CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Eastern Maine Medical Center	**Provider Cost Reimbursement Determination for Cost Year Ending: September 27, 2003 and September 25, 2004**
Provider	
vs.	**Review of:**
BlueCross BlueShield Association/ NHIC, Corp., c/o National Government Services, Inc.	**PRRB Dec. No. 2014-D10**
Intermediary	**Dated: June 2, 2014**

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 mandated in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The Intermediary submitted comments, requesting that the Administrator review and reverse the Board's decision in this case. Subsequently, the parties were notified of the Administrator's intention to review the Board's decision. The Center for Medicare (CM) submitted comments, requesting that the Administrator review the Board's decision. The Provider commented, requesting that the Administrator affirm the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE

The issue was whether the Intermediary's[1] exclusion of certain outside rotations from the Provider's direct Graduate Medical Education (GME) and Indirect Medical Education (IME) full time equivalent count was proper.

[1] Formerly known as Fiscal Intermediaries (FIs), CMS's payment and audit functions under the Medicare program are now contracted to organizations known as Medicare

BOARD'S DECISION

The Board found that the Intermediary's determination of the Provider's GME and IME payments was improper, and directed the Intermediary to audit the Provider's disallowed rotation schedules for fiscal years ending (FYEs) 2003 and 2004 by applying the Patient Protection and Affordable Care Act (ACA)[2] §§ 5504(a) and (b) to its review. The Board ordered that, once the Intermediary has completed review, the Intermediary should revise the Provider's number of resident full-time equivalents used for purposes of Medicare GME and IME for FYEs 2003 and 2004.

The Board found that § 5504 ACA changed the statutory provisions for the Medicare reimbursement of GME and IME. As such, the Board addressed whether these changes applied to this case. The Board found that §§ 5504(a) and (b) of the ACA specify that the changes to IME and GME reimbursement are effective for cost reporting periods or discharges, respectively, beginning on or after July 1, 2010 without retrospective application—however, § 5504(c) also authorizes application of these changes to "jurisdictionally proper pending appeals as of the date of enactment of this Act."

The Board also reviewed the preamble to the November 2010 Final Rule[3] and found that the implementing regulation, 42 C.F.R. § 413.78(g)(6), specifies that ACA §§ 5504(a) and (b) apply to "cost reports on which there is a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010." The Board noted that this finding is supported by the discussion in the preambles to the proposed rule published on August 3, 2010, as well as in the November 2010 Final Rule and the regulation adopted in the November 2010 Final Rule. The Board found that the preamble to the August 2010 Proposed Rule included examples that made it clear that CMS intended to apply ACA §§ 5504(a) and (b) to "pending, jurisdictionally proper appeals." The Board found that, while the proposed rule did not include a regulatory provision to implement the uncodified ACA § 5504(c), the November 2010 Final Rule did (namely 42 C.F.R. § 413.78(g)(6)) and the Board noted that it was bound by this regulatory provision. The Board claimed that this regulatory provision clearly allows a provider with a "pending, jurisdictionally proper appeal" specific to GME or IME as of March 23, 2010 to have ACA §§ 5504(a) and (b) applied to them (i.e., subsection (a) for a pending GME issue and subsection (b) for a pending IME issue). In this case, for both FYEs 2003 and 2004, the Provider had GME and IME issues

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Administrative Contractors (MACs). However, for the cost year at issue in this case, the term "Intermediary" will be used.

[2] Pub. L. 111-148 (Mar. 23, 2010).

[3] 75 Fed. Reg. 71,800.

pending on appeal as of March 23, 2010. Thus, the Board found, ACA § 5504(c) and 42 C.F.R. § 413.78(g)(6) are applicable to this case.

The Board found that the Intermediary's interpretation of the preamble discussion would conflict, and cannot be reconciled, with the plain reading of 42 C.F.R. § 413.78(g)(6), and, the Board found, as it is bound by regulations pursuant to 42 C.F.R. § 405.1867, it must reject the Intermediary's interpretation.

Thus, the Board found that the Provider satisfied the requirement in ACA § 5504(c) because, as of March 23, 2010, both of the subject appeals were pending before the Board and GME and IME payments were specific issues on appeal as required by the regulation. As a result, the Board found that ACA §§ 5504(a) and (b) must be applied to this case.

The Board next considered the effect of applying ACA §§ 5504(a) and (b) to the case before the Board. The Board found that the plain language of ACA §§ 5504(a) and (b) no longer requires a written agreement and that a provider must only meet the requirement of payment of the resident's stipend and fringe benefits during the time spent at the non-provider setting. Thus, the Board found, because the written agreement is no longer required under ACA §5504, the Intermediary's concerns about whether the Provider had a proper written agreement for each rotation at issue becomes moot. As such, the Board ordered the Intermediary to audit the rotations under appeal in these cases to determine if the requirements of the statute, including the provisions of ACA § 5504, and regulations were met as to the remaining rotations at issue, and revise the Provider's Medicare cost reports for FYEs 2003 and 2004, accordingly.

SUMMARY OF COMMENTS

The Intermediary commented, requesting that the Administrator reverse the Board's decision. The Intermediary noted that the Board found that § 5504(a) of the ACA applies retroactively, and, as a result, providers are no longer required to comply with longstanding regulatory requirements for IME and GME reimbursement for the offsite placement of medical residents (if they have a jurisdictionally proper pending appeal). The Intermediary argued that the implementing regulation at 42 C.F.R. §413.78(g)(6) applies prospectively and covers cost reporting periods starting on or after July 1, 2010.

The Intermediary cited to reasoning set forth in its supplemental Post-Hearing Memorandum. In further support, it noted that the statute, which is controlling, expressly provides that the law applies to cost reporting periods beginning on or after July 1, 2010. The Intermediary pointed out that there is no "conflict" between §

5504(c) of the statute and the regulation, and that the drafters of the statute clearly intended to prevent the amendments set forth in §§ 5504(a) and (b) from being applied to cost reports for periods after July 1, 2010 that were settled before the statute was enacted.

The Intermediary argued that there is no "conflict" between § 5504(c) of the statute, and the regulation, as the drafters of the statute clearly intended to prevent the amendments set forth in §§ 5504(a) and (b) from being applied to cost reports for periods after July 1, 2010 that were settled before the statute was enacted. In other words, the Intermediary noted, this section was intended to prevent retroactive application of the amendments. The drafters of the statute would not know when the statute would be enacted. Thus, they could not specify the enactment date of March 23, 2010, a date that was earlier than any possible settlement date for cost reporting periods beginning after July 1, 2010, rendering the limitation unnecessary. The drafters of the regulation knew the date the statute was enacted, and inserted that date into the regulation, but did not thereby intend to make the regulation retroactive. Rather, the Intermediary noted, the regulation remained a prohibition on applying the amendments to settled cost reports where no appeal was pending on the date the statute was enacted, not a mandate to apply the amendments to cost reports with appeals pending on the date the statute was enacted.

