PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

On the Record
2023-D24

PROVIDER –
Kaweah Delta Health Care District

RECORD HEARING DATE –
June 24, 2019

Provider No. – 05-0057

Cost Reporting Period Ended –
June 30, 2013

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions c/o
Cahaba Safeguard Administrators (J-E)

CASE NO. –
15-3002

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ISSUE STATEMENT

Whether the Provider is entitled to reasonable cost reimbursement for its graduate medical education ("GME") start-up costs for the fiscal year ending ("FYE") June 30, 2013.[1]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence submitted, the Provider Reimbursement Review Board ("Board" or "PRRB") finds that the Medicare Contractor properly adjusted the Provider's cost report for FYE June 30, 2013 because the Provider is not entitled to reasonable cost reimbursement for its GME start-up costs *within its FYE June 30, 2013 cost reporting period* since no residents were being trained in the Provider's approved programs *during that cost reporting period*.[2]

INTRODUCTION

Kaweah Delta Health Care District operates Kaweah Delta Medical Center ("Kaweah" or "Provider"), a general acute care hospital located in Visalia, California.[3] Kaweah is reimbursed under the Medicare program's inpatient prospective payment system ("IPPS"), and offers an array of services including acute inpatient, outpatient, home health, hospice and renal dialysis services. In addition, Kaweah has beds designated for psychiatric, rehabilitation, and skilled nursing services and operates a rural health clinic.[4] The Medicare contractor[5] assigned to Kaweah for this appeal is Noridian Healthcare Solutions (hereinafter "Medicare Contractor").

On January 19, 2015, the Medicare Contractor issued the Notice of Reimbursement ("NPR") for Kaweah's FYE June 30, 2013 cost report and allowed the reasonable cost reimbursement for Kaweah's direct GME program start-up costs. On May 8, 2017, the Medicare Contractor issued a Revised NPR ("RNPR") for Kaweah's FYE June 30, 2013 cost report adjusting costs that Kaweah claimed for its GME programs.[6] Specifically, the Medicare Contractor "reversed" the reasonable cost reimbursement for Kaweah's GME program start-up costs *as claimed in FYE June 30, 2013*.[7]

Kaweah timely appealed the Medicare Contractor's January 19, 2015 original NPR and met all jurisdictional requirements for a hearing. On July 7, 2017, the Provider appealed the RNPR and this RNPR appeal was consolidated by the Board into Case No. 15-3002.[8] On May 27, 2019,

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[1] Joint Stipulations (hereinafter "Stip.") at ¶ 2.
[2] Kaweah's FYE at issue in the instant appeal is its FY 2013 which runs from July 1, 2012, through June 30, 2013. *See* Stip. at ¶ 1.
[3] *Id*. at ¶ 2.
[4] Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 1.
[5] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[6] Medicare Contractor's FPP at 15.
[7] Stip. at ¶ 9.
[8] *Id*. at ¶¶ 10, 11.

Kaweah filed a Request for Record Hearing, which the Board approved on June 24, 2019. The parties have stipulated to and agreed upon most of the facts pertinent to this appeal.[9]

Kaweah was represented by Ronald S. Connelly, Esq. of Powers Pyles Sutter & Verville PC. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS

Kaweah's newly-established GME programs in Family Medicine and Emergency Medicine were accredited, with an effective date of July 1, 2012.[10] However, Kaweah did not begin training residents in those programs until a year later, on July 1, 2013 (*i.e.*, the first day of FYE June 24, 201**4**).[11] Per the pertinent regulations governing the establishment of a new teaching hospital's per resident amount ("PRA"), Kaweah's PRA for its new GME training program was established during its FYE June 30, 2014 cost reporting period (*i.e.*, the period in which the program started training its *first* resident). FYE June 30, 2013 was the year prior to Kaweah's PRA base period.[12] However, during its FYE June 30, 2013, after accreditation but prior to commencing resident training, Kaweah states that it "incurred significant costs establishing medical education programs, including costs related to a GME office, program director salaries, other start-up costs, and overhead."[13] The Parties agree that, "on its FY 2013 cost report, [Kaweah] claimed $3,059,214 in reasonable cost reimbursement for GME, and reported it as an 'other adjustment' on Line 39 of Worksheet E, Part B."[14]

