PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2020-D19

PROVIDER -
Loyola University Medical Center

Provider No.: 14-0276

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

RECORD HEARING –
January 12, 2018

Cost Reporting Period Ended -
June 30, 2006 and June 30, 2007

CASE NOS.: 10-0520 and 12-0427

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ISSUE STATEMENT:

Whether the Medicare Contractor should adjust the direct graduate medical education ("GME")[1] cap for Loyola University Medical Center ("Loyola" or "Provider") on Worksheet E-3, Part VI of the Provider's cost reports for fiscal years ("FYs") 2006 and 2007, for the addition of new programs.[2]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that, for Loyola's FY 2006 and FY 2007 cost reports, the Medicare Contractor used the correct GME cap on Worksheet E-3, Part VI Line 4 and correctly transferred that amount to Worksheet E-3 Part IV Line 3.04.

INTRODUCTION:

Loyola is an acute care teaching hospital located in Maywood, Illinois. The Provider operates GME programs for residents in various specialty and subspecialty areas. These programs have been approved by the Accreditation Council for Graduate Medical Education ("ACGME") and otherwise qualify under the Medicare program as an approved medical residency program eligible for Medicare reimbursement.[3]

The Medicare contractor[4] assigned to Loyola is National Government Services, Inc. ("Medicare Contractor"). On August 18, 2010, Loyola requested that the Medicare Contractor reopen its FY 2006 and FY 2007 cost reports to increase both its GME and indirect medical education ("IME") full time equivalent ("FTE") caps for four new medical residency training programs ("Four New Programs") *that were established after January 1, 1995 and before August 5, 1997*. On October 4, 2010, the Medicare Contractor reopened these cost reports and later issued revised notices of program reimbursement ("RNPRs") for FYs 2006 and 2007 on January 26, 2012 and February 23, 2012, respectively, adding the 6.17 FTEs from the Four New Programs to Loyola's IME cap. However, these RNPRs did not adjust Loyola's GME cap on Worksheet E-3, Part VI Line 4 or Worksheet E-3 Part IV Line 3.04, which deprived Loyola of increased GME payments.[5]

Loyola timely appealed the FY 2006 and FY 2007 RNPRs to the Board and met the jurisdictional requirements for a hearing on this issue.[6] The Board held a hearing on the record

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[1] Direct graduate medical education is referred to interchangeable as DGME or GME.
[2] *See* Board Jurisdictional Dec., Case No. 12-0427 at 5 (Nov. 29, 2017); Board Jurisdictional Dec., Case No. 10-0520 at 5 (Nov. 15, 2017).
[3] Provider's Final Position Paper (Case No. 10-0520) at 2; Provider's Final Position Paper (Case No. 12-0427) at 2.
[4] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[5] Provider's Final Position Paper (Case No. 12-0427) at 6: Exhibit P-4 (Case No. 12-0427); Provider's Final Position Paper (Case No. 10-0520) at 7; Exhibit P-4 (Case No. 10-0520).
[6] In its jurisdictional determination the Board found jurisdiction over the *narrow* issue of "whether the Medicare Contractor properly completed Worksheet E-3, Part VI." *See* Board Jurisdictional Dec., Case No. 12-0427 at 5 (Nov. 29, 2017); Board Jurisdictional Dec., Case No. 10-0520 at 5 (Nov. 15, 2017).

after granting the Parties' request for a record hearing. Loyola was represented by Ronald S. Connelly, Esq. of Power Pyles Sutter & Verville, P.C. The Medicare Contractor was represented by Joseph Bauers, Esq., of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW:

The Medicare Program pays teaching hospitals for GME based, in part, on the hospital's FTE resident count subject to a statutorily imposed cap.[7] Specifically, 42 U.S.C. § 1395ww(h)(4)(F) (2006) identifies the GME cap as follows:

> **(F) Limitation on number of residents in allopathic and osteopathic medicine**
>
> **(i) In general**
>
> Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, *subject to paragraph (7)*, 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 (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 period ending on or before December 31, 1996.
>
> ***
>
> **(H) Special rules for application of subparagraphs (F) and (G)**
>
> **(i) New facilities**
>
> The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and *subject to paragraph (7)*, prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.[8]

CMS promulgated regulations to implement this GME cap. Specifically, 42 C.F.R. § 413.79(c)(2) (2006) addresses how a hospital's 1996 GME cap is determined stating in pertinent part:

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[7] 42 U.S.C. § 1395ww(h).

