PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2026-D26

PROVIDER –
Cherry Hospital

HEARING HELD –
September 24, 2025

PROVIDER NUMBER – 34-4026

FISCAL YEAR END – June 30, 2013

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc.

CASE NUMBER – 20-1578

INDEX

ISSUE STATEMENT:

Whether the Medicare Contractor's determination that Cherry Hospital ("Provider") was not a teaching hospital for the fiscal year under appeal ending June 30, 2013, was proper.[1]

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly determined that the Provider was not entitled to Graduate Medical Education ("GME") or Indirect Medical Education ("IME"), nor was it entitled to payments on a reasonable cost basis for the medical and surgical services of its physicians for the fiscal year ending ("FYE") June 30, 2013. Accordingly, the determination to deny these payments to the Provider as a teaching hospital for the year in question was proper.

INTRODUCTION:

Cherry Hospital is "an inpatient regional referral psychiatric hospital located in Goldsboro, North Carolina."[2] The Medicare contractor[3] assigned to Cherry Hospital for this appeal is Palmetto GBA ("Medicare Contractor"). The instant appeal is taken from the Provider's Notice of Program Reimbursement ("NPR") for its FYE June 30, 2013. The Provider argues that it "is a teaching hospital under 42 CFR § 415.152 and is entitled to receive payment on a reasonable cost basis for direct medical and surgical services of physicians under 42 CFR § 415.160 and CMS Pub. 15-1, chapter 21, §2148 and indirect medical education expenses under 42 CFR § 412.105."[4] The amount in controversy is $590,031.[5]

The Provider explains that, prior to FY 2008, it was entitled to GME payments, but during FYE 2009, it "experienced a temporary loss of certification by [the Centers for Medicare and Medicaid Services ("CMS")]."[6] It was recertified during calendar year 2009, but the Medicare Contractor began to deny GME payments.[7] The Medicare Contractor contends that the Provider

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[1] Transcript ("Tr.") at 6 (Sept. 24, 2025); *but see* discussion *infra*, where the Board takes under the consideration a reframing of the issue of whether the disallowance of reasonable cost payment as well as direct and indirect GME payments is proper.

[2] Provider's Preliminary Position Paper ("Provider's PPP") at 2 (Dec. 11, 2020).

[3] 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 to organizations known as Medicare administrative contractors ("MACs"). The relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare Contractor" to refer both FIs and MACs, as appropriate and relevant.

[4] Provider's PPP at 2-3.

[5] *Id.* at 3.

[6] *Id.* at 5-6.

[7] *Id.* at 6. The Board notes that the provider number was 34-4003 until 2008 and then a new provider number was assigned (34-4026) after the "recertification." *See also* Exhibit ("Ex.") P-13 at 000166 (the Provider's FYE 6/30/2013 cost report, which indicates on worksheet S-2, line 3, columns 2 and 5, that CCN number 34-4026 was certified on 7/22/2009.) Note: The Provider's Preliminary Position Paper includes Exhibits A through D, and related sub-exhibits, while the Provider's Optional Responsive Brief (July 29, 2025) for the combined cases includes Exhibits P-1 through P-17. Citations throughout this decision reflect the difference in exhibit numbering.

is not entitled to GME payments as a teaching hospital for FY 2013 because it never established a Full Time Equivalent ("FTE") resident cap or per resident amount ("PRA") under its new provider number.[8] It argues that "[w]hen Cherry Hospital lost its Medicare certification on September 1, 2008, it also lost its claim to their [FTE] resident cap slots used to calculate GME payments."[9] It is the Medicare Contractor's contention that, in order to be reimbursed for GME payments as a teaching hospital, the Provider needs to obtain a PRA and an FTE resident cap, in accordance with 42 C.F.R. §§ 413.77 and 413.79, respectively.[10]

The Provider filed an individual appeal request on April 15, 2020 and met all jurisdictional requirements for a hearing before the Board. The Board held a video hearing on **September 24, 2025**. The Provider was represented by Joonu-Noel Coste, Esq. of the North Carolina Department of Justice. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF RELEVANT LAW:

A teaching hospital is defined as "a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry."[11] An Approved GME program is defined as:

> (1) A residency program approved by the Accreditation Council for Graduate Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation of the American Dental Association, or by the Council on Podiatric Medical Education of the American Podiatric Medical Association[.]
> (2) A program otherwise recognized as an "approved medical residency program" under § 413.75(b) of this chapter.[12]

The general provisions governing reasonable cost payment for direct medical and surgical services of physicians in teaching hospitals are set forth in 42 C.F.R. § 415.160. The regulation provides that teaching hospitals "may elect to receive payment on a reasonable cost basis for direct medical and surgical services of its physicians in lieu of fee schedule payments that might otherwise be made for these services."[13] The regulation also provides the conditions that a teaching hospital must meet in order to be paid on a reasonable cost basis, the effect of the election, as well as the alternative payment basis when the election is not made:

> (b) Conditions. A teaching hospital may elect to receive these payments only if—

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[8] Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 8 (June 19, 2025).
[9] *Id.* at 7.
[10] *Id.* at 8.
[11] 42 C.F.R. § 415.152.
[12] *Id.*
[13] 42 C.F.R. § 415.160; *see also* CMS Pub. 15-1, Ch. 21, § 2148, *available at* https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021929 (Last visited Sept. 2, 2026).