During the initial settlement of Kaweah's FYE June 30, 2013 cost report, the Medicare Contractor did not revise the "Other Adjustment" reported on Line 39 in the NPR dated January 19, 2015.[15] On July 15, 2015, Kaweah requested that the Medicare Contractor expand an existing reopening of its FY 2013 cost report in order to properly "apportion" its GME costs between Medicare and non-Medicare services, and to correct an error on Worksheet S-2, Part I, Line 57.[16] Subsequently, the Medicare Contractor issued a Notice of Reopening ("NOR") on July 30, 2015 with a stated purpose "to properly report graduate medical education costs."[17] The Medicare Contractor issued an RNPR on April 13, 2016, which removed all GME costs originally reported on Worksheet E, Part B, Line 39 (both the Medicare and non-Medicare

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[9] The parties submitted Joint Stipulations dated June 24, 2019.
[10] Initial accreditation was received from the Accreditation Council for Graduate Medical Education or "ACGME." *See* Exhibit P-3; Stip. at ¶ 18.
[11] Stip. at ¶¶ 19, 20.
[12] *Id.* at ¶ 24.
[13] Provider's FPP at 12.
[14] Stip. at ¶ 26.
[15] *See* Medicare Contractor's FPP at 15.
[16] *See* Exhibit C-7 (letter from Kaweah to the Medicare Contractor dated July 15, 2015). Kaweah's letter at Exhibit C-7 refers to a Notice of Reopening dated June 24, 2015 and "requests that the [Medicare Contractor] add the issue of [GME] costs to the FY 2013 reopening" because Kaweah "recently discovered that is GME costs were not apportioned between Medicare and non-Medicare services" and "[a]ccordingly, [Kaweah] was overpaid by $1,751,021." Kaweah also requested correction of "an error on Worksheet S-2, Part I, line 57." The referenced Notice of Reopening is identified as Attachment A to Kaweah's letter. However, Attachment A was not included as part of Exhibit C-7. As a result, the Board is unable to determine the scope or subject matter of the June 24, 2015 Notice of Reopening.
[17] *See* Exhibit C-6 at 4.

portions of the GME costs) as an "Other Adjustment,"[18] but which was not what Kaweah had requested in its July 15, 2015 letter.[19]

The Medicare Contractor subsequently issued yet another NOR on March 28, 2017, which stated that one purpose of the reopening was, "[t]o deny GME reasonable cost reimbursement per 42 CFR 413.77(e)(1) as Medicare does not pay for costs incurred prior to the date residents start training."[20] On May 8, 2017, the Medicare Contractor issued the final RNPR for that reopening, which included adjustments to remove the remainder of Kaweah's GME costs.[21] The Medicare Contractor's revisions included updates to Kaweah's "Yes" answers on Worksheet S-2, Lines 56 and 57 to reflect the fact that Kaweah did not train residents in approved GME programs during its FYE June 30, 2013. This is consistent with the Stipulations of the Parties at ¶¶ 19 and 20, which indicate that residents first began training in both the Family Medicine and Emergency Medicine programs on July 1, 2013.

On July 7, 2017, Kaweah timely filed its appeal of the May 8, 2017 RNPR and, for administrative efficiency, the Board combined Kaweah's RNPR appeal with Kaweah's appeal of its FY 2013 original NPR. At present, after multiple issue transfers and the Board's own motion Expedited Judicial Review determination for a different issue, the instant appeal only involves the GME start-up cost issue.

