PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2024-D18

PROVIDER– Parma Community General Hospital	**HEARING DATE –** December 7, 2021
Provider No.: 36-0041	**Fiscal Years Ending –** December 31, 2016 December 31, 2017
vs.	
MEDICARE CONTRACTOR – CGS Administrators	**Case Nos. –** 19-2081 and 21-1783

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ISSUE STATEMENT

Did the Medicare Contractor properly determine the Provider's Per Resident Amount ("PRA") for fiscal year ending December 31, 2016 ("FY 2016")?[1]

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor erred in using FY 2012 as the base period to set the PRA for Parma Community General Hospital ("Parma" or "Provider") at zero dollars ($0) effective for the Parma's FY 2016 cost reporting period. The Board remands this case to the Medicare Contactor to: (1) properly determine the PRA by using Parma's FY 2016 cost reporting period as the base period for establishing Parma's PRA based on the new Internal Medicine and Family Medicine residency programs; and (2) apply that newly-determined PRA to Parma's FY 2016 and 2017 cost reporting periods in order to reimburse Parma for its direct GME costs during those periods.

INTRODUCTION

Parma is an acute care hospital located in Parma, Ohio.[2] Parma's assigned Medicare contractor[3] is CGS Administrators ("Medicare Contractor").

Parma is part of the University Hospitals Health System ("UHHS"), based in Cleveland Ohio. In January 2014, Parma joined UHHS and, at that time, did not identify itself as a teaching hospital. Parma first identified itself as a teaching hospital one and one half (1½) years later, in July, 2015, when it sponsored two (2) new programs for graduate medical education ("GME") in Internal Medicine and in Family Medicine.[4]

Since Parma has a fiscal year end of December 31st, residents were not onsite in the first month of its FY 2015 cost reporting period. Pursuant to 42 C.F.R. § 413.77(e), Parma sought to use its FY 2016 as its base period for establishing its PRA since this was the first full year of teaching residents.[5] The Medicare Contractor disagreed with Parma. Instead, on May 22, 2019, the Medicare Contractor issued Parma's Notice of Program Reimbursement ("NPR") for FY 2016 using FY 2012 as the base period for establishing Parma's PRA and setting the PRA at zero dollars ($0) effective for FY 2016. As a result, the FY 2016 NPR did not reimburse Parma for any direct GME costs incurred during FY 2016. Similarly, in the NPR for FY 2017 issued on

[1] Transcript (hereinafter "Tr.") at 6.
[2] Medicare Contractor's Final Position Paper, Case No. 19-2081 (hereinafter "Medicare Contractor's FPP"), at 3 (Sept. 8, 2021).
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("Fis"), but these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both Fis and MACs as appropriate and relevant.
[4] Provider's Final Position Paper, Case No. 19-2081 (hereinafter "Provider's FPP"), at 1 (Oct. 8, 2021).
[5] *Id.*

August 4, 2021, the Medicare Contractor again applied the zero dollar ($0) PRA and did not reimburse Parma for any direct GME costs incurred during FY 2017.[6]

Parma appealed both the FY 2016 and 2017 NPRs to the Board and contends that the Medicare Contractor improperly used FY 2012 as the base year to establish a PRA of zero dollars ($0) and instead argues that FY 2016 should be used as the base year to establish a PRA based on the new GME programs for Internal Medicine and Family Medicine in that year.

In a letter dated October 8, 2021, Parma submitted a request for a *consolidated* hearing on its FY 2016 appeal under Case No. 19-2081 and its FY 2017 appeal under Case No. 21-1783. The Board granted that request for a *consolidated* hearing on October 25, 2021. In a document filed on November 18, 2021, the Parties have stipulated and agreed that the facts and circumstances in the cases are identical. Additionally, the Parties further stipulated and agreed "to waive position papers in Case No. 21-1783 and instead rely on their respective position papers submitted in Case No. 19-2081."[7]

The Board conducted a live hearing by video conferencing on December 7, 2021 since Parma timely appealed the Medicare Contractor's final determination and met the jurisdictional requirements for a hearing. Parma was represented by Andrew Ruskin, Esq. of K&L Gates, LLP. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

STATEMENT OF LAW AND FACTS

A. Relevant Law Regulations and Policy

Since the inception of Medicare, the program has shared in the costs of approved medical educational activities on a reasonable cost basis.[8] Initially, there was no statutory provision in existence that required Medicare to pay for the direct costs of medical education.[9] However, as the Secretary has explained, the Medicare program:

> [A]uthorized payment of a share of these costs by regulation because the Congressional committee reports that accompanied the original Medicare legislation, the Social Security Amendments of 1965 (Pub. L. 89-97), suggested that Medicare should share in these costs initially with the expectation that the community will later assume the costs of medical education.[10]

As a result, the Secretary promulgated regulations at 42 C.F.R. § 405.421 to govern "cost of educational activities" and defined approved educational activities to mean "formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of

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[6] Appeal Request for Case No. 21-1783, Stipulations (hereinafter "Stip.") at 1-2 (Nov. 18, 2021).
[7] Stip. at 2.
[8] 50 Fed. Reg. 27722, 27722 (July 5, 1985).
[9] *Id*. at 27723; *University of Cincinnati v. Bowen*, 875 F.2d 1207, 1211 (6th Cir., May 25, 1989).
[10] 50 Fed. Reg. at 27723.

care in an institution."[11] These activities include approved training programs for physicians, nurses, and certain professionals (for example, radiology technicians).[12]

Subsequently, within the July 5, 1985 Final Rule and pursuant to the authority of 42 U.S.C. § 1395x(1)(A), the Secretary promulgated amendments to 42 C.F.R § 405.421(a) (which was later re-designated to 42 C.F.R. § 413.85 in 1986[13]) "to establish a one year limit on the amount Medicare would reimburse a provider for the cost of approved educational activities[,] . . . based on its Medicare utilization"[14] for the purpose of "implement[ing] the Congressional intent that local communities assume a greater role in the costs of medical education."[15] However, the Secretary rescinded this final rule on May 6, 1986 due to certain legislation enacted by Congress.[16]

Congress first addressed Medicare payment of the direct GME costs within § 9202(a) of the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA-85") that added 42 U.S.C. § 1395ww(h).[17] However, less than a year later, Congress amended 42 U.S.C. § 1395ww(h) under § 9314 of the Omnibus Budget Reconciliation Act of 1986.[18] Through these amendments, Congress established the methodology to be used by the Secretary when determining Medicare payment for DGME, defined in the statute as "*direct costs* of approved educational activities for approved medical residency training programs."[19] Specifically, Congress requires the Secretary to calculate a hospital-specific approved PRA[20] for each hospital based on the hospital's allowable costs for its cost reporting period beginning in federal fiscal year ("FY") 1984.[21] The PRA is then multiplied by the weighted average number of full-time equivalent ("FTE") residents in an approved program (subject to certain limiting factors not relevant to this discussion), the product being known as the "aggregate approved amount."[22] This aggregate approved amount is then multiplied by a hospital's "Medicare patient load" defined as the fraction that represents the total number of inpatient bed-days during the hospital's cost reporting period which are attributable to patients with respect to whom payment may be made under Medicare Part A.[23] The resulting product represents the payment amount for a hospital cost reporting period.[24]

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[11] Principles of Reimbursement for Provider Costs and for Services by Hospital-based Physicians, 31 Fed. Reg. 14808, 14814 (Nov. 22, 1966).
[12] *Id*.
[13] 51 Fed. Reg. 34790, 34790 (Sept. 30. 1986).
[14] Medicare Program: Limit on Payments for Direct Medical Education Costs, 50 Fed. Reg. 27722 (July 5, 1985).
[15] *Id.* at 27723.
[16] 51 Fed. Reg. 16776, 16776 (May 6, 1986). *See also* 54 Fed. Reg. at 40287.
[17] Pub. L. 99-272, § 9202, 100 Stat. 82, 171 (1986). *See also* 54 Fed. Reg. 40286, 40287 (Sept. 29, 1989). COBRA-85 § 9202(i) added a new subparagraph (Q) to the definition of "Reasonable costs" in 42 U.S.C. § 1395x(v)(1)(Q) which nullified the July 5, 1985 Rule. 54 Fed. Reg. at 40287. Specifically, the new subparagraph (Q) states: "Except as otherwise explicitly authorized, the Secretary is not authorized to limit the rate of increase on allowable costs of approved medical educational activities."
[18] Pub. L. 99-509 §9314, 100 Stat. 1874, 2005 (1986).
[19] 42 U.S.C. § 1395ww(h)(5)(C) (emphasis added).
[20] Also known as the "approved FTE resident amount." 42 U.S.C. § 1395ww(h)(3)(B).
[21] For most hospitals, the cost reporting period beginning during Federal FY 1984 (that is, beginning on or after October 1, 1983, and before October 1, 1984) is the first cost reporting period under the prospective payment system. 54 Fed. Reg. at 40287.
[22] 42 U.S.C. § 1395ww(h)(3)(B).
[23] 42 U.S.C. § 1395ww(h)(3)(C).
[24] 42 U.S.C. § 1395ww(h)(3)(A).