> (1) ***The hospital notifies its intermediary in writing of the election*** and meets the conditions of either paragraph (b)(2) or paragraph (b)(3) of this section;
>
> (2) All physicians who furnish services to Medicare beneficiaries in the hospital agree not to bill charges for these services; or
>
> (3) All physicians who furnish services to Medicare beneficiaries in the hospital are employees of the hospital and, as a condition of employment, are precluded from billing for these services.
>
> (c) Effect of election. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to beneficiaries—
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> (1) Those services and the supervision of interns and residents furnishing care to individual beneficiaries are covered as hospital services, and
>
> (2) The intermediary pays the hospital for those services on a reasonable cost basis under the rules in § 415.162. (Payment for other physician compensation costs related to approved GME programs is made as described in § 413.78 of this chapter.)
>
> (d) Election declined. ***If the teaching hospital <u>does not</u> make this election, payment is made—***
>
> (1) For physician services furnished to beneficiaries on a fee schedule basis as described in part 414 subject to the rules in this subpart, and
>
> (2) For the supervision of interns and residents as described in §§ 413.75 through 413.83.

Hospitals may also be entitled to additional payment for indirect medical education ("IME") costs for GME programs.[14]

Payments for direct GME costs are permitted by Section 1886(h) of the Social Security Act (codified at 42 U.S.C. § 1395ww(h)). While there are other potential factors, the payments are generally calculated by multiplying the "aggregate approved amount" and "the hospital's Medicare patient load."[15] The "aggregate approved amount" is based on the weighted average

[14] 42 U.S.C. § 1395ww(d)(5)(B); 42 C.F.R. § 412.105.
[15] 42 U.S.C. § 1395ww(h)(3)(A)(i)-(ii); 42 C.F.R. § 413.76(b).

number of FTE residents and the PRA.[16] The PRA is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period.[17] The total FTE count has a weighting factor applied to each resident for the purposes of DGME calculation.[18] The "Medicare patient load" is "the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under Part A."[19]

In the preamble to the 2011 Outpatient Prospective Payment System ("OPPS") Final Rule ("2011 OPPS Final Rule"), published on November 24, 2010, the Secretary has further explained:

> Direct GME payments are made in accordance with section 1886(h) of the Act, based generally on hospital-specific PRAs, the number of FTE residents a hospital trains, and the hospital's Medicare patient share. IME payments are made in accordance with section 1886(d)(5)(B) of the Act, based generally on the ratio of the hospital's FTE residents to the number of hospital beds. Accordingly, the calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count; generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. In an attempt to end the implicit incentive for hospitals to increase the number of FTE residents, Congress instituted a cap on the number of allopathic and osteopathic residents a hospital is allowed to count for direct GME and IME purposes under the provisions of section 1886(h)(4)(F) of the Act for direct GME and section 1886(d)(5)(B)(v) of the Act for IME.[20]

When a teaching hospital closes or terminates its Medicare agreement, the displaced residents which made up its approved FTE count may be redistributed to other hospitals that meet certain criteria.[21] Indeed, in § 5506 of the Patient Protection and Affordable Care Act ("ACA"), Congress revised 42 U.S.C. § 1395ww(h)(4)(H), adding clause (vi), to direct the Secretary to redistribute the FTE resident cap of closed hospitals for purposes of direct GME costs:

> (vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—
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> (I) IN GENERAL.—Subject to the succeeding provisions of this

[16] 42 U.S.C. § 1395ww(h)(3)(B); 42 C.F.R. § 413.76(a).
[17] 42 C.F.R. § 413.77.
[18] 42 C.F.R. § 413.79(b).
[19] 42 U.S.C. § 1395ww(h)(3)(C).
[20] 75 Fed. Reg. 71800, 72212 (Nov. 24, 2010) (Copy at Ex. C-4 at C-0021).
[21] 42 C.F.R. § 413.79(h).