Finally, the Intermediary stated, the Board improperly read a "double negative" in the statute. The provision that the amendments may not be applied in a manner that requires reopening of settled cost reports as to which there is not a jurisdictionally proper appeal pending, has been applied as an affirmative requirement that the amendments are applicable to cost reports for which there are jurisdictionally proper appeals pending. The Intermediary pointed out that this reading changes the meaning of the statute, turning a prohibition against applying the amendments to settled cost reports without appeals pending, into a mandate to apply the amendments to other cost reports that do have appeals pending. The Intermediary noted that the Board's reading of the regulation contradicts the express language of the statute that provides for a prospective, rather than retroactive effect, and thus, the reading is clearly erroneous.

The Center for Medicare (CM) commented, recommending that the Administrator reverse the Board's decision. CM noted that this case centers on whether the Provider complied with applicable law and regulations in effect at the time of the Provider's FYE 2003 and 2004 cost reports, concerning IME and GME payments to hospitals for residents training in nonprovider settings. CM stated that it believed the primary issue in deciding the merits of this case is whether § 5504 of the Affordable Care Act applies to FYE 2003 and 2004 cost reports, or whether previous law

applies. CM stated that it disagreed with the Board's finding that § 5504 is retroactive, and instead stated that it believed that previous law applies in this case.

CM stated that § 5504 of the ACA changed certain requirements that a hospital must meet in order to count residency training time at a nonprovider site for GME and IME payment purposes. Section 5504(a) of ACA reduced the costs that hospitals must incur for residents training in nonprovider sites on a prospective basis. Specifically, §5504(a)(3) amended § 1886(h)(4) of the Social Security Act effective for "cost reporting periods beginning on or after July 1, 2010" for GME, to permit hospitals to count the time that a resident trains in activities related to patient care in a nonprovider site in its FTE count if the hospital incurs the costs of the residents' salaries and fringe benefits for the time that the resident spends training in the nonprovider site. Section 5504(b)(2) of the ACA made similar changes to section 1886(d)(5)(B)(iv) for IME payment purposes, with the provision being effective for discharges occurring on or after July 1, 2010 for IME. CM pointed out that, when Congress enacted § 5504 of the ACA, it retained the statutory language which provides that a hospital can only count the time so spent by a resident under an approved medical residency training program in its FTE count if that one single hospital by itself "incurs all, or substantially all, of the costs for the training program in that setting." In doing so, Congress also revised the statutory language in §§ 5504(a)(1) and (b)(1) to explicitly provide that this longstanding substantive standard and requirement continued to be applicable to "cost reporting periods beginning before July 1, 2010" for GME, and to "discharges occurring on or after October 1, 1997 and before July 1, 2010" for IME. CM noted that based on this statutory language, it believed it was clear that §§ 5504(a) and (b) are only effective prospectively as of July 1, 2010.

CM stated that CMS' position on the prospective nature of § 5504 was most recently clarified in the Federal fiscal year (FFY) 2015 IPPS proposed rule, published on May 15, 2014.[4] CM pointed out that the ACA was enacted on March 23, 2010, and that § 5504(c) of the ACA specifies that the amendments made by the provisions of sections 5504(a) and (b) "shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education…or for direct graduate medical education costs…" CM noted that, when CMS proposed to implement § 5504(c) in the August 3, 2010 proposed rule[5] and when CMS implemented § 5504(c) in the November 24, 2010 final rule,[6] CMS had to consider the meaning it was adding to §§ 5504(a) and

[4] 79 Fed. Reg. 27,978, 28,152-4.
[5] 75 Fed. Reg. 46,169, 46,385.
[6] 75 Fed. Reg. 71,800.

(b) of the ACA. CM argued that unlike, for example, § 5505 of the ACA which had an effective date prior to enactment of the ACA and, therefore, would apply to prior cost reporting periods, § 5504's applicable effective date for the new standards it created was July 1, 2010, a date that came after enactment of the Affordable Care Act and was fully prospective. CM pointed out that in the November 24, 2010 final rule, it is noted that:

> Section 5504(c) is fully prospective with an explicit effective date of July 1, 2010, for the new standards it creates. Nothing in section 5504(c) overrides that effective date. Section 5504(c) merely notes that the usual discretionary authority of Medicare contractors to reopen cost reports is not changed by the provisions of section 5504; it simply makes clear that Medicare contractors are not required by reason of section 5504 to reopen any settled cost report as to which a provider does not have a jurisdictionally proper appeal pending. It does not require reopening in any circumstance; and the new substantive standard is, in any event, explicitly prospective. We believe if Congress had wanted to require such action or to apply the new standards to cost years or discharges prior to July 1, 2010, it would have done so in far more explicit terms.[7]

It was also noted in the final rule that "[the] statute does not provide CMS discretion to allow the counting of resident time spent in shared nonprovider site rotations for cost reporting periods beginning prior to July 1, 2010."[8] CM stated that it continued to believe that Congress was clear in amending §§ 1886(h)(4)(E) and 1886(d)(5)(B)(iv) of the Act to provide for the new standards to be applied only prospectively, effective for cost reporting periods beginning on or after, and discharges occurring on or after, July 1, 2010. CM also noted that the plain meaning of § 5504(c) of the ACA is that the Secretary is not required to reopen a cost report when there is no jurisdictionally proper appeal pending as of March 23, 2010, the date of the enactment of the ACA, on the issue of payment for IME and direct GME. CM thus argued that § 5504(c) of the ACA is merely a confirmation of the Secretary's existing discretionary authority in one particular context, and that §§ 5504(a) and (b) of the ACA and their effective dates become all the more prominent, and are not affected by § 5504(c). CM stated that it believed it was apparent that the provisions of §§ 5504(a)(3) and (b)(2) of the ACA are not to be applied prior to July 1, 2010, irrespective of whether a hospital may have had a jurisdictionally proper appeal pending as of March 23, 2010, on an IME or direct GME issue from a cost reporting period occurring prior to July 1, 2010.

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[7] *Id.* at 72,136.
[8] *Id.* at 72,139.

CM noted that based on this, § 5504 is effective only prospectively and is to be applied only prospectively, and therefore, does not apply in this case to the Provider's FYE 2003 and FYE 2004 cost reports under appeal. Rather, the law and regulations in effect prior to July 1, 2010 would apply. CM stated that in terms of whether a written agreement was required during the Provider's cost reporting periods at issue, the regulations at 42 C.F.R. § 413.7.8(d)(2) require that, for portions of cost reporting periods occurring on or after January 1, 1999 and before October 1, 2004:

> [t]he 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.

CM pointed out that the Provider's argument that § 5504 does not require a written agreement is irrelevant because the regulations implementing § 1886(h)(4)(E) of the Act requiring a written agreement for purposes of counting resident time at nonhospital sites were in effect during the cost reporting periods at issue.

CM noted that in regards to the issue of teaching physicians volunteering their time in GME activities at nonprovider sites, CMS has stated that the relevant question is not whether volunteerism is permissible, but whether there is a cost to the nonprovider site for supervising the resident's training. If there is a cost, the hospital must reimburse the nonprovider site for those costs. That is, in situations where the teaching physician receives a predetermined compensation amount for his or her time at the nonprovider site that does not vary with the number of patients he or she treats, there is a cost for the teaching physician time spent in nonpatient care GME activities. In contrast, if the physician's compensation at the nonprovider site is based solely on his or her billings, there is no cost for teaching physician time spent in nonpatient care GME activities.