[8] (Bold emphasis in original and italics emphasis added.)

> (i) [F]or cost reporting periods beginning on or after October 1, 1997, a hospital's resident level may not exceed the hospital's unweighted FTE count (or, effective for cost reporting periods beginning on or after April 1, 2000, 130 percent of the unweighted FTE count for a hospital located in a rural area) for these residents for the most recent cost reporting period ending on or before December 31, 1996.

CMS regulations at 42 C.F.R. § 413.79(e)(2) (2006) permit the adjustment of a provider's 1996 cap for the addition of residents in medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997 stating, in pertinent part:

> (2) If a hospital had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, the hospital's unweighted FTE cap could be adjusted for new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997. The adjustment to the hospital's FTE resident limit for the new program is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program.

These regulations had the effect of some hospitals operating *below* their 1996 caps training fewer residents than Medicare would reimburse in contrast to other hospitals operating *above* their caps training more residents than Medicare would reimburse. In 2003, Congress decided to address this situation in § 422 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA")[9] by requiring a "one time" redistribution of "unused resident positions." MMA § 422(a) modified the statutory provision governing the determination of FTE residents for GME payments located at 42 U.S.C. § 1395ww(h)(4) by subjecting paragraphs (4)(F)(i) and (4)(H)(i), to a redistribution of certain unused resident positions as described in new paragraph (7). The purpose of the MMA § 422 redistribution was to reduce residents slots that were "unused" by certain hospitals and to redistribute those unused slots to certain other hospitals, beginning July 1, 2005. Specifically, the new § 1395ww(h)(7) (2006) states, in pertinent part:

> **(7) Redistribution of unused resident positions**
>
> **(A) Reduction in limit based on unused positions**
>
> **(i) Programs subject to reduction**
>
> **(I) In general**

[9] Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 422, 117 Stat. 2066, 2284 – 2287 (2003).

Except as provided in subclause (II), if a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), *effective for portions of cost reporting periods occurring on or after July 1, 2005*, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such otherwise applicable resident limit and such reference resident level.

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(ii) Reference resident level

(I) In general

Except as otherwise provided in subclauses (II) and (III), *the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before September 30, 2002*, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(II) Use of most recent accounting period to recognize expansion of existing program

If a hospital submits a timely request to increase its resident level due to an expansion of an existing residency training program that is not reflected on the most recent settled cost report, after audit and subject to the discretion of the Secretary, the reference resident level for such hospital is the resident level for the cost reporting period *that includes July 1, 2003*, as determined by the Secretary.

(III) Expansions under newly approved programs

Upon the timely request of a hospital, the Secretary shall adjust the reference resident level specified under subclause (I) or (II) to include the number of medical residents that were approved in an application for a medical residency training program that was approved by an appropriate accrediting organization (as determined by the Secretary) before January 1, 2002, but which was not in operation during the cost reporting period used under subclause (I) or (II), as the case may be, as determined by the Secretary.

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(D) Judicial review

There shall be no administrative or judicial review under section 1395ff, 1395oo of this title, or otherwise, with respect to determinations made under this paragraph.[10]

[10] (Bold emphasis in original and italics and underline emphasis added.)

With respect to § 1395ww(h), Congress makes it clear in § 1395ww(h)(7)(D) that there is no administrative or judicial review of any determinations made pursuant to paragraph (7).

CMS implemented § 1395ww(h)(7) by modifying its regulations. Specifically, for GME, CMS modified 42 C.F.R. § 413.79(c) (2006) to state, in pertinent part:

> (3) *Determination of the reduction to the FTE resident cap due to unused FTE resident slots*. If a hospital's reference resident level is less than its otherwise applicable FTE resident cap as determined under paragraph(c)(2) of this section or paragraph (e) of this section in the reference cost reporting period (as described in paragraph (c)(3)(ii) of this section), for the purpose of cost reporting periods beginning on or after July 1, 2005 the hospital's otherwise applicable FTE resident cap is reduced by 75 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level. . . .

Further, § 413.79(c)(3)(ii) defines the reference cost reporting period as "[a] hospital's most recent cost reporting period ending on or before September 30, 2002," unless a hospital submitted a "timely" request to use its cost reporting period that contains July 1, 2003 "to increase its resident level due to an expansion of an existing program and that expansion is not reflected on the hospital's most recent settled cost report." Finally, § 413.79(c)(3)(ii)(A)(3) specifies that a hospital could "timely" request that "CMS adjust the resident level for purposes of determining any reduction under paragraph (c)(3)" if the request, among other things, pertains to a new program . . . accredited . . . before January 1, 2002" but "not in operation during the reference cost reporting period."