Although the statute provides that the Secretary shall use a hospital's FY 1984 cost reporting as the base period for determining a hospital's PRA, Congress also instructed how to calculate the PRA for a hospital that did not meet this criteria because, during the FY 1984 cost reporting period, it either: (1) did not have an approved medical residency training program, or (2) did not participate in Medicare. Specifically, the statute states the following at 42 U.S.C. § 1395ww(h)(2)(F):

> TREATMENT OF CERTAIN HOSPITALS. – In the case of a *hospital* that *did not* ***have*** ***an approved*** *medical residency training* ***program*** or was not participating in the program under this subchapter for a cost reporting period beginning during fiscal year 1984, the Secretary shall, *for the first such period for which it* ***has such*** *a residency training* ***program*** and is participating under this subchapter, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.[25]

The Secretary implemented the above-quoted statutory directive, publishing the specific regulatory specifications with the 1989 Final Rule.[26] In the preamble to the 1989 Final Rule implementing the statutory mandates, a commenter stated the following (in pertinent part):

> [A] commenter representing a hospital that began its first GME program after its cost reporting period beginning in FY 1984 believes that the costs incurred for the first program year are not representative of the actual yearly costs of its program since it became fully operational. The commenter pointed out that the hospital incurred program costs prior to the entrance of residents into the program, that residents' salaries would be understated in the initial years because of the absence of senior residents from the program, that faculty physicians and plant facilities came into use at various times, and that start-up costs were inherently different from ongoing program costs . . . .[27]

In response to that concern, the Secretary modified the proposed regulatory language, explaining (in pertinent part):

> We believe that the commenters have raised some very valid points about new GME programs in that all elements of the program do not fall into place at the same time. Further, we believe that the applicable provision of section 1886(h) of the Act did not envision a situation in which a hospital's GME program began on July 1 of a given year, while the hospital's cost reporting period began on some other date, such as October 1 or January 1. In such a situation, the first year of the program would not be reflective of

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[25] (Bold, underline and italics emphasis added).
[26] 54 Fed. Reg. at 40286.
[27] *Id*. at 40310.

> the costs of the program since residents might be on duty and receiving a salary during as few as one or two months of the cost reporting period. *Further,* ***a strict application of the law*** *would preclude any recognition of start-up costs incurred in a cost reporting period before the arrival of residents since the counting of residents in the program is the payment vehicle for GME costs.*
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> Accordingly, we are modifying § 413.86(e)(4) (proposed § 413.86(c)(5)) to provide that the base period for determining per resident amounts in ***hospitals that begin a GME program*** *after the base period* will be the first cost reporting in which residents were on duty in their GME program during the first month of the cost reporting period. Any GME costs incurred for the prior cost reporting period will be made on a reasonable cost basis under section 1861(v) of the Act as was the case for cost reporting periods beginning prior to July 1, 1985.[28]

More recently, in the FY 2007 IPPS Final Rule, the Secretary implemented modifications to the PRA calculation methodology for new teaching hospitals which under 42 U.S.C. § 1395ww(h)(2)(F) necessarily means "a *hospital* that *did not* ***have an approved*** *medical residency training* **program** or was not participating in the [Medicare] program . . . for a cost reporting period beginning during fiscal year 1984, . . . [but later] ***has such*** *a residency training* ***program*** and is participating [in the Medicare program]."[29] In the preamble to that Final Rule, the Secretary described these changes as follows:

> *In the case of* ***a hospital that did not train*** residents in its FY 1984 cost reporting period, a PRA is determined by comparing and taking the lower of a PRA based on direct GME costs and FTE residents in a base year or the updated weighted mean value of PRAs of all hospitals located in the same geographic wage area. For ease of discussion, we refer to ***a hospital that did not*** participate in Medicare or ***have any approved medical residency training programs*** during the base period beginning between October 1, 1983, through September 30, 1984, ***and has*** since commenced participating in Medicare and *begun training residents in an approved program*, ***as a ''new teaching hospital.''*** A new teaching hospital's PRA is established by using the lower of its hospital-specific PRA based on the actual allowable direct GME costs and FTE residents during a base period as defined in § 413.77(e) or the updated weighted mean value of PRAs of other teaching hospitals in the same geographic area.

[28] *Id.*
[29] (Emphasis added.)

Existing regulations at § 413.77(e) specify that the base year for establishing a PRA for a new teaching hospital is the first cost reporting period in which the new teaching hospital participates in Medicare and the residents are on duty during the first month of that period. *If the new teaching* ***hospital begins training*** *residents but does not* ***have residents on duty*** *during the first month* of the first cost reporting period in which training occurs, the new teaching hospital is paid on a reasonable cost basis under § 413.77(e) for any GME costs incurred by that hospital during that period. *The intent of this policy for new teaching hospitals is to make a more accurate determination of a PRA based on the hospital's per resident direct GME costs in a cost reporting period in which GME costs have been incurred* ***for that entire period***. As we noted in a response to comments in a final rule published in the Federal Register on September 29, 1989 (54 FR 40310), we believe that where the new teaching hospital's cost reporting period begins on a date other than July 1 (the beginning of the academic year), for example, October 1 or January 1, the cost reporting period that includes costs and resident counts from the first year of the training program may not be reflective of the actual average costs per resident of the program because the full complement of residents might not be on duty, and those that are on duty might be receiving a salary for as few as 1 or 2 months of the cost reporting period. In the usual case, training in the program would continue into the following cost reporting period and residents would thus be on duty in the first month of this next cost reporting period. Consequently, our existing regulations at § 413.77(e)(1) specify that the PRA is to be determined by using the cost and resident data from the first cost reporting period during which residents are training in the first month of the cost reporting period.

It has come to our attention that, in rare instances, it is possible for a new teaching hospital, either through happenstance or by purposeful gaming of the policy, to continue to be reimbursed for direct GME costs on a reasonable cost basis even beyond the first cost reporting period during which residents begin training at the hospital as long as no residents are on duty at the new teaching hospital in the first month of the subsequent cost reporting period(s). We believe this scenario is contrary to the statutory intent of section 1886(h) of the Act, which instructs that instead of payment on a reasonable cost basis, the Secretary is to determine and base direct GME payments on a PRA for *each hospital* ***with a residency program***. For that reason, in the FY 2007 IPPS proposed rule (71 FR 24113), we proposed to revise § 413.77(e)(1) and (e)(1)(i) to provide that we will make a PRA determination even where residents are not on duty in the first month of a cost reporting period but where residents began training at the hospital

> in the prior cost reporting period. We proposed that, effective for cost reporting periods beginning on or after October 1, 2006, *if a **new teaching hospital <u>begins training</u>** residents* in a cost reporting period beginning on or after October 1, 2006, and no residents are on duty during the first month of that period, the fiscal intermediary establishes a PRA for the hospital using the lesser of: (1) The cost and resident data from the cost reporting period immediately following the one for which GME training at the hospital was first reported (that is, the base period); or (2) the updated weighted mean value of PRAs of all hospitals located in the same geographic wage area. We note that, as with existing policy, the base year need not be a full cost reporting year.
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> After consideration of the public comments received, we are adopting as final, without modifications, the proposed changes to § 413.77(e)(1) and (e)(1)(i) to provide that "effective for cost reporting periods beginning on or after October 1, 2006, *if **a new teaching hospital** does not **<u>have</u>** residents **on duty** during the first month of that period*, the PRA will be determined using information from the cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital even if the residents are not on duty during the first month of that period."[30]

The applicable regulations at 42 C.F.R. § 413.77(e)(1) (Oct. 2015) reflect the aforementioned history:

> (e) *Exceptions*—(1) *Base period for certain hospitals***.** If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the contractor establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Effective for cost reporting periods beginning on or after October 1, 2006, **if a hospital did not have any approved medical residency training programs** or did not participate in Medicare during the base period, **but either condition changes in a cost reporting period beginning on or after October 1, 2006**, **<u>and the residents are not on duty during the first month of that period</u>, the contractor establishes a per resident amount for the hospital using the information <u>from the first cost reporting period immediately following</u> the cost reporting period during which the hospital**

[30] 71 Fed. Reg. 47870, 48076-77 (Aug. 18, 2006) (emphasis added).