Finally, CM stated that, with respect to the moratorium on teaching physician costs, § 713 of the MMA imposed a one-year moratorium relating to certain nonprovider site teaching physician costs for the period from January 1, 2004, through December 31, 2004. During this one-year period, CMS was required to allow hospitals to count FTE allopathic or osteopathic family practice residents training in nonprovider settings for DGME and IME payment purposes without regard to the financial arrangement between the hospital and the teaching physician. In other words, the moratorium was related to payment of teaching physician costs, not to the requirement that a written

agreement be in place between the hospital and the nonprovider site. Therefore, to the extent that the Intermediary found the Provider's written agreements to be lacking, the moratorium is not applicable in this case.

In conclusion, CM noted that it disagreed with the Board's determination that §§ 5504(a) and 5504(b) can be applied retroactively to the Provider's FYEs 2003 and 2004 cost reports. CM stated that it believed §§ 5504(a)(3) and (b)(2) were prospective provisions that only applied effective July 1, 2010, and that § 5504(c) merely notes that the usual discretionary authority of Medicare contractors to reopen cost reports is not changed by the provisions of § 5504. Therefore, CM recommended that the Administrator overturn the Board's decision in this case.

The Provider commented, requesting that the Administrator affirm the Board's decision.[9] The Provider noted that the Board's Decision will not have a widespread impact, as it will affect only a finite number of appeals. The Provider pointed out that the Board's decision, if affirmed, will address only a small number of past cases, and will not affect future appeals, and that for this reason alone, CMS should not waste its limited resources reviewing this matter.

The Provider believed that the Board correctly determined that ACA § 5504(c) required retroactive application of § 5504(a)(3) and (b)(2), because the Provider maintained a timely jurisdictionally proper appeal. The Provider noted that reading § 5504 as a whole, subsections (a)(3) and (b)(2) apply prospectively except when the Provider has a jurisdictionally proper appeal pending as of the effective date of the ACA. The Provider argued that this interpretation not only naturally flows from the plain language of the statute, but that it makes perfect logical, and grammatical,

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[9] The Provider also commented that the Administrator's June 2, 2014 Notice of Review was defective as the Notice failed to indicate the "specific issues that are being considered" and instead referred generally to the broad issue before the Board, "and as such, the CMS Administrator's defective Notice has deprived the Provider of the essential elements of due process." The Administrator disagrees with the Provider's contention that the Notice of Review was deficient. The Notice specified that the Board's decision would be reviewed, in particular, the specific issue of "whether the Medicare Administrative Contractor erred by excluding outside rotations from the Provider's Graduate Medical Education and Indirect Medical Education full time equivalent count." The Notice of Review also stated that, involved in the review would be "whether the Board's decision is in keeping with the pertinent laws, regulations, and other criteria cited by the Board and by the parties in their comments" as well as "in light of prior decisions of the Administrator and relevant court decisions". The Provider's comments on the merits of the Board decision underlines that it was on notice as to the issues being considered.

sense. The Provider claimed that Congress was clearly aware of the continued problems created by CMS' outside rotation policy, and it stepped in to fix it, solving the problem going forward for all hospitals, and solving the problem retroactively for some hospital (like the Provider) that had jurisdictionally proper appeals regarding this exact issue.

The Provider noted that, while CMS contends that §§ 5504(a)(3) and (b)(2) may only be applied prospectively, if had Congress intended this, then it would never have included subsection (c). Subsection (c) governs the "application" of § 5504—specifically referring to the ''amendments" made by § 5504, and explaining how they should be applied. Thus, the Provider stated, the plain language of subsection (c), interpreted in accordance with the applicable rules of statutory construction, makes clear that Congress contemplated the retroactive application of subsections (a) and (b).

With respect to subsection (c), first the Provider averred, subsection (c) refers to a "reopening" which, in Medicare parlance, is a process used to correct a past decision that was incorporated into a final determination. The Provider argued that this reference to a "reopening" cannot possibly apply to a future year that begins on or after July 1, 2010, and can only mean a cost reporting period beginning before July 1, 2010, and ending (and appealed) prior to March 23, 2010. The Provider stated that Congress clearly contemplated that some past years may be reopened, Congress intended for the "amendments" to be applied during those reopenings, otherwise, it would not have been necessary for Congress to identify those past appealed years.

Second, the Provider argued that subsection (c) would have been drafted very differently if Congress intended it merely as a clarification that "Medicare contractors are not required by reason of § 5504 to reopen a cost report as to which a provider does not have a jurisdictionally proper appeal pending." The Provider noted that Congress could merely have stated that the "amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports." As Congress did not do that, the words it added must be presumed to have meaning.

Third, the Provider pointed out that Congress chose not to treat all ''settled hospital cost reports" the same, instead specifying different treatment for those "settled hospital cost reports" with a "jurisdictionally proper appeal pending as of the date of the enactment of this Act..." The Provider stated that Congress would not have distinguished certain "settled hospital cost reports" if it did not intend to make that distinction meaningful.

Thus, the Provider noted, there is no way to reconcile CMS' suggested interpretation against the plain language of the statute: if a reopening is not required even with a timely, jurisdictionally proper appeal, Congress would not have created subsection (c) at all, and specified such appeals. If subsection (c) does not contemplate retroactive application of the amendments, Congress would not make it apply only to cost reporting periods that ended well before the amendments became effective.

The Provider also commented that CMS' suggested interpretation of § 5504(c) is internally inconsistent. The Provider stated that, while it is true that Congress apparently left it to the Secretary's discretion whether to reopen in the absence of a timely, jurisdictionally proper appeal, such a conclusion does not support CMS' position that a reopening involving a timely, jurisdictionally proper appeal is also discretionary. Rather, the Provider argued, Congress clearly distinguished between cost report years for which there was a timely, jurisdictionally proper appeal, and years in which there was not. The Provider noted that CMS suggested interpretation treats these very different situations exactly the same, thereby rendering Congress' clear distinction meaningless. Moreover, if § 5504(c) "is merely a confirmation of the Secretary's existing discretionary authority…" then it naturally follows that the amendments made in §§ 5504(a) and (b) may be applied retroactively if such discretionary authority is exercised. The Provider argued that retroactive application of the amendments is the only possibility under Section 5504(c): the timely, jurisdictionally proper appeals referenced by Congress had to be pending on March 23, 2010—over three months before July 1, 2010. The Provider noted that even CMS must concede that it would be impossible to have an appeal for a fiscal year beginning on or after July 1, 2010 pending as of March 23, 2010, as an appeal may not be filed until a final determination has been made, or such final determination has not been made at least one year after the cost report has been filed. Thus, the Provider reasoned, CMS' argument is internally inconsistent as on the one hand, CMS suggests § 5504(c) permits a discretionary reopening of fiscal years that ended before the law was enacted, but on the other, CMS argues that § 5504 may be applied only in cost reporting periods beginning on or after July 1, 2010. The Provider noted that because subsection (c) clearly contemplates having the "amendments" of § 5504 "applied" to" settled hospital cost reports," it is clear that Congress intended retroactive application of the amendments in the specified circumstances, so long as the provider had filed a timely, jurisdictionally proper appeal.