On April 30, 2004, CMS issued the One-Time Notification under Change Request ("CR") 3247 providing guidance to hospitals related to the redistribution of resident slots under MMA § 422.[11] CR 3247 notified providers that in accordance with the Statute, for purposes of redistribution of resident slots, it would use "a hospital's most recent cost reporting period ending on or before September 30, 2002, for which a cost report has been settled (or if not, submitted (subject to audit)) to determine if a hospital's cap should be reduced, unless the hospital submits a ***timely*** request to utilize the cost report that includes July 1, 2003, due to an expansion of an existing residency training program that is not reflected on the most recent settled cost report."[12] CMS notified hospitals that, in order to be considered "timely" and proper, "a hospital's request to use its cost reporting period that includes July 1, 2003 ***must*** be signed and dated by the hospital's Chief Financial Officer (or equivalent), and submitted to its fiscal intermediary ***on or before June 14, 2004***."[13]

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[11] CMS Pub. 100-20, Transmittal 87, Change Request 3247 (May 26, 2004) (replaced Transmittal 77 issued on April 30, 2004) (copy at Exhibit I-26, Case No. 10-0520) (also available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R87otn.pdf).

[12] *Id.* at 4 (emphasis added).

[13] *Id.* at 1 (emphasis added) (noting that this date was originally June 4, 2004 per Transmittal 77, CR 3247, and that Transmittal 87, CR 3247, changed it to June 14. 2004). *See also* 69 Fed. Reg, 49120-21 (discussion on the June 14, 2004 deadline and the tight implementation timeframe required by Congress under MMA § 422).

Loyola established the Four New Programs (*i.e.*, the programs that are at issue) after January 1, 1995 but before August 5, 1997. It is the FTE slots from these programs that Loyola would like to add to its GME cap for purposes of Medicare payment of its GME costs for FYs 2006 and 2007. Below is the pertinent information related to the Four New Programs:

> Anesthesiology: Pain Management residency program, was a one-year program, accredited by the Accreditation Council for Graduate Medical Education ("ACGME"), effective May 25, 1995.[14]
>
> Clinical Cardiac Electrophysiology residency program, was a one-year program, accredited by the ACGME, effective July 1, 1995.[15]
>
> Hematology/Medical Oncology residency program, was a three-year program, accredited by the ACGME, effective July 1, 1996.[16]
>
> Clinical Neurophysiology residency program, was a one-year program, accredited by the ACGME, effective July 1, 1996.[17]

Loyola did not include the Four New Programs in the GME or IME caps that it reported on its FY 1999 – 2003 cost reports, even though the Four New Programs were eligible to be included.[18] In 2010, Loyola discovered this omission, and the first cost report that the Medicare Contractor reopened to include the Four New Programs was Loyola's FY 2004 cost report.[19] Specifically, on October 27, 2011, the Medicare Contractor reopened Loyola's FY 2004 cost report and added the Four New Programs to Loyola's GME and IME caps for FY 2004 and adjusted Medicare payment of Loyola's FY 2004 GME and IME costs based on the revised cap. Likewise, on January 12, 2012, the Medicare Contractor reopened Loyola's FY 2005 cost report to include the Four New Programs in Loyola's GME and IME Caps for FY 2005 and adjusted Medicare payment of Loyola's FY 2005 GME and IME costs based on the revised cap.[20]

On August 18, 2010, Loyola requested that the Medicare Contractor reopen Loyola's FY 2006 and FY 2007 cost reports to add the Four New Programs to its GME and IME caps for FYs 2006 and 2007 for the purpose of increasing Medicare payment of its GME and IME costs for FYs 2006 and 2007.[21] The Medicare Contractor reopened these cost reports and adjusted Loyola's