> **participates in Medicare and residents began training at the hospital**. The per resident amount is based on the lower of the amount specified in paragraph (e)(1)(i) or paragraph (e)(1)(ii) of this section, subject to the provisions of paragraph (e)(1)(iii) of this section. Any GME costs incurred by the hospital during the cost reporting period prior to the base period used for calculating the PRA are reimbursed on a reasonable cost basis.
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> (i) The hospital's actual cost per resident incurred in connection with the GME program(s) based on the cost and resident data from the hospital's base year cost reporting period as established in paragraph (e)(1) of this section.
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> (ii) Except as specified in paragraph (e)(1)(iii) of this section –
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> (A) For base periods that begin before October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area, as that term is used in the prospective payment system under Part 412 of this chapter.
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> (B) For base periods beginning on or after October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts (including primary care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals.
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> (iii) If, under paragraph (e)(1)(ii)(A) or (B) or (e)(1)(iv)(B) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region as that term is used in subpart D of part 412 of this subchapter.[31]

B. The Parties' Positions

The disagreement between Parma and the Medicare Contractor concerns ***when*** the PRA should be established. Parma asserts that, "[i]n July 2015, [it] became a teaching hospital when it became the program sponsor for a program in Internal Medicine and one in Family Medicine."[32] As Parma's fiscal year ends December 31st, "residents had not been onsite in the first month of the FY 2015 cost reporting period. Accordingly, pursuant to 42 C.F.R. § 413.77(e), [Parma] sought to

[31] (Italics emphasis in original and bold and underline emphasis added.)
[32] Provider's FPP at 1.

use FY 2016 as its base year for establishing its PRA."[33] However, the Medicare Contractor found evidence of certain residents training at Parma under community preceptors *prior* to FY 2015.[34] Specifically, the Medicare Contractor informed Parma that, for FY 2012, "UH[HS] Richmond Medical Center had a Podiatry program, and some of that program's documentation *indicated* Parma as a training site."[35] As a result, the Medicare Contractor reached back four years to FY 2012 to use data/information on a Podiatry program that was not sponsored by Parma to set an initial PRA of zero dollars ($0) and then applied that PRA for the first time to FY 2016 and then later to FY 2017.[36]

C. Post-Hearing Clarification

Subsequent to the hearing in these cases, the Board became aware of a legal development that may have impacted these cases. The Secretary issued a Final Rule on December 27, 2021 that implemented Medicare policies relative to DGME for teaching hospitals based on legislative changes provided by §§ 126, 127 and 131 of the Consolidated Appropriations Act of 2021 ("CAA").[37] The following are pertinent excerpts from the preamble to the December 27, 2021 Final Rule:

> We are finalizing provisions to implement sections 126, 127, and 131 of the CAA. . . . Section 131 of the CAA amended section 1886(h)(2)(F) of the Act to provide an opportunity to hospitals with such extremely low or $0 per resident amounts (PRAs) that meet certain criteria to reset and establish new PRAs if the hospital trains resident(s) in a cost reporting period beginning on or after enactment (December 27, 2020) and before the date that is 5 years after enactment (December 26, 2025).[38]
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> 5. Implementation of Section 131 of the CAA; Addressing Adjustment of Low Per Resident Amounts (Direct GME) and Low FTE Resident Caps (Direct GME and IME) for Certain Hospitals
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> Section 131 of the CAA provides us with the opportunity to reset the low or zero direct GME per resident amounts of certain hospitals. . . .
>
> a. Background on Establishment of PRAs and FTE Resident Caps for Hospitals Hosting Residency Training

[33] *Id.* at 1-2.
[34] Exhibit (hereinafter "Ex.") P-8 at 2.
[35] Provider's FPP at 2. *See also* Ex. P-8 at 2. The Medicare Contactor noted Podiatry residents rotating to Parma during the audit of UH Richmond Hospital's FY December 31, 2012, thus triggering the calculation of a PRA in Parma's FY December 31, 2012. *See* Medicare Contractor's FPP at 9; Provider's FPP at 2.
[36] Appeal Requests for Case Nos. 19-2081, 21-1783; Stip. at 1-2; Medicare Contractor's FPP at 5.
[37] Pub. L. 116-260, Div. CC at §§ 126, 127, 131, 134 Stat. 1182, 2967-76 (2020).
[38] 86 Fed. Reg. 73416, 73416-17 (Dec. 27, 2021).

Section 1886(h)(2)(F) of the Act does not require a hospital to incur costs, be the program sponsor, or train a certain minimum number of FTE residents, in order to become a teaching hospital. Accordingly, under the regulations at 42 CFR 415.152, "Teaching hospital" is defined as a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry. Our historical policy is that if a hospital has residents that are training in an approved GME residency program(s), and if the training is according to a planned and regular schedule (that is, not spontaneous or random), then we consider the hospital to be a teaching hospital, even if –

- It is not incurring the costs of the residents' salaries and fringe benefits,
- It is not the sponsor of the program,
- It is only training a very small number of FTE residents, and
- The program in which the residents are training does not have to be a "new" program under Medicare rules.

As discussed in the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25520), in the past, a number of hospitals have found themselves in the situation of the establishment of a low PRA, when they served as a training site for only small numbers of residents from programs sponsored by a medical school or another hospital. In many cases, these hospitals did not incur any salaries for those residents and may have incurred only insignificant overhead costs associated with the residents' presence at their facilities and, therefore, their PRAs were either very low or $0. ***Such low PRAs preclude meaningful direct GME payment in the future*** if these hospitals expand their training of residents and incur significant costs associated with the training. Section 131(a) of the CAA amends section 1886(h)(2)(F) of the Act to direct the Secretary, for such hospitals with such extremely low or $0 PRAs that meet certain criteria, to establish new PRAs using the methodology described in 42 CFR 413.77(e) if the hospital trains residents in a cost reporting period beginning on or after its enactment (December 27, 2020) and before the date that is 5 years after enactment (December 26, 2025). In accordance with 42 CFR 413.77(e), a new teaching hospital hospital's PRA is based on the *lower* of its actual GME costs per FTE during a specific base year, or the weighted average PRA of existing teaching hospitals located in the same core-based statistical area (CBSA) as the new teaching hospital. . . .

b. Hospitals Qualifying to Reset Their PRAs

Section 131(a) of the CAA also amends section 1886(h)(2)(F) of the Act to add a new clause (iii) to describe the categories of hospitals that qualify to receive a replacement PRA. For ease of reference, we will refer to these hospitals as Category A and Category B. As discussed in the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25520), a Category A Hospital is one that, as of the date of enactment (December 27, 2020), has a PRA that was established based on less than 1.0 FTE in any cost reporting period beginning before October 1, 1997. Typically, a Category A hospital is one that trained less than 1.0 FTE in its most recent cost reporting period ending on or before December 31, 1996, and received a very low or $0 PRA. A Category B Hospital is one that, as of the date of enactment (December 27, 2020), has a PRA that was established based on training of no more than 3.0 FTEs in any cost reporting period beginning on or after October 1, 1997, and before the date of enactment (December 27, 2020). This new subclause provides that the Secretary shall in lieu of these low PRAs, establish a new PRA in accordance with the process described in § 413.77(e), *for each such hospital if the hospital trains at least 1.0 FTE* (in the case of a Category A hospital) or *more than 3 FTEs* (in the case of a Category B hospital) (emphasis added). The recalculation period begins on December 27, 2020, and ends 5 years later.

In the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25520 through 25521), we proposed that to redetermine the PRA, the training occurring at a Category A Hospital or a Category B Hospital need *not necessarily* be training residents in a *new* program; the residents may be in either an approved program that is “new” for Medicare IME and direct GME purposes, or may be in an existing approved program. This is because the new subclause does not state that the training be in a “new” program, and furthermore, CMS’s current policy is that for a hospital which starts training residents for the first time, the PRA can be established based on the training of residents in either a “new” approved program, or an existing approved program. However, for a Category A Hospital, we proposed not to reset its PRA until we determine that the Category A Hospital trains at least 1.0 FTE, and that training must occur in a cost reporting period beginning on or after December 27, 2020 (date of enactment) and before December 26, 2025 (5 years after enactment). Similarly, for a Category B Hospital, we proposed not to reset its PRA until we determine that the Category B Hospital trains more than 3.0 FTEs, and that training must occur in a cost reporting period beginning on or after December 27, 2020 (date of enactment) and before December 26, 2025 (5 years after enactment). Because new section 1886(h)(2)(F)(iii) uses the word “trains” we interpret this to require “continuous” training, and

therefore, we proposed that for both Category A and Category B Hospitals, it is not relevant whether they may have trained at least 1.0 FTE or more than 3.0 FTEs in a cost reporting period or periods prior to December 27, 2020. While we proposed that such previous training of at least 1.0 FTE or more than 3.0 FTEs would not preclude resetting of a Category A Hospital's PRA or a Category B Hospital's PRA, we proposed that the relevant factor in determining when to reset their PRAs would be if and when the hospital trains the requisite amount of FTE residents in a cost reporting period beginning on or after December 27, 2020 (date of enactment) and 5 years after (December 26, 2025)…Once reset, in the absence of additional legislation, the PRAs for either a Category A Hospital or a Category B Hospital are permanent, subject to annual inflation updates under 42 CFR 413.77(c)(1). . . .

c. Calculating the Replacement PRA and Cost Reporting Requirements

Consistent with the new statute, in the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25521), we proposed to calculate the replacement PRA using the existing regulations in place at 42 CFR 413.77(e). First, we proposed to use as the PRA base period the *first* cost reporting period beginning on or after December 27, 2020 in which either the Category A Hospital or Category B Hospital trains their requisite threshold FTEs; that is, at least 1.0 FTE is trained at a Category A Hospital, and more than 3.0 FTEs are trained at a Category B Hospital. Then, as 42 C.F.R. 413.77(e)(1) states, we proposed to amend the regulations to add a new 413.77(e)(1)(iv) to establish the replacement PRA as the LOWER OF –

- The hospital's actual cost per resident incurred in connection with the GME program(s) based on the cost and resident data from the hospital's replacement base year cost reporting period; and

- The updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts (including primary care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals.