The Provider argued that CMS' interpretation of ACA § 5504(e), as set forth in the preamble to the Final Rule, was not a logical outgrowth of the proposed rule, and is therefore invalid. The Provider noted that in its proposed regulations, CMS confirmed its intent to apply the ACA § 5504(a) and (b) to pending appeals, stating "Section 5504(c) of the [ACA] specifies that the amendments made by the provisions of sections 5504(a) and (b) shall not be applied in a manner that would require the

reopening of settled cost reports except where the provider has a jurisdictionally proper appeal pending on the issue of direct GME or IME payments as of March 23, 2010...". CMS went on to define its interpretation of jurisdictionally proper pending appeal, which would have been unnecessary, the Provider argued, if it intended §§ 5504(a) and (b) to apply prospectively in all circumstances. However, the Provider pointed out, in the preamble to the final regulation, CMS announced—without changing the plain language of the applicable regulation—that it was adopting a very different position. Now CMS suggests that § 5504 may only apply prospectively, and that subsection (c) merely describes the MAC's general reopening powers. The Provider claimed that CMS' interpretation set forth in the preamble to the final rule is inconsistent with the plain language of the regulations it actually adopted, and, was not a logical outgrowth of the proposed rule or CMS' explanations of it. Accordingly, the Provider stated, any interpretation based upon the preamble to the final rule is invalid as a violation of the laws governing notice and comment rulemaking.

The Provider noted that the plain language of CMS' own regulation supports the Board's decision. The Provider argued that even assuming that § 5504(c) does not unambiguously support the Board's decision, the next step would not be deferring to CMS' statement in the preamble to the final rule, but instead, the CMS Administrator must apply the plain meaning of 42 C.F.R. § 413.78(g)(6). The Provider stated that this language clearly supports the Board's decision, as the regulation unambiguously states that the applicable sections:

> [C]annot be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which there is a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.

The Provider noted that the plain meaning of the word ''except" makes clear that a general rule applies (no reopening is required) unless the Provider satisfied the exception (a timely, jurisdictionally proper appeal), and does not in any way suggest that the application of the exception is discretionary.

The Provider also noted that the Board's decision could be affirmed on alternative grounds. The Provider pointed out that because the Board agreed with the Provider's arguments regarding ACA § 5504, it neglected to reach the Provider's alternative arguments. The Provider believed that the Board's decision may be affirmed on the alternative grounds set forth in the Provider's Final Position Paper and Post Hearing Brief, and noted that the exhibits and testimony clearly demonstrate that the Provider was relying upon CMS' initial guidance which clearly allowed volunteer rotations under these circumstances. Additionally, the Provider argued that if the CMS

Administrator modifies or reverses the Board's decision, she must then adopt specific findings of fact and conclusions of law regarding the Provider's alternative arguments, and these findings must be based upon the evidence in the record. The Provider requested that the CMS Administrator adopt the Provider's proposed findings, as detailed at pp. 18-19 of the Provider's Post Hearing Brief.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. The Administrator has reviewed the Board's decision. All comments timely submitted have been taken into consideration.

Since the inception of Medicare in 1965, the program has shared in the costs of educational activities incurred by participating providers. The regulations at 42 C.F.R. § 413.85(b) define approved educational activities to mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities include approved training programs for physicians, nurses, and certain allied health professionals.

Effective July 1, 1987, the Social Security Act was amended to allow hospitals to count the time residents spend training in sites that are not part of the hospital (referred to as ''nonprovider'' or ''nonhospital sites'') for purposes of direct GME payments under certain conditions. Section 1886(h)(4)(A) of the Act (as added by section 9314 of the Omnibus Budget Reconciliation Act of 1986 (OBRA '86)[10] provides that the Secretary ''shall establish rules consistent with this paragraph for the computation of the number of full-time equivalent residents in an approved medical residency training program.''

Section 1886(h)(4)(E) of the Act states that the Secretary's rules concerning computation of FTE residents for purposes of GME payments shall:

> [P]rovide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

[10] Pub. L. 99–509.

Regulations implementing this provision were published in the September 29, 1989 final rule.[11] The implementing regulation at 42 C.F.R. § 413.86(f)(4) (2003) and later redesiganted without substantive change to 42 C.F.R. § 413.78(d) (2004)[12], states that:

> For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in non-provider setting the time residents spend in non-provider 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:
>
> (i) The resident spends his or her time in patient care activities.
>
> (ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the costs 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 non-hospital site for supervisory teaching activities.
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> (iii) The hospital must incur all or substantially all of the costs for the training program in the non-hospital setting in accordance with the definition in paragraph (b) of this section.

In order to implement section 1886(h)(4)(E) (and later, section 1886(d)(5)(B)(iv)) of the Act, and to assist contractors in determining whether a hospital incurred ‘‘all or substantially all’’ of the costs of the program in the nonprovider setting, CMS required under § 413.86(f)(3)[13] and (f)(4)[14] that there must be a written agreement[15]

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[11] 54 Fed. Reg. 40,292. Effective for cost reporting periods 2003 and 2004.

[12] In 2004, the regulation at 42 C.F.R. § 413.86(f)(4) was redesignated to 42 C.F.R. § 413.78(d). *See* 69 Fed. Reg. 48,916, 49,235, 29,258 (Aug. 11, 2004).

[13] Now redesignated as § 413.78(c). Involves cost reporting periods on or after July 1, 1997 and before June 1, 1999.

[14] Now redesignated as § 413.78 (d).

[15] The nature of and the rationale for the written agreement requirement has been explained, and the statutory authority for the written agreement identified, in the preamble to other rules. *See, e.g.*, 63 Fed. Reg. 40,954, 40,986-89, 40,992-94, and 40,996 (July 31, 1998); 68 Fed. Reg. 45,346 (Aug. 1, 2003); 69 Fed. Reg. 48,916, 49,179-80 (Aug. 11, 2004); and 72 Fed. Reg. 26,870, 26969–70 (May 11, 2007).

between the hospital and the nonprovider site stating that the hospital will incur ''all or substantially all'' of the costs of training in the nonprovider setting. This provision is consistent with the statutory authority in sections 1815(a), 1861(v)(1)(A), 1886(h)(3)(B), 1886(h)(4)(A), 1886(h)(4)(E), and 1886(k). This written agreement has also been referred to as a ''written contract''.[16] The regulation at § 413.86(f)(4)[17] specifies that the written agreement must indicate the amount of compensation provided by the hospital to the nonprovider site for supervisory teaching activities.[18]

The phrase "all or substantially all" in 42 C.F.R. § 413.86(f)(4), now designated as 42 C.F.R. § 413.78(d) is defined in the definition section of the regulation as:

> [T]he residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.

