CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
North Dakota 99-01 Adjustment of FTE GME/IME Group **Provider** **vs.** **Blue Cross Blue Shield Association/ Noridian Administrative Services** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 12/31/1999; 12/31/2000; 6/31/2001** **Review of:** **PRRB Dec. No. 2008-D19** **Dated: February 26, 2008**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The CMS Center for Medicare Management (CMM) submitted comments requesting reversal of the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Subsequently, the Provider submitted comments requesting that the Administrator affirm the Board's decision. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue before the Board was whether the Intermediary properly disallowed reimbursement for direct graduate medical education (DGME) and indirect medical education (IME) costs in the non-hospital setting by reducing the Provider's full-time equivalent (FTE) resident counts.[1]

[1] Medcenter One Health Systems and St. Alexius Medical Center (the Providers), train residents participating in a three-year family practice residency program operated in conjunction with the University of North Dakota Medical School

The Board noted that the question in this case centers on the interpretation of the language in the governing statute and regulation that requires hospitals to incur all, or substantially all, of the costs of the training program at the non-hospital setting. The Board recognized that the Intermediary and CMS take the position that the statutory language requires a hospital to incur all, or substantially all, of the entire program at the non-hospital setting in order to claim any of the residents. Under this interpretation, the Board reasoned that if a hospital, as in the instant case, shares the costs of the training program equally with another hospital, neither hospital can claim any of the residents. However, the Providers asserted that the statute does not require an all or none interpretation. Each hospital can claim FTEs for the residents for whom that hospital incurs the costs of the residents' salary and fringe benefits and the supervising physicians' salaries attributable to training that resident.

The Board examined the language of the governing statute to determine whether it specifically addressed the issue in the case.[2] The Board found that both provisions in the statute have the "all, or substantially all," language, but neither provision specifically defines the term "program." The Board reasoned that the provisions do not state that a hospital must incur all, or substantially all, of the costs for the entire training program for all of the residents in order to claim any FTEs. Thus, the Board found that the statute does not determine which of the competing interpretations is correct.

The Board noted that legislative history often provides guidance in interpreting Congressional intent.[3] However, the Board found that the legislative history does not directly address the question in this case, even though it lends support to the Providers' position that the costs be "substantially incurred" related to the particular resident claimed.

The Board then looked to the regulation to determine whether it addressed the issue of paying for the costs of the entire program. The regulation sets forth the three conditions that a provider must meet to count residents' training time in non-hospital settings for DGME and IME payment purposes.[4] The Board noted that the regulation provides a definition for "all, or substantially all, of the costs for the training program in the non-hospital setting." However, the Board noted that it did

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(University). The Providers rotated residents through the Bismarck Family Practice Center (FPC), where a family practice residency program is based.

[2] See §1886(h)(4)(A), (E) and §1886(d)(5)(B), (iv) of the Social Security Act.

[3] See H.R. Rep No. 99-727, at 70, *reprinted in* 1986 U.S.C.C.A.N. 3607, 3660; *See also* Providers' Supplemental Position paper, pp. 12-15.

[4] See 42 C.F.R §413.86(f)(4) and 42 C.F.R. §412.105(f)(1)(ii)(C) (incorporating the DGME standards by reference to IME).

not state that a hospital must incur all, or substantially all, of the costs for an "entire" training program for all of the residents. Thus, the Board concluded that the language in the regulation did not resolve the issue.

The Board looked to the policy that was in place, and focused on the preamble to the Federal Fiscal Year (FFY) 2004 Inpatient Prospective Payment System (IPPS) final rule published in the Federal Register on August 1, 2003. The policy supported the Intermediary's position regarding the FTEs at issue in this case. The Board found that, prior to the publication of the 2004 IPPS final rule, CMS had not announced any policy interpreting the statute in the manner it sets out in the preamble. Accordingly, the Board found that the intermediaries were unaware of, and were not applying, this interpretation in their audits. In addition, providers were not given notice of such a policy. The Board concluded that, without communication from CMS of its policy during the periods in dispute, the only policy the providers could rely on was the intermediaries' practice, which was to permit hospitals to share the costs of training programs.

