

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D51

PROVIDER -
University of Louisville Hospital

Provider No.: 18-0141

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services

DATE OF HEARING -
March 18, 2009

Cost Reporting Period Ended -
December 31, 1999

CASE NO.: 04-2159

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ISSUE:

Whether the Intermediary improperly reduced the Provider's numbers of resident full-time equivalents ("FTEs") used for purposes of Medicare direct graduate medical education ("GME") and indirect graduate medical education ("IME") based on its contention that the Provider did not meet the written agreement requirement for counting resident time spent in non-provider settings in 42 C.F.R. §§ 412.105 and 413.86.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due 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 to organizations 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 the provider 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 receipt of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835(2008).

The Medicare program reimburses teaching hospitals for their share of costs associated with direct GME and IME. The calculation for reimbursement requires a determination of the total number of FTE residents in the teaching programs. The Medicare statute at 42 U.S.C. §1395ww(h)(4)(E) entitles a hospital to count the time its residents spend in patient care activities in non-hospital settings on or after July 1, 1987 for purposes of calculating GME reimbursement. The statutory provisions prescribe the content of the implementing regulations as follows:

Such 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 medical residency training program shall be counted towards the determination of full-time equivalency, without regard to

the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

Likewise, for discharges occurring on or after October 1, 1997, the Medicare statute at 42 U.S.C. §1395ww(d)(5)(B)(iv) entitles a hospital to count the time its residents spend in patient care activities in non-hospital settings for IME reimbursement purposes:

Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency 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.

CMS issued implementing regulations 42 C.F.R. §413.86 (for direct GME payments) and 42 C.F.R. §412.105 (for IME payments). The regulations additionally mandated that the hospital have a written agreement with the non-hospital site documenting the hospital's assumption of all, or substantially all, training costs at the non-hospital site. Medicare direct GME regulations at 42 C.F.R. §413.86(f)(4) thus permitted a hospital to claim the time a resident spends at a nonprovider setting if the resident trained in an approved program and 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 same requirements were also incorporated by reference in the IME regulations at 42 C.F.R. §412.105(f)(1)(ii)(C).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

University of Louisville Hospital (the Provider), is a nonprofit, general, short-term hospital located in Louisville, Kentucky. The Provider entered into a written agreement with the University of Louisville School of Dentistry (Dental School) in which it agreed to pay the costs incurred for dental residents' compensation and supervisory teaching activities while

the residents were engaged in patient care activities in the Dental School's approved GME program.¹ The agreement was effective as of January 1, 1999, but the last signature was dated December 20, 1999. National Government Services (the Intermediary) audited the dental FTEs and determined the agreement was not in effect until it was signed.² Accordingly, in computing the GME and IME resident FTEs, the Intermediary counted the time spent by dental residents training from December 20, 1999, the date all signatures were entered on the agreement, through December 31, 1999, the end of the cost reporting period.

The Provider appealed the Intermediary's final determination to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-1841. The Provider was represented by Stephanie A. Webster, Esq. of King and Spalding, L.L.P. The Intermediary was represented by Bernard Talbert, Esq. of BlueCross BlueShield Association.

PARTIES' STIPULATIONS:

The Provider and Intermediary have stipulated to the following facts in this case³:

- 1) The parties agree that the only remaining issue is whether the Intermediary improperly reduced the Provider's numbers of resident full-time equivalents ("FTEs") used for purposes of Medicare direct graduate medical education ("GME") and indirect graduate medical education ("IME") payments based on its contention that the Provider did not meet the written agreement requirement for counting resident time spent in a non-provider setting in 42 C.F.R. §§412.105 and 413.86.
- 2) The University Medical Center Inc., doing business as the University of Louisville Hospital ("Provider") is a 501(c)(3) tax-exempt corporation that is related to the University of Louisville ("University"), including both the University of Louisville Medical School ("Medical School") and the University of Louisville School of Dentistry ("Dental School").
- 3) Since 1996, the Provider and the University of Louisville have been parties to an Affiliation Agreement. Under that agreement, the Provider has served as the principal adult teaching hospital of the University, and the Provider must be available for the teaching, research and clinical care programs of the Medical School and the Dentistry School. Pursuant to this Affiliation Agreement, the Provider has worked with the Dental School to train oral surgery and dental general practice residents in the Dental School's graduate medical education programs.
- 4) In December 1999, the University of Louisville, on behalf of the Dental School, and the Provider, signed an "Agreement Regarding Payments for Graduate Medical Education." Under this agreement, the Provider pays the costs of training dental residents at the Dental School, including the costs of dental resident compensation and supervisory teaching activities. The agreement bore an effective date of January

¹ Provider's Supplemental Position Paper Exhibit P-4; Intermediary's Position Paper Exhibit I-2.

² Intermediary's Position Paper Exhibit I-1 at 6.

³ See, Stipulations of the Parties.

1, 1999.

- 5) Through its payment to the University of Louisville in the amount of \$795,142.00, consistent with the agreement described in paragraph 4 above, the Provider incurred all or substantially all of the costs of the dental residents' training in the Dental School during the fiscal year at issue.
- 6) Dental residents were engaged in patient care activities during the rotation time at issue here.
- 7) If the Provider prevails in this appeal, the Provider will be entitled to receive additional Medicare GME and IME payments based on revisions to the Provider's resident FTE counts to include an additional 27.4335 FTE residents for GME, and an additional 29.5724 FTE residents for IME. The approximate reimbursement impact of these FTEs is \$122,000.

PARTIES' CONTENTIONS:

The Intermediary contends that the regulation requires that a written agreement be executed and therefore in existence for every day for which the Provider wishes to have the residents time counted.⁴ The regulation at 42 C.F.R. §413.86(f)(4) specifies that the written agreement "...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..." (emphasis added). The Intermediary asserts that the use of the word "will" is clear evidence that the agreement must be entered into prior to the commencement of the fiscal year in which residents will be rotated to non-provider settings or before the hospital may begin to count residents training at the non-hospital site.⁵

The Intermediary disagrees with the Provider's assertions that the CMS Administrator's letter, dated February 19, 1999,⁶ permitted a retroactive written agreement. The Intermediary contends that the letter essentially gave providers more time, to make revisions to the non-provider setting written agreements and allowed Providers to forward the agreements to the Intermediary after January 1, 1999. Under no circumstances could the letter be read to support CMS approving a retroactive written agreement.⁷

The Intermediary maintains that the execution of the written agreement is a condition precedent for Medicare's obligation regarding IME and GME reimbursement.⁸ The Provider cannot dictate Medicare's obligation by simply specifying an effective date. The Intermediary argues that under generally accepted contract law principles Medicare is not bound to the effective date entered in a contract in which it is not a participant.⁹ Instead, a

⁴ Tr. at 28; Intermediary's Supplemental Position Paper at 6.

⁵ Intermediary's Final Position Paper at 5-6.

⁶ Intermediary's Final Position Paper Exhibit I-5

⁷ Tr. at 39; Intermediary's Supplemental Position Paper at 6.

⁸ Tr. at 31.

⁹ Tr. at 31 and 40-42.

third party has an obligation or right to look at the facts and circumstances leading to when the agreement was reduced to writing and created the contractual rights between the Provider and University.¹⁰ In this case it was December 1999, when the parties signed the agreement.