The definition of "all or substantially all" of the costs was clarified pursuant to the FY 1999 IPPS final rule (July 31, 1998).[19] The Secretary explained that:

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[16] 63 Fed. Reg. 40,954, 40,989 (July 31, 1998).

[17] Now redesignated as § 413.78(d)(2)

[18] The written agreement requirement was modified after the cost years in this case, in the FY 2005 IPPS final rule (69 Fed. Reg. 48,916, 49,179 (Aug. 11, 2004)), which revised the regulations at §413.78(e) to allow hospitals to choose to either enter into a written agreement with the nonprovider site before the hospital may begin to count residents training at the nonprovider site, or to pay concurrently for the cost of training at the nonprovider setting. Thus, in the absence of a written agreement, hospitals are required to pay ''all or substantially all'' of the costs of the training program in the nonprovider setting by the end of the third month following the month in which the training occurs.

[19] On May 11, 2007, after the cost years at issue in this case, the IPPS final rule (72 Fed. Reg. 26,949) explained the definition of ''all or substantially all" to mean at least 90 percent of the total costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of the teaching physician's salaries attributable to GME. With this definition, hospitals were not required to pay 100 percent of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the teaching physicians' costs attributable to GME at the nonprovider site. In addition, the May 11, 2007 final rule modified the regulation text at § 413.78(f)(3)(ii) to specify the longstanding policy that the required written agreement between a hospital and a nonprovider site must be in place before residents begin training at the nonprovider site. That final rule also specified the information that must be included in the

> We proposed that, in order for a hospital to include residents' training time in a nonhospital setting, the hospital and the nonhospital site must have a *written contract* which indicates the hospital is assuming financial responsibility for, at a minimum, the cost of residents' salaries and fringe benefits (including travel and lodging expenses where applicable) and the costs for that portion of teaching physicians' salaries and fringe benefits related to the time spent in teaching and supervision of residents. *The contract must indicate that the hospital is assuming financial responsibility for these costs directly or that the hospital agrees to reimburse the nonhospital site for such costs.* (Emphasis added.)

The implementing regulations require that, in addition to incurring all or substantially all of the costs of the program at the nonhospital setting, there must be a written agreement between the hospital and the nonhospital site. Notably in clarifying the definition of "all or substantially all" of the costs, pursuant to the FFY 1999 final rule[20], the Secretary also responded to commenters concerned of existing agreements between hospitals and nonprovider settings not conforming to this requirement. The Secretary noted that:

> One commenter noted that some arrangements between hospitals and nonhospital settings for the training of residents predate the GME base year. This commenter stated that hospitals did not compensate nonhospital sites for supervisory teaching physician costs and it would not be fair to shift these costs to teaching hospitals. The commenter also stated that teaching hospitals have already entered into written agreements with nonhospital sites under the existing rules. According to the commenter, the proposed rule would necessitate renegotiation of thousands of agreements, imposing tremendous transaction costs upon the academic medical community. The commenter noted that if the agreements are not renegotiated prior to the effective date, the hospital will be unable to count the residents for direct and indirect GME, and this will have a lasting effect because of the 3 year averaging rules. Another commenter stated that there are many complex contractual arrangements between hospital based programs and nonhospital sites regarding the placement, training and patient service utilization of residents, and any change in Medicare GME payment policy could

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written agreement, and stated that the amounts specified in the written agreement may be modified by June 30 of the applicable academic year.

[20] 63 Fed. Reg. 40,954 (July 31, 1998).

> have significant and unknown impacts on these current training structures.
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> Response: The GME provisions of this final rule will be effective January 1, 1999. All other provisions of this final rule are effective October 1, 1998. By making a later effective date for the GME provisions, hospitals and nonhospital sites will have 5 months following publication of this final rule to negotiate agreements that will allow hospitals to continue counting residents training in nonhospital sites for indirect and direct GME. These agreements are related solely to financial arrangements for training in nonhospital sites. We do not believe that the agreements regarding these financial transactions will necessitate changes in the placement and training of residents.[21]

Consequently, the Secretary contemplated and expected that the hospitals would have the opportunity to negotiate and have in place by January 1, 1999, prior to the beginning of the affected year, written agreements that met the necessary criteria for inclusion of the FTEs in the hospital resident counts.

CMS allowed physicians to volunteer their time as supervisory physicians, provided that the written agreement specified that the physician was volunteering.[22] However, CMS specified again that there must be a written agreement in place *before the time the residents begin training* in the nonhospital site.[23] Program Memorandum A-98-44[24], published December 1, 1998, in a section regarding "Volunteer Teaching Physicians" noted:

> Several questions have also arisen as to whether the written agreement can specify that the hospital is proving no compensation for supervisory teaching activities because the supervising physician in the nonhospital site is a volunteer. The fiscal intermediary must distinguish situations where there is no explicit compensation for supervisory teaching physician activities, from those where there are truly no costs. For instance, a nonhospital site may provide compensation to a teaching physician for services provided to patients and for supervising residents in a clinic.

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[21] *Id.* At 40,995.
[22] *See, e.g.*, 63 Fed Reg. 40,986, 40,996 (July 31, 1998).
[23] *See* Medicare Policy Clarifications on Graduate Medical Education Payments for Residents Training in Non-Hospital Settings (April 2005), "Question 8.
[24] Also known as HCFA Pub. 60A.

> Although there be no explicit compensation for supervising residents in this situation, the portion of the teaching physician's compensation attributable to the time spent supervising and teaching residents remains a "cost" to the nonhospital clinic. The written agreement must specify and identify this cost for the hospital to meet the criterion of incurring all or substantially all of the costs.
>
> We would distinguish this situation from those few unique situations where the nonhospital site has no supervisory costs and the physician is voluntarily participating in the training. For instance, the resident may be training in a physician's private office. In this situation, the physician may receive all compensation through fee-for-service arrangements and may agree to engage in supervising residents without expectation of additional compensation for teaching. If the physician agrees to participate in training without compensation, *the written agreement must indicate that there is no payment made from the teaching hospital to the private physician because the physician agrees to participate voluntarily in teaching.* Similarly, the private practice physician may be providing supervision to residents in a nonhospital site other than their private office, such as in a nursing home or skilled nursing facility without an expectation of compensation. In this situation, the physician would be voluntarily participating in teaching and the nonhospital site may have no costs associated with providing a training site to residents. The hospital may count the resident for indirect and direct medical education in this situation *if the written agreement indicates that the physician is voluntarily supervising residents and the nonhospital site does not incur graduate medical education costs.* (Emphasis added.)

With respect to the indirect medical education or IME adjustment, prior to October 1, 1997, for IME payment purposes, hospitals were not permitted to count the time residents spent training in nonhospital settings. Section 4621(b)(2) of the Balanced Budget Act of 1997 revised §1886(d)(5)(B) of the Act to allow providers to count time residents spend training in nonhospital sites for IME purposes, effective for discharges occurring on or after October 1, 1997. Section 1886(d)(5)(B)(iv) of the Act was amended to provide that:

> Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time

> equivalency if the hospital incurs all or substantially all, of the costs for the training program in that setting.