- If there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the

> updated weighted mean value of per resident amounts of all hospitals located in the same census region as that term is used in subpart D of Part 412 of this subchapter.

We will issue instructions to the MACs and to hospitals to provide for an orderly process of request and review for the purpose of receiving replacement PRAs. When the hospital trained the requisite number of FTEs in a particular cost reporting period, upon submission of that cost report, the hospital will notify its MAC that it believes a replacement PRA can be determined. The MACs of the Category A and Category B Hospitals will review the GME costs and FTE counts reported in the Medicare cost report, rotation schedules supporting the FTE counts, etc. to determine at what point the requisite threshold of FTE residents are trained. . . .[39]

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f. Summary of Finalized Policies with Regard to Section 131 of the CAA

After consideration of comments we received, we are finalizing the following policies with regard to section 131 of the CAA:

- In this final rule with comment period, we are finalizing policies for resets related to cost reports that are open, reopenable, or not yet settled. We will post a file on the CMS website containing an extract of the HCRIS cost report worksheets on which the FTE counts, caps, and PRAs, if any, would have been reported, starting with cost reports beginning in 1995. We are also seeking public comment regarding how to handle reviews of PRAs or FTE caps from cost reports that are beyond the 3-year reopening period (with the exception of Category A and Category B hospitals that agree with the HCRIS posting).

- Hospitals must first consult the HCRIS posting on CMS's website to determine reset eligibility. MACs will not reach out to hospitals.

- In cases where no PRA or caps are reported on a settled cost report, or when PRAs or caps are reported without any FTEs, and a cost report is settled but reopenable, the hospital gets the benefit of a reset without further review by the MAC.

- If, for open or reopenable cost reports, there is a PRA and/or FTE caps reported on the HCRIS web posting, and the hospital

[39] 86 Fed. Reg. at 73458-59.

believes its PRA in fact was established based on not more than 3.0 FTEs, or its IME and/or direct GME FTE caps were based on not more than 3.0 FTEs, a hospital has a 1-time opportunity to request reconsideration by its MAC which must be submitted electronically and received by the MAC on or before July 1, 2022.

- Hospitals that disagree with the 1-time MAC determination may appeal to the PRRB, assuming all conditions are met.

- Eligible hospitals for resets are those only that have a PRA base period that started prior to enactment and/or FTE cap building window that occurred/closed in a cost reporting period that started prior to enactment (December 27, 2020).

- FTE cap resets will only be based on new programs started after enactment and 5 years after (by December 26, 2025).

- Hospitals that qualify for a PRA reset may use as the new PRA base period either the earliest cost reporting period beginning between enactment and 5 years after in which they train FTEs in a new program, or the first cost reporting period beginning after issuance of this final rule with comment period. In any case, residents need not be on duty during the first month of the cost reporting period from which the per resident amount is established.

- Effective with cost reporting periods beginning on or after December 27, 2020, a PRA would be established if a hospital trains less than 1.0 FTE as a result of participating in a Medicare GME affiliation agreement. Otherwise, no PRA would be established until a hospital trains at least 1.0 FTE. In any case, residents need not be on duty during the first month of the cost reporting period from which the per resident amount is established.

- Effective with cost reporting periods beginning on or after December 27, 2020, a hospital must report training of less than 1.0 FTE on its Medicare cost report if that training is as a result of participating in a Medicare GME affiliation agreement. Otherwise, a hospital must report FTEs on its Medicare cost report when it trains at least 1.0 FTE.

- Hospitals eligible to reset their PRAs would get a new PRA replacing their old PRA(s): hospitals eligible to reset their FTE

> caps would receive an FTE cap adjustment equal to the sum of the original FTE cap and the new program FTE cap adjustment.[40]

On May 15, 2023, the Board issued a Request for Information ("RFI") to the Parties. The Board noted that based on the facts and circumstances in the instant cases, it appears as if Parma may potentially qualify as a Category B Hospital, as defined in the FY 2022 IPPS Final Rule and, if so, may be eligible for a PRA reset. As such, it appears as if the CAA and FY 2022 IPPS Final Rule may be relevant to the instant cases. However, as the Parties' final position papers were filed prior to the FY 2022 IPPS Final Rule being published on December 27, 2021, the Parties had not yet addressed the potential relevance of the CAA and the FY 2022 IPPS Final Rule. Accordingly, the Board ordered the Parties to file comments on the applicability of the CAA and the FY 2022 IPPS Final Rule and their impact on the instant appeals.

In a letter dated June 14, 2023, Parma responded to the Board's RFI. Parma stated that, "[a]lthough [Parma] continues to object to the establishment of a PRA based on its facts, in an abundance of caution, [it] nevertheless followed CMS instructions for consideration as qualifying for Category B status."[41] Parma states that it submitted a PRA reconsideration request to the Medicare Contractor on June 28, 2022, ahead of the July 1, 2022 deadline, in which it "confirmed that its dispute of the Medicare Contractor's determination at issue in [the instant cases] remains ongoing, no matter how the Medicare Contractor evaluates its request under the CAA" but that "since it is the Medicare Contractor's position that [Parma] established its PRA with an FTE count of 0.2910 FTEs, [Parma] requested confirmation that it qualifies as a Category B hospital."[42]

Parma goes on to explain that, on September 28, 2022, the Medicare Contractor responded to Parma's request and "[c]onsistent with its position in the [instant cases], . . . confirmed that 2012 was the relevant year for the PRA determination, and that [Parma]'s FTE count was less than 3 FTEs in that year."[43] According to the Parma, the Medicare Contractor also "acknowledged . . . that the PRA was properly under appeal, and that a final determination of qualification for a PRA recalculation would only be available if the Board rules in favor of the Medicare Contractor."[44] Accordingly, Parma concludes that it has "*contingent* status" as a Category B hospital and notes that "[t]he mere fact that it can avail itself of its Category B hospital status does not render the instant appeals moot by any means" since the CAA *only* applies to cost reporting periods beginning on or after the date of enactment of the CAA and, as such, could only be applicable to Parma's FY 2021 (well after the years at issue here).[45]

In its response to the Board's RFI, also dated June 14, 2023, the Medicare Contractor states that the December 27, 2021 IPPS Final Rule "does not support a PRA reset retroactive to [Parma]'s FY 12/31/2016 or FY 12/31/2017 cost reports" because "[w]hether [Parma] qualifies for a PRA reset can only be determined after resolution of the [instant appeals]."[46] The Medicare Contractor confirms that: (1) if the Board were to affirm the Medicare Contractor's determination that

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[40] 86 Fed. Reg. at 73468.
[41] Provider's June 14, 2023 Response to Board's Request for Information at 2.
[42] *Id*.
[43] *Id.*
[44] *Id.*
[45] *Id*.
[46] Medicare Contractor's June 14, 2023 Response to Request for Information at 2.

Parma's PRA was properly set at zero dollars ($0), Parma would qualify for a PRA reset as a Category B Hospital effective for FY 2021; or (2) in the alternative, if the Board reverses the Medicare Contractor's determination, then Parma's PRA would be based on the FY 2016 cost report, and Parma would not be eligible for a PRA reset since FY 2016 involved the training of more than the 3.0 FTE ceiling for a PRA reset.[47]

As part of its decision set forth below, the Board took into consideration the parties' positions regarding the CAA provisions.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Parma asserts that a PRA is established only after a hospital first "has" an approved medical residency training program. The key is: "whether conditions have changed for a hospital that did not 'have' an approved medical residency training program, meaning that it does now 'have' one. Under such circumstances, the [PRA] is established, at the latest, in the first cost reporting period following the cost reporting period in which training began in the hospital's program."[48]

Parma continues by arguing that there are not clear standards on what it means to "have" a GME program, but at a minimum there must be some degree of "intent" to have a GME program:

> CMS has never defined in regulation or guidance what exactly constitutes "having" an approved medical residency training program. However, applicable guidance suggests that it requires some degree of intentionality on the part of the institution. For instance, in addressing when two hospitals could be viewed as jointly participating in training, leading to a PRA calculation, CMS [] repeatedly referenced the need for an "arrangement" between the two hospitals. . . . in all instances where CMS references joint training leading to a PRA calculation, both hospitals are knowing and willing participants in an arrangement.[49]

Parma further contends that, consistent with this concept of intention, CMS has confirmed that there must be predictability in determining when to set a PRA:

> . . . CMS has stated that it is, and has always been since the inception of this policy, a regulatory objective to promote accuracy in the calculation of PRA values. Its policy of not requiring use of the first cost reporting period in which residents are training in a hospital's new program are based on the fact that the costs incurred in this atypical period may not be "reflective" of "actual" costs. Implicit in this policy statement is the view that *there should be some predictability to the determination of the PRA*, and some ability for hospitals *to engage* in planning to ensure an accurate calculation.