Since its inception, the Medicare program has "shared in the costs of approved medical educational activities…on a reasonable cost basis."[22] Initially, there was "no statutory provision requiring Medicare to pay for the direct costs of medical education."[23] However, 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.[24]

In response, the Secretary promulgated the regulation at 42 C.F.R. § 405.421, that governed "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

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[18] Provider's request letter (Exhibit C-7 at 3) identified the entire cost claimed as $3,059,214 and the Medicare portion of these costs as $1,308,193, resulting in an overpayment of $1,751,021 (for the non-Medicare costs). The Medicare Contractor determined, as part of the reopening, that no Medicare reimbursement was allowable, as no residents were trained by the provider in the fiscal year represented on the cost report. Thus, the adjustment in the RNPR (Adjustment No. 3 on Exhibit C-6, at 6) was to eliminate the GME costs entirely. The other adjustments made in the RNPR then set up Intern & Resident physician salaries on Worksheet A-8-2 (Adjustment No. 1 on Exhibit C-6 at 5), and applicable statistics to allocate this cost on Worksheet B-1 (Adjustment No. 2 on Exhibit C-6 at 5).
[19] *See* Exhibit C-6 at 1.
[20] *See* Exhibit C-3 at 4.
[21] *See* Exhibit P-1.
[22] 50 Fed. Reg. 27722 (July 5, 1985).
[23] 50 Fed. Reg. at 27723; *University of Cincinnati v. Bowen*, 875 F.2d 1207, 1211 (6th Cir. 1989).
[24] 50 Fed. Reg. at 27723.

quality of patient care in an institution."[25] These activities include approved training programs for physicians, nurses, and certain paraprofessionals (for example, radiology technicians).[26] Later, to "implement the Congressional intent that local communities assume a greater role in the costs of medical education"[27] the Secretary promulgated amendments to 42 C.F.R § 405.421(a) (later re-designated to 42 C.F.R. § 413.85) within the July 5, 1985 Final Rule,[28] in order "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."[29]

Congress ultimately addressed Medicare payment of direct GME costs within § 9202 of the Consolidated Omnibus Reconciliation Act of 1985,[30] that added 42 U.S.C. § 1395ww(h),[31] and was then amended under § 9314 of the Omnibus Budget Reconciliation Act of 1986.[32] Through these amendments, Congress established the methodology to be used by the Secretary when determining Medicare payment for direct GME costs, defined in the statute as "direct costs of approved educational activities for approved medical residency training programs."[33] Specifically, Congress requires the Secretary to calculate a hospital-specific approved per resident amount ("PRA")[34] for each hospital based on the hospital's allowable costs for its cost reporting period beginning in federal fiscal year ("FFY") 1984.[35] 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."[36] 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."[37] The resulting product represents the "payment amount for a hospital cost reporting period."[38]

Although the statute provides that the Secretary shall use a hospital's FY 1984 cost report as the base period for determining a hospital's PRA, Congress also instructed how to calculate the PRA for a hospital that, during the FY 1984 cost reporting period, either (1) did not have an approved medical residency training program, or (2) did not participate in Medicare:

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[25] 31 Fed. Reg. 14808, 14814 (Nov. 22, 1966) (Principles for Reimbursable Costs).
[26] *Id.*
[27] 50 Fed. Reg. 27722 (July 5, 1985).
[28] Under the authority of 42 U.S.C. § 1395x (v)(1)(A).
[29] Medicare Program: Limit on Payments for Direct Medical Education Costs, 50 Fed. Reg.27722 (July 5, 1985).
[30] Pub. L. 99-272, § 9202, 100 Stat. 82, 171-77 (1986). These provisions added a new 42 U.S.C. § 1395x(v)(1)(Q) which nullified the July 5, 1985 Rule. 54 Fed. Reg. 40286, 40287 (Sept. 29, 1989).
[31] 54 Fed. Reg. 40286, 40287 (Sept. 29, 1989).
[32] Pub. L. 99-509, § 9314, 100 Stat. 1874, 2005 (1986).
[33] Social Security Act § 1886(h)(5)(C).
[34] Also known as the "approved FTE resident amount." 42 U.S.C. § 1395ww(h)(3)(B).
[35] 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. 40286, 40287 (Sept. 29, 1989).
[36] 42 U.S.C. § 1395ww(h)(3)(B).
[37] 42 U.S.C. § 1395ww(h)(3)(C).
[38] 42 U.S.C. § 1395ww(h)(3)(A).