In the July 31, 1998 final rule[25], at § 412.105(f)(1)(ii)(C) (as cross-referencing §413.86(f)(4) [redesignated as § 413.78(d)]), CMS specified the requirements that a hospital must meet in order to include the time spent by residents training in a nonprovider site in its FTE count for purposes of IME payments. 42 C.F.R. §412.105(f)(1)(ii)(C) stated:

> 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 at § 413.86(f)(4) [redesignated as § 413.78(d)] are met.[26]

Section 713 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) imposed a one-year moratorium relating to certain non-provider site teaching physician costs for the period January 1, 2004, through December 31,2004. During this one-year period, hospitals were allowed to count FTE allopathic or osteopathic family practice residents training in nonprovider settings for IME and direct GME payment purposes without regard to the financial arrangement between the hospital and the teaching physician practicing in the nonprovider setting to which the resident was assigned.

Section 5504(a) of the Patient Protection and Affordable Care Act[27] or ACA amended section 1886(h)(4)(E) of the Act to reduce the costs that hospitals must incur for residents training in nonprovider sites in order to count the FTE residents for purposes of Medicare direct GME payments on a prospective basis. Section 5504(a) addressed section 1886(h) regarding GME payments and in subsection (3)(ii) provides that:

> [E]ffective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs these costs,

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[25] 63 Fed. Reg. 40,954, 41,005.

[26] *See infra* at p. 13 for regulatory text of 42 C.F.R. § 413.86(f)(4) redesignated at§ 413.78(d).

[27] Pub. L. 111-148 (Mar. 23, 2010).

> either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

Section 5504(b)(2) of the ACA made similar changes to section 1886(d)(5)(B)(iv) of the Act for IME payment purposes, with the provision being effective for discharges occurring on or after July 1, 2010, for IME:

> Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted towards the determination of full-time equivalency if a hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

Section 5504(c) specifies:

> APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).[28]

Notably, § 5504(a)(1) and (b)(1) concurrently amended the existing provisions of §§ 1886(h)(4)(E) and 1886(d)(5)(B)(iv) respectively. The existing provision of § 1886(h)(4)(E) was amended to state that:

> COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Subject to subparagraphs (J) and (K), such rules shall provide that only time spent in activities relating to patient care shall be counted and that—
>
> (i) *effective for cost reporting periods beginning before July 1, 2010*, all the time;[410] so spent by a resident under an approved medical residency training program shall be counted towards the determination

[28] This application provision was added as a note to 42 U.S.C. 1395ww.

> of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting… (Emphasis added.)

Further, the existing provision of § 1886(d)(5)(B) was amended to state:

> (iv)(I) *Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010,* all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting. (Emphasis added.)

In the November 24, 2010 final rule[29] with comment period, CMS revised the regulations at § 412.105(f)(1)(ii)(E) for IME and §§ 413.78(f) and (g) for direct GME to reflect the prospective changes made by §5504 of the ACA. Section 413.78(g) implements the statutory amendments set forth in §§5504(a)(3) and (b)(2) of the Affordable Care Act. The introductory regulatory language of §413.78(g) explicitly states that paragraph (g) governs only ''cost reporting periods beginning on or after July 1, 2010.'' Paragraph (g)(5) of §413.78 also expressly states that the paragraph is limited to ''cost reporting periods beginning on or after July 1, 2010.'' The IME regulations at § 412.105 were revised to reflect the statutory amendments, by incorporating by reference §413.78(g). Moreover, no change was made to the controlling regulation for the cost reporting periods at issue here, set forth at 42 C.F.R. §413.78(d).

In the comments section of the final rule, CMS responded to comments regarding the effective date:

> Another commenter claimed that the application provisions of section 5504(c) clearly apply the provisions of sections 5504(a) and (b) to cost reporting periods occurring before July 1, 2011 [sic]. The commenter asserted that because section 5504(c) expressly states that the provisions of this section ''shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending'' as of March 23, 2010, such nonprovider site training time should be allowed for those cost reports, even though the provisions of sections 5504(a) are only effective as of July 1, 2010.

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[29] 75 Fed. Reg. 71,800, 72,124-39.

CMS pointed out that:

> The effective date of the provisions of section 5504 is clearly July 1, 2010. This date is unambiguously stated in the plain text of section 5504(a), which states that it is ''effective for cost reporting periods beginning on or after July 1, 2010.'' Similarly, section 5504(b) is ''effective for discharges occurring on or after July 1, 2010.'' Our discussion of section 5504(c) in the August 3, 2010 proposed rule (75 FR 46385) only intended to explain our interpretation of the phrase ''a jurisdictionally proper appeal pending'' in the context of the plain language of the statute. However, we are clarifying in this final rule that, as noted above, and unlike some other provisions of the Affordable Care Act, *section 5504 is fully prospective, with an explicit effective date of July 1, 2010*, for the new standards it creates. Nothing in section 5504(c) overrides that effective date. Section 5504(c) merely notes that the usual discretionary authority of Medicare contractors to reopen cost reports is not changed by the provisions of section 5504; it simply makes clear that Medicare contractors are not required by reason of section 5504 to reopen any settled cost report as to which a provider does not have a jurisdictionally proper appeal pending. It does not require reopening in any circumstance; and the new substantive standard is, in any event, explicitly prospective. We believe if Congress had wanted to require such action or to apply the new standards to cost years or discharges prior to July 1, 2010, it would have done so in far more explicit terms.(Emphasis added.)

Thus, §413.78(g) is applicable only to cost reporting periods beginning on or after July l, 2010. Earlier cost reporting periods are governed by the preceding paragraphs of § 413.78.

Despite the clear effective dates, with respect to the applicability of § 5504(c) of the ACA and § 413.78(g)(6) of the regulations to periods prior to July 1, 2010, in the May 15, 2014 proposed rule[30], CMS noted:[31]

> Upon revisiting the existing regulation text, we determined that § 413.78(g)(6) was not written in a manner that is as consistent with section 5504(c) of the Affordable Care Act and reflective of our reading of that provision and our policy as it could be…In this

[30] 79 Fed. Reg. 27,978.
[31] Id. at 28,153-54.

proposed rule, we are reiterating our existing interpretation of the statutory amendments made by sections 5504(a), (b), and (c) of the Affordable Care Act and also proposing to clarify the regulation text implementing these provisions by revising the language at § 413.78(g)(6) to read more consistently with the language in section 5504(c) of the Affordable Care Act and to ensure no further confusion with respect to the applicability of section 5504(c) of the Affordable Care Act and § 413.78(g)(6) of the regulations.