SUMMARY OF COMMENTS

CMM commented that the Intermediary was correct in determining that both Providers failed to meet the statutory requirement. CMM refuted the Providers' argument that the statute does not support CMS' policy. CMM stated that the statute plainly specifies that a hospital may include the time a resident spends in non-hospital settings in its FTE resident counts "if the hospital incurs all, or substantially all, of the costs for the training program in that setting." CMM stated that only one hospital is to incur all, or substantially all, of the costs of the specific program at the non-hospital site. CMM argued that, under the statute, multiple hospitals who share the costs fail to meet the specific statutory requirement. CMM found that at the non-hospital setting, where family practice residents from both Providers train, a hospital may count the residents if it incurs all, or substantially all, of the costs of the family practice training program. CMM reasoned that, since neither hospital paid for "all, or substantially all," the costs related to the program, neither hospital satisfied the condition for counting FTE residents training in the non-hospital setting. CMM concluded that the Intermediary was correct to adjust the DGME and IME FTE resident counts for the Providers.

The Providers commented that the Board correctly interpreted the Social Security Act and its implementing regulation to allow a hospital to pay for, and claim, its share of the residents' training in a non-hospital setting. The Providers argued that the statute which authorizes reimbursement for the direct and indirect cost of residents' time training in a non-hospital setting does not define "all or substantially all of the costs for the training program in [the non-hospital] setting." The Providers

claimed that regulation promulgated by CMS allowed DGME and IME payments for a resident's rotations to a non-hospital site if: (1) the resident spent his or her time in patient care activities; (2) there was a written agreement between the hospital and non-hospital site that satisfies the regulatory requirements; and (3) the hospital incurred "all or substantially all of the costs for the training program in the non-hospital setting." Like the statute, the Providers noted, the regulation also does not define "program." The Providers claimed that CMS' announcement in 2003 was a dramatic change. This position was announced without any discussion of a policy purpose for the change.

The Providers claimed that the Board properly concluded that CMS' interpretation, which would preclude multiple hospitals from sharing the costs of non-hospital resident training, is inconsistent with Congress' intent to encourage non-hospital resident training and to expand GME and IME reimbursement in the non-hospital setting. The Providers noted that, in the least, the Board's factual finding that CMS' interpretation is a change in policy and is inapplicable to the fiscal years at issue, must be upheld. The Board was correct in finding that the first and only documented evidence of CMS' interpretation of its "longstanding" prohibition against shared non-hospital training is a comment in the preamble to the FFY 2004 IPPS final rule. In addition, the Providers argued that it presented a number of internal CMS documents demonstrating confusion within CMS about the meaning of the DGME and IME rules concerning shared non-hospital programs and the effective date of CMS' so-called longstanding prohibition against such programs.[5] The Providers noted that they also presented testimony establishing that the Intermediary audited the Providers' cost reports and never interpreted, nor applied, the DGME and IME statute to preclude the Providers' arrangement. The Intermediary did not present any evidence to rebut the Providers' evidence.[6] Thus, the Board correctly concluded that the Providers lacked notice of CMS' interpretation and were entitled to rely on the Intermediary's practice, which was to allow the Providers to share the costs of training residents at the non-hospital setting.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. Comments timely submitted have been included in the record and have been considered.

Since the inception of Medicare in 1965, the program has shared in the costs of educational activities incurred by participating providers. The regulations at 42

[5] See Transcript of Oral Hearing (Tr.), at 130-138.
[6] See Tr. at 133, 139.