> In the case of a hospital that did not have an approved medical residency training program or was not participating in the [Medicare] 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 [in Medicare] 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.[39]

The Secretary implemented the above-quoted statutory directive by publishing the specific regulatory specifications within the September 29, 1989 GME Final Rule ("1989 GME Final Rule").[40] In the preamble to the 1989 GME Final Rule, a commenter stated 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. . . .[41]

In response, 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 [42 U.S.C. § 1395ww(h)] 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 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*. . . .

[39] 42 U.S.C. § 1395ww(h)(2)(F).
[40] 54 Fed. Reg. 40286 (Sept. 29, 1989).
[41] 54 Fed. Reg. 40286, 40310 (Sept. 29, 1989).

> 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 [42 U.S.C. § 1395x(v)] as was the case for cost reporting periods beginning prior to July 1, 1985*.[42]

As a result, in the 1989 GME Final Rule, the Secretary finalized 42 C.F.R. § 413.86(e)(4)(i) to read, in pertinent part:

> (4) *Exceptions—(i) 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 [Medicare contractor] establishes a [PRA] 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. Any graduate medical education program costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis. . . .[43]

As part of the FY 2001 IPPS Final Rule, the Secretary redesignated 42 C.F.R. § 413.86(e)(4)(i) as § 413.86(e)(5)(i).[44] Subsequently, as part of the FY 2005 IPPS Final Rule, the Secretary redesignated § 413.86(e)(5)(i) as § 413.77(e)(1) where the regulation currently resides.[45]

Finally, in FY 2007 IPPS Final Rule, the Secretary updated 42 C.F.R. § 413.77(e)(1) to address certain concerns that the underlying policy is potentially being gamed or misapplied:

> 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)*.[46]

Accordingly, in the 2006 Final Rule, the Secretary modified § 413.77(e)(1) to read, in pertinent part:

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[42] *Id.* (emphasis added).
[43] 54 Fed. Reg. 40286, 40317 (Sept. 29, 1989).
[44] 65 Fed. Reg. 47054, 47109-10 (Aug. 1, 2000).
[45] 69 Fed. Reg. 48916, 49235, 49254-57 (Aug. 11, 2004).
[46] 71 Fed. Reg. 47870, 48077 (Aug. 18, 2006) (emphasis added).

> (e) *Exceptions*—(1) *Base period for certain hospitals.* . . . 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 [Medicare contractor] establishes a [PRA] 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 begin training in the hospital. . . . **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**.[47]

The above regulatory language at § 413.77(e)(1) remained essentially unchanged through FYE June 30, 2013, the cost reporting period at issue in this appeal. Specifically, the parties to this appeal disagree as to the application of the last sentence in the subsection; "[a]ny 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[.]" Specifically, the Parties dispute whether that sentence applies to Kaweah's FY 2013 GME start-up costs.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Kaweah contends that the regulation at 42 C.F.R. § 413.77(e)(1) supports its claim for GME cost reimbursement when it states: "[a]ny 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."[48] Kaweah claims that it incurred GME costs in FY 2013, when it established its residency programs but did not begin training residents until FY 2014. Based on these facts, Kaweah asserts that "[t]he plain text of the regulation . . . entitles the Provider to reasonable cost reimbursement in FY 2013 because that was the year prior to the base period, which was established in FY 2014."[49]

Kaweah argues that the pertinent regulation not only permits reasonable cost reimbursement for "any" GME cost prior to the base period, but that such reimbursement is not conditioned on the hospital training residents prior to the base period.[50] Kaweah claims that the cost of its entire residency program, including the start-up costs incurred prior to the commencement of resident training, are reimbursable under the pertinent regulations because the regulations cover *all* direct GME costs related to "approved programs."[51] Kaweah states that a residency program "is "approved" if it is either accredited by the Accreditation Council for Graduate Medical Education ("ACGME") or if training in the program may count toward the resident's certification by the

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[47] 71 Fed. Reg. 47870, 48142 (Aug. 18, 2006) (bold emphasis added).
[48] Provider's FPP at 13 (quoting 42 C.F.R. § 413.77(e)(1)).
[49] *Id.* at 13.
[50] *Id.*
[51] Provider's FPP at 14 (emphasis added). Kaweah states that "[t]he scope of the DGME regulations at 42 C.F.R. §§ 413.75-83 are intended to cover all costs related to 'approved programs,' not just costs involving resident training." *Id*.

