Whether the provider is entitled to higher GME/IME FTE resident caps for new training programs.

1. **Facts**

The GME FTE regulations for new programs are at 42 CFR § 413.79(e)

and the IME FTE regulations for new programs are at 42 CFR § 412.105(v).

Below are excerpts of the regulations applicable to the subject case:

42 CFR § 413.79(e)

*New medical residency training programs.* If a hospital establishes a new medical residency training program as defined in paragraph (l) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (c) of this section may be adjusted as follows:

(1) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012, the hospital's unweighted FTE resident cap under paragraph (c) of this section may be adjusted for new residency training programs based on the sum of the products of the highest number of FTE residents in any program year during the third year of the first new program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program. If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins training residents in a new medical residency training program(s) for the first time on or after October 1, 2012, the hospital's unweighted FTE resident cap under paragraph (c) of this section may be adjusted for new residency training programs based on the sum of the products of the highest number of FTE residents in any program year during the fifth year of the first new program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

(i) If a hospital begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012, and if the residents are spending portions of a program year (or years) at one hospital and the remainder of the program at another hospital(s), the adjustment to each qualifying hospital's cap for a new medical residency training program(s) is equal to the sum of the products of the highest number of FTE residents in any program year during the third year of the first new program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program and the number of years the residents are training at each respective hospital. If a hospital begins training residents in a new medical residency training program(s) for the first time on or after October 1, 2012, and if the residents are spending portions of a program (or years) at one hospital and the remainder of the program at another hospital(s), the adjustment to each qualifying hospital's cap for new residency training program (s) is equal to the sum of the products of three factors (limited to the number of accredited slots for each program):

(A) The highest total number of FTE residents trained in any program year during the fifth year of the first new program's existence at all of the hospitals to which the residents in the program rotate;

(B) The number of years in which residents are expected to complete the program, based on the minimum accredited length for each type of program.

(C) The ratio of the number of FTE residents in the new program that trained at the hospital over the entire 5-year period to the total number of FTE residents that trained at all hospitals over the entire 5-year period.

(ii) If a hospital begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012, prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's first new residency program(s), the hospital's cap may be temporarily adjusted during each of the first 3 years of the hospital's first new residency program using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year. If a hospital begins training residents in a new medical residency training program(s) for the first time on or after October 1, 2012, prior to the implementation of the hospital's adjustment to its FTE cap beginning with the sixth year of the hospital's first new residency program(s), the hospital's cap may be adjusted temporarily during each of the first 5 years of the hospital's first new residency program using the actual number of FTE residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(iii) If a hospital begins training residents in a new medical residency training program for the first time on or after January 1, 1995, but before October 1, 2012, the cap will not be adjusted for new programs established more than 3 years after residents begin training in the first new program, or if a hospital begins training residents in a new medical residency training program for the first time on or after October 1, 2012, the cap will not be adjusted for new programs established more than 5 years after residents begin training in the first new program.

**…**

(4) A hospital seeking an adjustment to its FTE cap must provide documentation to its fiscal contractor justifying the adjustment.

(5) The cap will not be adjusted for expansion of existing or previously existing programs.

42 CFR § 412.105(v):

(C) For new programs started prior to October 1, 2012, if a hospital qualified for an adjustment to the limit established under paragraph (f)(1)(iv) of this section for new medical residency programs created under paragraph (f)(1)(vii) of this section, the count of residents participating in new medical residency training programs above the number included in the hospital's full-time equivalent count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in paragraph (f)(1)(v)(B) of this section for a period of years. Residents participating in new medical residency training programs are included in the hospital's full-time equivalent count before applying the averaging rules after the period of years has expired. For purposes of this paragraph, for each new program started, the period of years equals the minimum accredited length for each new program. The period of years for each new program begins when the first resident begins training in each new program.