When we proposed to implement section 5504(c) in the August 3, 2010 proposed rule (75 FR 46385) and when we implemented section 5504(c) in the November 24, 2010 final rule with comment period (75 FR 72136), we had to consider what new meaning it was adding to sections 5504(a) and (b) of the Affordable Care Act because unlike, for example, section 5505 of the Affordable Care Act which has a effective date prior to enactment of the Affordable Care Act and, therefore, would apply to prior cost reporting periods, section 5504's applicable effective date for the new standards it creates was July 1, 2010, a date that came after enactment of the Affordable Care Act and was fully prospective…We continue to believe that Congress was clear in amending sections 1886(h)(4)(E) and 1886(d)(5)(B)(iv) of the Act to provide for new standards to be applied *only prospectively, effective for cost reporting periods beginning on or after, and discharges occurring on or after, July 1, 2010.* We also continue to believe that the plain meaning of section 5504(c) of the Affordable Care Act is that the Secretary is not required to reopen a cost report when there is no jurisdictionally proper appeal pending as of March 23 2010, the date of the enactment of the Affordable Care Act, on the issue of payment for IME and direct GME. Therefore, we believe that section 5504(c) of the Affordable Care Act is merely a confirmation of the Secretary's existing discretionary authority in one particular context, and that sections 5504(a) and (b) of the Affordable Care Act and their effective dates become all the more prominent, and are not affected by section 5504(c).

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[W]e continue to believe the language in paragraph (g)(6) (along with the remainder of paragraph (g)) only applies to cost reporting periods beginning on or after July 1, 2010 and does not apply retroactively to cost reporting periods beginning before July 1, 2010. We had intended

> that the language under § 413.78(g) do no more than simply paraphrase the language in section 5504(c) of the Affordable Care Act.
>
> Accordingly, we believe that it is apparent that the provisions of sections 5504(a)(3) and (b)(2) of the Affordable Care Act are *not to be applied prior to July l, 2010, irrespectively of whether a hospital may have had a jurisdictionally proper appeal pending as of March 23, 2010, on an IME or direct GME issue from a cost reporting period occurring prior to July 1, 2010.* (Emphasis added.)[32]

In this case, the Provider is a nonprofit, short-term, acute care hospital located in Bangor, Maine. The Provider argued that it entered into agreements with various physicians where the physicians would voluntarily supervise residents without compensation from the Provider while the residents were engaged in patient care activities. The agreements had various affective dates which roughly coincided with the Provider's fiscal year (FY) 2003 and FY 2004. Some of the agreements were written, however, in other instances, no written agreement has been produced. Additionally, several of the agreements were dated after the agreed upon period of supervision had already started.[33]

The Intermediary audited the rotation schedules and agreements and disallowed 369 weekly rotations or 7.1 FTEs for FY 2003 and 144 weekly rotations or 2.77 FTEs for FY 2004. Based on additional documentation submitted by the Provider, the Intermediary revised these disallowances. For FYE September 27, 2003, of the original 369 disallowed weeks, 205.75 were found allowable. These included all rotations that took place within the hospital, all outside rotations with timely agreements, and any outside rotation with supervising physician compensation methodology which supports Solo or Fee for Service.[34] The 163.25 weeks deemed not allowable were any rotation with no signed agreement, any agreement signed

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[32] Consequently, § 413.78(g)(6) was further clarified by repeating again in 413.78(g) that: "Cost reporting periods beginning before July 1, 2010 are not governed by paragraph (g) of this section."

[33] *See* Exhibit P-7 in Provider's Supplemental Position Paper for Case No. 06-1337, dated September 28, 2012, and Exhibit P-7 in Provider's Supplemental Position Paper for Case No. 07-1505, dated September 28, 2012. The Administrator notes that for FYE September 25, 2004, there are also 11 disallowed weeks which are listed as "No Rotation". The key notes, "Resident graduate- no rotation". Apparently these weeks were included by the Provider, although the documentation would seem to indicate that no rotation took place.

[34] *See* p. 4 of the Intermediary's Supplemental Position Paper for Case No. 06-1337, dated November 1, 2012.

after the rotation took place, and any rotation for which the compensation arrangement with the supervising volunteer physician was not properly documented.[35] For FYE September 25, 2004, of the original 144 disallowed weeks, 70.7 were found allowable. These included all rotations that took place within the hospital, all outside rotations with timely agreements (Non-Moratorium) and signed agreement (Moratorium), and any outside rotation with supervising physician compensation methodology which supports Solo or Fee for Service (Non-Moratorium).[36] The 73.3 weeks found not allowable were any rotation (whether within the Moratorium or not) with no signed agreement, any agreement outside the Moratorium signed after the rotation took place, and any rotation for which the compensation arrangement with the supervising volunteer physician was not identified by the Provider.[37] In addition, the Provider conceded that an additional 6 weekly rotations or 0.12 FTEs for FY 2003 and 11 weekly rotations or 0.21 FTEs for FY 2004 should be removed from the subject appeal. As a result of the Intermediary revisions and the Provider concessions, the remaining weekly rotations or FTEs at issue are 156.85 weekly rotations or 3.02 FTEs for FY 2003 and 62.6 weekly rotations or 1.21 FTEs for FY 2004. The Intermediary disallowed these FTEs based on: the lack of a timely fully executed written agreement; the agreements failure to state the amount of compensation; or because the teaching physician was contended to have volunteered the time supervising the residents and failed to document the method of physician compensation (salaried or billings).

The Administrator finds that based on the statute and regulation, the Board was incorrect in determining that §5504(c) of the ACA allows for retroactive application of §§5504 (a)(3) and (b)(2). As such, the Board improperly determined that the Intermediary erred in applying the applicable law and regulations in effect for the Provider's FYE 2003 and 2004 cost reports as also required by §§5504 (a)(1) and (b)(1) and §1886(d)(5)(E)(iv)(I) and §1886(h)(4)(E)(i) of the Act. The Administrator determines that had Congress intended §5504 to be applied retroactively, it would have expressly stated this intent, as it did in other sections of the ACA.[38] Instead, in this case, Congress expressly prescribed that the statute is prospective for (a)(3) and (b)(2) for cost reporting periods (or discharges) beginning on or after July 1, 2010, and that the longstanding policy and rules continue to apply for cost reporting periods

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[35] *See id*. at pp. 4-5.

[36] *See* p. 4 of the Intermediary's Supplemental Position Paper for Case No. 07-1505, dated November 1, 2012.

[37] *See id.*

[38] *See, e.g.,* § 1556(c), ("The amendments made by this section shall apply with respect to claims filed under part B or C of the Black Lung Benefits Act…after January 1, 2005, *that are pending on or after the date of enactment of this Act.*") (emphasis added).

(and discharges) prior to July 1, 2010 under §§ 5504 (a)(1) and (b)(1) and §1886(d)(5)(E)(iv)(I) and §1886(h)(4)(E)(i). The statute states that for cost reporting periods before July 1, 2010 for GME and for discharges occurring after October 1, 1997 and before July 1, 2010 for IME, the residents' time in nonhospital setting went toward a hospital's FTE count only "if the hospital incurs all, or substantially all, of the costs for the training program in that setting." "Effective for cost reporting period beginning on or after July 1, 2010" for GME and "for discharges occurring on or after July 1, 2010" for IME residents time in nonhospital settings[39] count towards a hospital's FTE count if the hospital simply "incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting." Congress expressly indicated in the statute the standards that are to be applied to the respective cost reporting periods and discharges.