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[47] *Id.*
[48] Provider's FPP at 5.
[49] *Id.* at 5-6.

> Such predictability and ability to plan can only result from a regulatory policy that triggers the PRA calculation only after the hospital is on reasonable notice that it has become a teaching hospital. *Hospitals that have no active involvement in occasional precepting at their facilities can hardly be viewed as having such reasonable notice*.[50]

Parma asserts that the requirement that a resident be "on duty" at a training site is more than simply being "on site":

> The regulation also specifies that residents that are onsite triggering the creation of a PRA are "on duty" at the hospital and receiving a salary. . . . *[T]he hospital is* ***not*** *simply* ***an <u>adventitious</u> training site***. It is directly responsible for the training activities, and the residents are accountable to the hospital in return. Had the regulation and the Federal Register guidance simply used the term "onsite" rather than "on duty," that would have implied that mere physical presence suffices to trigger PRA creation.[51]

Indeed, Parma argues that the "on duty" criteria clearly must reflect some level of intentionality and predictability:

> In light of the plain meaning of the statute and regulation, criteria can be discerned as to whether a hospital has become a teaching hospital. Those criteria must reflect the overarching purpose that *a provider have* ***some level of <u>intentionality</u>*** *about its participation in a teaching program*, ***including some degree of <u>predictability</u> as to when residents are onsite***. CMS itself considers training that is unplanned and sporadic as not qualifying a hospital as a teaching hospital. Residents who are merely following a preceptor onsite are not "on duty" at the hospital. Under any reasonable interpretation, therefore, of applicable law, the facts [here] do not rise to the level of causing [Parma] to have become a teaching hospital with a PRA.[52]

Parma sets forth criteria that it maintains must exist for determining whether a hospital "has" a training program, based upon the Merriam-Webster dictionary definition of the term "has." Parma contends that a hospital must meet at least one of the following criteria:

> 1) ***Holds or maintains the program***. This criterion would be met with evidence that a hospital has furnished resources, financial or otherwise, that supported and sustained the program.

[50] *Id.* at 7-8 (emphasis added).
[51] *Id.* at 8 (emphasis added).
[52] *Id.* at 9-10 (emphasis added).

2) ***Owns and thereby controls the program to achieve a benefit***. This criterion would be met by showing that a hospital has had some ability to modify the program, and uses the program to achieve some benefit for the hospital.

3) ***Could fairly be viewed as having the attribute of having a program.*** A hospital would have the attribute of having a program if the hospital viewed itself, or had others view it as, a teaching hospital.[53]

In applying these criteria to these cases, Parma asserts that the alleged FY 2012 Podiatry Program did not meet any of these criteria:

> [T]here is no evidence of the satisfaction of any of these criteria. [Parma] did not furnish any support to the Podiatry Program. The residents were there entirely *at the discretion of the preceptors,* and were not furnished use of any hospital resources. Likewise, [Parma] had *no control* over the Podiatry Program, which belonged exclusively to [UHHS Richmond Medical Center]. Finally, Parma did ***not*** hold itself out as a teaching hospital.[54]

Parma further explains its lack of control over the Podiatry Program as further evidence that there was neither predictability for, nor intention to have, a GME program within the meaning of 42 C.F.R. § 413.77(e)(1):

> [T]he plain meaning of the statute and regulation both support that there needs to be some intentionality and constancy before a hospital suddenly becomes a teaching hospital and creates a PRA. . . . even CMS has stated that the PRA calculation is only triggered after there has been training occurring onsite ***according to a planned and regular schedule***. . . . [T]here must be at least *some baseline level of coordination* between the hospital and the program before a PRA is established. With respect to the Podiatry Program, the community preceptors were in charge of where the residents would go on a day-to-day basis, as they brought the residents with them wherever they were performing procedures. . . . [T]he residents were not onsite at [Parma] pursuant to a planned and regular schedule.[55]

In its Final Position Paper, Parma concluded that there was no "planned and regular schedule" as evidenced by the fact that the FTEs for the alleged Podiatry program at Parma were so insignificant and resulted in a PRA of zero dollars ($0):

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[53] *Id.* at 10.
[54] *Id.* at 11 (italics and bold emphasis added).
[55] *Id.* (emphasis in original).

> [T]he Provider has calculated the sum total of all of the time spent by residents at Parma during [FY] 2012, as evidenced in the resident calendars, which is **0.291** FTEs. Provider Exhibit P-10. With 26 residents in the Program, that converts to just over **0.01** FTEs worth of training for any individual resident spent onsite at Parma. That level of training hardly constitutes a "planned and regular schedule" for any particular resident.[56]

The Medicare Contractor disagrees and, in support, points to the regulation at 42 C.F.R. § 413.86. More specifically, the audit adjustment at issue (Audit Adjustment No. 32) and the Medicare Contractor's position papers cite to § 413.86 in support of its position. For example, in its Supplemental Position Paper:

> During the audit [of the FYE 12/31/16 cost report], it was noted that the Provider claimed FTE's from UH Regional Hospital totaling 0.30 for Podiatry, 0.35 for Emergency Medicine, and 0.12 for Physical & Rehab Medicine programs. The auditor noted that the Podiatry program from UH Regional Hospitals is not a new program, but a continued accreditation". The auditor performed their due diligence and reviewed the 2012 audit for UH Regional Hospital and found residents were on duty at Parma in 2012. ***By following 42 C.F.R. § 413.86(e)(4)*** *which states: "the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period." (Emphasis added)*, the MAC adjusted the PRA to zero. Nowhere does the regulation require that the FTEs and costs must be reported on the cost report. Rather, the information merely be ascertainable from the cost reporting period.[57]

Indeed, the Medicare Contractor represents in the concluding paragraph of both its Final Position Paper and Supplemental Position Paper that its "***followed*** *42 C.F.R. § 413.86(e)(4)* [*sic* 413.86(e)(5)] to calculate the PRA" at issue.[58] Specifically, these position papers are essentially verbatim the same:

> The MAC has ***followed*** *42 C.F.R. § 413.86(e)(4)* [*sic* 413.86(e)(5)] *to calculate the PRA* as residents rotated to the Provider in 2012 for a

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[56] *Id.* at 14 (emphasis in original).
[57] Medicare Contractor's Supplemental Position Paper at 8 (emphasis added and footnotes omitted). *See also, e.g.,* Medicare Contractor's FPP at 8 (citing and quoting "42 C.F.R. § 413.86(e)(i) [*sic* 413.86(e)(5)(i)] and "42 C.F.R. § 413.86(e)(4)"); *id.* at 9 (citing and quoting "42 C.F.R. § 413.86(e)(4)"); *id.* at 12 (citing and quoting "42 C.F.R. § 413.86(f)(1)").
[58] *Id.* at 16 (emphasis added); Medicare Contractor's Supplemental Position Paper at 11 (emphasis added).

> Podiatry Program. The MAC respectfully requests the Board to affirm the MAC's adjustment to the Provider's PRA.[59]

The Medicare Contractor rejects Parma's argument that residents who merely follow a preceptor onsite are not "on duty" at the hospital. The Medicare Contractor points to the dictionary definition of "on duty" which specifies "on duty" to be "engaged in or responsible for an assigned task or duty." The Medicare Contractor asserts that "the residents that rotated to [Parma] were completing their assigned tasks for which they were responsible (*i.e.*, completing rotations with a preceptor)."[60] Thus, contends the Medicare Contractor, "the residents were "on duty" at the Provider."[61]

The Medicare Contractor states that "[o]n June 17, 2021, [it] received the resident rotation schedules for the [UHHS] Richmond [Medical Center] podiatry program from July 2011 to June 2013"[62] and has included these schedules in the record for Case No. 19-2081 as Exhibit C-7. The Medicare Contractor asserts that these schedules show the location where the resident's rotations ***were planned***. The Medicare Contractor describes the rotation schedules as follows:

> Parma is noted as a rotation site along with fifteen other facilities under the facility key "UH Pod Surg." From July 2011 to June 2012, UH Pod Surg rotation is present 33 times, and 24 times from July 2012 to June 2013. . . . The rotation schedules show Parma is a "planned" rotation site. The residents knew in advance they would be performing rotations, in part, at Parma.[63]

The Medicare Contractor contends that the PRA is initiated regardless of whether a hospital "has" a training program.[64] In support of its position, the Medicare Contractor points to a Medicare Learning Network ("MLN") Matters article issued October 27, 2017 wherein CMS states:

> In order for a PRA to be established, the residents need not be in a newly approved residency program, *nor must the hospital be the sponsor, nor incur costs*. Rather, a hospital counts the respective share of the FTE resident that *trains in its hospital*, whether it employs the resident or not.[65]

Therefore, the Medicare Contractor contends that "[Parma]'s argument that it is required to have or maintain a training program for the PRA to be initiated is incorrect."[66]

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[59] Medicare Contractor's FPP at 16 (emphasis added). The Medicare Contractor's Supplemental Position Paper at 11 states the exact same thing except that "Program" in the first sentence is not capitalized and the phrase "to the Provider's PRA" in the second sentence is stated as "to the Per Resident Amount."
[60] Medicare Contractor's FPP at 10.
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.* at 11.
[65] (Emphasis added.)
[66] Medicare Contractor's FPP at 12.