American Board of Medical Specialties."[52] Kaweah points out that both of its GME programs, Family Medicine and Emergency Medicine, were accredited by the ACGME.[53]

According to Kaweah, the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 402.2 defines direct GME ("DGME") costs related to approved programs to include such things as stipends, that may be directly attributable to residents, as well as costs that may be incurred prior to resident training begins such as "program director salaries, a GME program office, and related overhead."[54]

In further support of its position, Kaweah points to language in the preamble to the 1989 GME Final Rule in which the Secretary implemented the statutory mandates regarding prospective payment for GME by publishing its methodology for determining such payments.[55] Specifically, Kaweah states that CMS, in response to the comment quoted *supra* pertaining to hospital program costs incurred "prior to the entrance of residents into the program[,]"[56] recognized that, "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 [*i.e.*, FTEs] is the payment vehicle for GME costs."[57] Thus, Kaweah argues that:

> CMS amended the final rule to establish the PRA in "the first cost reporting period in which residents were on duty in their GME program during the first month of the cost reporting period." . . . In order to recognize start-up costs before the arrival of residents, CMS stated, "Any GME costs incurred for the prior cost reporting period will be made on a reasonable cost basis under [42 U.S.C. § 1395x(v)] as was the case for cost reporting periods beginning prior to July 1, 1985.[58]

Kaweah contends that the Medicare Contractor is *incorrect* that "[i]t is the date that the residents start training, rather than the date of the program approval, that governs this policy" under 42 C.F.R § 413.77(e)(l)."[59] Rather, Kaweah argues that, *for purposes of reasonable cost reimbursement*, the date residents start training has no relevance:

> [T]he date that the residents start training does govern DGME payment that are determined by the PRA and the resident FTE count. But, the date that the residents start training does not govern reasonable cost reimbursement in the fiscal year immediately prior to the year in which the base period is established because Medicare pays the reasonable cost of "approved programs," defined as accredited

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[52] *Id.* at 14 (paraphrasing 42 C.F.R. § 413.75(b)).
[53] *Id.* at 12.
[54] *Id.* at 16-17 (citing to PRM 15-1 § 402.2).
[55] 54 Fed. Reg. 40286, 40310 (Sept. 29, 1989).
[56] Provider's FPP at 15.
[57] *Id.* (quoting from 54 Fed. Reg. 40310 (Sept. 29, 1989)).
[58] *Id.* at 15.
[59] Provider's FPP at 17.

> programs, and the regulation plainly pays all costs of approved programs prior to the year in which the PRA is established.[60]

Kaweah also contends that the Medicare Contractor misinterprets PRM 15-1 §§ 400, 402.1 and 2802(B)(2), which state that approved programs must be "operated" by a provider and that the Medicare Contractor is incorrect in its claim that Kaweah did not operate the program prior to the start of resident training.[61] Kaweah disagrees and argues:

> The requirement to "operate" a program applies only to nursing and allied health programs governed by a different regulation, 42 C.F.R. § 413.85. That regulation defines "approved educational activities" (i.e. nursing and allied health education activities) as "formally organized or planned programs of study" that are "operated by providers.[62]

Kaweah argues that "[t]he DGME regulation does not state that the Provider must operate the programs. Any mandate from the PRM for the Provider to operate the programs is a substantive rule that is invalid under the APA because it was not promulgated through notice and comment rulemaking."[63] Thus, Kaweah asserts that, "even if it were true that the Provider did not 'operate' the programs in FY 2013, [it] would still be entitled to reasonable cost reimbursement for its start-up costs."[64]

The Medicare Contractor maintains that, pursuant to 42 C.F.R. § 413.77(e)(1), it adjusted Kaweah's cost report and removed the as-filed "Other Adjustment" of $3,059,214 in GME reimbursement "because a provider cannot be reimbursed for reasonable GME costs prior to the date residents start training[]."[65] In support of its argument, the Medicare Contractor points to preamble language in the 2006 Final Rule that states:

> 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***.[66]

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[60] *Id.*
[61] *Id.* at 22-23.
[62] *Id.* at 20.
[63] *Id.*
[64] *Id.*
[65] Medicare Contractor's FPP at 17.
[66] *Id*. at 20 (quoting 71 Fed. Reg. 48076, 48076-77 (Aug. 18, 2006)) (underline emphasis in original and bold and italics emphasis added).

