CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Kaiser Foundation Hospitals—Southern California Region 1999 - 2003 GME FTE CAP Group **Providers** **vs.** **Palmetto GBA/First Coast Service Options** **Intermediary**	**Reimbursement Determination for Cost Reporting Periods Ending: 12/31/1999, 12/31/2000, 12/31/2001, 12/31/2002 and 12/31/2003** **Review of:** **PRRB Dec. No. 2011-D1** **Dated: October 1, 2010**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. CMS' Center for Medicare (CM) commented, requesting reversal of the Board's decision. The Providers submitted comments, requesting affirmation of the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue is whether the Intermediary has improperly adjusted the Providers' direct graduate medical education (GME) intern and resident full-time (FTE) counts for their respective fiscal years ended (FTEs) 12/31/1999 through 12/31/2003 by disallowing various FTEs associated with rotations to the Providers' outpatient medical office clinics in FYE 12/31/1996, the GME FTE cap base year.

The Board, reversing the Intermediary's adjustment, held the Intermediary is not precluded by the three year limitation on reopening from adjusting the Providers' respective GME FTE caps for purposes of determining the Providers' GME reimbursement for the cost years at issue. The Board found that the Providers'

1996 GME FTE caps, as reflected on their 1998 cost reports, were understated. Although the Intermediary acknowledged the error, the Intermediary declined to correct the 1996 GME FTE cap. Because of the reopening regulations, more than three years had passed since the 1998 cost reports became final. The Board stated that the legal issue before it is whether the correction of the Providers' GME FTE caps constitutes a reopening of their 1998 cost reports which are subject to the three year regulatory limitation period.

Citing to two court cases, the Board found instructive the court's reasoning.[1] In Regions, the Board noted that the Supreme Court held that the Secretary's regulation did not precluded reaudits of 1984 base years to exclude certain costs because these reaudits would not disturb the actual 1984 reimbursement and reimbursement for any later cost years on which the three-year reopening window had closed. The Court further stated that resulting adjusted reasonable cost figures were to be used solely to calculate reimbursement for still open and future years. Likewise, the Board cited to Healtheast, where the Court considered whether the intermediary could exclude interest in later periods from loans made in earlier period which were found to be unnecessary. The Court found that the three-year limitation on reopening applies solely to the amount of total reimbursement. The reconsideration of factual issues, with no intention of changing the total reimbursement applicable to a year, does not fall with the definition of an "intermediary determination" and is not subject to the three-year limitation. The Board also cited to its decision in a prior case involving erroneous base year costs.

In the current case, the Board found that, similarly, the aim of adjustments to the Providers' respective 1996 GME FTE caps is to accurately determine historical data such that each subsequent year's cost report reflects accurate data. Since such an adjustment would have no effect on reimbursement for FYEs 1996 or 1998 or any closed year, it would not constitute a reopening of the Provider's 1996 or 1998 cost years. The Board concluded that the cited cases confirm that for the purposes of 42 CFR 405.1185(a), a cost report is only reopened when the total amount of reimbursement in the fiscal period covered by the cost report is altered. The correction of factual issues in a closed year does not constitute a reopening when the corrections are made for the purposes of determining a provider's reimbursement in a later open year.

Moreover, the Board was not persuaded by the preamble language cited by the Intermediary that GME FTE caps can only be corrected by reopening the respective 1998 cost reports. The Board determined that neither the governing GME statute

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[1] Regions Hospital v. Shalala, 522 U.S. 448, 452 (1998)(Provider's Exhibit P-9); and Healtheast Bethesda Lutheran Hospital & Rehabilitation Center v. Shalala, 164 F.3d 415 (8th Cir. 1998)(Provider's Exhibit P-8).

nor regulations mandate the use of the 1998 FTE count as it appears on the audited 1998 cost report for purposes of establishing the GME FTE cap. Thus, consistent with the regulatory and statutory language, the Board concluded that the correction of the understated GME FTE caps does not require a reopening on any closed cost reports and therefore is not subject to the three year limitation on reopening.[2]

COMMENTS

CMS' CM commented, requesting reversal of the Board's decision. CM argued that a final determination of a hospital's FTE resident cap is made in a hospital's cost reporting period ending December 31, 1998. CM maintained that the FYE December 31, 1998 cost reports are the first cost reports to set forth the 1996 GME FTE cap amount. Thus, since the 1998 cost report is no longer reopenable, the GME FTE cap determination is closed and cannot be reopened or corrected to add or subtract any FTE counts. CM noted that a request to reopen the 1998 cost report was not made within three years of the date of notice of the intermediary's determination as required by the regulation. Thus, the caps, as determined in the cost reports for FYE December 31, 1998 are final and cannot be revised. CM also noted that the case law relied on by the Board and Providers is not relevant to this matter.

