# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D41

**PROVIDER** –
Kingston Hospital
Kingston, New York

Provider No.: 33-0004

**vs.**

**INTERMEDIARY –**
BlueCross BlueShield Association/ National Government Services – New York (formerly Empire Medicare Services)

**DATE OF HEARING –**
October 17, 2008

Cost Reporting Periods Ended -
December 31, 2000; December 31, 2001

**CASE NOs.**: 05-0350; 06-0452

**INDEX**

ISSUE:

Whether the intermediary properly adjusted the Provider's direct graduate medical education (DGME) and indirect medical education (IME) full-time equivalent (FTE) count for the fiscal years ended December 31, 2000 and December 31, 2001.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement to a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h; 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Since the inception of the Medicare program, Congress always allowed the cost of training physicians, based on the premise that " . . . these activities enhance the quality of care in an institution." [1] In 1983, Congress recognized that teaching hospitals incur indirect operating costs that would not be reimbursed under the prospective payment system or by the direct graduate medical education (DGME) payment methodologies and authorized an additional payment, known as the indirect medical education (IME) payment, to hospitals with GME programs. 42 U.S.C. §1395ww(d)(5)(B). Specifically, the IME payment compensates teaching hospitals for higher-than-average operating costs that are associated with the presence and intensity of resident training in an institution but which cannot be specifically attributed to, and does not include, the costs of residents' instruction. The IME adjustment attempts to measure teaching intensity based on "the ratio of the hospital's full-time equivalent interns and residents to beds." Id. Thus, the

[1] H.R. Rep. No. 213, 89th Cong., 1st Sess., 32 (1965); see also Report to the Congress, Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals, at 5 (Aug.1999).

IME payment amount is based, in part, upon the number of intern and resident FTEs participating in a provider's GME Program.

For fiscal years 2000 and 2001, the regulations governing IME reimbursement were codified at 42 C.F.R. §412.105(f) (2000). The regulations state in pertinent part:

> For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purposes of determining the indirect medical education adjustment is determined as follows:
>
> (i) The resident must be enrolled in an approved teaching program . . .
>
> (ii) In order to be counted, the resident must be assigned to one of the following areas:
> (A) The portion of the hospital subject to the prospective payment system.
> (B) The outpatient department of the hospital.
> (C) Effective for discharges beginning on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency program is counted towards the determination of full-time equivalency if the criteria set forth at §413.86(f)(4) are met.

The regulations at 42 C.F.R. §413.86(f)(4) state in pertinent part:

> For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met - -
>
> (i) The resident spends his or her time in patient care activities.
> (ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.
> (iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

The issue in this case involves the interpretation of the regulations at 42 C.F.R. §413.86(f)(4) for the proper accounting of FTEs in the IME calculation.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Kingston Hospital (Provider) is a not-for-profit general hospital located in Kingston, New York. In 1983, the Provider and Benedictine Hospital (another New York hospital) jointly established the Mid-Hudson Family Health Institute, Inc. (Institute). The Institute is a not-for-profit corporate entity that is separate from its affiliated teaching hospitals. The Institute operates a diagnostic and treatment center as well as an accredited residency program that trains medical school graduates to become board-certified family physicians. During the period from July 1983 through March 2001, the Provider executed a series of three agreements with the Institute under which the Provider agreed to cover the Institute's deficits, provide cash flow and assume the eventual responsibility for the management and cost of the residency program. In fiscal years 2000 and 2001, the residency program had approximately 20 participants who split their time between the Provider, Benedictine Hospital and various off-site family practice clinic locations. For those years, the Provider claimed approximately nine FTEs on its cost reports for the time spent by the residents at the Provider and off-site clinics.[2] In its FY 2000 and 2001 NPRs, National Government Services – New York (Intermediary) excluded the time spent by the Provider's interns and residents at non-provider settings operated by the Institute for failure to comply with the written agreement requirements set forth in 42 C.F.R. §413.86(f)(4)(ii). At issue is whether the Provider's collective agreements satisfied the requirements of the regulation.

The Provider appealed the denial to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Provider was represented by Roy W. Breitenbach, Esq. of Garfunkel, Wild & Travis, P.C. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider challenges the validity of 42 C.F.R. §413.86(f)(4) as contrary to the following statutory provisions in effect during the relevant fiscal year (2001) and that addressed indirect medical education reimbursement:

> . . . [e]ffective for discharges occurring on or after October 1, 1997, all time spent by an intern or resident inpatient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

42 U.S.C. §1395ww(d)(5)(B)(iv), 2001.

[2] See Transcript (Tr.) at 51-53.