The Intermediary urges the Board to follow its ruling in *Hallmark Health System, Inc. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2008-D4 ¶81,863 (Oct. 16, 2007). The Intermediary noted that while *Hallmark* involved multiple issues, the case validated the importance of the written agreement and the Intermediary's argument that the contract be executed prior to the resident being included in the FTE count.¹¹

The Provider contends that the Intermediary's reduction of its resident FTEs to exclude time spent by the dental residents in non-provider settings is improper for several reasons. First, the Intermediary's application of the written agreement requirement is inconsistent with the plain meaning of the Medicare statute. 42 U.S.C. §§ 1395ww(h)(4)(E) and 1395ww(d)(5)(B)(iv).¹² Specifically, the Provider asserts that the GME and IME statutes do not require a written agreement, and instead mandate that the Secretary must count time spent by all residents training in an approved program without regard to the setting in which the training occurs, so long as the residents are involved in patient care and the hospital incurs substantially all of the costs for the training program in that setting. The Provider notes that the parties have stipulated that these two statutory requirements are satisfied.¹³

Second, the Provider contends the Intermediary's position conflicts with the plain language of the regulations.¹⁴ 42 C.F.R. §§412.105(f)(1)(ii)(C) and 413.86(f)(4). The Provider contends that for the period at issue the regulation does not squarely address the issue of the timing of the agreement, let alone require a prospective agreement.¹⁵ The regulation states: "The written agreement between the hospital and nonhospital site must indicate that the hospital will incur the cost of the resident's salary and..." 42 C.F.R. §413.86(f)(4)(ii) (emphasis added). The Provider asserts that the use of the term "will incur" cannot reasonably be read to mean that the agreement must be executed and in place before the training takes place. This is because any written agreement that is going to bind the parties to any action will, by necessity, be framed in the future tense.¹⁶

The Provider notes that in situations where CMS has required a prospectively executed written agreement, it has explicitly stated the requirement in the regulations.¹⁷ For example, in the IME/GME context, CMS stated that written agreements for affiliated provider groups for purposes of aggregating residency caps must be provided to the fiscal intermediary and CMS by July 1 of each year.¹⁸ The Provider emphasized there is no such specific date of

¹⁰ Tr. at 31.

¹¹ Intermediary's Supplemental Position Paper at 7, Tr. at 42 – 43.

¹² Tr. at 10-11 and 15; Provider's Supplemental Position Paper 6-9.

¹³ Stipulations ¶¶ 5 and 6.

¹⁴ Tr. at 12, 15; Provider's Supplemental Position Paper 10-13.

¹⁵ Id.

¹⁶ Tr. at 20 - 21; Provider's Supplemental Position Paper 10-12.

¹⁷ Tr. at 18-20; Provider's Supplemental Position Paper 13.

¹⁸ 63 Fed. Reg. 26318, 26341 (May 12, 1998).

execution requirement in the regulations pertaining to written agreements for non-provider sites.

The Provider further asserts that the Intermediary's application of the written agreement requirement is inconsistent with the intent of the regulation. Specifically, when CMS implemented the written agreement requirement in 1989, the rule was made effective retroactively to residents' training on or after July 1, 1987, thereby explicitly permitting retroactive agreements.¹⁹ In 1998 and 1999, CMS amended the regulations to require greater detail on what the agreement had to say about the training program costs and to ensure that the hospitals actually incurred "all or substantially all" of the costs of the program.²⁰ The Provider emphasized that in amending the regulations, CMS did not even refer to when the agreement had to be executed.²¹

The Provider further contends that the Intermediary's position that the regulations require a prospectively executed agreement is inconsistent with the agency's guidance and interpretation of the written agreement requirement, as set forth in contemporaneous CMS communications concerning the regulation. Specifically, the then CMS (formerly HCFA) Administrator Nancy-Ann Min DeParle issued a letter, dated February 19, 1999, explaining that while the written agreement requirement was effective January 1, 1999, the agreements themselves did not need to be sent to fiscal intermediaries prior to that date.²² Instead, the Administrator explained, the written agreements had to cover the period beginning January 1, 1999 and be retained as supporting documentation for the cost reporting process. The Provider asserts that the letter from former Administrator DeParle demonstrates that the purpose of the written agreement requirement was to ensure that hospitals were meeting the statutory requirement of paying all or substantially all of the costs of the residents training in the non-provider sites, without regard to when the agreements were executed.²³

The Provider acknowledges that the Board and the Administrator have previously addressed the issue of written agreements governing residents training in non-provider settings²⁴ The

¹⁹ 54 Fed. Reg. 40286, 40317 (Sept. 29, 1989); Tr. at 17; Provider's Supplemental Position Paper 10.

²⁰ 63 Fed. Reg. 40954 at 40987 (July 31, 1998) and 64 Fed. Reg. 41490 at 41517 (July 30, 1999). Tr at 17.

²¹ Tr. at 18.

²² Letter from CMS (formerly HCFA) Administrator Nancy-Ann Min DeParle to Jordan J. Cohen, M.D. President of Association of American Medical Colleges (February 19, 1999) (Provider's Supplemental Position Paper Exhibit P-2).

²³ Tr. at 18; Provider's Supplemental Position Paper 12.

²⁴ *Chestnut Hill Hospital v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2004-D22, (Medicare & Medicaid Guide (CCH) ¶81,157 (May 2, 2003) (contained in Provider's Supplemental Position Paper Exhibit P-11), (The Board upheld the intermediary's disallowance of resident time spent training in a non-provider site because there was an insufficient written agreement in place between the hospital and the non-provider site); *Covenant Health Care v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2007-D55, Medicare & Medicaid Guide (CCH) ¶81,762 (Aug. 2, 2007) (contained in Provider's Supplemental Position Paper Exhibit P-9) (The Board reversed the intermediary's disallowance, holding that the hospital and the non-provider clinic were related entities and therefore considered part of the same overall organization. Consequently no written agreement between the two entities was required), *rev'd by* CMS Adm'r Dec. Medicare and Medicaid Guide (CCH) ¶81,790) (Oct. 3, 2007) (contained in Provider's Supplemental Position Paper Exhibit P-10); *Santa Barbara Cottage Hospital v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2007-D78, Medicare & Medicaid Guide (CCH) ¶81,789 (Sept. 28, 2007) (contained in Provider's Supplemental Position Paper Exhibit P-12) (The Board upheld the intermediary's disallowance, concluding that the memoranda of understanding

Provider asserts that the prior decisions are readily distinguishable from the instant case because the only factor at issue here is the timing of the execution of the written agreement. There is no dispute that a written agreement between the hospital and the non-provider site existed; that the agreement was executed and created an obligation prior to the end of the cost reporting period in question; that the residents at issue were engaged in patient care activities during their rotations to the non-provider site; and that the Provider agreed to incur, and in fact did incur all or substantially all of the costs of the residents' training at the non-provider site.²⁵

The Provider also contends that the Intermediary's refusal to accept the Provider's written agreement conflicts with general contract law principles and the Kentucky contracts law (the law of the Provider's location) permitting a contract to be retroactive.²⁶ In its rebuttal statement, the Provider contends that the Intermediary has offered no authority regarding its "third party" argument that it should look behind the written agreement's effective date.²⁷ The Provider asserts that the purpose of the written agreement, as required by CMS, was to determine whether the hospital incurred the costs of the claimed training time. The effective date of the agreement is really only relevant to that determination. There is no dispute in this case that the Provider incurred the costs for the claimed training time back to the beginning of 1999.²⁸

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented, and the parties' contentions, the Board finds and concludes that the Intermediary's determination of the Provider's GME and IME payments were improper because it excluded resident time spent training in a non-provider setting that met all the statutory and regulatory requirements.

This appeal presents the issue of whether residents' times spent training at non-provider sites can be excluded solely because the written agreement, which was made effective to the beginning of the cost reporting period, was executed at the end of the cost reporting period for which resident time is claimed. The Board concludes that such time should not be excluded.

The Board finds the Intermediary's determination is inconsistent with the plain language and manifest intent of the GME and IME statute and regulations. Congress amended paragraph (4) in subsection 1395ww(h) and significantly curtailed CMS's authority to

executed after the cost reporting periods at issue do not satisfy the written agreement requirement); *Hallmark Health System, Inc. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2008-D4 ¶81,863(Oct. 16, 2007) (contained in Provider's Supplemental Position Paper Exhibit P-8) (The Board upheld the intermediary's disallowance because among other things, the provider failed to show that the provider incurred all or substantially all of the costs of the program; and that the written agreement did not create an obligation at the start of the fiscal year or during the cost reporting period).

²⁵ Tr. at 22-24; Provider's Supplemental Position Paper 14; Stipulation ¶¶ 4-6.

²⁶ Tr. at 12, Provider's Supplemental Position Paper 19.

²⁷ Tr. at 41-42, and 47.

²⁸ Tr. at 47-48.

promulgate rules with respect to residents' training in non-provider settings. See Omnibus Budget reconciliation Act of 1986, Pub. L. No. 99-509, §9314(a); see also H.R. Rep. No. 99-727, at 69-70 (1986), reprinted in 1986 U.S.C.C.A.N 3607, 3659-60. The statute states, in pertinent part:

(A) *Rules.* The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

* * * *

(E) *Counting Time Spent in Outpatient Settings.* Such 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 medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

42 U.S.C. §1395ww(h)(4)(A), (E) (emphasis added). Similarly, the IME statute was amended in 1997 to mandate that all residents' time spent training in a non-provider setting "shall be counted" if the same two conditions are met. 42 U.S.C. §1395ww(d)(5)(B)(iv).

In particular, the statute mandates that CMS's rules must be "consistent with" the requirement that CMS must count all residents' training in an approved program, without regard to the setting in which the training occurs, so long as the residents are involved in patient care and the hospital incurs substantially all of the costs for the training program in that setting.

For the period at issue, the regulations implementing the Medicare GME and IME non – provider setting provisions also contain a third condition not found in the statute. The regulatory provision, in pertinent part, states:

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. (emphasis added).

42 C.F.R. §413.86(f)(4)(ii) and incorporated by reference in the IME regulations at 42 C.F.R. §412.105(f)(1)(ii)(C).

The Intermediary's view that the use of the term "will incur" necessarily means that the regulation requires a prospective agreement totally ignores the use of the term "is providing" in the very next sentence. The Board finds that the plain language of the regulation is silent as to the issue of the timing of execution of the written agreement and does not prohibit retroactive written agreements.

Since the regulations do not address the timing of execution of the agreement, the Board looks to the agency's intent, at the time the regulations were implemented and/or amended, to determine how the regulation should be interpreted. When CMS first implemented the written agreement requirement in 1989 for purposes of GME only, the agency intended to permit retroactive written agreements, because the rule was made effective retroactively to residents' training on or after July 1, 1987.²⁹ When CMS amended the regulations in 1998 and 1999, the agency reaffirmed that the purpose of the written agreement requirement was to ensure that the hospitals actually incurred all, or substantially all, of the costs of the programs in the non-provider setting.³⁰ The Board finds CMS's intent was to permit retroactive agreements. Indeed, the focus of the regulatory revisions was on the actual payment of costs by the hospitals, a fact that is undisputed, and not on the timing of the execution of the agreement.

Permitting the written agreements between hospitals and non-provider sites to have retroactive effect to the beginning of a cost reporting period is consistent with CMS's interpretations of the regulations. It is also consistent with other correspondence issued by CMS emphasizing that the purpose of the written agreement requirement was related to the hospitals' payment of all or substantially all of the costs of the program. Specifically, a CMS Administrator's letter, dated February 19, 1999, explained that while the written agreement requirement would be effective January 1, 1999, the agreements themselves did not need to be sent to fiscal Intermediaries prior to that date. However, the agreements had to cover the period beginning January 1, 1999 and be retained as supporting documentation.³¹