The Providers commented, requesting affirmation of the Board's decision. The Providers argued that under the regulation, the Providers' unweighted GME FTE counts for FYE December 31, 1996 impose a cap on the Providers' weighted GME FTE counts for future years. The Providers' maintained that the application of an erroneously low 1996 FTE count in future years will result in an erroneous cap on the FTEs the Providers can claim in those years. Thus, the Provider's argued that the 1996 cap should properly reflect FTEs associated with clinic rotations in 1996, in accordance with the 1996 Administrator decision.[3]

The Providers' argued that using the correct 1996 FTE figure which reflects clinic rotations that should have been included in 1996, as the cap for future years does not constitute or require a reopening of either the Providers' 1996 cost reports, on which the current 1996 GME FTE caps are based, or the Providers' 1998 cost

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[2] With respect to the Anaheim 2001 appeal, the Board found that there is nothing precluding the Intermediary from applying what the parties agree is the most accurate FTE figures to two of Anaheim's open cost reports. Consequently, the Board stated that although the Anaheim appeal for FYE 2001 has been dismissed, the Intermediary may correct Anaheim's FTE count for 2001 only to the extent it impacts Anaheim's GME reimbursement calculation for FYE 2002 and 2003.

[3] See Provider's Exhibit P-4

reports, on which the 1996 GME FTE cap first appeared. Relying on case law cited by the Board, the Providers noted that the reopening regulation applies solely to the amount of total reimbursement due to a provider in that particular cost year, and does not apply to the reconsideration of predicate factual issues which do not change the total reimbursement amount applicable to the cost year which may not be reopened.

Moreover, the Providers' reasoned that applying an accurate 1996 cap (based on FTEs rotating in all areas of the hospital complex in FY 1996) in each of years that the Providers have properly appealed is consistent with the regulation and intent of congress as expressed in the statutory language. Further, the Providers' maintained that the agency's commentary in another GME provision supports its position. CMS recognized that ensuring the accuracy of the figures used to determine GME payments was of primary importance and justified reauditing cost reports to determine base-year per resident amounts. Thus, the Providers' concluded that if it is not appropriate to allow an erroneous per resident amount to impact reimbursement in subsequent years, it is equally inappropriate to allow an erroneous 1996 GME FTE cap to govern later years. The Providers' also urged the Administrator to adopt the Board's decision with respect to Anaheim.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

The Medicare program provides health insurance to the elderly and disabled.[4] The program entitles an eligible beneficiary to have payment made on his or her behalf for the care and services rendered by participating hospitals, termed "providers." See id. Providers, in turn, are reimbursed by insurance companies, known as "fiscal intermediaries," that have contracted with the Medicare administrator, the Centers for Medicare and Medicaid Services ("CMS").[5] The fiscal intermediary determines the amount of reimbursement due to the provider under Medicare law, including regulations published by CMS.[6] Relevant to this case, section 1815 of the Social Security Act provides that:

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[4] *See* Title XVIII, Section 1801, et seq.
[5] *See* Section 1816 of the Social Security Act. 42 C.F.R. §413.20.
[6] *See* Section 1816 of the Act. 42 C.F.R. § 413.20.

> (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid …, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

Consistent with this statutory requirement, a basic tenet of Medicare payments whether made under reasonable cost or inpatient prospective payment system methodology is that providers must file cost reports for each cost reporting period. The regulation at 42 CFR 413.20(b) provides that: "Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year…." The regulation at 42 CFR 413.24(f) explains that:

> For cost reporting purposes, the Medicare program requires each provider of services to submit periodic reports of its operations that generally cover a consecutive 12 month period of the provider's operations.