The provisions that were in effect for direct graduate medical education provided . . . t]he Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program . . . 42 U.S.C. §1395ww(h)(4)(A) and " . . . [s]uch rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting. 42 U.S.C. §1395ww(h)(4)(E).

The Provider argues that none of these statutory provisions require or grant the Secretary the authority to impose a written agreement requirement such as contained in 42 C.F.R. §413.86(f)(4)(ii).[3] Accordingly, the requirement is invalid as exceeding the Secretary's authority and is improperly applied to the Provider.

The Provider also argues that, even if the Secretary did have the authority to impose a requirement for a written agreement, the Intermediary failed to excuse the Provider from compliance with that requirement in accordance with the provisions of Section 713 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.[4] The Section provides that:

> [d]uring the 1 year period beginning on January 1, 2004, for purposes of [determining indirect medical education and direct graduate medical education reimbursement provisions], the Secretary shall allow all hospitals to count residents in osteopathic and allopathic family practices programs in existence as of January 1, 2002, who are training at non-hospital sites, without regard to the financial arrangement between the hospital and the teaching physician practicing in the non-hospital site to which the resident has been assigned."[5]

The Provider contends that the Secretary interprets Section 713 to excuse the written requirement for (1) all training that occurred in calendar year 2004; and (2) all training that incurred before 2004, if the reimbursability of that training was determined by one of the fiscal intermediaries during 2004.[6] The Secretary's specific instructions state:

> When settling cost reports during January 1, 2004 through December 31, 2004 (Calendar Year (CY) 2004), a hospital that seeks to count allopathic or osteopathic family practice FTE residents training in a nonhospital setting(s) is allowed to count those FTEs for IME and direct GME purposes even in instances where the written agreement

[3] Now 42 C.F.R. 21413.78(d)
[4] Public Law 108-173.
[5] See Exhibit P-28; 117 Stat. 2066, 2340-41 (December 6, 2003).
[6] See Centers for Medicare and Medicaid Services, One Time Notification Manual, Publication 100-20, Transmittal No. 61 (March 12, 2004); See also Exhibit P-30.

> between the hospital and a teaching physician or a nonhospital site does not mention teaching physician compensation, specifies only a nominal amount of compensation, or states that the teaching physician is "volunteering" his/her time training the residents.[7]

The Provider contends that its FY 2000 cost report was settled by the Intermediary during calendar year 2004 and the Section 713 exception, therefore, applies. The Provider also contends that although its FY 2001 cost report was filed with the Intermediary in 2002 and settled in 2005, the issue governed by Section 713 (i.e., reimbursability of training in nonhospital settings) was before the Intermediary during calendar year 2004, the calendar year during which the exception was available and, had the Intermediary completed its audit work in 2004, the exception would apply. The Provider argues that the failure of the Intermediary to complete its audit work during 2004 was beyond the control of the Provider and that it is manifestly unfair to base the Provider's entitlement to the Section 713 exception on the Intermediary's audit schedule. The Provider contends that it is entitled to the benefits of the Section 713 exception in the calculations for both its FYs 2000 and 2001 reimbursements.[8]

Notwithstanding its arguments relative to the legal validity of the written requirement or the availability of the Section 713 exception, the Provider contends that it satisfied the requirements of 42 C.F.R. §413.86(f)(4). There is no dispute that residents spent their time in patient care activities and therefore met the requirement of 42 C.F.R. §413.86(f)(4)(i).[9] At issue is the existence of an agreement that accommodates the requirements of the regulations and supports the reimbursement of costs incurred by the Provider.[10] The Provider argues that it entered into a series of agreements with the Mid-Hudson Family Health Services Institute, the terms of which evidence the Provider's obligation to incur the costs of the residency program. The Provider executed the first agreement (called the Undertaking) in 1983.[11] Under its provisions, the Provider and Benedictine Hospital jointly and severally guaranteed sufficient funds to meet the deficits of the Institute and provide cash flow to assure its viability. The agreement was under the auspices of the New York State Department of Health's oversight. The Provider, through periodic payments to maintain the Institute's cash flow, and payments to cover year-end shortfalls, was effectively responsible for paying all of the salaries and fringe benefits of the residents allocated to its resident count. Accordingly, the Provider contends that under governing regulations the Undertaking is sufficient to satisfy the written agreement requirement of 42 C.F.R. §413.86(f)(4)(ii).