The Medicare Contractor contends that this preamble language makes clear that reasonable cost reimbursement for a new teaching program only applies when the hospital begins training residents:

> Throughout the [preamble] discussion of GME reimbursement for new teaching hospitals, *reimbursement for GME is based on* ***when the hospital begins training residents***. It is not addressing costs the hospital incurs prior to the start of a new teaching program, for which the Provider seeks cost reimbursement in this issue. It is the [Medicare Contractor]'s position that the Provider cannot receive cost reimbursement for the costs incurred in FYE June 30, 2013, leading up to the training of its residents.[67]

The Medicare Contractor concedes that "the final sentence of 42 C.F.R. [§] 413.77(e)(1) states that 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."[68] However, the Medicare Contractor argues that "the key point is that this refers to GME costs . . ."[69] and that Kaweah's costs "are not qualifying GME costs, as [Kaweah] was not involved in the training of residents in an approved GME program during the June 30, 2013, cost reporting period."[70] The Medicare Contractor goes on to state that the GME reimbursement mandated under 42 C.F.R. § 413.77 relates to "direct medical education costs of interns and residents in approved programs"[71] and that Kaweah's costs do not fall into this category as no interns or residents were being trained during the fiscal year at issue.[72]

Finally, the Medicare Contractor contends that these costs do not meet the definition of approved direct medical education costs because "[t]he Provider's approved medical education programs were not operated during this fiscal period."[73] Therefore, the disallowed costs "are considered normal operating costs, rather than direct medical education costs…[and] do not qualify as pass-through costs, but are reimbursed as part of the IPPS payments."[74]

The dispute before the Board involves regulatory interpretation of the last sentence of 42 C.F.R. § 413.77(e)(1). Specifically, the dispute revolves around whether the phrase "any GME costs" in that sentence, encompasses and includes Kaweah's GME program start-up costs incurred in the cost reporting period prior to its base period. The Medicare Contractor argues, generally, that a hospital is not eligible for GME payment unless and until the hospital's approved residency program begins training residents. Kaweah counters that the regulatory subsection at issue does not condition the pre-base period reasonable GME cost reimbursement on the commencement of resident training and that the plain text of the subsection allows for reimbursement of "any GME" cost incurred during the prescribed cost reporting period.

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[67] *Id.* at 20-21 (emphasis added).
[68] *Id.* at 21.
[69] *Id.*
[70] *Id.*
[71] *Id.* at 22.
[72] *Id.*
[73] *Id.* at 25.
[74] *Id.* at 25-26.

The Board observes that the development and evolution of the Secretary's GME regulations did not follow a "typical" regulatory path. The Secretary initially implemented Medicare payment for a hospital's GME costs not based upon statutory mandates, but, rather, based upon Congressional committee reports that accompanied the original Medicare legislation in which the committee suggested that Medicare should, at first, share in the costs of medical education with the expectation that the community would later assume the fiscal responsibility.[75] Thus, although Medicare had been reimbursing teaching hospitals on a reasonable cost basis for their approved educational activities since the inception of Medicare, Congress did not legislate GME payments until 1985, when it passed § 9202 of the Consolidated Omnibus Reconciliation Act of 1985 and § 9314 of the Omnibus Budget Reconciliation Act of 1986, as described *supra*.[76]

The GME payment methodology mandated by Congress involves the calculation of a teaching hospital's PRA based upon the hospital's FY 1984 cost reporting period. However, Congress granted the Secretary discretion to develop a methodology, within certain parameters, to determine a PRA for those hospitals that either begin a medical education program or begin participating in the Medicare program after their federal FY 1984 cost reporting period.[77]