Under Medicare law, a final determination as to payment is defined as the intermediary's "final determination of the total program reimbursement due the provider for items and services furnished to individuals for which payment may be made under this title for this period" and "final determinations of the Secretary as to the amount of payment" under section 1886(d). The IPPS payment system likewise requires that a provider file a cost report and that an intermediary issue an NPR.[7]

Pursuant to the filing of the cost report, under both the reasonable cost and IPPS payment methodology, the intermediary issues a notice of program reimbursement, which is a result of those payment claims set forth on the cost report. The intermediary's final determination, as the amount of total program reimbursement

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[7] 42 CFR 405.1803(a)(2)(2006) The Administrator notes that section 1878(a)(1)(A)(ii) as a practical matter allows a provider to appeal pursuant to the formal published rate notice instead of waiting for the issuance of the NPR and also recognizes at section 1878 that hospital that has receives payment under 1886 and "has submitted such reports within such time as the Secretary may require in order to make payment" may obtain a hearing.

for the cost reporting period, issued under both reasonable cost and IPPS, is also referred to as a notice of program reimbursement or NPR.

The regulation also allows for the reopening of such a determination under 42 CFR 405.1885, which states that:

> Reopening a determination or decision.
> (a) A determination of an intermediary, … may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary … either on motion of such intermediary … or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary… or where there has been no such decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.[8]

Relevant to this case, prior to 1983, Medicare reimbursed providers on a reasonable cost basis. Section 1861(v)(1)(a) of the Act defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included…." Section 1861(v)(1)(a) of the Act does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters. In 1983, §1886(d) of the Act was added to establish the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital services furnished to Medicare beneficiaries.[9]

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[8] Paragraphs (d) and (e) provide that: "(d) Notwithstanding the provisions of paragraph (a) of this section, an intermediary determination or hearing decision, a decision of the Board, or a decision of the Secretary shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault of any party to the determination or decision. (e) Notwithstanding an intermediary's discretion to reopen or not reopen an intermediary determination or an intermediary hearing decision under paragraphs (a) and (c) of this section, CMS may direct an intermediary to reopen, or not to reopen, an intermediary determination or an intermediary hearing decision in accordance with paragraphs (a) and (c) of this section."

[9] Pub. Law 98-21 (1983).

Under IPPS, providers are reimbursed their inpatient operating costs based on prospectively determined national and regional rates for each patient discharge, rather than on the basis of reasonable operating costs. Under §§ 1886(a)(4) and (d)(1)(A) of the Act, the costs of approved medical education activities were specifically excluded from the definition of "inpatient operating costs" and, thus, were not included in the PPS hospital-specific, regional, or national payment rates or in the target amount for hospitals not subject to PPS. Instead, payment for approved medical education activities costs were separately identified and paid as "pass-through," i.e., paid on a reasonable cost basis.[10] Later, for the cost years at issue, the direct costs of the approved graduate medical education program were paid under the methodology set forth at section 1886(h) of the Social Security Act. These provisions were promulgated at 42 C.F.R. § 413.86 (1997).

However, Congress recognized that teaching hospitals might be adversely affected by implementation of inpatient PPS because of the indirect costs of the approved graduate medical education programs. These may include the increased department overhead as well as a higher volume of laboratory test and similar services as a result of these programs which would not be reflected the IPPS rates.[11] Thus, under §1886(d)(5)(B) of the Act, hospitals subject to IPPS, with approved teaching programs, receive an additional payment to reflect these IME costs. The regulation at 42 C.F.R. §412.105 governs IME payments to Medicare providers. The regulation states that CMS "makes an additional payment to hospitals for indirect medical education costs" in part by determining the ratio of the number of FTE residents to the number of beds.[12]

A factor in both the IME and GME payment is the number of residents in the providers program. The IME regulation at 42 CFR 412.105(g)(1995) states that:

> Count of residents for cost reporting periods beginning before July 1, 1991. For cost reporting periods beginning before July 1, 1991, in order to have residents included in the count under paragraph (a)(1) of this section, the following requirements must be met:
> ….