The Provider also argues that its subsequent agreements with the Institute further demonstrate its operational control and financial responsibility for the residency program. The Provider executed a second agreement in 1999.[12] Under its terms, the Provider

---

[7] Id at ¶ I-B-3a.
[8] See also: Cf. Chestnut Hill Hospital V. Thompson, 2006 WL 2380660, at 5 n.2 (D.D.C., August 15, 2006); Exhibit P-31.
[9] Transcript, p. 14-15.
[10] See 42 C.F.R. §413.86(f)(4)(ii) and (iii).
[11] Exhibit P-10.
[12] Exhibit P-11.

retained its original financial responsibilities and established its facility as the residency site for several disciplines.[13]

The Provider executed a final agreement in 2001with the Institute. Benedictine Hospital left the program and the Provider notified the State of New York that it was assuming full responsibility for the entire residency program.[14] Under the new agreement, the Provider became the final guarantor of compensation or salary due the residents (be they inpatient or outpatient services).[15] The Provider also assumed supervisory responsibilities for all residents within the various medical services at the hospital.[16] Further, the Provider was to serve as the exclusive in-patient training site and the Institute was to provide salaries, malpractice insurance and program coordination. The Provider argues that the terms and conditions of the 2001 agreement clearly demonstrate that the provider fulfilled the written agreement requirement established by 42 C.F.R. §413.86(f)(4)(ii).

The Provider also argues that it in fact incurred all costs for 2000-2001 training programs as required by 42 C.F.R. §413.86(f)(4)(iii). The Provider contends that the Institute paid for the direct and indirect costs associated with the residency program almost exclusively from the periodic cash flow payments made by the Provider to the Institute and by the additional payments made by the Provider to the Institute to cover operating deficits and shortfalls in the Institute's financing. The Provider contends that both independent and internal audits clearly established that the costs of the residency program were fully borne by the Provider.[17]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider did not satisfy the requirements for a written agreement that are established under 42 C.F.R. §413.86(f)(4). The Intermediary argues that 42 C.F.R. §413.86(f)(4)(ii)[18] provides that for time spent by residents training in a nonhospital setting to be included in the FTE resident count, a written agreement must be in place between the hospital and the nonhospital site providing that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the nonhospital site. The hospital must also provide reasonable compensation to the nonhospital site for supervisory teaching activities and the written agreement must specify that compensation amount. The Intermediary contends that each of the three agreements offered by the provider in satisfaction of the requirement is deficient. The 1983 "Undertaking" is not an agreement with the non-provider setting (i.e., the Institute) and fails to specify that the hospital is responsible for the salaries of participating residents and the cost of supervisory teaching.[19] Further, the agreement only requires the Provider to cover deficits in circumstances where costs exceed revenues. Absent such circumstances, the Provider has no financial responsibility to support the Institute.

---

[13] Transcript, pp. 60-61.
[14] Transcript, p.71; Exhibit P-20.
[15] Transcript, p. 64-65.
[16] Transcript, pp. 66-67.
[17] Transcript, pp. 74-99.
[18] Now 42 C.F.R. §413.78(d)
[19] Transcript, p.152-153.

Accordingly, the 1983 Undertaking agreement is not a binding commitment to fund the residency program prior to its commencement or before rotations begin.

The Intermediary argues that under the 1999 Agreement financial responsibility for residents' salaries and fringe benefits still remains with the Institute.[20] Further the agreement is silent relative to which party would have the financial responsibilities for supervisory educational activities, i.e. the costs of supervising the residents.

The third agreement executed by the Provider became effective July 1, 2001. The agreement was entered into after the close of fiscal year 2000 and 6 months after the beginning of the FY 2001 and after residents were placed into non-provider settings. 42 C.F.R. §413.86(f)(4) requires that the written agreement be executed before residents begin their rotations to the non-provider setting.[21] Accordingly, the Intermediary argues that the agreement was executed too late to apply to the fiscal years (2000 and 2001) under appeal.

The Intermediary also contends that the Section 713 exception to the requirement for a written agreement is not available to the Provider. CMS interpreted the moratorium that was available under the Section 713 to apply to prior period cost reports that were settled during calendar year 2004, and to cost reports that are settled after 2004 that cover training that occurred during the period of January 1, 2004 through December 31, 2004. 69 F.R. 28196, 28314 (May 18, 2004). The Agency specifically recognized that a gap in applicability could result in pre-2004 cost reports not settled in calendar year 2004:

> For example, a hospital might be permitted to count certain FTE family practice residents that were included in its FY 2001 cost report in accordance with the moratorium because that cost report is settled during CY 2004. However, the hospital might not be permitted to count certain FTE family practice residents in its FY 2002 and FY 2003 cost reports because these cost reports would not be settled during 2004 and the moratorium would not apply. The hospital then could be permitted to count certain FTE practice residents in its FY 2004 cost report in accordance with the moratorium who actually trained in a nonhospital setting during CY 2004.