C.F.R. §413.85(b) define approved educational activities to mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities include approved training programs for physicians, nurses, and certain allied health professionals. The Medicare program reimburses for both the direct and indirect costs of graduate medical education. Under §1886(h) of the Act and the implementing regulation at 42 C.F.R. §413.86, Medicare reimburses hospitals for the costs of direct graduate medical education. Under §1886(d)(5)(B) of the Act and the implementing regulation at 42 C.F.R. §412.105, Medicare reimburses hospitals for the costs of indirect medical education or IME.

Since July 1, 1987, the Social Security Act has permitted hospitals to count the time residents spend training in sites that are not part of the hospital, (non-hospital sites), for purposes of direct graduate medical education.[7] Section 1886(h)(4)(E) of the Act states that the Secretary's rules concerning computation of FTE residents for purposes of DGME payments shall:

> [P]rovide 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*. (Emphasis added.)

The regulation governing payment for GME at 42 C.F.R. §413.86(b)(1999) similarly states:

> For purposes of this section the following definitions apply:
> ….
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> *All or substantially all of the costs for the training program in the non-hospital setting* means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the costs of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.

Further, the regulation explains at 42 C.F.R. §413.86(f)(3) that:

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[7] Omnibus Budget Reconciliation Act of 1986 (Pub. L. No. 99-509).

> On or after July 1, 1987, and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in non-provider settings, such as freestanding clinics, nursing homes and physician offices in connection with *approved programs* is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:
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> (i) The resident spends his or her time in patient care activities.
> (ii) There is a written agreement between the hospital and the outside entity that states the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.[8]

In response to the payment of certain qualified non-hospital providers for GME, the regulation at C.F.R. §413.86(f)(4)(1999) was amended to specify that:

> For portions of cost reporting periods occurring on or after January 1, 1999,[and before October 1, 2004,][9] the time residents spend in non-provider 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:
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> (i) The resident spends his or her time in patient care activities.
> (ii) The written agreement between the hospital and the non-hospital site must indicate that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the non-hospital site and the hospital is providing reasonable compensation to

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[8] See also 62 Fed. Reg. 45966, 46007 (Aug. 29, 1997) (Section 413.86(f)(1) allows hospitals to include resident time in non-hospital sites when the hospital incurred all or substantially all of the costs. Under section 413.86(f)(1(iii)(B) we have defined "all or substantially all" to mean that the hospital has a written agreement with the non-hospital site that it will continue to pay the residents' salary for training in that setting ....)

[9] For periods after October 1, 2004, the regulation was amended to allow providers to count the FTE residents in the calculation without a written agreement if certain criteria were including that "all or substantially all" of the costs are paid by the hospital met. The regulation at 42 C.F.R. §413.86(f) was re-designated to 42 C.F.R. §413.78(d) (2007) and included at (d)(4) that the hospital is subject to the principles of community support and redistribution of costs as specified in section 413.81.

> the non-hospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the non-hospital site for supervisory teaching activities.
> (iii) The hospital must incur *all or substantially all of the costs for the training program in the non-hospital setting* in accordance with the definition in paragraph (b) of this section. [Emphasis added].

Prior to October 1, 1997, for IME payment purposes, hospitals were not permitted to count the time residents spent training in non-hospital settings. Section 4621(b)(2) of the Balanced Budget Act of 1997 revised §1886(d)(5)(B) of the Act to allow providers to count time residents spend training in non-hospital sites for IME purposes, effective for discharges occurring on or after October 1, 1997. Section 1886(d)(5)(B)(iv) of the Act was amended to provide that:

> [A]ll the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a non-hospital 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.(Emphasis added.)

The regulation, at 42 C.F.R. §412.105(f)(1)(ii)(C) (1999), was amended to read that:

> Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a non-hospital 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)*[10] are met. (Emphasis added.)

While the statute and regulation does not define "program," it does define "approved residency training program," which may reasonably be concluded to encompass the use of the term "program."[11] In particular, Section 1886 (h)(5)(A) explains that the term "approved medical residency training program means a residency or other post-graduate medical training participation in which may be counted towards certification in a specialty or sub-specialty, and includes formal post-graduate training programs in geriatric medicine approved by the Secretary." In addition, the

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[10] Re-designated at §413.78(c) and §413.78(d).