[10] Section 1814(b) of the Act.
[11] See 50 Fed. Reg. 35646, 35681 (1985).
[12] The statute states that: The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under the regulations (in effect as of January 1, 1983) under section (a)(2) [i.e. under the reasonable cost routine cost limits] …. (Emphasis added.)

> (5) Residents who are assigned to a setting other than the inpatient or outpatient department of the hospital (such as freestanding family center or an excluded hospital unit) on the day that the count of interns and residents….is made are not counted as full time equivalents…..Only the percentage of time that these residents spend in the portion of the hospital subject to the prospective payment system or in the outpatient department of the hospital on the day the count is made is used to determine the indirect medical education adjustment…..

Subsequently, the regulation at 42 CFR 412.105, was amended to reflect various statutory changes effective after 1991, which included:

> (f) Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991. (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:
> (i) The resident must be enrolled in an approved teaching program….
> (ii) In order to be counted, the resident must be assigned to one of the following areas:
> (A) The portion of the hospital subject to the prospective payment system.
> (B) The outpatient department of the hospital.
> (C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth in §413.78(c) or §413.78(d) of this subchapter, as applicable, are met.

Thus, prior to October 1, 1997, the criteria for the counting of residents for purposes of GME differed from those set forth for IME. That is the calculation of the IME FTE count was not automatically the same as the GME FTE count. The regulation at 42 CFR 42 CFR 412.78(formerly 413.86) states that:

> (b) No individual may be counted as more than one FTE. A hospital cannot claim the time spent by residents training at another hospital. Except as provided in paragraphs (c), (d), and (e) of this section, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time

> resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.
> (c) On or after July 1, 1987, and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—
> (1) The resident spends his or her time in patient care activities.
> (2) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.
> (d) For portions of cost reporting periods occurring on or after January 1, 1999, and before October 1, 2004, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—
> (1) The resident spends his or her time in patient care activities.
> (2) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.
> (3) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in §413.75(b).
> (4) The hospital is subject to the principles of community support and redistribution of costs as specified in §413.81.

In addition, relevant to this case, in 1997, Congress "capped" the number of FTE residents a hospital can claim for Medicare DGME and IME payment purposes at the number of FTE residents in the hospital's "base year" of fiscal year 19963. [1] The cap, as set forth at section 1886(h)(4)(H) of the Act for IME payments,[13] states that:

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[13] . Section 4623 of the Balanced Budget Act of 1997. Pub. L. No. 105-33 (August 5, 1997).

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 the total number of full-time equivalent residents … may not exceed the number of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996. [14]

This provision set forth at 413.79(c)(2) (formerly 413.86),[15] relevant for the GME cap, states that:

> (2) Determination of the FTE resident cap. Subject to the provisions of paragraphs (c)(3) through (c)(6) of this section and §413.81, for purposes of determining direct GME payment—
> (i) For 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.
> (ii) If a hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, and before October 1, 2001, exceeds the limit described in this section, the hospital's total 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.
> …..
> d) Weighted FTE counts. Subject to the provisions of §413.81, for purposes of determining direct GME payment—
> (1) For the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count is equal to the

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[14] The Balanced Budget Act of 1997 (BBA-97) also placed a limitation on resident FTEs for purposes of determining the payment by amending section 1886(d)(5)(B)(v)of the Act as follows: "In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or non-hospital setting may not exceed the number of such full time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 1, 1996.

[15] This provision was codified at 42 C.F.R. §413.86(g)(4) and (5).

> average of the weighted FTE count for the payment year cost reporting period and the preceding cost reporting period.
> (2) For cost reporting periods beginning on or after October 1, 1998, and before October 1, 2001, 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.
> (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.

The Intermediary explained the above statutory and regulatory applications of the cap to the cost years in this case as follows:

> The unweighted FTE cap was determined based on information stated in the ' 96 cost reports. The FTE cap was subsequently applied throughout the 12/31/99, 12/31/200, 12/31/2001. 12/31/2002 and 12/31/2003 cost reporting periods. The issue begins with the 199 cost reports as it relates to the prior 1998 period unweighted cap. The 1996 unweighted cap was shown first determined and shown in the '98 cost report settlement. This was the only determination regarding the application of the '96 unweighted cap. There was no other communications… regarding the cap determination just in the cost reports. ….The '98 period will reflect only the '98, 97 unweighted FTE counts and the 96 unweighted FTE cap. These amounts will then flow into the '99 reporting period and the determination of the three–year average required by 42 section 413.86(g)(4). This entire process then rolls forward throughout each provider cost reporting period into 2003 and beyond.[16]

In sum, pursuant to the Balanced Budget Act of 1997, the GME FTE cap, which was derived from the 1996 GME FTE count, was used to compute the hospital's IME payments beginning in fiscal year 1999.

Finally, the parties have taken notice of the Administrator's decision *Kaiser Foundation Group –IME Costs,* PRRB Dec. No. 96-D50, (*Kaiser I*) rendered in

[16] Transcript of Oral Hearing (Tr.) at 25-26.

October 1996. As courts have recognized, Administrator decision are not precedential. Consistent with that principle, the Administrator held that "after a review of the unique facts presented in this case, the Administrator finds that the time spent by interns and residents in the Kaiser's HCPP should be counted for purposes of determining the Providers' IME adjustment factor. The finding is limited to the narrow facts and circumstances in this case for this cost reporting period." The Kaiser I case involved providers commonly owned by Kaiser, but not involved in this present case.[17] That case also involved whether the time interns and residents spent at certain clinics were properly included for purposes of the providers' IPPS IME adjustment for the cost year ending 1988. Thus, the *Kaiser I* case involved providers not part of the present case, involved the IME FTE count, not the separate and distinct issue of GME, and involved a cost year that occurred at least 10 years before the cost years involved in this present case.

The Providers contended that, as a result of *Kaiser I*, certain Kaiser owned facilities were allowed to count the time spent for FTEs in the outpatient clinics for IME. However during this same time span, the Providers in this case did not claim, nor apparently did they appeal, the continued exclusion of this time in the separate and distinct GME FTE count. More specifically relevant to this case, the Providers failed to include (or appeal) for GME purposes, the outpatient clinic time in the 1996 cost reports or in the 1998 cost reporting period cap determination, nor seek reopening within the three year period set forth in the regulation at 42 CFR 405.1885 for the 1996 and of 1998 cost years. The Providers instead request that the GME FTE cap be now increased to reflect "FTEs associated with clinic rotations in 1996, in accordance with the 1996 Administrator decision" in *Kaiser I*.[18]

The Administrator first notes that the referenced 1996 Administrator decision was for 1988 cost years, did not involve the Providers in this case, did not involve the counting of GME FTEs and thus was not binding for the 1996 cost years for these Providers. Further, the Providers cannot point to any final determination addressing the GME FTE cap for the FY 1996 cost years which requires a retroactive implementation. The Providers acknowledged that they never claimed the additional clinic rotation time for GME or appealed the GME FTE count in prior years to those appealed in this case. The Administrator concludes that the Provider may not request to have the GME FTE cap increased pursuant to the appeal of the subsequent cost years under the facts of this case.

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[17] The Providers in that case involved Provider Nos. 05-0075, 05-512, 05-0073/05-T073, 05 -0076, 05-0541, 05-0071, 05-0072, 05-0674, 05-425.

[18] Provider Final Position Paper at 8.

Although the Providers refer to various cases for their position,[19] the most analogous case is *Tulsa Regional Medical Center*, PRRB Dec. 2008-D43. The IME FTE cap was established and implemented at the same time as the GME cap. In that case, the Intermediary reopened cost years subsequent to the cap period to apply a correct cap. The issue in that case focused on whether the correction of the subsequent years required a reopening of the FY 1996 cap base year, where the Intermediary inadvertently used the GME FTE count for the IME FTE cap base calculation. The Board determined that the: "primary issue in dispute is whether the IME base year FTE cap is properly derived from Worksheet S-3 or Worksheet E, Part A. Neither the statute, nor the regulation identifies where within the cost report the IME FTEs are to be found." The Board ultimately held that the IME FTE count determined in the 1996 cost report was 88.14. The Board ruled that the Intermediary did not violate the three-year limitation on reopening a cost report because 88.14, rather than 107.00, was "the number 'determined' in the 1996 cost report on Worksheet E-3.[20] Consequently, the intermediary action in December 2004 was not a reopening of the 1996 cost report but, rather, an application of the determined 1996 base year FTE cap." [21]