The Medicare Contractor maintains that the rotations at Parma were "planned" and not sporadic.[67] In support, the Medicare Contractor describes the Podiatry Programs as follows:

> [T]raining was planned to take place at the Provider during the year since the preceptor *regularly* took residents on site to [Parma]. The planned onsite training specifically portrays a "baseline level of coordination" between [Parma] and the [Podiatry] program even if there was no other involvement.[68]

The Medicare Contractor argues that the "UH Pod Surg." rotation on the resident rotation schedules "clearly shows that Parma is one facility that the residents were planned to be [at,] and residents were expected to complete training at Parma."[69]

Finally, the Medicare Contractor also disagrees with Parma's contention that the training that occurred at Parma was sporadic based on its assertion that the resident calendars suggest Parma rotations were well planned and had a pattern or some degree of predictability:

> A detailed review of the resident calendars shows the rotations that occurred at Parma were well planned and there were similarities and patterns within months, and between months. Therefore, any arguments . . . that the training which occurred at Parma was "sporadic" simply fail.[70]

In reviewing the record, the Board finds that the totality of the evidence does not support the Medicare Contractor's assertion that, under 42 C.F.R. § 413.77(e)(1), Parma somehow triggered the FY 2016 calculation of a PRA based on FY 2012, when: (a) certain Podiatry residents from UHHS Richmond Medical Center were on a non-hospital rotation to a Podiatry practice; and (b), as part of that rotation, the resident accompanied their preceptor Podiatrist to certain surgeries being performed by that preceptor across 15 different potential surgery sites of which Parma was one site where some surgeries were performed; and (c) during such surgeries, the resident received training from that preceptor. In making this finding, the Board first reviewed the operative regulatory language:

> *[I]f a hospital did not* ***<u>have</u>*** *any* ***approved*** *medical residency training programs* or did not participate in Medicare during the [1984] base period, ***but either condition changes*** *in a cost reporting period beginning on or after October 1, 2006*, and the residents are not ***on duty*** during the first month of that period, the contractor establishes a per resident amount for the hospital using the information from the first cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital.

[67] *Id.* at 13.
[68] *Id.* at 14 (emphasis added).
[69] *Id.* at 14-15.
[70] *Id.* at 15.

The Board agrees with the Provider that, under § 413.77(e)(1), the event that prompts a Medicare Contractor to set a PRA is for a hospital "to *have* [an] *approved* residency training program." It is only after this triggering event occurs that having residents "on duty" becomes relevant and that relevance is simply how to determine the calculation of the PRA relative to that new approved program. This reading is consistent with the statutory provision at 42 U.S.C. § 1395ww(h)(2)(F) *upon which the regulation is based* because, under§ 1395ww(h)(2)(F), determining a PRA for a hospital: (1) occurs only if that " *hospital* that *did not* ***have an approved*** *medical residency training* ***program*** or was not participating in the [Medicare] program . . . for a cost reporting period beginning during fiscal year 1984"; and (2) is prompted only "for the first such period for which it ***has such*** *a residency training* ***program*** and is participating [in the Medicare program]."[71] When determining a PRA is prompted, the statute specifies that the PRA is to be set "as the Secretary determines to be appropriate" but "based on approved FTE resident amounts for *comparable* programs."[72] It is through the hospital *having* an ***approved*** GME program that there is intention and predictability behind the statute and implementing regulation and the statute makes clear that the PRA is to be based on "comparable programs." Here, it is clear that the Podiatry program used by the Medicare Contractor to set the PRA for Parma was not comparable to the new Internal Medicine and Family Medicine programs.[73]

Indeed, the Board notes that the Medicare Contractor *commits error* by citing to and relying on the wrong regulation, *§ 413.86*, because***, after October 1, 2004,*** § 413.86 no longer existed due to redesignation *and the relevant redesignated regulation (42 C.F.R. § 413.77(e)(1)) was superseded by subsequent revisions made to it in the FY 2007 IPPS Final Rule.* Specifically, as part of the FY 2005 IPPS Final Rule, the Secretary redesignated the then-existing § 413.86 into nine separate sections.[74] Significantly, the portion of § 413.86 governing the setting of PRAs for new programs started after 1985 was located at 42 C.F.R. § 413.86(e)(5) and was redesignated as 42 C.F.R. § 413.77(e).[75] As discussed above, the Secretary modified 42 C.F.R. § 413.77(e) to add the following operative language:

> Effective for cost reporting periods beginning on or after October 1, 2006, *if a hospital did* **not have** *any* **approved** *medical residency training programs* or did not participate in Medicare during the base period, *but either condition changes in a cost reporting period beginning on or after October 1, 2006*, ***and the residents are not on duty during the first month of that period***, the contractor establishes a per resident amount for the hospital *using the information from the first cost reporting period* ***immediately following the cost reporting period during which*** *the hospital participates in Medicare and* ***residents began training at the***

[71] (Emphasis added.)
[72] (Emphasis added.)
[73] Not only is the substantive nature of a Podiatry program different from those for Internal Medicine and Family Medicine (*e.g.,* markedly different specialties and accredited by different professional organizations), but also the Secretary has made clear that "podiatric residents[] are excepted from the statutory cap on the count of FTE residents for both direct GME and IME payment purposes." 68 Fed. Reg. 45346, 45435 (Aug. 1, 2003).
[74] 69 Fed. Reg. 48916, 49090, 49234-39 (Aug. 11, 2004).
[75] *Id.* at 49235 (showing crosswalk from 42 C.F.R. § 413.86(e)(5) to 42 C.F.R. § 413.77(e)).

> ***hospital***. *The per resident amount is based on* the lower of the amount specified in ***paragraph (e)(1)(i)*** or paragraph (e)(1)(ii) of this section, subject to the provisions of paragraph (e)(1)(iii) of this section. Any GME costs incurred by the hospital during the cost reporting period prior to the base period used for calculating the PRA are reimbursed on a reasonable cost basis.
>
> (i) The hospital's actual cost per resident incurred *in connection with the GME program(s)* based on the cost and resident data ***from the hospital's base year*** cost reporting period ***as established in paragraph (e)(1) of this section***.
>
> (ii) Except as specified in paragraph (e)(1)(iii) of this section –
>
> ****
>
> (B) For base periods beginning on or after October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts (including primary care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals.
>
> (iii) If, under paragraph (e)(1)(ii)(A) or (B) or (e)(1)(iv)(B) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region as that term is used in subpart D of part 412 of this subchapter.

Under the operation of § 413.77(e)(1), Parma's first base period is FY 2016 (*i.e.*, "the first cost reporting period ***immediately following*** the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital"[76]). Indeed, FY 2015 is the year prior to the base period (*i.e.*, in the year prior to FY 2016) and the Medicare Contractor paid Parma for its reasonable start-up costs associated with its newly-approved Internal Medicine and Family Medicine programs during FY 2015 as made clear in the following Note 2 to the Medicare Contractor's audit workpapers for FY 2016:

> NOTE 2 The Provider did not claim GME FTEs on the prior year cost report [*i.e.*, FY 2015]. The PY desk review (411-01 B) did conduct a review of salaries and other expenses with no adjustments necessary. Audit inquired of the provider why IME FTEs were claimed but GME FTEs were not claimed in 2015. Per

[76] (Emphasis added.)

> the provider at 411-1 AF, since 2015 was the first year as a new teaching facility, the provider would be reimbursed on pass through costs, therefore, no FTEs were entered on WKST E-4 for GME. *Audit notes that GME FTEs can still be entered on WKST E-4 since the [2015] cost report will still **calculate the pass through costs accordingly***. Since 2015 will not be used in any future cost reports' rolling average and there is no reimbursement impact, then no further review is necessary. Lastly, the list of FTEs claimed is detailed on the PY desk review workpaper at 411-01 B and was reconciled to the cost report with only an immaterial variance noted. NFRN [No Further Review Necessary].[77]

In order to pay Parma for its reasonable startup costs for its new GME programs during FY 2015, the Medicare Contractor necessarily made a finding that Parma did not previously have a residency program and was a new teaching hospital effective for FY 2016 relative to the newly-approved programs it started at the mid-point of FY 2015.

Even if Parma were not required to have an *approved* residency program in order to prompt setting a PRA or the Secretary was not required set the PRA "based on approved FTE resident amounts for *comparable* programs,"[78] the Board would still find that there is ***not*** sufficient information in the record to establish that ***Parma*** had a Podiatry program during FY 2012.[79]

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[77] Ex. C-8 at 2, Note 2 (emphasis added). *See also* Tr. at 217-18. Did the Medicare Contractor later reverse its payment of the reasonable cost start up costs paid in FY 2015? Indeed, consistent with the above, Parma has presented documentary evidence at Exhibit P-15 that the Medicare Contractor did not attribute any residents to Parma in its audit of the FY 2012 cost report. These concerns highlight how messy, unwieldy and inconsistent, the Medicare Contractor's position appears to be. Indeed, it raises questions about predicate fact issues and suggests that the Medicare Contractor may have violated the Secretary's predicate fact policy set forth in 42 C.F.R. § 405.1885(a)(1)(3) by making a contrary finding in FY 2016. However, the Board need not resolve this dispute based on its findings as discussed *infra*.