The Board notes that, in the preamble to the 1989 GME Final Rule, in response to a provider comment, the Secretary stated he was aware that a hospital's GME program may not start on July 1 of the year and that some GME programs would begin on some other date, such as October 1 or January 1. In this situation, the Secretary acknowledged that the first year of such a GME program "would not be reflective of 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."[78] As a result, the Secretary stated he would modify 42 C.F.R. § 413.86(e)(4) (proposed § 413.86(c)(5)) to provide that, for hospitals starting a GME program after the 1984 cost reporting period, the base period for determining the PRA would be "the first cost reporting period in which residents were on duty in their GME program during the first month of the cost reporting period."[79] Further, the Secretary's response continued, stating that "any GME costs incurred for the prior cost reporting period will be made on a reasonable cost basis under [42 U.S.C. § 1395x(v)] as was the case for cost reporting periods beginning prior to July 1, 1985."[80] The Secretary explained that:

> [B]asing payments on an unrepresentative base period could have an adverse effect on a hospital; however, we are also bound by the statutory language of [42 U.S.C. § 1395ww(h)(2)(E)], which deals with hospitals that start a GME program only after 1984. We believe that the modifications we are making in § 413.86(e)(4) of the proposed rule represent a reasonable compromise between these two conflicting objectives but are also consistent with the statutory language.[81]

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[75] 50 Fed. Reg. 27722, 27723 (July 5, 1985).
[76] *See supra* notes 30-32 and accompanying text.
[77] 54 Fed. Reg. 40286, 40287-40288 (Sept. 29, 1989).
[78] *Id.* at 40310.
[79] *Id.*
[80] *Id.*
[81] *Id.*

Recognizing that not all GME programs would begin training residents on the first day of a cost reporting year, CMS revised 42 C.F.R. § 413.86(e)(4) (1989) to read:

> 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 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. Any graduate medical education program costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis.

The Board reviewed the revised regulation, in conjunction with the preamble, and concludes that the phrase "[a]ny graduate medical education costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis" relates to the situation where a hospital begins training residents during the cost reporting period, but does not have any residents on duty *during the first month* of that first cost reporting period in which training occurs. The Secretary exercised his discretion to reimburse this period based on reasonable cost,[82] and then establishes a PRA for the hospital, using the information from the first full cost reporting period (where the residents rotated during the first month of the cost reporting period) immediately following the cost reporting period during which the hospital participates in Medicare and residents begin training in the hospital.

As explained below, this discrete exception to the PRA is not applicable to this case. Kaweah's residents ***first*** started rotations on July 1, 2013 which is also the *first* month of Kaweah's FYE June 30, 201**4** cost reporting period. Thus, Kaweah's PRA is established in FYE June 30, 2014 as that is the first cost reporting period in which residents were on duty in their GME program during the first month of the cost reporting period. More importantly, for purposes of this case, Kaweah had ***no*** residents rotating during the fiscal year that ended on June 30, 2013, the period at issue. The Board interprets the statute, the regulation, the Federal Register and other Medicare guidance[83] to mean that Kaweah's claimed GME costs in its FYE June 30, 2013 do *not* and *cannot* qualify for reasonable cost reimbursement *during that period* because Kaweah did not train any residents *during that period*.[84] In this regard, the Board agrees with the Medicare Contractor that Kaweah did not begin operating the GME program at issue until it began training its first resident because PRM 15-1 § 2802(B)(2) states that "Approved educational activities mean formally organized or planned programs of study ***actually*** *operated* by providers in order to enhance the quality of care in an institution (see 42 CFR 405.421l)" and merely obtaining formal approval/organization is not enough to begin "actually operat[ing]" a GME program.

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[82] *See infra* notes 84 and 85 and accompanying text.
[83] *See infra* notes 84 and 85 and accompanying text.
[84] This does not mean that those cases were not reimbursable at all, but rather they were not reimbursable on the FYE June 30, 201**3** cost report. *See infra* note 85 and accompanying text (discussing how these start up costs should have been claimed on the FYE June 30, 201**4** cost report).