Id.

The Intermediary contends that CMS's rationale is to apply the statutorily provided moratorium broadly to all residents who trained in calendar year 2004, including those who commenced training earlier if those cost reports were settled in CY 2004. The Agency fully recognized that there would be gaps in coverage and the moratorium would not apply to earlier cost reports not settled in CY 2004. Finally, the Intermediary asserts

[20] Provider Exhibit 11, ¶8 and ¶9.
[21] Hallmark Health System , Inc. v. BCBS/National Government Services-Maine, PRRB Dec. No. 2008-D4 (October 16, 2007).

the moratorium only applies to agreements that fail to specify teaching physician compensation. In this circumstance, the moratorium does not apply because the provider not only failed to specify teaching physician compensation but had no written agreement at all. The Intermediary argues further that CMS's interpretation of the statute is reasonable and, as such, cannot be set aside.[22]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds and concludes that the Intermediary's calculation of the Provider's direct GME and IME reimbursement was proper.

The twofold issue before the Board is whether the requirements for a written agreement that are established under 42 C.F.R. §413.86(f)(4) are applicable to the facts and circumstances of this case and, if so, have they been met.

The Provider initially argues that the imposition of a written requirement is not authorized under the statutes,[23] exceeds the Secretary's authority and is contrary to law. The Board does not agree. 42 U.S.C. §1395hh(a)(1) states: "The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter . . ." The statute provides the Secretary with broad discretionary power to promulgate regulations "as may be necessary" to implement the statutory mandates set through Congressional action while providing effective administration of the program. The Board can find nothing in the language of the regulation at 42 C.F.R. §413.86(f)(4) that conflicts with the mandate of the statute or effectively compromises Congressional intent with respect to direct GME or IME reimbursement. Accordingly, the Board concludes that the regulations were properly prescribed by the Secretary and may be appropriately applied to the Provider's circumstances.

The Provider also argues that, even if the Secretary did have the authority to impose a requirement for a written agreement, it should be exempted from compliance with that requirement in accordance with the provisions of Section 713 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The Board's examination of Section 713 indicates that it spoke exclusively to supervisory teaching costs in cases where the agreement between the hospital and the non-provider setting failed to specify physician compensation for supervisory teaching activities. In this case, there is no agreement evidencing the Provider's responsibility to cover the costs of resident's salaries and fringe benefits or any category of supervisory teaching costs. Accordingly, the Board concludes that the Provider does not qualify for relief under Section 713.

Notwithstanding the legal validity of the written requirement or the availability of the Section 713 exception, the Provider argues that it satisfied the requirements of 42 C.F.R.

---

[22] Thomas Jefferson University Hospital v. Shalala, 512 U.S. 504 (1994).
[23] See FNs 4,5 and 6 s*upra*.

§413.86(f)(4). There is no dispute that residents spent their time in patient care activities and, therefore, met the requirement of 42 C.F.R. §413.86(f)(4)(i). The Provider argues that it entered into a series of agreements that evidence the Provider's obligation to incur the costs of the residency program as required by 42 C.F.R. §413.86(f)(4)(ii) and that it incurred all or substantially all of the costs associated with that program as required by 42 C.F.R. §413.86(f)(4)(iii). The Intermediary counters that the agreements fail to comply with the fundamental elements required under the regulation. The issue for the Board's is whether the existing agreements satisfy the requirements of the regulations.

After examining the three agreements executed by the Provider, the Board finds the initial 1983 agreement was not an agreement between the Provider and the Mid-Hudson Family Health Institute but, rather, an agreement between the Provider and Benedictine Hospital to establish the Institute. It is therefore not the agreement between the Hospital and the nonhospital site required by the regulation. Although the agreement indicates that the Provider will contribute funds to meet any deficits and provide adequate cash flows, it makes no provision for the costs of the residents' salaries and fringe benefits while the resident is training in the nonhospital site.[24] It is also silent relative to the compensation the hospital is providing to the nonhospital site for supervisory teaching activities. Both are required elements under 42 C.F.R. §413.86(f)(4)(ii).

The Board's examination of the 1999 agreement indicates that the Provider will assume educational and supervisory responsibility for residents training within the hospital.[25] However, the agreement places responsibilities for the residents' salaries and portions of their fringe benefits with the Institute.[26] This arrangement is in direct contravention of the requirements at 42 C.F.R. §413.86(f)(4)(ii) and renders this agreement deficient.