[78] (Emphasis added.)

[79] Indeed, the following exchange that suggests that there may have been additional information regarding the podiatry program sponsored by UHHS Richmond relied upon by the Medicare Contractor that was not made part of the record for this case notwithstanding the Medicare Contractor's obligation under 42 C.F.R. § 405.1853(a)(3) to make it part of the record in this case:

Board Member: When the MAC reviews the IRIS Providers, one thing they commonly do is look at duplicates and overlaps and then they put those facilities on notice. They get a letter that says, hey you're both claiming this guy for January of 2015. So, it's not unreasonable that a MAC when they do an audit of Richmond and find 10 hospitals that each have 0.2 FTE could do the same thing if they wanted to. It's basically the same concept, there's a duplication. Except in this case, there's not even a duplication because they're not claiming it, Richmond is. But, if the MAC's contention is that it's wrong and those other hospitals should be claiming it, I feel like the MAC should be issuing a Notice of Reopening, but they're not doing that.

Board Chair: You had indicated that there was an adjustment to take off the Parma time relative to the Richmond Cost Report. Are you saying there was no adjustment to take off the other hospitals' time?

MAC Rep: No, it is my understanding, I was flipping back through my notes of a little bit earlier to see if I could find that citation, and regrettably, I couldn't in a short period of time. But it was my understanding that all of the non-Richmond

The Board finds that the Medicare Contractor places too much emphasis on the fact that Parma appears as one of fifteen (15) potential different surgical sites under the facility key "UH Pod Surg" on the UHHS Richmond Medical Center Podiatry program resident rotation schedule at Exhibit C-7.[80] The Board does not agree with the Medicare Contractor's view that this is evidence of Parma being a facility where the residents were planned or scheduled to be, or where residents were expected to complete their training during FY 2012.[81] In this respect, the Medicare Contractor recognized that Parma was ***not*** part of UHHS during Parma's FY 2012 and that UHHS Richmond did not plan a rotation to Parma prior to the academic year but rather planned a rotation to the ***nonhospital*** offices of a particular preceptor Podiatrist:

> Although the rotation to Parma may not be planned prior to the start of the academic year, the director of the podiatry program has approved ahead of time for students to rotate with that particular ***non-hospital*** preceptor. *It is a planned training that the students will rotate with that doctor*. It's reasonable the doctor is ***not*** going to know ahead of time all the locations they will take the students to if they rotate between several sites.[82]

Instead, the primary concern of the Medicare Contractor appears to revolve around the fact that, *as part of the rotation to **the non-hospital offices** of the preceptor Podiatrist*, that preceptor Podiatrist may take the resident with him/her to surgeries being performed at a hospital (inpatient or outpatient), one of which may have been Parma:

> However, it is reasonable, that because Parma is one location they often rotate to as shown by the 2012 rotation calendars, that they are likely to rotate to Parma at some point during the year as these doctors have a relationship with Parma. Although *the exact site is **not** planned ahead of time prior to the start of the academic year*, *it is planned for the student to rotate with the doctor*, who likely will rotate between X number of hospitals, one of them being Parma. Auditor has determined the provider has not shown Parma was not a training participant prior to July 2015 and that the PRA was not established years ago. No changes will be made based on the provider's response.[83]

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rotations or time were adjusted off. But if the board would like more information on that, I'm happy to obtain it. As far as IRIS reports for other hospitals, I just don't know the answer to that.

Board Member: I'm not just concerned if it's been taken off, I want to know if it's been put on to the other hospitals. That's what you're suggesting needs to be done. I want to know, did the MAC take it upon itself to do it?

MAC Rep: I don't know the answer to that question . . . .

See also Ex. C-8 at 1 which is the Medicare Contractor's FY 2016 workpaper listing 36 "source" documents, many of which are not part of the record for this case.

[80] *See* Medicare Contractor's FPP at 10.

[81] *Id.*

[82] Ex. P-8 at 2 (emphasis added) (Notification of Pending Cost Report Settlement (Apr. 11, 2019)).

[83] *Id.*

This alone is insufficient to establish that Parma *had* a program and that Parma *was training* UHHS Richmond Podiatry residents.[84] Rather, the Board finds that Parma has provided conclusive evidence that it did not *have* a planned rotation schedule to train UHHS Richmond Podiatry residents and, as such, did not *have* podiatry residents "on duty" at Parma.

Parma has provided copies of three (3) UHHS Richmond "Affiliation Agreement[s] for Non-Hospital Sites" for the nonhospital site rotations to the offices of a preceptor Podiatrist[85] in effect during FY 2012 as well as testimony from a former UHHS Richmond Medical Center Podiatry resident on the *nature* of this nonhospital site rotation. The witness explained that it was a rotating schedule where the resident was covering podiatry surgeries with a preceptor Podiatrist and that the surgeries were performed *mostly* on an *outpatient* basis.[86] The objective of the rotation was not just advancing training on foot and ankle surgery but also included non-surgical objectives such as: (1) "hav[ing] the opportunity to formulate a differential diagnosis with their attending physician" and (2) "gain[ing] the ability to implement an appropriate plan of management."[87] Essentially, the resident was assigned to a preceptor Podiatrist and followed that preceptor such that when he was in the office, the resident was in the office and, if he went to surgery, they followed him to surgery.[88] If surgery was performed, there were multiple different potential locations where it could be performed, *in both freestanding/non-hospital and hospital settings*. In other words, the resident was not assigned specifically to Parma as a training site location *but rather to the* ***nonhospital*** *offices of a preceptor Podiatrist*. The resident was assigned to a preceptor Podiatrist who, on a given day, may or may not have had a surgery to perform and, if so, *may have* performed the surgery at Parma or another facility (hospital-based or freestanding nonhospital facility) on any given day. With respect to UHHS Richmond Medical Center's Podiatry Program during FY 2012, Parma was not part of UHHS and was not a "planned" training location as that term is generally understood in connection with resident rotation schedules. In fact, a Podiatry resident could have completed the program and would have been able to sit for Board certification *without ever going to Parma*.[89]

The aforementioned witness testimony is corroborated in a declaration from the Director of the Podiatry Program at Richmond Medical Center wherein he makes the following statements:

> 5. The resident calendars reviewed by the Medicare Contractor are ***not*** the same as resident rotation schedules. The resident calendars are completed ***retrospectively***, *once the training has already occurred*. In contrast, rotation schedules are completed ***prospectively*** *prior to the beginning of the academic year*.

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[84] Again, during FY 2012, Parma was not part of UHHS and had no contractual relationship with the GME program at UHHS Richmond or the nonhospital rotation(s) to the offices of the Podiatrist preceptor(s) at issue. In particular, Parma was not a party to the Affiliation Agreements at Exhibit P-6.
[85] Ex. P-6.
[86] Tr. at 101-02, 151.
[87] Ex. P-6 at 68.
[88] Tr. at 90
[89] Tr. at 90-92, 110.

6. In some cases, the resident calendars that were reviewed by the Medicare Contractor reference "Parma" as a resident location. The use of the term "Parma" indicates that the resident was onsite at [Parma] for some period of time on that day.

7. The use of the term "Parma," however, is ***not*** meant to imply that Parma was serving as the host location for the rotation. In each case where the Medicare Contractor noted that the term "Parma" was used, the actual rotation *was based* ***out of a preceptor's office*** *in the greater Parma community*.

8. A number of preceptors working with the Program perform surgeries at [Parma]. However, that is only one of the locations where these preceptors practice Podiatry. In a given day, the preceptors could allow the Program residents to accompany them to several different locations. [Parma] could be one location, but the resident could have spent some other portion of the day at an office, or even several offices, where the preceptor bases his or her practice.