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[14] Stipulations (Case No. 12-0427) at ¶ 4. As the underlying facts laid out in the Stipulations agreed to by the parties in Case No. 12-0427 are virtually identical to those agreed to by the parties in Case No. 10-0520, the Board generally will cite only to those for Case No. 12-0427 unless there are some unique facts only discussed in the Stipulations for Case No. 10-0520.
[15] *Id.* at ¶ 5.
[16] *Id.* at ¶ 6.
[17] *Id.* at ¶ 7.
[18] *Id.* at ¶ 12.
[19] *Id.* at ¶ 13; Provider's Rebuttal to MAC's Supplemental Final Position Paper (Case No. 12-0427) at n.4, 4-5.
[20] Stipulations (Case No. 12-0427) at ¶¶ 13-15. The Medicare Contractor claims it reopened and settled these cost reports in error. *See* Medicare Contractor's Supplemental Position Paper (Case No. 10-0520) at 5. The Board will not address whether the FY 2004 and 2005 cost reports were reopened and settled in error as the 2004 and 2005 cost reports are not part of this appeal and, thus, are outside the scope of this case.
[21] Stipulations (Case No. 12-0427) at ¶ 16.

IME Cap.[22] For GME, the Medicare Contractor included the Four New Programs on Worksheet E-3 Part IV Line 3.02 but did not include them on Worksheet E-3 Part VI Lines 2 or 4, because Loyola's GME cap had been reduced by the MMA § 422 redistribution.[23] Loyola disagrees with the Medicare Contractor's determination that the Four New Programs should not be included in its total GME cap on Worksheet E-3, Part VI Line 4 of the Medicare cost reports for FYs 2006 and 2007.[24]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Loyola argues that it is entitled to an adjustment to its GME cap for the Four New Programs as it relates to Medicare payment of its GME costs for FYs 2006 and 2007. Loyola asserts that the Four New Programs were all eligible to be added to the cap based on 42 C.F.R § 413.79(e)(2) and that, as a result, the Four New Programs should be included in the total cap amount on its FYs 2006 and 2007 cost reports.[25] Loyola claims that the Medicare Contractor erred when it reopened Loyola's FYs 2006 and 2007 cost reports because, even though it adjusted the GME cap on Worksheet E-3 Part IV to reflect the addition of the 6.17 slots for the Four New Programs, it failed to adjust Worksheet E-3 Part VI with the revised cap, thereby depriving Loyola of increased GME payments.[26]

Loyola concedes that it was an "oversight" on its part that it did not earlier claim the slots associated with the Four New Program but claims that there is no statue or regulation to support the Medicare Contractor's refusal to allow Medicare GME payments attributable to slots for the Four New Program on its FYs 2006 and 2007 cost reports.[27] While Loyola recognizes that its GME cap was reduced as part of the MMA § 422 redistribution,[28] Loyola asserts that the changes CMS made to its cost reporting forms in 2010 (Cost Report Form 2552-10) prove that CMS allows new program additions after the implementation of MMA § 422.[29] Loyola alleges that the Medicare Contractor has conceded that the 2010 version of the cost reporting forms would allow slots for the Four New Programs to be added to the GME and IME caps and for Medicare payment of its GME costs to be calculated based on this increased cap.[30]

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[22] Provider's Final Position Paper (Case No. 12-0247) at 6; Provider's Final Position Paper (Case No. 10-0520) at 7.
[23] Medicare Contractor's Final Position Paper (Case No. 12-0427) at 9; Medicare Contractor's Final Position Paper, (Case No. 10-0520) at 12-13; Stipulations at ¶ 25; Stipulations (Case No. 10-0520) at ¶ 38.
[24] Provider's Rebuttal to Medicare Contractor's Supplemental Position Paper (Case No. 12-0427) at 5-6. Worksheet E-3 Part VI Line 4 is transferred to Worksheet E-3 Part IV Line 3.04 limiting payment. *See* Stipulations (Case No. 12-0427) at ¶¶ 23-24.
[25] Provider's Final Position Paper (Case No. 12-0427) at 5; Provider's Final Position Paper (Case No. 10-0520) at 6-7.
[26] Provider's Final Position Paper (Case No. 12-0427) at 6; Provider's Final Position Paper (Case No. 10-0520) at 7 (referring to the Medicare Contractor's adjustment to Worksheet E-3 Part IV Line 3.02 but no adjustment to Worksheet E-3, Part VI, Line 4).
[27] Provider's Rebuttal to Medicare Contractor's Supplemental Final Position Paper (Case Nos. 12-0427) at 5-6. As the Provider filed virtually the same rebuttal brief in both cases, the Board is only citing to the one filed in Case No. 12-0427.
[28] Stipulations (Case No. 10-0520) at ¶ 35.
[29] Provider's Rebuttal to Medicare Contractor's Supplemental Final Position Paper (Case Nos. 12-0427) at 4.
[30] *Id.*

In addition, Loyola argues that the GME cap is a predicate fact that can be adjusted in a subsequent cost reporting period.[31] In support of its position, Loyola refers to the *Kaiser Found. Hosps. v. Sebelius* case ("*Kaiser*") [32] and notes that, in *Kaiser*, both the U.S. District Court for D.C. and D.C. Circuit Court of Appeals ("D.C. Circuit") held that the FTE cap could be adjusted in the hospitals' fiscal years 1999 to 2003, to include FTEs that were never claimed by the hospitals on their FY 1996 cost reports. The D.C. Circuit stated that Medicare regulations permit "modification of predicate facts in closed years provided the change will only impact the total reimbursement determinations in open years."[33]

The Medicare Contractor disagrees that Loyola can claim the slots for the Four New Programs after the Medicare program had reduced Loyola's GME cap by 7.84 FTE slots pursuant to MMA § 422. The Medicare Contractor asserts that the cap reduction under MMA § 422 was based on the number of ***unused*** slots reported at a specific point in time and neither the Medicare Contractor nor the Provider can re-do or recalculate that reduction.[34] Moreover, the Medicare Contractor asserts that, even if Loyola had "timely disclosed the FTEs for these four residency programs, its unused resident Cap slots would have been greater, resulting in a greater number of FTE reductions under [MMA] Section 422."[35]

The Medicare Contractor further asserts that its adjustments to the cost report to add the Four New Programs was proper and that it properly ignored the Four New Program additions to the cap because Loyola's GME cap had already been previously adjusted *and* frozen pursuant to the process mandated by MMA § 422.[36] The Medicare Contractor claims that Loyola should have included the New Programs on its reference cost reporting period[37] for MMA § 422 and, as a result of forgoing this opportunity, MMA § 422 precludes any revision to or appeal of Loyola's cap.[38]

The Board reviewed the cost report instructions for Worksheets E-3, Part VI and E-3, Part IV that were in effect for FYs 2006 and 2007 to determine if the Medicare Contractor properly calculated Loyola's GME cap for FYs 2006 and 2007. At the outset, it is important to recognize that Loyola's FY 2006 cost report was the *first* cost report where Loyola's GME cap was determined *pursuant to MMA § 422*[39] and, as a result, Loyola was required to complete Worksheet E-3 Part VI. The instructions for Worksheet E-3, Part VI state, in pertinent part:

> 3633.6 Part VI – Direct GME and IME Payments related to MMA section 422 (Public Law 108-173) "Redistribution of Unused

[31] Provider's Reply Position Paper (Case No. 12-0427) at 7-9; Provider's Reply Position Paper (Case No. 10-0520) at 8-10.
[32] 708 F.3d 226, 232-33 (D.C. Cir. 2013), *aff'g*, 828 F. Supp. 2d 193, 201 (D.D.C 2011).
[33] *Id.*
[34] Medicare Contractor's Supplemental Final Position Paper (Case No. 10-0520) at 6.
[35] *Id.* (referencing New Medicare Contractor Exhibit I-24 attached to this filing to support of this assertion).
[36] Medicare Contractor's Final Position Paper (Case No. 10-0520) at 12-13; Medicare Contractor's Final Position Paper (Case No.12-0427) at 9.
[37] As discussed *supra*, § 413.79(c)(3)(ii) defines the reference cost reporting period as "[a] hospital's most recent cost reporting period ending on or before September 30, 2002," unless a hospital submitted a *timely* request to use its cost reporting period that contains July 1, 2003.
[38] Medicare Contractor's Supplemental Position Paper (Case No. 10-0520) at 5-7.
[39] 42 C.F.R. § 413.79(c)(3).