The Provider contends (and the Board agrees) that subsection (a)(3) and (b)(2) apply prospectively *except* when a provider has a "jurisdictionally proper appeal". However, paragraph (c) established that, if there was no pending appeal concerning a final cost report when the ACA was enacted, that cost report will not be reopened. Notably, § 5504(c) *does not* establish *that if there was* a pending appeal concerning a final cost report when the ACA was enacted, *that the cost report must be reopened*; (*i.e.*, the ACA applied retroactively), contrary to the Provider's contention and the Board's findings.[40]

With respect to the Secretary's interpretation, the Provider also argued that subsection (c) would be superfluous if §§5504(a)(3) and (b)(2) were prospective only. However, the Secretary has properly given effect to each part of the applicable statute in that time spent by residents in nonhospital settings for cost reporting periods commencing before July 1, 2010 would count towards a hospital's FTE count only if the hospital incurred all, or substantially all, of the costs for the training program. Time spent by residents in nonhospital settings for cost reporting periods commencing on or after July 1, 2010 would count if the hospital incurred the costs of stipends and fringe benefits for the residents. Neither section would apply in a way that would require the reopening of a closed cost report for which there was not a

[39] CMS recognized that § 5504 of the ACA also changed the manner in which the Act refers to sites outside the hospital in which residents train as "nonprovider settings." 78 Fed. Reg. 50.495, 50,734 (Aug. 13, 2013). For purposes of the review for these cost years, the term "nonhospital" setting is used.

[40] This has been referred to as the fallacy known as "negating" or "denying the antecedent." *New England Power Generators Assn., Inc. v. FERC*, 707 F.3d 364, 370 (D.C. Cir. Feb. 15, 2013).

pending appeal when the ACA was enacted.[41] Simply put, the Provider's reading would nullify the standards set forth in §5504(a) and (b) with respect to §1886(h)(4)(E)(i) and (ii) and §1886(d)(5)(B)(iv)(I) and (II). In addition, the Secretary's regulation promulgated the same standard and language as the statutory provisions. Thus, the Provider's arguments similarly fail in that regard with respect to the attack on the regulation.

Regarding the issue of teaching physicians volunteering their time in GME activities at nonprovider sites, the dispute in this case is not whether the Provider may use teaching physician volunteers, but rather, whether the Provider has met the regulatory and program requirements in order to include the FTEs in the GME and IME methodology. One criterion is that the regulation requires the written agreement to *specifically* reference compensation paid for supervisory teaching activities, and also the specific amount of compensation that is provided. The plain language of 42 C.F.R. § 413.86(f) states that the written agreement between the hospital and the nonhospital site must "indicate that the hospital *will* incur the cost of the resident's non-hospital site", indicating that the agreement should be in writing prior to the resident's rotation. This issue was previously addressed in *University of Louisville Hospital v. Blue Cross Blue Shield Association/National Government Services*, CMS Administrator Decision No. 2010-D51 (Nov. 20, 2010). In this case, the Administrator noted:

> The plain language of the regulation requires that the written agreement between the hospital and the nonhospital site must state, *inter alia*, 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. This prospective requirement that a written agreement be in place is also consistent with the Secretary's response to commenters, in the July 1999 final rule, that the agreement is to have been negotiated and put in place prior to the January 1, 1999 effective date of the clarifying regulatory change. Finally, this requirement is also consistent with Medicare general record keeping principles as set forth at section 1815 of the Act.

[41] In addition, as subsection (c) applies to the entirety of §§ 5504 (a) and (b), it does not require the Secretary to affirmatively reopen to confirm the correct application of the longstanding policy reaffirmed by Congress in its amendments to (a)(1) and (b)(1), although the Secretary has the discretion to do so under the regular reopening rules for this cost reporting periods prior to July 1, 2010.

Thus, the regulation at 42 C.F.R. § 413.78(d) and its consistent application support the contention that the written agreement between the hospital and nonprovider setting must be executed prior to the commencement of the rotations.

In addition, relevant to this case generally and specifically with respect to physician volunteers, is whether there is a cost to the nonprovider site for supervising the resident's training. If there is a cost, the hospital must reimburse the nonprovider site for those costs. Thus, in situations where the teaching physician receives a salary that does not vary with the number of patients treated, there is a cost for the teaching physician time spent in nonpatient care GME activities. In contrast, if the physician's compensation at the nonprovider site is based solely on billings, there is no cost for teaching physician time spent in nonpatient care GME activities. As previously noted, Program Memorandum A-98-44 requires the fiscal intermediary to distinguish situations where there is "no explicit compensation for supervisory teaching physician activities, from those where there are truly no costs" and requires that the written agreement "must specify and identify this cost for the hospital to meet the criterion of incurring all or substantially all of the costs".

However, even applying the existing rules, pre-ACA, the Provider argued that it satisfied CMS' requirement regarding written agreements and that these agreements stated that the physicians were volunteering their time as required. The record shows that the disallowed FTEs involved written agreements that were signed by the parties *after* the non-provider rotation started, or not signed at all by the supervising physician; instances where there was no written agreement at all; written agreements noting that the physician was a volunteer, but where the physician was identified by the Provider as salaried, or the compensation basis was not specified; instances where the resident was away and no rotation took place; and instances where there was no name of a resident matched to a teaching physician, or the teaching physician name was missing from rotation schedule.[42]

The Administrator finds that, where there is no agreement, no timely agreement, or fully executed timely agreement, the Provider has failed the requirement of a timely executed written agreement. Where there is no name of a resident matched with a supervisory physician or a teaching physician was missing from the rotation schedule, or the resident was not documented as participating in the rotation, the Provider has failed to meet the necessary documentation requirements. Where the supervisory physician is a volunteer, the appropriate documentation must be provided on the physicians' salaried or compensation basis, or else the regulatory documentation requirement, *inter alia*, that the Provider incurr all or substantially all

[42] *See* p. 2 of the Intermediary's Post Hearing Memorandum, dated February 12, 2013 for the Intermediary's breakdown of the remaining FTEs involved in this case.

of the costs are not met. Thus, the Intermediary's exclusion of the disallowed FTEs was proper.

With respect to the moratorium on teaching physician costs, §713 of the MMA imposed a one-year moratorium relating to certain nonprovider site teaching physician costs for the period from January 1, 2004, through December 31, 2004. During this one-year period, CMS was required to allow hospitals to count FTE allopathic or osteopathic family practice residents training in nonprovider settings for GME and IME payment purposes without regard to the financial arrangement between the hospital and the teaching physician. In other words, the moratorium was related to payment of teaching physician costs, not to the requirement that a written agreement be in place between the hospital and the nonprovider site. Therefore, to the extent that the Intermediary found the Provider's written agreements to be lacking, the moratorium is not applicable in this case. The moratorium would only apply to the financial arrangement, where all other requirements were met including a contemporaneous written agreement, which were not the facts applicable to the rotations at issue.

DECISION

The Administrator reverses the decision of the Board in accordance with the foregoing opinion. The Intermediary's exclusion of outside rotations from the Provider's Graduate Medical Education and Indirect Medical Education full time equivalent count was proper

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

Date: 7/23/14

/s/

Marilynn Tavenner
Administrator
Centers for Medicare & Medicaid Services