The MAC determined that the provider was approved for twelve new resident training programs. Nine of the twelve programs first began training residents March 1, 2008, which is also the begin date for the provider’s cost reporting period that ended February 28, 2009. The provider’s cost reporting period ended February 28, 2011, was the third year of the new programs. The GME/IME FTE resident caps became effective beginning with the provider’s cost reporting period ended February 29, 2012 (PRRB Appeal Case No. 17-0417). Table 1 is presented below to summarize the twelve programs.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Table 1 |  |  |  |  |  |  |
| **Program Name** | **First Began Training** | **Accredited Length in Years** | **Highest Class During 3rd Year of Program** | **Accredited Slots** | **Largo GME FTE Cap** | **Largo IME FTE Cap** |
| Anesthesiology | 03/01/2008 | 4 | PGY 1 | 8 | 5.50 | 5.50 |
| Dermatology | 03/01/2008 | 3 | PGY 3 | 9 | 6.99 | 6.93 |
| Family Practice | 03/01/2008 | 3 | PGY 1 | 21 | 20.18 | 20.10 |
| General Surgery | 03/01/2008 | 5 | PGY 2 | 5 | 4.39 | 4.39 |
| Internal Medicine | 03/01/2008 | 3 | PGY 1 | 36 | 35.00 | 35.00 |
| Interventional Cardiology | 07/01/2010 | 1 | PGY 1 | 2 | 0.65 | 0.65 |
| Pulmonary Critical Care | 07/01/2009 | 3 | PGY 1 | 3 | 2.42 | 2.42 |
| Cardiology | 03/01/2008 | 3 | PGY 1 | 6 | 3.07 | 3.07 |
| Gastroenterology | 03/01/2008 | 3 | PGY 1 | 6 | 2.83 | 2.83 |
| Rheumatology | 03/01/2008 | 2 | PGY 1 | 4 | 1.58 | 1.58 |
| Orthopedic Surgery | 07/01/2010 | 5 | PGY 2 | 5 | 4.28 | 4.28 |
| Internship | 03/01/2008 | 1 | PGY 1 | 24 | 16.15 | 16.13 |
| **Totals** |  |  |  |  | **103.04** | **102.88** |

Source: MAC Workpapers (Exhibit C-1)

As an example, the MAC will focus on describing the computations used to revise the GME FTE resident cap, specific to the Internal Medicine Program (See Exhibit C-1, page 12). The computations for the IME FTE resident cap are similar. The MAC first determined there were a total of 26.5466 FTE residents in the third year of the program (March 1, 2010, through February 28, 2011) at all training locations. The 26.5466 FTE resident count consisted of 12.2041 FTE residents in their first year of the program, 7.2795 FTE residents in their second year of the program and 7.063 FTE residents in their third year of the program. To calculate the new program FTE cap, it was necessary to multiply the highest number of FTE residents in any program year, in the third year of the program, times three, the accredited length of that program (12.2041 X 3 = 36.61). This amount is limited to the number of accredited slots, which is 36.00 FTE’s. The MAC then allocated the 36.00 FTE resident cap between the provider and other facilities. The allocation was based on the percentage of participating residents at each facility. The number of FTE residents participating in the program at the provider was 58.6011, over the three-year initial period of the program. The number of FTE residents at other facilities was 1.6798. There was a total of 60.2809 GME FTE residents that trained in the program in the initial 3 years of the program. The provider’s percent of the total resident FTEs was 97.21 percent (58.6011 ÷ 60.2809 = 97.21%). The other facilities percent of the total resident FTEs was 2.79 percent (1.6798 ÷ 60.2809 = 2.79%). Based on these percentages, the MAC determined that the portion of the total program cap applicable to the provider was a 35.00 FTE resident cap. The remaining portion, a 1.00 FTE resident cap was applicable to other facilities.

1. **Argument**

The MAC contends that the caps were calculated in accordance with Medicare laws, regulations, and program instructions.

The provider offers three main arguments about the methodology used to calculate the GME/IME Caps. They are 1) Out-Rotation Apportionment, 2) Accredited Slot Limit, and 3) Resident Time Counting Errors.

Out Rotation Apportionment

The provider argues that the MAC should have computed the new training program GME/IME FTE resident caps based only on the provider’s number of GME/IME FTE residents trained at their facility, rather than all GME/IME FTE residents in the program that were trained at other sites. The provider also argues that the examples, presented by The Centers for Medicare & Medicaid Services (CMS) of the means of calculating GME/IME FTE resident caps, of a new program, (which the MAC followed), do not apply. The MAC disagrees with the provider’s assertions. The provider fails to recognize that the GME/IME FTE resident cap calculations are necessary to determine the GME/IME FTE resident caps for the entire program. In addition, the provider’s method allows for a means of artificially increasing the GME/IME FTE resident caps for a provider and for all hospitals that participate in a new resident training program. The MAC’s method provides for an accurate means of calculating the GME/IME FTE resident caps and an equitable means of distributing of the allowable GME/IME FTE resident caps. The MAC’s method complies with the Medicare regulations and policy, that were in place prior to the issuance of August 31, 2012, *Federal Register* (77 FR 53416), which provided clarification of existing regulations. (Exhibit C-3)

The calculation of both GME and IME payments are affected by the number of FTE residents that a hospital can count. Generally, the greater number of FTE residents a hospital counts, the greater the amount of GME and IME payments a hospital may receive. To end the incentive for hospitals to increase the number of FTE residents, a limit was established on the number of allopathic and osteopathic FTE residents a hospital may claim for GME and IME payment purposes. The Balance Budget Act of 1997 established that a hospital’s FTE resident count for GME payments, may not exceed the hospital’s unweighted FTE resident count for the hospital’s most recent cost reporting period ending on or before December 31, 1996. A similar limit was enacted for FTE resident counts for a hospital’s IME payment effective with discharges occurring on or after October 1, 1997. CMS was required to establish rules for calculating GME/IME FTE resident caps for new programs established on or after January 1, 1995, which would otherwise be zero. Under the established method, a hospital’s unweighted FTE resident cap may be adjusted, based on the product of multiplying the highest number of FTE residents in any program year during the third year of the new program, for each new residency training program established during the three-year period (known as the three-year window).

The three-year window, in which a hospital can “grow” its program for the purpose of establishing its FTE resident caps, was increased to a five-year window through the Affordable Care Act (ACA). When the proposed rules were published for implementing the ACA (Federal Register, Vol. 77, No. 92, May 11, 2012), CMS also proposed to add a discussion of the methodology used to calculate qualifying teaching hospitals’ cap adjustments for a new residency training program if residents training in a new program are rotating to more than one hospital. The proposed method became part of the final rule. Refer to 77 FR pages 27979 and 27980 (May 11, 2012) and 77 FR page 53418 (August 31, 2012) (Exhibit C-3). Because the purpose is to establish a cap for a new program, rather than only one of the hospitals participating in the program, CMS looks at the highest total number of FTE residents training in any program year at all participating hospitals, to which the residents rotate and multiplies that highest FTE resident count by the number of years, residents are expected to complete the program. That product is allocated to the hospitals participating in the program, based on each hospital’s ratio of the number FTE residents in the new program over the course of the grow-period, to the total number of FTE residents that trained under the new program.

In this specific case, the provider wishes to base their FTE resident cap only on the highest number of residents, in any program year, *they* trained in the last year of the three-year grow period, rather than the percentage of all residents trained, over the three-year grow period. If the other training sites were Medicare certified acute-care hospitals, that needed to establish FTE resident caps for the new program, they surely would be arguing that the method, outlined in the Federal Registers (proposed and final rules), is the appropriate method. Using the method outlined in the Federal Register, which the MAC relied upon, accurately calculates overall FTE resident caps for the new resident training programs and appropriately allocates the caps to all hospitals that participated in the training.

The provider’s method is clearly flawed because, if it is applied to two or more hospitals (certified for Medicare), participating in a new training program, it could establish FTE resident caps in total (combing all hospitals’ caps) greater than the total number of resident slots approved for the program. Again, the MAC asserts the method outlined in the Federal Registers and applied by the MAC, determines the FTE resident cap for the entire new program and then equitably allocates it to the participating providers.

The provider argues that MAC applied regulations that are only applicable to new programs, beginning on or after October 1, 2012. The provider also argues that CMS implemented rule changes without following proper procedures. The MAC disagrees with the provider’s contentions. The method outlined in the Federal Register (proposed and final rules) is a clarification rather than a rule change, for all applicable hospital’s participating in a new training program. The method enforces the existing regulations by limiting a new program FTE resident cap to the number of residents trained in the grow period and/or the number of training slots approved by the Accrediting Council for Graduate Medical Education.

The Provider argues that there was not a single resident that spent an entire program year at another hospital; therefore, no adjustment is required for residents that rotated to other hospitals. The Provider incorrectly interpreted the regulations that were in place when the Internal Medicine program began. The regulation at 42 C.F.R. § 413.79(e)(1)(i) previously stated:

If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital the adjustment to each respective hospital’s cap is equal to the product of the highest number of residents in any program year during the third year of the first program’s existence and the number of years the residents are training at each respective hospital.

This regulation does not state that providers and contractors should focus on the rotation of an individual resident. If the regulation is only applicable when a single resident spent an entire program year at another hospital, the regulation would have likely stated, if *a resident* spent an entire program year… However, the regulation addresses all residents. Furthermore, if the regulation only applied when a single resident rotated for an entire year to another hospital, there would be no need for the regulation. It would be a very rare incident that any single resident would spend an entire year (or years) at another hospital, when the other residents of the same program are training at other hospitals.

The Provider’s interpretation is flawed. One must ask, why would a Provider be entitled to a cap that is based on the number of FTE residents they did not train? The Provider relies on an unclear sentence in the regulations. It would be a rather small view of the complex Medicare regulations and policies at issue, to hold that one sentence (one that is clearly taken out of context) is controlling, in the determination of the Provider’s allowable DGME/IME FTE resident caps.

As explained in the August 31, 2012, Federal Register (77 FR 53418) (Exhibit C-3):

We also noted that § 413.79(e)(1) applies in instances where the residents in the new program train only at one hospital; § 413.79(e)(1)(i) applies when residents in the new program train at more than one hospital, regardless of whether each of those hospitals are hospitals that qualify for a permanent cap adjustment or existing teaching hospitals with previously established caps.

The change in the regulation was to allow for a five-year cap building window for hospitals that begin new programs on or after October 1, 2012. The basic methodology of calculating the cap for the period during which the three-year cap building window applied was not changed.

The Board issued a decision, regarding DGME/IME FTE caps [Beaumont Hospital, Wayne (formerly known as Oakwood Annapolis Hospital) v. Wisconsin Physicians Service, (“Beaumont-Wayne v. WPS”), 2018-D33]. The MAC contends the Board rendered an incorrect decision. Specific to that case were stipulations regarding the cap not exceeding the total accredited slots. The Board concluded that no adjustment was required for out-rotations since the residents were only spending a portion of the year at other hospitals and not the entire program year at the other hospitals. The Board also concluded that the 2012 regulation was not a modification, but rather a change to the way out-rotations were handled in the calculation of the GME/IME FTE caps for a new medical residency training program. However, the Medicare Administrator vacated the Board’s decision.[[1]](#footnote-1) The Administrator found that CMS formally made corrections and *clarifications* in the August 31, 2012, *Federal Register* (77 FR 53416) to better elucidate policies developed in the 1999 rulemaking.

The provider in *Beaumont* appealed the Administrator’s reversal of the Board’s decision to the District Court in the Eastern District of Michigan, Southern Division in Case no. 18-12352. (*Beaumont Hospital – Wayne f/k/a Oakwood Annapolis Hospital vs. Alex Azar II*, Case 2:18-cv-12352-VAR-MKM.[[2]](#footnote-2) The Court was asked to decide: (i) whether the 2007 version or the 2012 version of the regulation is a clarification or new enactment, and (ii) the calculation of GME and IME costs pursuant to the 2007 regulation.

The issue in *Beaumont* was whether the provider was entitled to additional reimbursement under the Medicare Act for costs it incurred to train medical residents who spent partial years training at other teaching hospitals during fiscal years 2004 through 2007. The parties disagreed whether the 2007 regulation required CMS to apportion the GME and IME caps to each hospital that trained residents in the new program.

Beaumont established a new family medicine training program. Thereafter, Beaumont applied the FTE caps on an aggregate basis. Beaumont had a three-year window for establishing its FTE resident cap. The program was accredited for 30 total positions or slots. During the first three years of the program, some residents spent time training at two other hospitals – Beaumont Hospital-Dearborn and Beaumont Hospital-Trenton.

In calculating Beaumont’s FTE resident caps, the MAC apportioned caps based on the percentage of time spent training at the hospital. Beaumont appealed the MAC's decision to the PRRB, which determined the MAC improperly calculated the provider’s GME and IME FTE resident caps. The Board then directed the MAC to adjust Beaumont’s new family medicine training program cap to 29.28 for both [D]GME and IME. The PRRB concluded that the administrative regulation,

governing a hospital's FTE count was unambiguous, and that this regulation did not exclude residents rotating within other hospitals from Beaumont’s FTE count for purposes of calculating the amount to be reimbursed the hospital could include residents and time spent at other hospitals.

The Administrator of the Centers for Medicare and Medicaid Services reviewed and reversed the PRRB's decision. The Administrator concluded that Medicare only intended to reimburse teaching hospitals for resident time spent at the specific hospital. Accordingly, the Administrator concluded that the MAC properly reduced Beaumont’s direct GME and IME FTE resident counts to exclude FTE resident training time in another teaching hospital. Beaumont appealed the

Secretary's decision to the District Court.

The Court agreed with the Administrator’s decision by denying Beaumont additional reimbursement. The Administrator and Secretary reasonably read the regulation to require an adjustment to FTE caps for out-rotations at different teaching hospitals. The Administrator’s decision was reasonable and not arbitrary, capricious, or in violation of the law.

The Court determined that while the 2007 regulation did not explicitly state that residents training for partial years at multiple hospitals were to be deducted from the FTE cap, the regulation discusses how to treat residents who out rotate for more than one year and the preamble explained how to count residents who out rotated for less than a full training year. In 2012, CMS clarified the issue regarding residents who rotate outside the teaching hospital. *See* 42 C.F.R.

§ 413.79(e)(1)(i) (2012). The 2012 clarification did not constitute a substantive change in payment policy. In August 1997 – prior to any of the cost reporting years at issue – the Secretary published for comment for calculating the FTE count for hospitals that established a new medical residency program on or after January 1, 1995. The 2012 clarification addressed how to treat residents who spent an entire program year at one hospital and the remaining year at another hospital during the first three years of the residency program. The 2012 regulation explicitly excluded time that a resident spent for a portion of the year training at another teaching hospital.

The Court found that the Administrator reasonably inferred that – pursuant to the 1999 preamble – Beaumont was not permitted to count residents in its FTE cap who out-rotated for less than one year. Accordingly, the Court concluded that the Administrator did not act arbitrarily or capriciously when denying Beaumont’s request for relief. The Administrator’s decision is supported by substantial evidence and was not contrary to law. The Court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the

Administrator of an agency.

The regulations as written in 2007 were first implemented in the July 30, 1999, IPPS final rule (64 FR 41519 – 41520).[[3]](#footnote-3) The preamble to the 1999 rule specifically addressed rotations to other hospitals for both whole years and partial years. The preamble states:

Response: In situations where residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital during the first 3 years of the new residency program, each hospital that trains the residents receives an adjustment to its cap based on the product of the highest number of residents in any program years during the third year of the first program's existence and the number of years that the residents are training at each respective hospital. In situations where the residents spend partial years at different hospitals during the first 3 years of the new residency program, each hospital that trains the residents receives an adjustment to its cap based on product of the highest number of residents in any program year during the

third year of the first program's existence and the minimum accredited length of the program.

The preamble also illustrates how an FTE cap for a new program is established when residence spend partial years at other hospital.

In sum, the MAC’s method of determining the caps for the new resident training programs accurately computes the allowable caps and equitably allocates them to the hospitals that participated in the program during the three-year window/ growth period of the program. The MAC’s computations are supported by the regulations that were in place when the provider’s training program began, and the clarifying regulations, issued in the August 31, 2012, Federal Register.

Accredited Slots Limit

The provider proposes that the accredited slots limit should be applied at the end of FTE cap calculation and offered an example (Table 5 of the provider final paper) that did not relate to any of the four programs impacted by the accredited slot limits (Family Practice, General Surgery, Internal Medicine, and Orthopedic Surgery). As shown below, using the provider’s proposed methodology, the hospital claims 100% of the accredited slots for three of the four programs even though residents in these programs rotated to facilities other than just Largo.





It is unclear why the provider referenced eight programs impacted by the accredited slot limit, as the MAC workpapers clearly indicate only the four programs shown above were impacted by this factor. However, the MAC’s method for determining the add-on cap for all twelve programs was consistent with the method used for another provider, JFK Medical Center. The Administrator agreed with the MAC’s calculation[[4]](#footnote-4), stating:

…the Administrator finds that the MAC was correct in adjusting the Provider’s DGME and IME FTE caps to account for out-rotations and used the correct methodology to determine the cap. The Administrator finds that the methodology used by the MAC to make its calculations was consistent with Medicare law, the regulations and program instructions, and resulted in an accurate and equitable means to distribute the allowable FTE caps. The Administrator finds that considering all three years of the cap-building period in calculating the Provider’s cap adjustment within the context of both hospitals, collectively, is appropriate, as it provides a more complete picture of the actual rotations that will be part of the approved residency training program….

The MAC contends that the accredited slot limit ceiling applies to each program, not just the Largo resident rotations. Thus, the order of application was appropriate. The provider cites language from 42 C.F.R. § 413.79(e)(1) “…The adjustment to the cap may not exceed the number of accredited slots **available** to the **hospital** for the new program.” (emphasis added). If each hospital with resident rotations in the program used the Largo methodology, the new program caps would exceed the accredited slot limit.

Resident Time Counting Errors

The MAC calculations were based on the FTE counts made available from the provider. The MAC agrees that non allowable time, such as time spent in didactic conferences held at locations which are not primarily engaged in furnishing patient care services, or time spent by a resident out on an extended leave of absence (under FMLA for example), should not be considered in the calculations of the overall program FTE counts for each of these new medical residency programs. However, these items were already removed when properly identified. The provider seems to comingle their arguments between whether the FTEs in dispute are “non-countable time” or “non-countable activities”, and whether it is the methodology used or the data within the calculations pertaining to the 1st and 2nd years of the cap building period that is in dispute.

On August 31, 2017, the MAC requested support to specifically identify the FTEs in dispute (see Exhibit C-5). On December 18, 2017 the provider submitted spreadsheets to help identify and narrow this portion of the dispute but did not provide sufficient detail behind any of these “non-countable activities” which may have been inadvertently included in the calculation of the overall New Program FTE Cap (based upon rotations from just the 3rd year of the cap building period) or inadvertently included in the calculation of the denominator used for the apportionment of the overall New Program FTE Cap to Largo Medical Center (based upon rotations from the entire 3 years of the cap building period). We need to see the source documentation for the residents’ time, locations, and activities in the form of the “master” (i.e. “block”) rotation schedules for each one of the “new” GME programs in order to properly identify and verify the specific “non-countable activities”. We also have concerns with the unorthodox methodology used by the provider for its calculations of the FTE counts, which makes it difficult to reconcile the FTE counts to the source documentation for the residents’ time, locations, and activities in the form of the “master” (i.e. “block”) rotation schedules for each one of the “new” GME programs. We would need detail to be able to tie these FTE counts from the entire 3 years of the cap building period back to the FTE counts which were allowed on the corresponding prior cost reporting periods for the FYE’s of 02/28/2011, 02/28/2010 and 02/28/2009.

Other provider arguments

The provider attempts to justify their position by including an example of FTE resident cap computations related to another provider at Exhibit P-35. This is not germane to the instant case. Each determination of a provider’s FTE resident cap is based the unique circumstances applicable to each case. If a MAC errs with a computation, does it establish policy for all other cases, determined by the MAC or another MAC? The simple answer is no.

**C. Conclusion**

The provider has failed to persuade the MAC to recognize an alternative method of calculating the provider’s GME/IME FTE resident caps for the new training programs. Accordingly, the burden of proof, which was upon the provider, has not been met. Therefore, the Board must find that the MAC’s determination was not arbitrary or capricious and did in fact adhere to Medicare Law, Regulations & Program Instructions. Thus, the Board must conclude that the provider is not entitled to higher GME/IME FTE resident caps.

IV. LAW, REGULATIONS, PROGRAM INSTRUCTIONS

Law:

Social Security Act;Section 1861(v)(1)(A);Section 1886(d)(5)(B);Section 1886(h)(8);Section 1886(h)(4)(H)(i)

Regulations:

42 C.F.R., Part 412, Subpart G;Section 412.105;42 C.F.R., Part 413, Subpart B;Sections 413.20, 413.24;42 C.F.R., Part 413, Subpart F;Section 413.79

Federal Registers:

FR Vol. 77, No. 92, May 11, 2012;FR Vol. 77 No. 170, August 31, 2012;FR Vol. 64, No. 146, July 30, 1999

V. EXHIBITS

##### C-1 MAC’s Work Papers – FYE 2012 FTE Resident Caps

##### C-2 MAC’s Work Papers – FYE 2013 through 2018 DGME/IME

##### C-3 Federal Registers, May 11, 2012 & August 31, 2012

##### C-4 Administrator Decision, Review of PRRB Dec. 2018-D33

##### C-5 Email Correspondence

##### C-6 Federal Register, July 30, 1999

##### C-7 Beaumont – District Court Decision

##### C-8 Administrator Decision, Review of PRRB Dec. 2023-D17

1. Exhibit C-4 [↑](#footnote-ref-1)
2. Exhibit C-7 [↑](#footnote-ref-2)
3. Exhibit C-6 [↑](#footnote-ref-3)
4. *See* Exhibit C-8. [↑](#footnote-ref-4)