> Residency Slots".--Use this worksheet in conjunction with Worksheet E-3, Part IV and Worksheet E, Part A to calculate payment for direct GME as determined under 42 CFR 413.75 through 413.83 and IME as determined under 42 CFR 412.105 for hospitals that received an adjustment (reduction or increase) to their FTE resident caps for direct GME and/or IME under Section 422 of Public Law 108-173. Do not use this worksheet if the cost reporting period ends prior to July 1, 2005 or if the cost reporting period ends after July 1, 2005 but the hospital did not receive an adjustment to either the GME or IME cap under Section 422 of Public Law 108-173.
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> ***
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> Line 2--Reduced Direct GME FTE Cap. Effective for cost reporting periods ending on or after July 1, 2005, enter the reduced direct GME cap as specified under 42 CFR §413.79(c)(3). However, if the resulting reduced direct GME cap is less than zero (0), enter zero on this line.
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> ***
>
> Line 4 -- …. For cost reporting periods beginning on or after July 1, 2005, enter the count on line 2. This is the hospital's reduced direct GME FTE cap.[40]

The amount from Worksheet E-3, Part VI, Line 4 is transferred to Worksheet E-3, Part IV, Line 3.04, and is the cap that limits Loyola's GME reimbursement for FYs 2006 and 2007.[41] PRM 15-2 § 3633.4 contains the instructions for Worksheet E-3, Part IV, Line 3.04 and states:[42]

> Line 3.04-- … If this hospital's FTE cap is reduced under 42 CFR § 413.79(c)(3) due to unused resident slots, (Worksheet S-2, line 25.05, column 1 is "Y"), effective for cost reporting periods ending on or after July 1, 2005, enter the sum of line 3.03 and line 4 from Worksheet E-3, Part VI.

The Board reviewed Loyola's FY 2006 and 2007 cost reports and finds that Worksheet E-3, Part VI, Line 4 and Worksheet E-3, Part IV, Line 3.04 were completed correctly. Based on the cost report instructions, Worksheet E-3, Part VI, Lines 2 and 4 both correctly list Loyola's GME cap as 314.60 FTEs, as determined by MMA § 422. This FTE amount was transferred to Worksheet E-3, Part IV, Line 3.04 as required.[43] The Board understands that Loyola would like the Medicare Contractor to add Loyola's 6.17 New Program slots to Loyola's GME cap based on 42 C.F.R. § 413.79(e)(2), but there is nothing in the Worksheet E-3, Part VI instructions allowing the addition of any new programs (whether it was a prior "new" programs not previously

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[40] Provider Reimbursement Manual, CMS Pub. 15-2 ("PRM 15-2"), Ch. 36 § 3633.6.
[41] Stipulations (Case No. 12-0427) at ¶¶ 23, 24; Stipulations (Case No. 10-0520) at ¶¶ 36, 37.
[42] PRM 15-2 § 3633.4.
[43] Exhibit I-24 (Case No. 10-0520) at 1; Stipulations (Case No. 10-0520) at ¶¶ 25, 38.

accounted for or a new program added during the fiscal year) to either Line 2 or Line 4. As Worksheet E-3, Part VI is only used for hospitals impacted by the MMA § 422 redistribution, the Board finds the cost report instructions correctly exclude new programs under 42 C.F.R. § 413.79(e)(2), as any new programs under (e)(2) were already addressed by the MMA § 422 redistribution calculation.[44]

In defining the otherwise applicable cap under MMA § 422, both the Statute and associated regulations were clear that the reduction applied to the 1996 cap calculated under paragraph (c)(2) ***and*** *the addition of new programs under paragraph (e)(2),* as reported in the reference cost reporting period. The reference cost reporting period was defined as the hospital's most recent cost reporting period ending on or before September 30, 2002 except in certain situations where hospitals were allowed to submit a timely request to use the cost reporting period that included July 1, 2003.[45] The Four New Programs under (e)(2) were in existence in 2002 and Loyola should have included them in the otherwise applicable cap on Loyola's reference cost reporting period for MMA § 422.[46] As Congress intended the MMA § 422 determinations to be final,[47] Loyola cannot modify its add-on amount under (e)(2), as modifying that amount would be modifying its MMA § 422 determination. Moreover, the finality of the MMA § 422 determination is clear because Congress specifically precluded Board review (as well as judicial review) of any determination under 1395ww(h)(7), which necessarily includes any new program add-ons under paragraph (e)(2).[48]

The Medicare Contractor correctly points out if Loyola properly included the 6.17 FTE slots from the Four New Programs on its 2002 cost report, Loyola's GME cap would have been reduced by 12.47 slots rather than 7.84 slots, resulting in a revised GME cap for Loyola of 316.15.[49] The pool of slots redistributed to other hospital would have increased by 4.63 slots.[50] Loyola is now asking the Board to add these 6.17 slots ***in full*** to its reduced cap of 314.60 so that Loyola has a revised GME cap of 320.77,[51] which is more than if Loyola had correctly completed its GME cap on its reference cost reporting period. The Board does not agree that Loyola should benefit from its own error to the determent of the other hospitals that should have received these 4.63 additional slots through the MMA § 422 redistribution process.