The effective date of the 2001 agreement is well past the close of fiscal year 2000 and six months after the beginning of FY 2001 and after residents were placed into nonhospital settings. In Hallmark Health System v. BCBS/National Government Services-Maine,[27] the Board considered the timing necessary for an agreement to meet the requirements of 42 C.F.R. §413.86(f)(4)(ii). The regulation reads: "The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salaries . . ." (emphasis added). The Board concludes "will incur" is in anticipation of an agreement that establishes the Provider's liability for the residents' costs in advance of their incurrence. An agreement which post dates the placement of residents in the nonhospital setting cannot be applied retroactively to establish compliance with the regulation. Accordingly, the Board majority concludes that the 2001agreement does not meet the requirements of the regulation.

---

[24] Exhibit P-10.
[25] Exhibit P-11, ¶5.
[26] Id, ¶8.
[27] Hallmark Health System , Inc. v. BCBS/National Government Services-Maine, PRRB Dec. No. 2008-D4 (October 16, 2007).

The Provider also contends that it covered virtually all of the costs of the resident program through its periodic cash flow payments and by the additional payments made by the Provider to the Institute to cover operating deficits and other shortfalls in the Institute's financing. The Board does not dispute that the Provider absorbed some measure of the costs generated by the residency program. However, the agreements that exist in support of the resident program indicate that the responsibility for the residents' salaries and fringe benefits rests with the Institute. The Provider's responsibilities are dependent upon the financial deficiencies of the Institute's operation. The Board was not provided evidence of the nature of costs that were absorbed by the Provider and what amounts related to inpatient or outpatient care, or to training costs at the nonhospital site. Absent this documentation the Board is precluded from making a conclusive determination of compliance with the requirements. Further, even if the Provider absorbed the entire cost of the program, the regulations do not recognize actual cost absorption as an alternative means of compliance with its other requirements.

## DECISION AND ORDER

The regulations at 42 C.F.R. §413.86(f)(4) were properly prescribed by the Secretary and may be appropriately applied to the Providers circumstances. The Provider is not in compliance with the regulation's requirements for a written agreement nor is the Provider eligible for an exemption under Section 713 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The Intermediary's adjustments reducing the Provider's direct graduate medical education and indirect medical education full-time equivalent counts were proper.

## BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes (Concurring in part)
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.
John G. Bowers, C.P.A.

## FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 23, 2009

Concurring Opinion of Yvette C. Hayes

I concur with the Board majority's opinion that the 2001 agreement effective July 1, 2001 does not meet the written agreement criteria established by the regulations at 42 C.F.R. §413.86(f)(4)(ii).

The Board majority cited to Hallmark Health System Inc v. BCBS/National Government Services – Maine, PRRB Dec. No. 2008-D4 (October 16, 2007) (Hallmark). In Hallmark, the Board found that the agreement at issue did not create an obligation during the cost reporting period. The Board found the use of the words "will incur" rather than "has incurred" to mean that, in order for an agreement to be considered to have been in effect, it had to be executed during the cost reporting period.

In this instant case, the Board majority has applied the rationale of Hallmark and taken it one step further by stating:

> An agreement which post dates the placement of residents in the non-hospital setting cannot be applied retroactively to establish compliance with the regulation.

In other words, if the agreement is not in place either prior to the start of the cost reporting period or until after the residents are working at a non-hospital setting, the agreement is not considered to meet the requirements of the regulations. I disagree. Based on the Board's findings in Hallmark and if all other criteria required by the regulations were met, the 2001 Affiliation Agreement dated April 26, 2001 was effective for the residency training program 'school' year beginning July 1, 2001. This agreement was in effect for the last 6 months of the Provider's cost reporting period and covers all residents training in the approved medical residency program as of the start of the school year. The agreement would apply to costs incurred from July 1, 2001 through December 31, 2001 of the Provider's cost reporting period.
Per my analysis of the 2001 Affiliation Agreement:

It meets criteria (1) and (2):

(1) The agreement was in writing. See Provider Exhibit P-12.
(2) The written agreement is between the hospital (The Kingston Hospital) and the non-hospital site (Mid-Hudson Family Health Institute, Inc.).

However, it does not meet criteria (3) through (5):

(3) The written agreement does not indicate that the hospital (Kingston) will incur the cost of the residents' salaries and fringe benefits while they are training at the non-hospital site.
(4) The written agreement does not indicate that the hospital (Kingston) is providing compensation to the non-hospital site for supervisory teaching activities.

(5) The written agreement does **not** specify how much compensation the hospital (Kingston) is providing to the non-hospital site for supervisory teaching activities.

Even though the agreement would apply only to a portion of the Provider's cost reporting period, I concur with the Board's decision that the 2001 Affiliation Agreement does not meet all of the requirements of the regulations.

_____

Yvette C. Hayes