The facts at issue in this case are opposite of those presented in the case of *Tulsa Regional* and, thus, the facts cannot support a finding that a reopening is not necessary to satisfy the Providers present claims. The Administrator finds that the Intermediary's conclusion here, that a reopening would be necessary and that a correction otherwise was beyond its authority, is consistent with that case. In this case, the Providers are not requesting the use of the GME cap base year FTE count reflected on the 1996 cost report and subsequently incorporated as the basis for the

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[19] The Administrator also finds that the cases cited by the Board are not controlling here. For example, among other things, the GME reaudit case involved a regulation provision that specifically allowed for the reaudit of the base year costs and specially limited the reaudit to the classification of costs originally reported on the costs reports and did not allow for the inclusion of costs not before claimed, while, the interest case is consistent with a Manual provision and involves the adjustment to the costs incurred for that year under general accounting rules.

[20] See also Worksheet E , Part A CMS Form 2552-92.

[21] In that case, the provider alleged that 88.14, not 107.00, was the IME FTE count upon which the hospital's IME reimbursement for fiscal year 1996 was calculated. The Intermediary contended that the fact that the 1996 IME FTE count was 88.14 was evident, from Worksheet E of the cost report. Worksheet E does not explicitly state the IME FTE count, but its calculations are based on an IME FTE count of 88.14, and it references Workpaper M-7-2, which clearly notes an IME FTE count of 88.14. The fact that Worksheet S-3 erroneously listed an IME FTE count of 107.00, did not alter the fact that the true IME FTE count utilized to calculate the hospital's reimbursement for 1996 was 88.14.

1998 unweighted cap on Worksheet E-3.[22] The Providers have not alleged that the 1996 GME FTE count used in determining the cap was different from the settled 1996 cost reports. Rather the Providers are requesting the use of a GME FTE cap count that is different from that shown in the 1996 and 1998 final determinations. The Providers' requested cap number is based on a legal theory represented in a decision on IME clinic rotations for a 1998 cost year which these Providers now allege should require the correction of the 1996 data in the applicable years in this case.

The Administrator finds that the increase in the FTE cap requested by the Provider would require that the 1996 and 1998 cost reports be reopened and a determination be made with respect to the GME FTE count for the FY 1996 year. However, the parties agreed that both the FYs 1996 and 1998 cost years for the Providers are beyond the reopening period.[23] The Providers cannot seek such a change in its GME FTE base year cap through the appeal of the subsequent years to which the cap has been applied in this case. The Administrator also finds there is no regulatory authority to adjust the FTEs as the Providers proposed. Such an increase would not be based on any final cost report determination relating to these Providers' 1996 cost years. The reference in the BBA cap provisions to the hospital's "most recent cost reporting period ending on or before December 31, 1996" necessarily refers to the cost report settlement process that captures the data for that period as required within the framework of the Medicare program pursuant to, *inter alia*, section 1815 of the Act, and 42 CFR 413.20 and 413.24, etc..[24] Accordingly, the Board's decision is reversed.

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[22] In this regard, for this present case, only the related Worksheets E-3 are in the record for the FY 1998 cost years and not for the FY 1996 cost years.

[23] Providers' Final Position Paper at n. 5.

[24] The Board seemed to erroneously separate the payment determination and related recordkeeping for a cost reporting period from the cost report settlement process. See e.g., "(Board Member) Q: I guess my point is the regulation doesn't say what you say. You say that the 1996 FTE count as reported in the 1998 cost report is the only—is the amount that must be used. (Intermediary) A: Correct. Q: And I'm saying the regulation does not say that. A: Well there no other way—no other place to get it." Tr. 49-50. Similarly, the Intermediary explained that: "Well I think in 413.86(g)(4) of 42 CFR, they're talking about as it applies from one cost reporting period to another, and only place that you find these numbers where the determination is made [is] in the cost report. You just don't pull them out of thin air, they have to be in the cost report and roll forward from one year to the next." Tr. 38.

DECISION

The decision of the PRRB is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF THE HEALTH AND HUMAN SERVICES

Date: 11/30/10 /s/

Marilyn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services