[11] Notably, §1886(h)(4)(E) refers to time so spent by a resident "under an approved residency training program shall be counted … if the hospital incurs all, or substantially all, of the costs <u>for the training program in that setting</u>." [Emphasis added].

regulation at 42 C.F.R §413.86(b) sets forth a similar definition of the term "approved residency program."

Notably, the definition of "all, or substantially all," of the costs for the training program was clarified pursuant to the FFY 1999 Inpatient Prospective Payment System (IPPS) final rule (July 31, 1998). The Secretary explained in the FFY 1999 IPPS final rule that:

> We proposed that, in order for a hospital to include residents' training time in a non-hospital setting, the hospital and the non-hospital site must have a written contract which indicates the hospital is assuming financial responsibility for, at a minimum, the cost of residents' salaries and fringe benefits (including travel and lodging expenses where applicable) and the costs for that portion of teaching physicians' salaries and fringe benefits related to the time spent in teaching and supervision of residents.
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> The contract must indicate that the hospital is assuming financial responsibility for these costs directly or that the hospital agrees to reimburse the non-hospital site for such costs.

One commenter objected to the changes on the basis that some arrangements between hospitals and non-hospital settings for the training of residents predated the GME base year. However, the Secretary explained that:

> [H]ospital and non-hospital sites will have 5 months following publication of this final rule to negotiate agreements that will allow hospitals to continue counting residents training in non-hospital sites for indirect and direct GME. These agreements are related solely to financial arrangements for training in non-hospital sites. We do not believe that the agreements regarding these financial transactions will necessitate changes in the placement and training of residents.[12]

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[12] 63 Fed. Reg. 40986, 40995 (July 31, 1998). One commenter asked whether hospitals would be eligible to receive payments in situations where the teaching faculty volunteers their services and neither the hospital or non-hospital entity incurs costs for supervisory teaching physicians, but the hospital incurs the costs of resident salaries and fringe benefits (including travel and lodging expenses where applicable). 63 Fed. Reg. 40996. The Secretary found that, for purposes of satisfying the requirement of a written agreement, the written agreement between a hospital and a non-hospital site may specify that there is no payment to the clinic for supervisory activities because the clinic does not have these costs.

The Secretary also stated, in response to a commenter who suggested that CMS should encourage "affiliations," that the revised definition of "all or substantially all" of the costs provides incentives for hospitals and non-hospital sites to reach agreement with regard to financial arrangements for training in non-hospital sites to avoid the situation where neither entity receives payment for GME.[13]

The Preamble to the FFY 2004 IPPS final rule published in the Federal Register on August 1, 2003 offered further explanation. The Secretary, in response to comments regarding the proposed rule, stated the following policy:

> [W]e believe that the statutory provisions cited above require hospitals to assume the cost of the full complement of residents training in the program at the non-hospital sites in order to count any FTE residents training at that site.

Subsequently, in the FFY 2008 IPPS rule, the Secretary addressed the existing policy in discussing the definition of "all or substantially all" costs and stated that:

> Global agreements with lump sum payment amounts, either for teaching physician costs or for non-hospital training in general, have not been sufficient under existing policy and would not be sufficient under the finalized policy. Similarly, as under current policy, if two (or more) hospitals train residents in the same accredited program, and the residents rotate to the same non-hospital site(s), the hospitals cannot share the costs of that program at that non-hospital site (for example, by dividing the FTE residents they wish to count according to some predetermined methodology), as we do not believe this is consistent with the statutory requirement at section 1886(h)(4)(E) of the Act which states that the hospital incur "all, or substantially all, of the costs for the training program in that setting."[14] (Emphasis added.)

