs held at 80 but the fellows dropped by 10.

**In its cost reporting period beginning on January 1, 1999, the hospital had 80 unweighted residents and 80 weighted residents.**

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| **FY** | **Residents in IRP** |  | **IRP Weighting** |  | **Fellows** |  | **Fellows Weighting** |  | **Weighted FTE Count** | **Unweighted FTE Count** | **% of IRPs to Total** |
| 1999 | 80.00 | X | 1.00 | + | - | X | 0.50 | = | 80.00 | 80.00 | 100.0% |

In the current year, the IRPs stayed at 80 and the fellows were gone.

**The 3-year weighted average for the hospital’s cost reporting beginning January 1, 1999, is 85 (90+85+80/3).**

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| **FY** | | **Residents in IRP** | |  | **IRP Weighting** | |  | **Fellows** | |  | | **Fellows Weighting** | |  | **Weighted FTE Count** | | **Unweighted FTE Count** | | **% of IRPs to Total** | | |
| 1997 | | 80.00 | | X | 1.00 | | + | 20.00 | | X | | 0.50 | | **=** | 90.00 | | 100.00 | | 80.0% | | |
| 1998 | | 80.00 | | X | 1.00 | | + | 10.00 | | X | | 0.50 | | **=** | 85.00 | | 90.00 | | 88.9% | | |
| 1999 | | 80.00 | | X | 1.00 | | + | - | | X | | 0.50 | | **=** | 80.00 | | 80.00 | | 100.0% | | |
|  | |  | |  |  | |  |  | |  | |  | | **Total** | | | 255.00 | |  | | |  | |
|  | |  | |  |  | |  |  | |  | |  | | **3 Yrs** | | | 3.00 | |  | | |  | |
|  | |  | |  |  | |  |  | |  | |  | |  | | | 85.00 |  | | |  | | | |

The preamble follows with steps two, three, and four in the DGME payment process. These steps are not part of the dispute. The issue hasn’t surfaced yet as none of the 3 years had an unweighted FTE count that exceeded the base year unweighted count. The problem comes next in the preamble.

**To address situations in which a hospital increases the number of FTE residents over the Cap, notwithstanding the limit established under section 1886(h)(4), we are establishing the following policy for determining the hospital’s weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.**

**Determine the ratio of the hospital’s unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, to the hospital’s number of FTE residents without application of the Cap for the cost reporting period at issue.**

**Multiply the ratio determined above by the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period.** [dentistry/podiatry residents are not part of the Cap]. **This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1,1997. The hospital’s unweighted count of interns and residents beginning on or before October 1, 1997 will not be subject to the FTE limit.**

**For example, if the hospital’s FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital’s number of residents for its December 31, 1990** [s/b 1998] **cost reporting** **period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted at 0.5), the hospital’s weighted FTE count for determining direct GME payment is equal to (100/110) \*100, or 90.9 residents.**

**If a hospital’s unweighted count of residents in specialties other than dentistry and podiatry does not exceed the limit, the weighted FTE count equals the actual weighted FTE count for the cost reporting period. The weighted FTE count in either instance will be used to determine a hospital’s payment under the 3-year rolling average payment rules. We believe this proportional reduction in the hospital’s unweighted FTE count is an equitable mechanism for implementing the statutory provision.**

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| **FY** | | **Resident# in IRP** | |  | **IRP Weighting** | |  | **Fellows** | |  | | **Fellows Weighting** | |  | **Weighted FTE Count** | | **Unweighted FTE Count** | | | **% of IRPs to Total** | |
| 1996 | | 80.00 | | X | 1.00 | | + | 20.00 | | X | | 0.50 | | = | 90.00 | | 100.00 | | | 80.0% | |
| 1998 | | 90.00 | | X | 1.00 | | + | 20.00 | | X | | 0.50 | | = | 100.00 | | 110.00 | | | 81.8% | |
|  | |  | |  |  | |  |  | |  | |  | |  | | | **Ratio** | | 90.9% |  | |
|  | |  | |  |  | |  |  | |  | | **Weighted** | | **1998** | | | **FTE Count** | | 100.00 |  | |
|  | |  | |  |  | |  |  | |  | |  | |  | | | **Allowed** | | 90.9 |  | |

Comparing the example for 1998 to the base year, the IRPs went up by 10 and the fellows held steady at 20. In the base year, the ratio of IRPs to the total was 80% (80 IRPs and 20 fellows=100 Total). In the example year, the ratio became 81.8% (90 IRPs and 20 fellows=110 Total). The relative mix of IRPs and fellows will influence the final weighted count even if the unweighted count does not change. (In the preamble at the top right second paragraph at 46005, the comparison year is mistakenly shown as 1990. The fact that the proper comparison year should be 1998 is clear from the text.)

First it is clear from the example that the unweighted count in the current year (CY) exceeded the unweighted count in the base year (BY) by 10. Yet the increase in allowable FTEs is 0.9 or less than 1.0 FTE. Objectively, that disparity if perceived by commenters as wrong (which it is not) would have set off the same complaint that the Provider is making now. To paraphrase the current argument again, the base year unweighted FTE count is the “limit” when the current year unweighted count exceeds the base year unweighted count no matter what the IRP/fellow mix. As will be seen when the final rule and preamble is brought into play, no reader raised that complaint.

There are three more examples using 1998 compared to 1996 to be raised to illustrate other variables as applied to the formula. First, in 1998 the IRPs held at 80 but the fellows increased by 5 up to 25. Now the unweighted count exceeds the unweighted count in the base year by 5. (105 over 100). The weighted count is 92.5. The ratio of IRPs to total here is 76.2%. Applying the formula, the FTE count is (100/105) \* 92.5 =88.1. Here, reducing the ratio of IRPs to total did have a negative effect when measured against the allowable (i.e. weighted base year) final count.

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| **FY** | **Residents in IRP** |  | **IRP Weighting** |  | **Fellows** |  | **Fellows Weighting** | | |  | | **Weighted FTE Count** | | | **Unweighted FTE Count** | | | **% of IRPs to Total** | | |
| 1996 | 80.00 | X | 1.00 | + | 20.00 | X | | 0.50 | | | **=** | | 90.00 | | | 100.00 | | | 80.0% | | |
| 1998 | 80.00 | X | 1.00 | + | 25.00 | X | | 0.50 | | | **=** | | 92.50 | | | 105.00 | | | 76.2% | | |
|  |  |  |  |  |  |  |  | | |  | | **Ratio** | | | 95.2% | | |  | | |
|  |  |  |  |  |  |  | **Weighted** | | **1998** | | | | | **FTE Count** | | | 92.50 | | |  | | |
|  |  |  |  |  |  |  |  | | |  | | **Allowed** | | | 88.1 | | |  | | |

Next, consider an increase in the number of IRPs from the base year example of 20 and an elimination of the fellows. The weighted and unweighted count is now 100. The allowable FTE count is then 100. Eliminating the fellows does eliminate the adverse effect of the 1.0 versus 0.5 weighting factor difference between IRPs and fellows.

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| **FY** | | **Residents in IRP** | | |  | **IRP Weighting** | | |  | **Fellows** | |  | | **Fellows Weighting** | |  | **Weighted FTE Count** | **Unweighted FTE Count** | | | **% of IRPs to Total** | |
| 1996 | | 80.00 | | | X | 1.00 | | | + | 20.00 | | X | | 0.50 | | **=** | 90.00 | 100.00 | | | 80.0% | |
| 1998 | | 100.00 | | | X | 1.00 | | | + | - | | X | | 0.50 | | **=** | 100.00 | 100.00 | | | 100.0% | |
|  | |  | |  |  | | |  |  | | |  | |  | |  | | **Ratio** | | 100.0% |  | |
|  | |  | |  |  | | |  |  | | |  | | **Weighted** | | **1998** | | **FTE Count** | | 100.00 |  | |
|  | |  | |  |  | | |  |  | | |  | |  | |  | | **Allowed** | | 100.0 |  | |

The last illustration has the IRPs dropping by 20 and the fellows increasing by 30 (this is a common complaint of large teaching hospitals). Now the unweighted count is 110 but the weighted count is 85. (60 x 1.0 + 50 x 0.5). Applying the formula (100/110) \* 85 = 77.3 which represents this year’s final FTE count.

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|  | **Residents in IRP** |  | **IRP Weighting** |  | **Fellows** |  | **Fellows Weighting** |  | **Weighted FTE Count** | | **Unweighted FTE Count** | | **% of IRPs to Total** | |
| 1996 | 80.00 | X | 1.00 | + | 20.00 | X | 0.50 | **=** | 90.00 | | 100.00 | | 80.0% | |
| 1998 | 60.00 | X | 1.00 | + | 50.00 | X | 0.50 | **=** | 85.00 | | 110.00 | | 54.5% | |
|  |  |  |  |  |  |  |  |  | **Ratio** | | 90.9% | |  | |
|  |  |  |  |  |  |  | **Weighted** | **1998** | | **FTE Count** | | 85.00 | |  | |
|  |  |  |  |  |  |  |  |  | **Allowed** | | 77.3 | |  | |

In the examples in the FR and those described above, the variables that could have been visualized in reading the preamble and the interim final rule are covered (no change in the base year, a drop in just the fellows, a drop in the IRPs and elimination of fellows, an increase in IRPs and no change in fellows, no change in IRPs and increase in fellows, an increase in IRPs and elimination of fellows and finally a reduction in IRPs with a larger increase in fellows. What was the provider community reaction?

At 63 FR 26318 (May 12, 1998), the final rule responding to comments from the August 19, 1997 interim final rule was published. (See Exhibit C-5). The exhibit includes comments on many aspects of changes in counting residents. The comments on the 3-year rolling average where the issue here lies, start at 63 FR 26330 in the middle column. The discussion of what to do when a hospital increased its unweighted resident FTEs over its base unweighted count is repeated virtually verbatim and concludes as before,

**We believe this proportional reduction in the hospital’s unweighted FTE count is an equitable mechanism for implementing the statutory provision.**

While there were many other complaints and criticisms on the implementation of the Cap and the 3-year rolling average, none were lodged against the “formula” as is being done in this Appeal. Anyone considering the example used where an increase of 10 IRPs resulted in a 0.9 increase in allowable FTEs would have understood the implementation mechanism and that the unweighted base year FTE count was not an absolute measure of allowable FTEs in a payment year without considering anything else. While the unweighted count was a factor in establishing each hospital’s going forward limit, so was that years mix of IRPs and fellows. That was clear after August 12, 1997 and is equally clear now.

Using mostly farfetched and unrealistic examples, The Provider assume their basic position that the formula is illegal is correct and then cites a number of federal cases in which the Court struck down positions taken by a number of government agencies as being in conflict with the underlying statutes as support. The real question is whether the challenged formula is illegal.

The Providers here are attempting to adjust not only the appeal year FTE count but also the prior and penultimate years that flow into the appeal year FTE rolling average. The MAC will not oppose that effort on any jurisdictional basis. However, the question of the Board’s authority to entertain the argument as well as the analysis above also apply in full to those years.

1. **Regulation As Amended Subsequent to FFY 2023 Final Rule**

The FFY 2023 Final Rule retroactively modified the regulations at 42 C.F.R. § 413.79(c)(2)(iii) and 42 C.F.R. § 413.79(d)(3) as follows:

413.79(c)(2)(iii) - Effective for cost reporting periods beginning on or after October 1, 2001, if the hospital's unweighted number of FTE residents exceeds the limit described in this section, and the number of weighted FTE residents in accordance with paragraph (b) of this section also exceeds that limit, 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 limit. If the number of FTE residents weighted in accordance with paragraph (b) of this section does not exceed that limit, then the allowable weighted FTE count is the actual weighted FTE count.

413.79(d)(3) - For cost reporting periods beginning on or after October 1, 2001, the hospital's weighted FTE count for primary care and obstetrics and gynecology residents is equal to the average of the weighted primary care and obstetrics and gynecology counts for the payment year cost reporting period and the preceding two cost reporting periods, and the hospital's weighted FTE count for nonprimary care residents is equal to the average of the weighted nonprimary care FTE counts for the payment year cost reporting period and the preceding two cost reporting periods. 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 in paragraph (c)(2)(iii) of this section.

The reasons for the amended regulations were included in the August 10, 2022, Federal Register (87 FR 49065-49072) (Exhibit C-6). It was determined that the existing regulations did not comply with the statute. The amended regulations would apply retroactively to open cost reports. It included a summary as follows:

After consideration of comments received, we are finalizing our proposed policy and regulations text at 42 CFR 413.79(c)(2)(iii) to state that, effective for cost reporting periods beginning on or after October 1, 2001, if the hospital’s unweighted number of FTE residents exceeds the limit described in this section of the final rule, and the number of weighted FTE residents in accordance with § 413.79(b) also exceeds that limit, 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 limit. If the number of FTE residents weighted in accordance with § 413.79(b) does not exceed that limit, then the allowable weighted FTE count is the actual weighted FTE count. In response to comments, we are also making a conforming change to the regulations text at 42 CFR 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). In addition, in response to comments, we are applying the new payment methodology to the MMA section 422 FTE cap.

The MAC is currently analyzing the impact of updating the cost reports in accordance with the modified regulatory text. It is anticipated, based on communications with the Provider representative, that these appeals will be resolved through an administrative resolution.

1. **Conclusion**

There is no dispute that the MAC’s determination of allowable DGME FTEs was correct under the regulations published at the time of the NPR.

The Provider is arguing (based on the prior regulatory text) that in applying the Cap in a payment year, the relationship between IRPS and fellows which determined the allowable FTEs in the base year is irrelevant to future years where the Cap is to be applied. All that matters is the base year raw or unweighted FTE count. The MAC’s position was that the Medicare Agency (then HCFA/now CMS) analyzed the relevant laws when it developed the regulations applying the Cap and the three-year rolling average to cost reporting years beginning on and after October 1, 1997.

The amended regulatory text is now a central point to consider. It is anticipated that this issue will be resolved administratively by applying the amended regulations to the appealed cost reports.

IV. LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

Laws:

42 U.S.C. 1395ww(h)(4)(F)(i);42 U.S.C. 1395ww(h)(4)(C);42 U.S.C. 1395ww(h)(4)(G)(i)

Regulations:

42 CFR 413.79(c)(2)(iii);42 CFR 413.79(d)(3);42 CFR 405.1867;42 CFR 405.1842;42 CFR 413.86;CMS Pub 15-2, Section 4034

Federal Register:

62 FR 45966, 46004-46005;63 FR 26318;87 FR 49065-49072

V. EXHIBITS

##### C-1. Schedule of Providers from the PRRB Portal – Case No. 22-0877GC

##### C-2. Schedule of Providers from the PRRB Portal – Case No. 22-0878GC

C-3. CMS Pub 15-2, Section 4034

C-4. 62 FR 46004

C-5. 63 FR 26330

C-6. 87 FR 49065-49072