The Board notes that its interpretation of the regulation perfectly aligns with the cost report instructions from PRM 15-2 § 4004.1 (Worksheet S-2) in effect for the cost report year under appeal, which read as follows:

> Line 56--Is this a hospital involved in training residents in approved graduate medical education (GME) programs? Enter "Y" for yes or "N" for no *in column 1. The BBRA provided that payments that are made to teaching hospitals for costs of direct GME associated with services to Medicare Advantage (MA) enrollees will be reduced by an estimated percentage in each calendar year (CY). If the response to column 1 is "Y", are you impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes or "N" for no in column 2.*
>
> Line 57--If line 56 is yes, is this the first cost reporting period in which you are training residents in approved programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, were residents training during the first month of the cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is yes, complete Worksheet E-4. If column 2 is "N", complete Worksheets D, Parts III and IV, and D-2, Part II, if applicable.

The pass-through instructions are laid out for Worksheet D, Part III in PRM 15-2 as follows:

> 4024.3 Part III - Apportionment of Inpatient Routine Service Other Pass-Through Costs.--This part computes the amount of pass-through costs other than capital applicable to hospital inpatient routine service costs. Complete only one Worksheet D, Part III, for each title *(*)*. Report hospital, subprovider, hospital-based SNF and NF/ICF-IID (if applicable) information on the same worksheet, lines as appropriate.
>
> Column 3--Transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line, plus or minus post step-down adjustments (reported on Worksheet B-2), the applicable medical education costs for interns and residents when Worksheet S-2, Part I, line 57, column 1, is yes, and column 2, is no. **Otherwise do not transfer the costs.**
>
> **NOTE:** If you qualify for the exception in 42 CFR 413.77(e)(1), because this is the first cost reporting period in which you are training residents in approved programs and the residents were not on duty during the first month of this cost reporting period, then all direct GME costs are reimbursed as a pass-through based on reasonable cost.

It is clear, from the instructions for both Worksheet S-2, Line 57 and Worksheet D Part III, Column 3, that the pass-through cost reimbursement calculations on Worksheet D Part III are ***only*** completed *for the first cost reporting period in which the hospital is training residents in approved programs* ("Y" on Worksheet S-2, Line 57, Column 1), if these residents were also ***not*** training during the first month of that cost reporting period ("N" on Worksheet S-2, Line 57, Column 2). Otherwise, the instructions are clear that the related costs should ***not*** be transferred. In the case of Kaweah, ***no*** residents were being trained in the FYE June 30, 201**3**, thus, Worksheet S-2, Line 57, Column 1 should be answered "N," and costs should not be transferred to Worksheet D Part III. For the following year, FYE June 30, 201**4**, Kaweah would answer "Y" for Worksheet S-2, Line 57 on BOTH columns 1 & 2, and, again, the costs would not be transferred, as Kaweah would be paid, using the GME PRA, not pass-through cost reimbursement, in that fiscal year.[85]

DECISION AND ORDER

After considering the Medicare law and regulations, the arguments presented, and the evidence submitted, the Board finds that the Medicare Contractor properly adjusted Kaweah's FYE June 30, 2013 cost report because Kaweah is not entitled to reasonable cost reimbursement for its GME start-up costs *within its FYE June 30, 2013 cost reporting period* since no residents were being trained in Kaweah's approved programs *during that cost reporting period*.

Board Members Participating:

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Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

8/3/2023

X Clayton J. Nix

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

[85] The Board notes that, since Kaweah began training its first resident in FYE June 30, 2014 (and as such began operating its program in FYE June 30, 2014), Kaweah could have treated the direct costs related to the GME programs which were incurred in FYE June 30, 2013 as start-up costs, and amortized them over a period of years after the program began training residents. *See, e.g.*, PRM 15-1 § 2132 (amortization of start-up costs that are related to "patient care functions" or "non-allowable functions"); PRM 15-1 § 2150.2(B)(2) (amortization of start-up costs of a home office with cross reference to § 2132). If this had been done, a portion of those start-up costs would have been included in the cost report *for FYE June 30, **2014***. These costs may then have been considered in that fiscal year in the calculation of Kaweah's PRA. However, it appears that Kaweah did not make any such amortization(s), and the FYE June 30, 201**4** cost report and any related PRA calculations are not before this Board as part of this appeal.