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[44] 42 U.S.C. § 1395ww(h)(7). *See also* 42 C.F.R. § 413.79(c)(3) (stating: "If a hospital's reference resident level is less than its otherwise applicable FTE resident cap as determined under paragraph(c)(2) of this section or *paragraph (e) of this section* in the reference cost reporting period (as described in paragraph (c)(3)(ii) of this section), for the purpose of cost reporting periods beginning on or after July 1, 2005 the hospital's otherwise applicable FTE resident cap is reduced by 75 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level." (emphasis added)).

[45] 42 U.S.C. § 1395ww(h)(7); 42 C.F.R. § 413.79(c)(3).

[46] Stipulations (Case No. 12-0427) at ¶¶ 4-7 (showing the Four New Programs were operational at Loyola prior to 2002).

[47] 69 Fed. Reg. 48916, 49119 (Aug. 11, 2004) (stating that "Congress did intend for determinations of the fiscal intermediary with regard to FTE resident cap reductions, to be final, without any external appeal mechanisms").

[48] 42 U.S.C. § 1395ww(h)(7)(D).

[49] Exhibit I-24 (Case No. 10-0520) at 1.

[50] This is calculated by subtracting Loyola's actual MMA § 422 reduction of 7.84 slots from the corrected reduction of 12.47 slots if Loyola had timely added the Four New Programs. 12.47 less 7.84 equals 4.63.

[51] Exhibit I-24 (Case No. 10-0520) at 1. *See also* Exhibit P-1 (Case No. 10-0520) at 2 (showing a revised GME cap of 320.77 for the prior year (*i.e.*, FY 2005)).

Additionally, the Board is not persuaded by Loyola's argument that its cap could have been increased for the Four New Programs if the Medicare Contractor used the 2010 version of the cost report (CMS-2552-10) when reopening Loyola's FY 2006 and FY 2007 cost reports. First, the Board points out that the Medicare Contractor did in fact use the *correct* version of the cost report, CMS-2552-96, when it reopened Loyola's FYs 2006 and 2007 cost reports since the CMS-2552-10 is to be used only for cost reporting periods beginning on or after May 1, 2010.[52] Notwithstanding, the Board reviewed the CMS-2552-10 cost report and instructions. The 2010 version of the cost report requires all teaching hospitals to use a *new* Worksheet E-4 to report the GME cap. This is different than the earlier version of the cost report that required Worksheet E-3, Part IV for all hospitals and Worksheet E-3, Part VI specifically for hospitals that were impacted by MMA § 422.[53]

The Board finds that, even if the CMS-2552-10 cost report were applicable and could be used for FYs 2006 and 2007, there is nothing in the instructions for the CMS-2552-10 or otherwise that would allow a hospital that had had its cap reduced by MMA § 422, to adjust the 1996 cap or the new program add-on under 42 C.F.R. § 413.79(e)(2), after the hospital's cap had been reduced pursuant to MMA § 422. The CMS-2552-10 instructions for Worksheet E-4, Line 2, limit the add-on for new programs to "*hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2),*" but these instructions do not specifically allow (or even address) a hospital to modify the amount of its new program add-on, when the hospital's cap was determined by MMA § 422.[54] The Statute and regulations related to MMA § 422 make it clear that any hospital operating under its GME limit during the reference cost reporting period, must have its cap reduced by 75 percent of its unused resident slots. Additionally, the Statute specifically defines the reference cost reporting period for that determination as the hospital's cost reporting period ending prior to September 30, 2002, unless the hospital submitted a "timely" request to use its cost report that contained July 1, 2003.[55] CMS explained the tight timeframe required by MMA § 422 and established June 14, 2004 as the due date for such a "timely" request.[56] The Board finds that neither the Statute nor regulations provide for an exception to the 75 percent reduction or a modification to the MMA § 422 determination, if a hospital later determines it omitted information from its reference cost reporting period. Rather, the Statute is clear that Congress intended for determinations related to resident cap redistributions be final and, to this end, prohibited administrative and judicial review of those determinations.[57]

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[52] PRM 15-2 § 4000.