> clause, *the Secretary shall*, by regulation, *establish a process under which, in the case where a hospital* (other than a hospital described in clause (v)) with an approved medical residency program ***closes*** *on or after a date that is 2 years before the date of enactment of this clause*, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.
>
> ***
>
> (IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).[22]

Thus, in the 2011 OPPS Final Rule, CMS implemented the ACA § 5506 redistribution of FTE resident slots of "closed hospitals."[23] As part of the same Final Rule, CMS published a Table identifying "closed hospitals" (those that had closed between March 23, 2008 and August 3, 2010) and specified that the FTE caps associated with each of these hospitals (as listed in that Table) would be redistributed pursuant to ACA § 5506.[24] Accordingly, the Final Rule also established an application process through which hospitals could apply to CMS to receive an increase in FTE caps based on the FTE cap slots being redistributed from these "closed hospitals."[25] Of relevance to this case, the application process gives a hospital that assumes the GME program of a closed hospital the highest priority for the FTE cap slots being redistributed from that GME program:

> *Ranking Criterion One. The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, same program director, and same (or many of the same) teaching staff).* We proposed this ranking criterion because we understand that there are situations where, when a hospital is acquired and its provider agreement is terminated and a new provider agreement is established in the place of the old one, the new formed "acquiring" hospital continues to operate the GME programs seamlessly and in the same manner as under the previous provider agreement. If this situation occurs, we believe the new hospital with the new provider

[22] Pub. Law. 111-148, § 5506, 124 Stat. 119, 661-662 (2010) (emphasis added).
[23] 75 Fed. Reg. at 72212-72236.
[24] *Id.* at 72215-72216, 72211.
[25] *Id.* at 72215.

> agreement is demonstrating a strong commitment to not only maintain the GME programs in the community for the long term (that is, continuity), but to also allow the residents that were at the hospital when the change in provider agreement occurred to continue to train there, such that no residents are displaced and no training is interrupted.[26]

Significantly, shortly after the publication of the 2011 OPPS Final Rule, CMS published a correction to that Final Rule to add Cherry Hospital, under provider number 34-4003, to the Table listing teaching hospitals that had closed in this time period, and that Table identified Cherry Hospital as having a termination date of September 1, 2008 and a DGME cap of 1.0 and an IME cap of 0.00.[27] As a result of this correction to the FY 2011 OPPS Final Rule, the FTE caps associated with Cherry Hospital under provider number 34-4003 were to be redistributed under the process detailed in the 2011 OPPS Final Rule.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Prior to September 1, 2008, Cherry Hospital "was designated as a teaching hospital and received payments for [GME]"[28] with an FTE cap for DGME of 1.0.[29] Also, prior to this time, the Provider received notification from its Medicare Contractor of updates and changes to its projected PRA for each fiscal year.[30] Effective September 1, 2008, Cherry Hospital's Medicare Agreement was terminated, resulting in its decertification from the Medicare Program under provider number 34-4003.[31] The Provider concedes that once the Medicare Agreement was terminated, Cherry Hospital was a "closed" hospital for the purposes of 42 U.S.C. § 1395ww(h)(4)(H)(vi).[32] The Provider was certified with a newly-assigned provider number, 34-4026, on July 22, 2009.[33] The record contains no evidence that Cherry Hospital applied for any redistributed FTE cap slots associated with the terminated provider number under the process detailed in the 2011 OPPS Final Rule, or that the Provider's Medicare Contractor provided any updated or projected PRAs once Cherry Hospital was recertified and operating under its new provider number.[34]

On its FY 2013 filed cost report, Cherry Hospital selected "Y" on Worksheet S-2, Part 1, Line 56.00 for "teaching hospital approved."[35] It also selected "Y" on Worksheet S-2, Part 1, Line

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[26] *Id.* at 72216 (italics in original).
[27] 76 Fed. Reg 13292, 13293-13294 (Mar. 11, 2011) (copy at Ex. C-3).
[28] Medicare Contractor's FPP at 6.
[29] *See* 76 Fed. Reg at 13294.
[30] *E.g.*, Ex. P-7 (Notice of Per Resident Amount Updates & Changes (Nov. 7, 2007)) (notifying Cherry Hospital of its projected PRA for FYE 6/30/2008, as well as documenting historical PRAs from its FYEs 6/30/1992 through 6/30/2007).
[31] *See* Medicare Contractor's FPP at 5; Provider's PPP at 6; Tr. at 49, 55, 97.
[32] Tr. at 49.
[33] Medicare Contractor's FPP at 5-6; Tr. at 97.
[34] *See* Tr. at 53-54.
[35] *See* Ex. P-13 at 000167.