The Board finds the Intermediary's refusal to accept the Provider's written agreement based solely on the contention that the regulatory provisions require a prospectively executed agreement is inconsistent with CMS policy in analogous situations. For example, under 42 C.F.R. §489.13(d)(2), as a condition of participation in the Medicare program, CMS allows provider agreements to be made effective retroactively up to one year prior to the date of execution. Moreover, in situations where CMS has required a prospectively executed written agreement, it has done so explicitly in the plain language of the regulations. For example, in the IME/GME context, CMS stated that written agreements for affiliated provider groups for purposes of aggregating residency caps must be provided to the fiscal intermediaries and CMS by July 1 of each year.³² There is no such explicit requirement

²⁹ 54 Fed. Reg. 40317 (1989)(final rule adding 42 C.F.R. §413.86(f)(1)(iii)). In 1997, after Congress amended the statute to provide for the inclusion of residents time in non-provider settings for purposes of IME, CMS incorporated the same requirements for IME as used for GME. 62 Fed. Reg. 46029 (August 29, 1997) (to be codified at 42 C.F.R. §412.105(f)(1)(ii)(C) incorporating by reference 42 C.F.R. §413.86(f)(4)).

³⁰ 63 Fed. Reg. 40986-88 (July 31, 1998); 64 Fed. Reg. 41517-18 (July 30, 1999).

³¹ Provider's Supplemental Position Paper Exhibit P-2.

³² 63 Fed. Reg. 26318, 26341 (May 12, 1998).

here.

The Board is aware of its prior decisions addressing the issue of written agreements governing residents' training in non-provider sites.³³ However, unlike those prior Board decisions, the only issue in the present case is the "timing" of the execution of the written agreement. As stipulated by the parties: a written agreement existed between the Provider and the non-provider site; the agreement was executed and created an obligation prior to the end of the cost reporting period; the residents at issue were engaged in patient care activities during the rotations to the non-provider site; and the Provider agreed to incur and actually did incur all or substantially all of the costs of the residents' training at the non-provider site.³⁴

In this case, the question to be addressed by the Board is whether the Intermediary should be permitted to exclude the residents' time spent training at the non-provider setting during 1999 simply because the written agreement was signed in December 1999. We conclude that the Intermediary should not be permitted to exclude the residents' time. As set forth above, nowhere in the regulations is there a requirement that the written agreement be executed by a specific date or time. 42 C.F.R. §§412.105(f)(1)(ii)(C) 413.86(f)(3)-(4). Instead, as CMS explained in both the final rules and correspondence, the written agreement requirement was intended to ensure that the hospitals pay all, or substantially all, of the costs of the residents' training at non-provider sites.³⁵ The focus of the regulatory provision was on whether actual payment of the costs was made by the providers, and not on the timing of the execution of the written agreement.

Finally, with respect to the principles of contract law, the Board notes that Kentucky contract law (the law of the Provider's location) specifically allows parties to a contract to agree to predate a contract and provides that such contract will have a binding effect.³⁶ Accordingly, as the written agreement meets the requirements of the statute and regulations, and is consistent with the state contract laws, the Board finds the Provider meets the written agreement requirement for counting resident time spent in a non-provider setting.

DECISION AND ORDER:

The Provider satisfied the written agreement requirement for counting resident time spent in a non-provider setting in accordance with 42 C.F.R. §§412.105 and 413.86. The Intermediary's adjustments reducing the Provider's number of resident full-time equivalents used for purposes of Medicare direct -GME and IME were improper and are reversed.

³³ See cases cited *supra* footnote 16.

³⁴ Stipulations ¶¶. 4 – 6.

³⁵ 64 Fed. Reg. at 41517(July 30, 1999) and. Letter from CMS (formerly HCFA) Administrator Nancy-Ann Min DeParle to Jordan J. Cohen, M.D. President of Association of American Medical Colleges (February 19, 1999) (Provider's Supplemental Position Paper Exhibit P-2).

³⁶ Provider's Post-Hearing Brief at 22.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Keith E. Braganza, C.P.A.
John G. Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 29, 2010