[53] *See* PRM 15-2 § 3633.6 Worksheet E-3, Part VI instructions stating: "Do not use this worksheet if the cost reporting period ends prior to July 1, 2005 or if the cost reporting period ends after July 1, 2005 but the hospital did not receive an adjustment to either the GME or IME cap under Section 422 of Public Law 108-173."

[54] The instruction for Worksheet E-4 Line 2 in PRM 15-2 § 4034 states: "For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2), the cap for each new program accredited or begun on or after January 1, 1995, and before August 6, 1997, is reported on this line and is effective in the fourth program year of each of those new programs. Worksheet E-4 computes a hospital's GME cap by combining Lines 1 through 4." The Board finds this calculation is correct as Worksheet E-4 is used by all teaching hospitals, even those that were not impacted by MMA § 422. As previously explained, Loyola does not qualify to modify its add-on for new programs on its 2006 and 2007 cost reports.

[55] 42 U.S.C. § 1395ww(h)(7); 42 C.F.R. § 413.79(c)(3)(ii).

[56] 69 Fed. Reg. 48916, 49121 (Aug. 11, 2004).

[57] 69 Fed. Reg. 49119; 42 U.S.C. § 1395ww(h)(7)(E).

Finally, the Board finds that the Medicare Contractor's exclusions of the Four New Programs from Loyola's GME cap was not based on the Medicare Contractor's refusal to modify a predicate fact because the Medicare Contractor modified Loyola's IME cap adding the additional 6.17 New Program FTE slots.[58] The Board also finds that the *Kaiser* decision is not applicable because these cases do not involve the modification of a hospital's cap for FYs 1999 to 2003 or the modification of a predicate fact for which the Board has authority to modify. Rather the Board finds that, when reopening Loyola's 2006 and 2007 cost reports, the Medicare Contractor did not add the 6.17 New Program FTEs to Loyola's GME cap because Loyola's GME cap, for cost reporting periods beginning on or after July 1, 2005, was determined by MMA § 422 and MMA § 422 precludes administrative and judicial review of the MMA § 422 determination.[59]

The Board finds that, after reopening Loyola's FY 2006 and FY 2007 cost reports, the Medicare Contractor correctly completed Worksheet E-3, Part VI, Lines 2 and 4[60] by excluding the 6.17 New Program FTEs from Loyola's GME cap of 314.60 consistent with MMA § 422. The Medicare Contractor correctly transferred the GME cap of 314.60 from Worksheet E-3, Part VI, Line 4 to Worksheet E-3, Part IV, Line 3.04, limiting Loyola's GME reimbursement.[61]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that, for Loyola's FY 2006 and FY 2007 cost reports, the Medicare Contractor used the correct GME cap on Worksheet E-3, Part VI, Line 4 and correctly transferred that amount to Worksheet E-3, Part IV, Line 3.04.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

8/31/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

[58] *See* Exhibit I-6 at 2 in both Case Nos. 12-0427 and No. 10-0520 for Worksheet E, Part A, Line 3.05 and Line 3.07 reflecting the addition of Loyola's 6.17 New Program FTEs to the IME cap for FYs 2006 and 2007. Note that Loyola's IME cap was not adjusted by MMA § 422.

[59] When reopening Loyola's 2006 and 2007 cost reports the Medicare Contractor did not revise Worksheet E-3, Part VI, Lines 2 or 4 from what Loyola originally submitted because these Lines reflect the MMA § 422 cap. *See* PRM 15-2 § 3633.6 (providing instructions for Worksheet E-3 Part VI Lines 2 and 4).

[60] PRM 15-2 § 3633.6 Worksheet E-3 Part VI Lines 2 and 4 requiring the reporting of the MMA § 422 cap. *See also* Exhibit I-24 (Case No. 10-0520) at 1.

[61] The instructions in PRM 15-2 § 3633.4 for Worksheet E-3, Part IV, Line 3.04 state "if this hospital's FTE cap is reduced under 42 CFR §413.79(c)(3) due to unused resident slots, (Worksheet S-2, line 25.05, column 1 is "Y"), effective for cost reporting periods ending on or after July 1, 2005, enter the sum of line 3.03 and line 4 from Worksheet E-3, Part VI." For both FY 2006 and FY 2007, Worksheet E-3 Part IV Line 3.04 reflects a GME cap of 314.60 and Worksheet E-3 Part VI Line 4 reflects a GME Cap of 314.60. *See* Exhibit I-6 (Case No. 10-0520) at 4, 6; Exhibit I-6 (Case No. 12-0427) at 4, 6.