58.00, for "cost reimbursement for teaching physicians"[36] and reported an FTE cap of 1.00 and an actual FTE count of 1.24.[37] Other than these two line item responses, no formal written election or notification that Cherry Hospital desired to be paid on a reasonable cost basis for its physician services as a teaching hospital was submitted to the Medicare Contractor in accordance with 42 C.F.R. § 415.160(b)(1).[38]

Nevertheless, the Provider still alleges it "is a teaching hospital under 42 CFR § 415.152 and is entitled to receive payment on a reasonable cost basis for direct medical and surgical services of physicians under 42 CFR § 415.160 and CMS Pub. 15-1, chapter 21, §2148 and [IME] expenses under 42 CFR § 412.105."[39] The Provider explains that Vidant Medical Center ("VMC") is the teaching hospital for the Brody School of Medicine at East Carolina University and Campbell University and that Cherry Hospital is "a ***teaching site*** for the Brody School of Medicine[.]"[40] The Provider states it "has an agreement with VMC which permits the rotation of residents enrolled in an accredited psychiatry training program at VMC to participate in clinical experiences at Cherry [Hospital]."[41] The Provider claims that VMC's psychiatric graduate program is an approved GME program since it is approved by the Accreditation Council for Graduate Medical Education ("ACGME").[42] It argues that it "is engaged in the program by providing for rotations of residents from the psychiatry program at [VMC]" and thus meets the definition of a "teaching hospital."[43]

As previously stated, the Medicare Contractor refutes that the Provider meets the criteria of a teaching hospital that is entitled to GME payments because it had not obtained a PRA or FTE resident cap, which are required for reimbursement as a teaching hospital.[44] At the hearing, Cherry Hospital's witness, the Accounting Manager for the Office of the Controller with the North Carolina Department of Health and Human Services, testified that it is their position that Cherry Hospital properly elected to receive payment on a reasonable cost basis for its physician services, and that, "[s]ince no FTE cap or [ ] per resident amount is used in the calculation of payments, based on reasonable cost, Cherry Hospital is not obligated to establish these factors in order to receive reasonable cost payments as a teaching hospital."[45] Thus, the Provider's theory of its case is that reasonable cost reimbursement does not depend on first establishing an FTE count or PRA under provider number 34-4026 or determining whether Cherry Hospital's rotation arrangement with VMC satisfies the definition of "teaching hospital"[46] under § 415.152—rather, it hinges simply on whether Cherry Hospital validly elected reasonable cost reimbursement under 42 C.F.R. § 415.160(b). Accordingly, the main issue is whether the Medicare Contractor's

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[36] *See id.*; Tr. at 108.
[37] Provider's PPP at 6.
[38] Tr. at 110; *see* also notes 77-79 and accompanying text, *infra*.
[39] Provider's PPP at 2-3; Tr. at 21.
[40] Provider's PPP at 5 (emphasis added).
[41] *Id.*
[42] *Id.* at 7; *see also*, 42 CFR § 415.152; Ex. P-5.
[43] *Id.* (citing 42 C.F.R. § 415.152).
[44] Medicare Contractor's FPP at 8.
[45] Tr. at 69; *see also* Ex. P-8 at 000084.
[46] That is, "a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry."

denial of its GME and IME payments, along with the disallowance of reasonable cost reimbursement for physician services, was proper.

It is undisputed that under its terminated provider number (34-4003), VMC's residents' rotations at Cherry Hospital permitted the Provider to be classified and to receive reimbursement, as "a [teaching] hospital engaged in an approved GME residency program," pursuant to 42 C.F.R. § 415.152.[47] However, once the hospital closed and was subsequently granted a new Medicare provider number (34-4026) on July 22, 2009, Cherry Hospital neither applied for the FTE cap slots that were redistributed from the terminated provider number under the process detailed in the 2011 OPPS Final Rule and thus, did not obtain a PRA or FTE resident cap under its new provider number. Since then, the Medicare Contractor has removed teaching costs from Cherry Hospital's cost reports because it "has not met the requirements to be a teaching hospital."[48]

In order to receive GME payments for the FY at issue, Cherry Hospital must have had an FTE cap and PRA.[49] When Cherry Hospital's Medicare Agreement was terminated under provider number 34-4003, its FTE cap became subject to redistribution to other teaching hospitals, pursuant to ACA § 5506 and 42 C.F.R. § 413.79. Indeed, the 2011 OPPS Final Rule states: "[t]hus, if a teaching hospital closes, its direct GME and IME FTE resident cap slots would be 'lost,' because those cap slots are associated with a specific hospital's Medicare provider agreement, which would be retired upon the hospital's closure."[50] As such, Cherry Hospital, under provider number 34-4026, has no FTE cap, as the cap slots from provider number 34-4003 were lost and it failed to apply for those slots to be redistributed to it under the process detailed in the 2011 OPPS Final Rule.

The Provider repeatedly refers to the termination of its previous provider number as a "temporary decertification"[51] but this is merely a retroactive description that attempts to deflect from the fact that, as of September 1, 2008, provider number 34-4003 was permanently decertified from the Medicare Program and, as a result, there was public notice in the 2011 OPPS Final Rule of the FTE cap slots from that closed program being redistributed. This specific provider number has never been recertified. Cherry Hospital was issued a **new** provider number, 34-4026, on July 22, 2009. There is no automatic carry-forward or transfer of a previous hospital's FTEs to a new provider, even if it overlaps with the same campus or programs as the prior hospital. Indeed, 42 U.S.C. § 1395ww(h)(4) specifically dictates that FTEs are forfeited by closed hospitals, and an application process was also implemented for other hospitals to request assignment of any forfeited FTEs.[52] Indeed, as discussed above, Cherry Hospital, as provider number 34-4026, could have applied through this process for the forfeited FTEs from the prior provider number/provider agreement,[53] but there is no evidence in the record that it did so. This

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[47] *See* Medicare Contractor's FPP at 6 ("Prior to September 1, 2008, Cherry Hospital was designated as a teaching hospital and received payments for graduate medical education (GME).").
[48] *Id.*
[49] 42 U.S.C. §1395ww(h)(3); 42 C.F.R. §§ 413.76, 77, 79.
[50] 75 Fed. Reg. at 72212.
[51] Provider's Response to MAC's Final Position Paper at 6-7, 10-11 (July 29, 2025).
[52] 75 Fed. Reg. at 72215.
[53] *Id.*

conclusion is further supported by the Provider's own testimony. The witness agreed on cross-examination that a Medicare provider number functions similarly to a Social Security number for hospitals and that, when a hospital is decertified and later recertified under a new provider number, they are treated as two separate hospitals for Medicare purposes, even if the hospital's doors never closed or stopped treating patients.[54] The witness also agreed that, upon recertification under a new provider number, the hospital must be recognized anew as a teaching hospital, and that for Medicare purposes, a teaching hospital under one provider number is not the same as a teaching hospital under a different provider number.[55]

Although not clearly articulated, the Provider also attempts to raise an "*ex post facto"* issue (*i.e.*, retroactive application of a law) with regard to the application of FTE cap redistribution process, mandated by § 5506 of the ACA, to its FTE cap that existed before the enactment of that law.[56] In essence, the Provider questions how the ***2011*** OPPS Final Rule (published in the November 24, 2010 Federal Register) can be applied to their FTE cap prior to their ***2008*** Medicare Provider Agreement termination.[57] It is well settled that, absent clear congressional intent that a statute be applied retroactively, the law must operate prospectively.[58] When amending 42 U.S.C. § 1395ww(h)(4)(H) to set forth the "redistribution of residency slots after a hospital closes" provision, Congress expressly stated its intent to apply the redistribution process to teaching hospitals that closed "on or after a date that is 2 years before the date of enactment of this clause," which was March 23, 2010.[59] Accordingly, in the 2011 OPPS Final Rule, the Secretary acknowledged:

> Although certain of the FTE cap increases granted pursuant to section 5506 ***will be based on hospital closures that occurred prior to this notice and comment rulemaking procedure***, we indicated in the August 3, 2010 proposed rule that the process we proposed to establish in the final rule would also be used for all

[54] Tr. at 72-73.
[55] *Id.* at 73-74.
[56] *See* Tr. at 13 – 14 ("And there is a distinction made that does discuss [sic], in 2010–again, after 2009 –that seeks to ex post facto explain that Cherry Hospital was deprived of these FTEs.") The Provider conflates what it characterizes as a 2010 "*ex post facto*" explanation after 2009, with a notice and comment argument regarding the correction to the November 24, 2010 Federal Register publication in the March 11, 2011 Federal Register.
[57] Also note that by continuously referencing 2009, the year in which it was certified as a new Medicare provider, Cherry Hospital is under the misconception that the FTE cap associated with its terminated Medicare provider agreement / number is still associated with its new provider agreement / number.
[58] *See Landgraf v. USI Film Prods*., 511 U.S. 244, 280, (1994), where the Supreme Court held:

> When a case implicates a federal statute enacted after the events in suit, the court's first task is to determine whether Congress has expressly prescribed the statute's proper reach. If Congress has done so, of course, there is no need to resort to judicial default rules. When, however, the statute contains no such express command, the court must determine whether the new statute would have retroactive effect, *i.e.,* whether it would impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed. If the statute would operate retroactively, our traditional presumption teaches that it does not govern absent clear congressional intent favoring such a result.

[59] *See* Pub. Law. 111-148, § 5506, 124 Stat. 119, 661 (2010).

> future teaching hospital closures. ***We indicated that we were in the process of instructing the Medicare contractors to notify us of every teaching hospital that has closed since March 23, 2008, and of the direct GME and IME FTE caps for each of those closed hospitals. We plan to use this information to determine how many slots are currently available for increases to other hospitals' FTE resident caps.***[60]

Thus, Cherry Hospital's alluded *ex post facto* argument fails.

Additionally, the Provider argues it was never given notice of the redistribution of its FTE resident cap.[61] The Provider points to a March 11, 2011 Federal Register notice, which added Cherry Hospital to a table titled "List of Teaching Hospitals That Have Closed On or After March 23, 2008, and Before August 3, 2010," and to the Secretary's accompanying determination that notice-and-comment procedures were unnecessary for that correction.[62] The Board rejects the Provider's argument. The rule governing the FTE resident caps distribution after the closure of a teaching hospital (since March 23, 2008) was established through notice-and-comment rulemaking. Particularly, the August 3, 2010 Proposed Rule was open for comment until August 31, 2010—well after Cherry Hospital's September 1, 2008 decertification, and after the July 1, 2009 effective date of its new provider agreement.[63] Thus, Cherry Hospital had notice of the proposed implementation of the redistribution mandated by § 5506 and the opportunity to publicly comment on the proposal because its FTE cap would clearly be impacted. Accordingly, and as acknowledged by Cherry Hospital's witness,[64] the lack of comment on the technical correction listing Cherry Hospital as a closed hospital is not a due process violation since the Provider was on constructive notice through the properly published proposed rule and ACA § 5506.

Moreover, the 2011 OPPS Final Rule ***did not negatively*** change previous policies related to the reassignment of a closed hospital's FTE cap to another hospital but, rather, specifically set forth the process to preserve the closed hospitals' FTE caps for the entire teaching hospital community upon the expiration of temporary assignments.[65] This preservation was necessary because over seven (7) years earlier, through the 2005 IPPS Final Rule,[66] CMS promulgated 42 C.F.R.

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[60] 75 Fed. Reg. at 72212 (Bold and italics emphasis added).
[61] Tr. at 14, 56-57.
[62] *Id.* at 54-56; *see also* Ex. C-3.
[63] 75 Fed. Reg. 46170, 46170 (Aug. 3, 2010).
[64] Tr. at 99-100.
[65] 75 Fed. Reg. at 72212 (stating "Under existing regulations at § 413.79(h) for direct GME and §412.105(f)(1)(ix) for IME, a hospital that is training FTE residents at or in excess of its FTE resident caps and takes in residents displaced by the closure of another teaching hospital may receive a temporary increase to its FTE residents caps so that it may receive direct GME and IME payment associated with those displaced FTE residents. However, those temporary FTE resident cap increases are associated with those specific displaced FTE residents, and the increases expire as those displaced residents complete their training program. *Thus, if a teaching hospital closes, its direct GME and IME FTE resident cap slots would be 'lost,'* ***because those cap slots are associated with a specific hospital's Medicare provider agreement, which would be retired upon the hospital's closure***." (Bold and italics emphasis added).
[66] 69 Fed. Reg. 48916 (Aug. 11, 2004).

§ 413.79(h) to address the temporary assignment of FTE caps associated with displaced residents of closed hospitals. And since these assignments were temporary, upon the displaced residents' completion of their transferred residency programs, the closed hospitals' FTE caps would terminate in accord with terminated provider agreement.[67]

Further, the Provider insists there is no evidence showing its resident caps were **actually** removed following its "temporary decertification."[68] First, this misplaces the burden of proof: the Provider must establish that it met the criteria to be eligible for and receive GME payments.[69] Nevertheless, the Board notes that Cherry Hospital's FTEs were **specifically** listed as subject to this redistribution in the Federal Register.[70] The Board finds that the FTE slots associated with provider number 34-4003 were, in fact, subject to redistribution and not retained in any fashion for Cherry Hospital to automatically receive them when it was assigned an entirely new provider number 34-4026. Additionally, the enactment of ACA § 5506, the promulgation of its implementing regulations, and the numerous Federal Register publications discussed above demonstrate the Provider was on constructive notice of the loss of its FTEs and of the process through which it could apply for those slots, under their new provider number, as part of the redistribution. Even if the forfeited FTE slots were never *actually* redistributed or claimed by another hospital, there is nothing in the record to demonstrate that Cherry Hospital ever applied for FTE slots under provider number 34-4026 (notwithstanding the priority status it would have had, had it done so[71]). The failure to apply for FTE cap slots resulted in Cherry Hospital not being assigned GME or IME FTE caps, which also prohibits recovery of indirect medical education expenses under 42 CFR § 412.105 (that the Provider also seeks,[72]) since that calculation requires an FTE count which is compared with the Provider's IME FTE cap. Indeed, the identification of Cherry Hospital's closed FTE slots in the regulations identifies only a 1.0 DGME cap, and a 0.0 IME Cap associated with provider number 34-4003, which was available for redistribution through the application process.[73] There is no evidence that Cherry Hospital had any IME cap prior to the termination of its provider number/provider agreement in 2008.

In addition to specific GME and IME payments, the Provider asserts it "is entitled to receive payment on a reasonable cost basis for direct medical and surgical services of physicians under 42 CFR § 415.160 and CMS Pub. 15-1, Chapter 21 § 2148[.]"[74] The election to receive reasonable cost payment for direct medical and surgical services of physicians is only available for teaching hospitals.[75] As the Board has found in previous cases, "[t]he definition of 'teaching setting' [in 42 C.F.R. § 415.152] suggests that being 'engaged in an approved GME residency program' is more than just actually having residents but also receiving 'Medicare payment for

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[67] *Id.* at 49149.
[68] Provider's Response to MAC's Final Position Paper at 10-11; Tr. at 50-51, 117-119.
[69] *See* 42 C.F.R. § 405.1871(a)(3).
[70] *See* 76 Fed. Reg at 13293-13294 (listing Cherry Hospital as a closed hospital with its DGME cap of 1.0 being subject to redistribution).
[71] See *supra* note 26 and accompanying text.
[72] Provider's Response to MAC's Final Position Paper at 3.
[73] *See* 76 Fed. Reg. at 13294.
[74] Provider's Response to MAC's Final Position Paper at 3.
[75] 42 C.F.R § 415.160(a).

the services of residents . . . under the direct GME payment provisions.'"[76] Even assuming Cherry Hospital satisfies the definition of a teaching hospital under § 415.152, the Board finds that the Provider failed to "notif[y] its intermediary [*i.e.*, Medicare contractor] in writing of the election" required under 42 CFR § 415.160(b)(1) to receive reasonable cost reimbursement for its physician services.

The record establishes, through the Provider's own witness, that no written election separate from the cost report was ever submitted. The witness testified on cross-examination that there is no letter from Cherry Hospital to Palmetto GBA, and no letter from Cherry Hospital to the prior intermediary, Cahaba Safeguard Administrators, claiming an election to receive "reasonable cost reimbursement as opposed to any other form of reimbursement."[77] She confirmed that, to her knowledge, the Provider is not aware of any such written notification ever having been submitted, and agreed that the record before the Board contains nothing beyond the "Y" entries on Worksheet S-2, Lines 56 and 58.[78] The Provider nonetheless contends that indicating "Y" on Worksheet S-2, Lines 56 and 58 for its FY 2013 cost report constituted adequate notice of its election.[79] The Board rejects this contention, consistent with the Board's findings in *VA Behavioral Health*.

In *VA Behavioral Health*, at least one hospital converted from a general acute care hospital to a free-standing psychiatric hospital under a new provider number, but after that provider number change, it never made an election to receive reasonable cost reimbursement.[80] Other hospitals participating in the appeal insisted that indicating "Y" on Worksheet S-2, Lines 56 and 58 sufficiently made an election through the cost report.[81] The Board rejected these arguments, finding that "the cost report instructions are clear that a hospital should be making an election filing **separate and apart** from the cost report form itself[.]"[82] The Board similarly holds here that 42 C.F.R. § 415.160(b)(1) requires the hospital to submit an affirmative, written notice of election outside of the cost report to the Medicare Contractor, and that this written notice must affirm that the hospital meets the conditions of paragraph (b)(2) or (b)(3) of the same section. The Board further notes that the textual distinction in the cost report itself reinforces this conclusion. Specifically, Worksheet S-2, Line 58, in the past tense, asks, "did" the facility elect cost reimbursement for physician services, as opposed to "is the facility electing cost reimbursement for teaching physicians?"[83] An inquiry of whether the facility "did" something

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[76] PRRB Decision 2024-D24, *VA Behavioral Health CYs 2016 & 2017 Disallowance of Professional Costs CIRP Group v. Palmetto GBA* at 4 (July 26, 2024) ("*VA Behavioral Health*"). The definitions within the subpart of the C.F.R. which pertains to the reasonable cost election and GME payments define a "[t]eaching setting" as "any provider . . . in which Medicare payment for the services of residents is made under the direct GME payment provisions of §§ 413.75 through 413.83 . . .."

[77] Tr. at 69-70.

[78] *Id.* at 108-110.

[79] *Id.* at 62-65; Provider's Response to MAC's Position Paper at 11-12.

[80] *VA Behavioral Health* at 8-9.

[81] *Id.* at 9.

[82] *Id.* at 16 (Bold emphasis added).

[83] Specifically, the hospital cost reporting instructions ask: "If line 56, column 1, is "Y" for yes, ***did*** you elect cost reimbursement for physician direct medical and surgical services as defined in 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148? Enter "Y" for yes or "N" for no. If yes, complete Worksheet D-5." PRM 15-2, Ch. 40,

is in reference to a completed action in the past, while an inquiry of "is" the facility doing something asks about a current action or ongoing action in the present. Accordingly, the common usage of present and past tense verbs in posed questions further supports the conclusion that a written election must be submitted to the Medicare Contractor outside the cost report itself. This interpretation also makes practical sense in that the teaching hospital's election should occur prior to or at the beginning of the fiscal year at issue given the following facts: (1) *at the beginning of the fiscal year for which an election is being made*, a hospital has to ensure that it has in effect any physician agreements required under 42 C.F.R. § 415.160(b)(2)-(3) and that, during the course of that fiscal year, neither it nor its physicians submit claims for Part B physician services furnished in the hospital;[84] and (2) given the potential impact on Part B claim submissions and other aspects of the cost report, the Medicare Contractor should receive prospective notice of the hospital's written election rather than retrospectively as part of a cost report that is filed five (5) months ***after*** the cost reporting period has ended. In this case, the record contains no evidence that such a written election was made.[85]

Further, there is no evidence in the record before the Board as to whether the Provider meets the criteria in 42 C.F.R. § 415.160(b)(2) and (3), which are required in order to receive reasonable cost reimbursement for the physician medical and surgical services. Specifically, the record contains no verifiable evidence that "(1) [a]ll physicians who furnish services to Medicare beneficiaries in the hospital agree not to bill charges for these services; or (2) [a]ll physicians who furnish services to Medicare beneficiaries in the hospital are employees of the hospital and, as a condition of employment, are precluded from billing for these services."[86] For example, physician contracts may dictate that the physicians agree not to bill charges for these services, or employment agreements may state that the physicians are precluded from billing for these services. However, the record contains no examples of such contracts or agreements, nor any other evidence to support that those conditions were met. The Provider can only receive payment on a reasonable cost basis if it meets these conditions, but the record does not demonstrate that the Provider met these conditions. The Board notes that the fact that these questions are not on the cost report form also serves to support the Board's conclusion that the election cannot be made on the cost report but must be submitted to the Medicare Contractor outside the cost report itself. While it is possible that Cherry Hospital, under the terminated provider number 34-4003, properly made the necessary election in the past, there is no evidence in the record that any such election was made under the current provider number 34-4026, and the Provider's witness testified that she had no knowledge of any letter to the Medicare

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§ 4004.1, Line 58, *available at* https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021935 (last visited Sept. 2, 2026) (Bold and italics emphasis added.) *See also*, Ex. P-13 at 000167 (showing line 58 on the Provider's FYE 6/30/2013 cost report, which asks the question "If line 56 is yes, ***did*** this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, Section 2148? If yes, complete worksheet D-5." (Bold and italics emphasis added.)) S*ee also,* Tr. at 108 - 109.

[84] In this respect, the Board notes that 42 C.F.R. § 415.160(d) specifies that, if an election is declined, physician services are paid on a fee schedule basis. This only makes sense if an election is made prospectively and not as part of the cost report submission process, as highlighted by the facts that the cost report is filed five (5) months following the close of the fiscal year and that Part B claims must be submitted generally within twelve (12) months of the date of service., 42 C.F.R. § 424.44(a)(1).

[85] *See* supra notes 77-79 and accompanying text.

[86] 42 C.F.R. § 415.160(b)(2) and (3).

contractors (Palmetto and Cahaba) making that election, or any form of election other than checking "yes" on the cost report.[87]

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In summary, the Board finds that Cherry Hospital's FTE slots were forfeited when its Medicare Agreement under provider number 34-4003 was terminated, and that there is nothing to show it ever applied for FTE slots following the assignment of its new provider number, 34-4026. Without an FTE count or PRA, the Provider was not entitled to GME payments for its FY 2013, pursuant to 42 C.F.R. § 413.76. Without an FTE count, it was also ineligible to receive IME payments, pursuant to 42 C.F.R. § 412.105. And, regardless of whether Cherry Hospital satisfies the definition of a "teaching hospital" under 42 C.F.R. § 415.152, the Provider failed to submit a written election to its Medicare Contractor, establishing that it met the necessary conditions, as required by 42 C.F.R. § 415.160(b)(1), to receive reasonable cost reimbursement for physician medical and surgical services.

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly determined that the Provider was not entitled to GME or IME payments, nor was it entitled to payments on a reasonable cost basis for the medical and surgical services of its physicians for the fiscal year ending June 30, 2013. Accordingly, the determination to deny these payments to the Provider as a teaching hospital for the year in question was proper.

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FOR THE BOARD:

9/8/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

[87] Tr. at 70, 83, 106-107.