The record shows that the two hospitals each paid 50 percent of the residual costs related to the non-hospital setting (FPC) to the University of North Dakota School of Medicine.[15] In the instant case, the Administrator finds that neither Provider paid "all or substantially all" of the costs of the program, but rather, the Providers shared

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[13] 63 Fed. Reg. 40995.
[14] 72 Fed. Reg. 26870, 26968 (May 11, 2007).
[15] See Intermediary's Position Paper, Exhibit I-6.

the costs equally between them.[16] As the statute and regulations are written, the Administrator finds that where multiple hospitals share the costs, they fail to meet the specific statutory requirement. Thus, the Administrator finds that, since neither Provider paid for all or substantially all of the costs of the program, neither Provider has satisfied the condition for counting FTE residents training in the non-hospital setting, as specified by the plain and clear language of the statute.

In allowing the counting of the FTEs, the Board and the Provider both stated that the statute does not define the term "program." The Provider argued that the record shows that both Providers incurred all or substantially of the costs for the respective residents they requested to have included in their GME/IME count. Consequently, the Board found that the Providers, in paying the costs for their respective residents, complied with the statutory requirements for inclusion of the FTES in their respective IME/DGME counts.

The Administrator finds that the controlling statutory language at sections 1886(h)(4)(E) and 1886(d)(5(B)(iv) plainly refer to an "approved medical residency program" in the same paragraph that requires the hospital to "incur all or substantially all of the costs for the "training program in that setting." Consequently, the costs of the "training program in that setting" are the costs of the "approved

[16] The Administrator notes that, up to the time of the filing of position papers, the Intermediary maintained that the Providers did not meet the documentation requirement of a written agreement. The Intermediary stated in its position paper that the Providers "may" have met the documentation requirements through submissions made in its appeal. While that issue was not further addressed before the Board, the Administrator finds that the documents at P-7 do not, on their face, appear to set forth all the requirements of a written agreement of 42 CFR 413.86. The Statement of Agreement was dated 1995, prior to the cost years at issue, and was to June 30, 1997. It is only followed up with a letter from the Medical School to the Providers, dated July 23, 1997, recording that "[o]perating deficits will be covered by the hospital to the extent that they are incurred, consistent with the agreed upon goal and sound practices. This particular agreement will last three years." Neither document indicates the compensation the hospital is providing for resident/supervisory teaching activities and, on its face, is agreeing to incur the costs for operating deficits, not the costs incurred for the training program. See, e.g., State of Agreement at 2 ("The Consortium shall be fiscally responsible for the Program only to the level no greater than the per resident actual reimbursement from the Medicare or all payer pool"; "Program shall be responsible for the Program expenses as much as possible from the generation of Patient revenue, Grants & Contracts revenue, State Appropriations from [the medical school], and other revenue produced by Faculty, Residents or Staff. …")

medical residency program," a term that is defined in the statute and regulation. In this instance, the "approved medical residency program" at issue is the family practice residency program operated by the University of North Dakota Medical School in conjunction with the two Providers at the non-hospital setting. A medical school official testified in describing the residency program that:

> We [the medial school] operate a family residency program in Bismarck, North Dakota. That program trains 15 to 18 residents per year. It's a three-year program. We accept five to six students each year of the three year program. The University of North Dakota employs the facility, employs the staff, leases the clinic building and has administrative responsibilities for accreditation of the program and operations of the program. [17]
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> Family residency programs are required to have a clinic to model…how clinics work in real life for outpatient settings so we lease a faculty in the Bismarck community where our actual family practice residency program is housed so the family practice residency clinic is where our faculty have offices, our residents have offices, we have nurse lab tech, x-ray techs, all of the things that you would see in a regular family medicine clinic. [18]

Similarly, the Statement of Agreement explains that:

> Whereas the [School of Medicine] …is conducting a post-graduate M.D. program for Family Medicine in Bismarck North Dakota, therein referred to as the Program; and
> Whereas [the medical school] is conducting the Program for the express purposes of training family physicians needed for the practice of medicine and of maintaining and improving the quality of medical practice and care within the State of North Dakota…. [19]

In this case, by definition the "program" at issue in the case is the family practice residency program. Therefore, the hospital must have incurred all or substantially

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[17] Tr. at 38.

[18] Tr. at 41-42.

[19] Provider Exhibit P-7. The Medical School also had other various residency programs. For example, the medical school had a residency program in surgery in Fargo and Grand Forks, a residency program in psychiatry in Fargo, and an internal medicine program in Fargo. Tr. 76-77.

all of the costs of the family practice residency program in that non-hospital setting. The Administrator finds that it is redundant to require the statute to modify the word "program" with the word "entire" when it has already referred to "the training program." Moreover, the term "resident" is used in that part of the sentence referring to counting time spent in the setting, not in that part of the sentence referring to incurring "all, or substantially all, of the costs of the training program in that setting." Thus, the Administrator finds that, the Board's reading, where the Hospital can claim the FTE of a resident as long as it incurs all or substantially all of the costs of that resident training in that program in the non-hospital setting is a strained interpretation of the language of the statute. The Administrator finds the Secretary's policy is a reasonable interpretation of the plain language of the statute.

The Providers also argued that they met the criteria as applied by CMS as they each paid all or substantially all of the training program—that is, each Provider claims to have paid an amount equal to the total costs for all the residents salaries, etc.[20] With respect to the payments, the Medical School officer stated that:

> [T]he University of North Dakota actually pays all of the aggregate costs up front through the University of North Dakota financial system. We pay the faculty, we pay the staff, and we pay the residents stipend and benefits, the faculty supervision costs community faculty supervision costs. Other operating costs that occur within this residency program are all paid within the university accounting system. We then bill the hospitals 50 percent of those costs that are not paid for by other university sources, other university sources being patient revenues that we bill out from the faculty and residents that practice in the clinic and other medical school resources that we put in to help finance the program. The two hospitals are then billed for the difference in the costs versus what the university puts in and we bill them on a 50 percent basis.[21]

The Administrator notes that, neither the Statement of Agreement,[22] nor testimony, shows that one of the providers was responsible for all or substantially all of the costs of the residents and supervising costs of the physicians in that setting. Instead, the record shows that the Providers were contractually obligated to share in the

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[20] See, e.g., Provider Exhibits P-14, P-15.

[21] Tr. at 40. The medical school official further explained that: "Q. Part of the costs are reimbursed by billings …[?] A. Correct. Q. So it is not 100 percent borne by the two hospitals? A. No. There are portions of our costs that are paid for by our own patient billings. That is correct." Tr. at 76.

[22] Provider Exhibit P-7.

payment of any deficit in the operating funds of the family practice clinic. Arriving at that deficit amount required the totaling of all the costs of the clinic which included overhead, personnel costs, supplies, capital costs and other costs and offsetting those costs by the medical school revenue from the clinics, grants, and other sources. The amounts paid by the Providers were not identified or allocated for any particular item of the many costs that were included in the deficit. Thus, neither Provider can show that, under the agreement terms, or otherwise, they paid all, or substantially all, of the costs of the program.

The Administrator also disagrees with the Board's conclusion that the legislative history suggests that it is the costs of the resident claimed, not the costs of the program. The Providers reference certain legislative history in the house bill to support its contention that Congress intended to allow the counting of the residents under these circumstances. While the Administrator agrees that Congress intended to encourage training in this setting, it was not a carte blanche policy and, *inter alia*, the conference agreement settled upon more restrictive language which included the "all, or substantially all," language. H. R. Rept. No. 99-5300 at 312 (1986)(Conf. Rep.)

Therefore, the Administrator concludes that the requirement to incur the "all, or substantially all," of the costs of the program was not met by the Providers in this case.

DECISION

The Administrator reverses the decision of the Board in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: **4/25/08** **/s/**

Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services