9. In light of this variability, the percentage of any given preceptor rotation spent at [Parma], or whether any time is spent at [Parma] at all, is unplanned by the Program.[90]

Parma's witness provided additional evidence that Parma was not a planned training location. The witness confirmed that, when she was a Podiatry resident at UHHS Richmond Medical Center during the time at issue:

1. She never sought or was granted privileges at Parma.
2. She never took instructions from any one at Parma.
3. She was not provided with any orientation.
4. No one at Parma wrote an evaluation of her performance.
5. She was never told about a designated institutional officer or graduate medical education committee at Parma.
6. There was no GME coordinator at Parma.
7. She never had any reason to believe that Parma had any influence on the shaping of the Podiatry program, either through appointing faculty members or designing curricula.[91]

Additional testimony at the hearing established that Parma was not an accredited training hospital *for any specialty in FY 2012*. Parma neither claimed nor incurred any direct GME costs *associated with training residents* in their FY 2012 cost report. No individual employed by Parma trained any residents in podiatric medicine in FY 2012. *Effective on the first day of FY 2015*, Parma become an accredited program sponsor in Internal Medicine and Family Medicine. Accordingly, on its as-filed FY 2015 cost report, Parma reported direct GME costs and asked to

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[90] Ex. P-5 (Declaration of William J. Saar, D.P.M.).
[91] Tr. at 121-124.

have its initial PRA calculated based upon its FY 2016 cost report, because FY 2016 was the first year that Parma had residents on duty in the first month of a fiscal year.[92]

The Board notes that Parma has calculated the sum total of all of the time spent by residents at Parma during FY 2012, as evidenced in the resident calendars, as 0.291 FTEs. As noted by the Board questions during the course of the hearing, this equates to approximately 3.5 months. Indeed, the Board notes that, based upon the Richmond Director of Podiatry Program's declaration, discussed above,

> [i]n a given day, the preceptors could allow the Program residents to accompany them to several different locations. [Parma] could be one location but the resident could have spent some other portion of the day at an office, or even several offices, where the preceptor bases his or her practice.[93]

As such, a calculation of FTEs based upon counting each day noted as "at Parma," is guaranteed to over-value the FTEs, as that single day was not spent ONLY at Parma. Thus, the calculation of 0.291 FTEs or 3.5 months is the maximum possible, and most likely, the actual amount is even less. In this regard, the Board looks to the discussion in the 1989 Final Rule wherein CMS states that one or two months of cost would not be reflective of the costs of the program. The Board also looks to the preamble language in the FY 2007 IPPS Final Rule wherein CMS states that the intent of its PRA calculation methodology for new teaching hospitals "is to make a more accurate determination of a PRA based on the hospital's per resident direct GME costs in a cost reporting period in which GME costs have been incurred for that entire period."[94]

The Board finds that the use of Parma's FY 2012 cost report to set an *initial* PRA of zero dollars ($0), effective with FY 2015, conflicts with CMS's intent of "more accuracy" in establishing a PRA calculation methodology for new teaching hospitals. Using the *alleged* costs of a non-sponsored podiatry program at Parma from FY 2012 (if indeed there were any) are not reflective of the costs of the new sponsored residency programs that Parma began operating in FY 2015, and the use of the FY 2012 data for the non-sponsored program does not lead to an accurate determination of Parma's PRA for FY 2015. To use the costs of a non-sponsored podiatry program to develop a PRA for the Internal Medicine and Family Medicine programs clearly sponsored by Parma is nonsensical and clearly not consistent with the directive in the statute that the PRA be "based on approved FTE resident amounts for *comparable* programs." Indeed, the Medicare Contractor recognizes that using the FY 2012 costs of training residents at Parma results in a PRA of zero dollars ($0), which is clearly unreasonable – and further implies that it costs the hospital nothing in FY16 to train residents in not one, but two residency programs.[95] Therefore, the Board rejects the Medicare Contractor's position that: (1) Parma's FY 2012 cost report should be used to set a PRA on the FY 2016 cost report; and (2) this PRA should be applied for FY 2017.

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[92] Tr. at 165-167.
[93] Ex. P-5.
[94] 71 Fed. Reg. 47870, 48077.
[95] Tr. at 178-181.

The Board also rejects the Medicare Contactor's inference from the October 27, 2017 MLN Matters article that a PRA is initiated regardless of whether a hospital "has" a training program. The Board interprets this article as guidance on how a hospital should determine an FTE count to use to compare to direct GME costs *in the development of a PRA*. The record does not establish that there were any direct GME costs on Parma's FY 2012 cost report so there are no FTEs that would apply to that cost.[96]

Moreover, an MLN Matters article is not where CMS *sets* policy because, as explained on the main webpage for MLN Matters Articles, they are educational and "***explain*** national Medicare policies on coverage, billing, and payment rules for specific provider types."[97] Rather, CMS sets policy in its manuals, memorandum, and rulemakings. Here, the Medicare Contractor has only cited to an MLN Matters article and has not provided any reference to a CMS manual provision, memorandum or rulemaking to confirm that CMS adopted the alleged policy. Accordingly, the Board declines to give any weight to the MLN Matters Article cited by the Medicare Contractor.

Contrary to the Medicare Contactor's position, the evidence in the record ostensibly establishes that, during its audit of Parma's FY 2016 cost report, the Medicare Contractor reached a conclusion that FY 2016 represented Parma's ***first*** full year of training residents as a new teaching hospital which per the regulation would trigger the calculation of a PRA:

> *Per review of the prior year and current year desk review workpapers at 411-01 B and 411-01 H, respectively**, the provider became a <u>new</u> teaching facility <u>in</u> the prior year, <u>FY 2015</u>.*** Per review of the settled PY cost report at 411-01 C, WKST S-2, pt I, line 57 on page 21, the provider reported the FY 2015 as the first cost reporting period during which residents trained at this hospital. However, residents did not start training in the first month of the cost reporting period. ***Therefore, the current year is <u>the first full cost reporting period that residents trained at this facility</u>.*** However, Audit notes that some residents claimed are not in Parma sponsored programs. See WP 411-02, Procedure 3.

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[96] As previously noted, UHHS Richmond entered into "Affiliation Agreement[s] for Non-Hospital Sites" with certain "Facilit[ies]" where each "Facility" was the office of a Podiatrist. Per ¶5 of these Affiliation Agreements (Exhibit P-6 at 22-23, 39-40, 56-57), 90 percent or more of the direct costs were incurred by UHHS Richmond: "UH[HS] is responsible for bearing ninety percent (90%) of all or substantially all of the cost of any Rotation hereunder (the "Total Costs"). This amount includes: (a) the costs attributable to the Resident (including a Resident's salary, benefits, and, where applicable, travel, and lodging expenses approved by UH[HS] prior to the start of the rotation) ("Resident Costs"); and (b) any teaching physician costs to the Facility as defined and applied by CMS ("Facility Costs"). Each Schedule shall detail the Estimated Total Costs for Rotation. Prior to June 30 of each year, in which a Rotation occurred, UH[HS] will provide notice to Facility of the actual Total Costs of all Rotations to a Facility since July 1, of the previous year ("Notice of Actual Total Costs"). The parties agree that the Notice of Actual Total Costs shall automatically amend this Agreement to incorporate such actual total costs (and the calculation of 90% of such cost) into this Agreement."

[97] (Emphasis added.) The main page MLN Matters Articles is located at: https://www.cms.gov/training-education/healthcare-provider-resources/mln-publications-multimedia/articles (last accessed May 30, 2024).

> *The provider submitted documentation to support* ***when the first resident rotated at Parma hospital.*** *Per review of 411-01 AH,* ***the first resident rotated at Parma in July 2015.*** NFRN.
>
> Since this provider is a new teaching facility and the current year is the first full year of training residents, then audit will include all residents in the sampling population and allow the PPS sampling program to select residents accordingly. See WP 411-02 for the review of the sample.[98]

The record also contains evidence that the Medicare Contractor was at least, at one point, in the process of calculating a PRA for Parma using data from Parma's FY 2016 cost report:

> We cannot calculate an accurate PRA until after the audit is completed on the 12/31/16 cost report. The regionally adjusted national average for 12/31/16 is 100,904, which is what you used on the cost report. The as filed costs per resident does exceed that amount.[99] The 12/31/16 projected PRA of the last new program in this CBSA is 97,641. The PRA for 360041 will be close to that, but will vary based on all of the data from the most recently settled cost reports for all of those same hospitals at the time that the review is completed.[100]

Indeed, as noted above, in apparent recognition of this fact, Parma received reimbursement for its reasonable start-up costs during FY 2015. To summarize, the weight of the evidence in the record supports a finding that Parma's FY 2016 cost report should be used as the base period for establishing its PRA.

As such, the Board notes that, as the Board reverses the Medicare Contractor's determination that Parma's PRA was properly set at $0, the provisions in the CAA do not apply to Parma.

DECISION AND ORDER

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor erred in using FY 2012 as the base period to set Parma's PRA at zero dollars ($0) effective for Parma's FY 2016 cost reporting period. The Board remands to the Medicare Contactor to: (1) properly determine the PRA by using Parma's FY 2016 cost reporting period as the base period for establishing Parma's PRA based on the new Internal Medicine and Family Medicine residency programs; and (2) apply that newly-

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[98] Medicare Contractor's Supplemental Position Paper, Ex. C-8 at 3 (emphasis added).

[99] Referring to the Provider's Final Position Paper, Ex. P-13, identified as UHHS Parma 12-31-16 Base Year PRA, which shows that the Medicare Contractor calculated a PRA of $131,180 based on cost and FTE count data from Parma's 12/31/16 cost report.

[100] Provider's Final Position Paper, Ex. P-12 which represented an email communication from the Medicare Contractor to the Provider.

determined PRA to Parma's FY 2016 and 2017 cost reporting periods in order to reimburse Parma for its direct GME costs during those periods.

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FOR THE BOARD:

6/17/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV