CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Borgess Medical Center and Bronson Methodist Hospital **Provider** **vs.** **Blue Cross Blue Shield Association/ National Government Services, Inc.** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: Various** **Review of:** **PRRB Dec. No. 2011-D46** **Dated: September 27, 2011**

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 U.S.C. 1395oo(f)). Comments were received from CMS' Center for Medicare (CM) and the Intermediary on Issue No. 1, requesting that the Administrator reverse the Board's decision. Comments were also received from the Providers' on the Issue No. 1, requesting that the Board's decision be affirmed. Accordingly, this case is now before the Administrator for final administrative review.[1]

ISSUE

Issue No. 1 was whether the Intermediary's adjustment to the direct graduate medical education (GME) and indirect medical education (IME) counts for residents training at the

[1] The Board's decision included Issue No. 2 involving the calculation of the Providers' Supplemental Security Income (SSI) percentage for cost reporting period ending June 30, 2003. The Board remanded Issue No. 2, to the Intermediary for recalculation of the Providers' disproportionate share hospital (DSH) adjustment payments consistent with the terms of CMS Ruling 1498-R. The Administrator summarily affirms Issue No. 2 of the Board's decision.

Kalamazoo Center for Medical Studies/Michigan State University (KCMS) nonhospital site clinics was proper.

BOARD DECISION

The Board held that the Intermediary's adjustment, removing the time residents spent in a nonprovider setting from the full-time equivalent (FTE) count, was improper. In reaching this determination, the Board found that the Intermediary was barred from raising the issue of the written agreement requirement because the cost reports at issue were never reopened for that reason. The Board found that four of the seven cost reports in question were reopened because "the hospital did not incur all or substantially all of the cost of training in that setting." The Board also found that one of the seven costs reports in question was reopened "to incorporate adjustments to the prior and penultimate years resident FTE count for Direct and Indirect Medical Education payments." Finally with respect to the remaining cost reports in question, the Board found that the Master Affiliation Agreement (Agreement) together with the nonhospital site's financial statements satisfied the regulatory requirement for a written agreement.

With respect to the regulatory requirement of the provider incurring "all or substantially all of the costs of the program" the Board concluded that neither the statute, nor the regulations, clearly required the interpretation by CMS that a single hospital had to incur the entire cost of the training program in order for the hospital to claim the residents. The Board found that the policy stated in the preamble to the 2004 Inpatient Prospective Payment System (IPPS) final rule was not being applied as stated. The Board found that in practice, Intermediaries' were permitting hospitals to share in the costs of the training program. Therefore, since the record in this case showed that the Providers jointly and equally fully supported the costs of the medical education training program, the Providers have met the "all or substantially all" requirement.

COMMENTS

The CM submitted comments requesting that the Administrator review and reverse the Board's decision. With respect to the written agreement requirement, CM disagreed with the Board's determination that the Intermediary was barred from raising the issue of the written agreement for five of the seven cost reporting periods. CM argued that the regulatory written agreement requirement and the statutory "all or substantially all" requirement are inextricably intertwined in the regulations. CM contended that the Providers must meet all of the regulatory requirements for counting residents in a nonhospital setting to be determined to meet the § 1886(h)(4)(E) requirements regarding "all or substantially all" of the costs for the training program in that setting. Furthermore, the written agreement, as specified in the regulations, must include, among other things,

information that shows that the provider is incurring all or substantially all of the costs at the nonhospital site. The fact that the regulatory written agreement requirement was not specifically mentioned should not be a reason for barring the written agreement issue.

CM agreed with the Intermediary that the Providers failed to meet the written agreement requirements. CM contended that the Master Affiliation Agreement (Agreement) does not constitute an equivalent to the written agreement required by the regulations. The record shows that the Agreement was drawn up in 1973 and does not speak to the hospital/nonhospital sites. The Agreement only states, "the Providers agree to share jointly and equally in the responsibility of providing the corporation sufficient financing to carry out its purpose." It does not state that a hospital will pay all the costs at any specific nonhospital site.

In addition, CM disagreed with the Providers' contention that the Intermediary could not disallow the counting of residents because the Intermediary allowed the Providers to count those FTEs over a number of prior years. CM stated that it was unfortunate that the cost reporting error was not found and corrected sooner, but once the error was discovered, the Intermediary had a responsibility to correct the error.

Finally, the fact that the Providers are related parties has no bearing on the written agreement requirement. In the August 1, 2003 rule one commenter inquired whether the teaching hospital is required to pay for the teaching physician services related to the offsite rotations at the medical school clinic before the FTE residents participating in the rotation can be counted for purposes of IME or direct GME payment. CM stated that:

> Under the commenter's scenario, the hospital may be prohibited from counting the FTE residents… because of failure to incur "all or substantially all of the cost" under § 413.86(f)(4) if the hospital is not incurring the supervisory physician's salary attributable to direct GME.

The Intermediary commented requesting that the Administrator review and reverse the Board's decision with respect to Issue No. 1. The Intermediary contended that the Providers did not meet the regulatory requirements for claiming the FTE residents during off-site residency training.

The Providers commented requesting that the Administrator affirm the Board's decision. The Providers disagreed with CM's comments that the written agreement requirement and the "all or substantially all" requirement are "inextricably intertwined." The Providers contended that the written agreement and the "all or substantially all" requirements are separate and distinct requirements of the GME/IME requirements. The Providers' argued that the reference to one of the requirements does not constitute notice of reopening with respect to the other requirement. Moreover, during the cost reporting periods in dispute the

written agreement and the "all or substantially all" requirements were located in different subsections of the regulations. The Providers contended that, under these regulations a hospital could either have a written agreement in place or it could pay "all or substantially all" of the costs of the nonhospital site training program within three months following the month when the training occurred. Therefore, in light of the Intermediary's failure to notify the Providers that the written agreement issue would be addressed in the reopening, the Intermediary should be barred from raising this issue in the reopening and on appeal.

The Providers argued that the Board correctly determined that the Agreement between the Providers and the nonhospital site satisfied the written agreement requirement. The Providers' contended that the purpose of the written agreement requirement is to assure that providers claiming residents rotating to nonhospital sites pay for the cost of training, and to assure that such costs are not paid by an unrelated nonhospital site. In this case, the Agreement and the other documents clearly establish that all of the funding for the nonhospital site programs came from the Providers.

Finally, the Providers agreed with the Board's determination that, neither the statute, nor the regulations, requires that a single hospital pay for and claim all of the residents training at a particular nonhospital site location. For the cost reporting periods at issue the Providers contended that CMS has not provided clear guidance on the "all or substantially all" regulatory requirement. In this case, the record clearly established that the Providers paid the entire cost of the training program, including the training at nonhospital sites, pursuant to the MAA.

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 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 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 §412.105, Medicare reimburses hospital for the costs of indirect medical education or IME.

Since July 1, 1987, the Social Security Act has permitted hospital to count the time residents spend training in sites that are not part of the hospital, (non-hospital sites), for purposes of direct GME.[2] 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.)

In promulgating the provisions of section 188g(h)(4)(E) of the Act, the Secretary noted in the proposed rule, dated September 21, 1988, for the "Changes in Payment Policy for Direct Graduate Medical Education Costs" at 53 Fed. Reg. 36589: that "Section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509) enacted on October 21, 1986, added section 1886(h)(4)(E) of the Act to allow a hospital, for purposes of determining FTEs, to count the time residents spent in patient care activities outside the hospital setting if the hospital incurs all or substantially all of the training costs in the outside setting. This change is effective as of July 1, 1987. To implement…this legislative change…,we are proposing to add a new $13.86 that would deal with payment for GME costs…" Pursuant to the final rule for "Changes in Payment for Direct Graduate Medical Education Costs:" at 54 Fed. Reg. 40286 (Sept 29, 1989) the provision was promulgated at 42 CFR 413.86 and provided that:

> On or after July 1, 1987, the time residents spend in nonprovider 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.

As a result of additional changes to the program, Secretary re-evaluated the standard being applied and concluded that:

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

> Presently, under sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act, if a hospital incurs ‘‘all or substantially all’’ of the costs of training residents in the nonhospital site, then the hospital may include the resident in its indirect medical education (IME) and direct GME full-time equivalent count. Under §413.86(f)(1)(iii), currently a hospital incurs ‘‘all or substantially all’’ of the costs of training the resident in the nonhospital site if the hospital pays the residents’ salaries and fringe benefits. Based on our review of data in Medicare cost reports on the Hospital Cost Reporting Information System (HCRIS), we decided to reexamine the issue of what constitutes ‘‘all or substantially all’’ of the costs of training the resident. In our analysis, we determined that, on average, residents’ salaries and fringe benefits are less than half of the total amount of the direct costs of a hospital’s GME program. Therefore, we are proposing to revise the standard for incurring ‘‘all or substantially all’’ of the costs for the training program in the nonhospital setting.
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> We propose to redefine ‘‘all or substantially all’’ of the costs for the training program in the nonhospital setting to include at a minimum:
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> - the portion of costs of the teaching physicians’ salaries and fringe benefits that are related to the time spent in teaching and supervision of residents; and
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> - residents’ salaries and fringe benefits (including travel and lodging expenses where applicable).[3]

In response to commenters, the Secretary stated in the Final IPPS Rule for FFY 1999 Rates at 64 Fed. Reg. 40954., 40992 (July 31, 1998), that:

> Comment: Several commenters agreed that it is appropriate to provide GME payment to the entity that incurs ‘‘all or substantially all’’ of the costs whether it be the hospital or the qualified nonhospital provider. Many of these commenters, however, believe that ‘‘all or substantially all’’ of the costs should be limited to resident salaries and fringe benefits.
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> Response: We disagree. Section 1886(h)(4)(E) of the Act states that hospitals may include residents in their FTE counts for direct GME if the hospital incurs ‘‘all or substantially all of the costs of the training program in that setting.’’ Section 1886(d)(5)(B)(iv) of the Act allows hospitals to count residents for IME effective October 1, 1997 if the hospital ‘‘incurs all or

[3] 63 FR 25576, 25597 (May 8, 1998) (Proposed IPPS Rule for FFY 1999 Rates)

> substantially all of the costs for the training program in that setting.'' As we stated previously and in the preamble to the proposed rule (63 FR 25597), we reviewed data on resident costs from recent Medicare hospital cost reports and found that, on average, resident salaries and fringe benefits account for less than half of total direct GME costs. We believe that the revised policy, which requires hospitals to incur a higher percentage of total training costs in the nonhospital setting than are accounted for by resident compensation reflect a better measure of ''all or substantially all'' of the costs than current policy.

Moreover, the Secretary stated that:

> Payment to hospitals. A hospital may include a resident's training time in a nonhospital setting in its FTE counts for direct GME and for IME if the hospital incurs ''all or substantially all'' of the costs for training in the nonhospital setting. We proposed that, in order for a hospital to include residents' training time in a nonhospital setting, the hospital and the nonhospital 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 nonhospital site for such costs. The contract must also contain an acknowledgment on the part of the qualified nonhospital provider if the nonhospital site is an FQHC or RHC that, since the residents' time is being counted by the hospital, the nonhospital site must report GME costs on the Medicare cost report in a nonreimbursable GME costs center.[4]

In addition, the Secretary stated, in response commenters, that:

> Response: We do not believe that we are establishing a burdensome regulatory structure with tremendous documentation requirements. For hospitals seeking to count the time of residents training in the nonhospital site, we are requiring a written agreement between the hospital and the nonhospital site stating that the hospital will incur ''all or substantially all'' of the costs.

[4] 63 Fed. Reg. 40954, 40989 (July 31, 1998)

> The written agreement must indicate that the hospital is incurring the cost of the resident salaries and providing compensation for supervisory teaching physician costs. The agreement must also specify the amounts paid to the nonhospital site. These agreements and amounts paid by the hospital to the nonhospital site may be the product of negotiation between the hospital and nonhospital site. The hospital does not have to report the nonhospital site's GME costs. We anticipate that in the course of any negotiation between the hospital and nonhospital site, the nonhospital site may need to identify its training costs. However, this is a matter between the hospital and nonhospital.[5]

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

> [H]ospitals and nonhospital sites will have 5 months following publication of this final rule to negotiate agreements that will allow hospitals to continue counting residents training in nonhospital sites for indirect and direct GME. These agreements are related solely to financial arrangements for training in nonhospital sites. We do not believe that the agreements regarding these financial transactions will necessitate changes in the placement and training of residents.[6]

Regarding the allocation of the costs between the nonhospital provider and the hospital, the Secretary again made clear that the policy for a hospital to count the FTE in the nonhospital setting, the hospital must incur "all or substantially all" of the costs, and not that the hospital incur "all or substantially" all of its respectively allocated costs of the nonhospital site. The Secretary stated that:

> Comment: Several commenters were concerned that if neither the hospital or nonhospital site incurs ''all or substantially all'' of the costs, neither setting

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[5] 63 Fed. Reg. 40954, 40993 (July 31, 1998)

[6] 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 nonhospital 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 nonhospital site may specify that there is no payment to the clinic for supervisory activities because the clinic does not have these costs.

> would receive payment even though each entity incurs a portion of the training costs. One commenter suggested that there will be difficulty allocating costs under our proposed definition of ‘‘incurring costs’’ and stated that we should encourage affiliations and provide simpler and clearer guidance for institutions.
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> Response: Under this final rule, an entity must incur ‘‘all or substantially all’’ of the costs to receive payments for the time the resident spends in the nonhospital site. Since we do not conduct cost-finding to determine who bears ‘‘all or substantially all’’ of the graduate medical education costs, we are generally dependent on hospital and non-hospital provider agreements to determine who bears them. As stated earlier in this final rule as well as in the proposed rule, we do not believe it would be administratively feasible to apportion payments appropriate to the hospital and nonhospital site in situations where neither the hospital or nonhospital site agree on who incurs ‘‘all or substantially all’’ of the costs. We must also consider the statutory prohibition on double payments in these situations. Furthermore, although it may be appropriate to provide payment for GME costs where the nonhospital site incurs only a portion of the training costs, we do not believe it would be equitable to allow a nonhospital site to be paid where it was incurring only a portion of the costs but only allow payment to a hospital when it incurs ‘‘all or substantially all’’ of the costs.
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> In response to the commenter who suggested that we should encourage ‘‘affiliations,’’ we believe the revised definition of ‘‘all or substantially all’’ of the costs provides incentives for hospitals and nonhospital sites to reach agreement with regard to financial arrangements for training in nonhospital sites to avoid the situation where neither entity receives payment for GME.
> 63 Fed Reg 40954, 40995 (July 31, 1998)

Consistent with the preamble the regulation at 42 CFR 413.86(b) was modified to define:

> All or substantially all of the costs for the training program in the nonhospital setting means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.[7]

In addition, 42 CFR 413.86(f) was modified to state that:

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[7] 42 C.F.R. § 413.86(b)(3)(2000).

> (3) On or after July, 1, 1987 and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' 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 that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.[8]
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> (4) For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:
>
> > (i) The resident spends his or her time in patient care activities.
> > (ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

Finally, relevant to this case, the regulation at 42 CFR 413.86(f) had a technical changed made to it pursuant to the "Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2000 Rates" The proposed rule at 64 Fed. Reg. 24716, 24734 (May 7, 1999) explained that:

> 2. Hospital Payment for Resident Training in Nonhospital Settings
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> Under sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act, hospitals may

[8] See also 62 Fed. Reg. 45966, 46007 (Aug. 29,1997)(Section 413.86(f)(1) allows hospitals to include resident time in nonhospital 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 nonhospital site that it will continue to pay the residents' salary for training in that setting…)

> count residents working in nonhospital sites for indirect and direct medical education respectively if the hospital incurs ‘‘all or substantially all’’ of these education costs. The requirements for counting the time residents spend training in nonhospital settings are addressed at § 413.86(f)(4). Currently, the requirements for hospital payment under this provision are that the resident spend his or her time in patient care activities and that a written agreement exist between the hospital and the nonhospital site. This written agreement must indicate that the hospital will incur the cost of the residents' salaries and fringe benefits while the residents are training in the nonhospital site and that the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. In addition, the written agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.
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> Under the statute, the time residents spend at nonhospital sites may be counted ‘‘if the hospital incurs all, or substantially all, of the costs of the training program in that setting.’’ The existing regulations text, however, is framed in terms of the hospital having an agreement that it ‘‘will incur’’ the costs in the nonhospital setting. We are proposing to make a technical change to the regulations text by adding a new §413.86(f)(4)(iii), to clarify that in order to count residents at a nonhospital site, the hospital must actually incur all or substantially all of the costs for the training program, as defined in §413.86(b), in the nonhospital site. This definition of all or substantially all requires the hospital to incur the expenses of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME.

In response to comments, in the final IPPS Rule for FFY 2000 rates at 64 Fed Reg. 41490, 41518 (July 30, 1999), the Secretary explained that:

> Comment: Many commenters supported our technical change under the proposed § 413.86(f)(4)(iii), which provides that, in order to count residents training at a nonhospital site for purposes of direct and indirect GME payment, the hospital must actually incur all or substantially all of the costs for the training programs. However, we believe several commenters misunderstood our technical change. The commenters believed that the change was unnecessary because the existing regulations, which were issued in the July 31, 1998 final rule, provide adequate guidance for purposes of the hospital claiming direct and indirect GME for resident training in the nonhospital site.
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> Response: We proposed to make the technical change in § 413.86(f)(4)(iii) for two reasons. First, we stated in the preamble to the July 31, 1998 final rule

> that we are requiring the hospital to actually incur all or substantially all of the cost, but the regulation text only indicated that the hospital must have an agreement to incur the cost; that is, the regulation text did not include specific language requiring that the hospital actually incur the cost. Second, we defined the phrase ''all or substantially all'' in § 413.86(b) but inadvertently omitted using the phrase in the policy specified in § 413.86(f)(4).

Consequently, the regulation was thus clarified to state that:

> 4) 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 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. (Emphasis added).

Prior to October 1, 1997, for IME payment purposes, hospitals were not permitted to count the time residents spent training in nonhospital settings. Section 4621(b)(2) of the Balance Budget Act of 1997 revised § 1886(d)(5)(B) of the Act to allow providers to count time residents spend training in nonhospital 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 nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital

[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 met including that "all or substantially all" of the costs are paid by 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)(2001), was amended to read that:

> Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency program is counted towards the determination of full time equivalency *if the criteria set forth at 413.86(f)(4)*[10] are met.

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, § 1886(h)(5)(A) explains that the term "approved medical residency training program means a residency or other postgraduate medical training participation in which may be counted towards certification in a specialty or subspecialty, and includes formal post-graduate training programs in geriatric medicine approved by the Secretary." In addition, the regulation at 42 C.F.R. § 413.86(b) sets forth a similar definition of the term "approved residency program."

The Preamble to the FFY 2004 IPPS final rule published in the *Federal Register* on August, 1, 2003,[12] offered further explanation. The Secretary, in response to comments regarding the community support and redistribution principles, stated:

> [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 nonhospital sites in order to count any FTE residents training at that site. [68 Fed. Reg. 45346, 45450 (Aug. 1, 2003)].

Subsequently, in the FFY 2008 IPPS rule, the Secretary again 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 nonhospital training in general, have not been sufficient under existing policy and would not be sufficient under the finalized policy, if two (or more) hospitals train residents in the same accredited program, and the residents rotate to the same nonhospital site(s), the hospitals cannot share 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].

[12] 68 Fed. Reg. 45346 (Aug. 1, 2003).

> costs of that program at that nonhospital 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 requirements 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."[13](Emphasis added).

Finally, while the board found this language did not prohibit Providers in joint programs from sharing the cost of such training situations, the Administrator finds that such a reading was only possible after Congress revised the statutory language pursuant to the Patient Protection and Affordable Care Act.[14] The Patient Protection and Affordable Care Act at § 5504(a) and (b) revised the language so that beginning with July 1, 2010, hospitals could count a proportional share of the training time at nonhospital sites if more than one hospital incurred the residence training cost at that site.

The issue in this case is whether the Providers have complied with the statutory and regulatory requirements to claim their FTEs in a nonhospital setting. More specifically, the regulation requires that a provider incur "all or substantially all" of the costs of the training program at the nonhospital setting and that there be a written agreement between the Provider and the nonhospital setting.

Applying the relevant law and program policy to the foregoing facts, the Administrator initially finds that, the regulations at 42 C.F.R. § 405.1885 and §405.1887, controls reopening of determination or a decision. The regulation at 42 C.F.R. § 405.1885 (2000) provides that a determination of an intermediary may be reopened with respect to "findings on matters at issue in such determination by such intermediary." In addition, "any such request to reopen must be made within 3 years of the date of the notice of the intermediary…." Finally, 42 C.F.R. § 405.1887 provides all parties to any reopening shall be given written notice of the reopening," with a complete explanation of the basis for the revision or revisions." "The parties are allowed a reasonable amount of time in which to "present any additional evidence or argument in support of their position."

In this case, the notice of reopening stated that the Intermediary was reopening the cost report "to remove the rotations which occur at the Kalamazoo Center for Medical Studies/Michigan State University (KCMS) "[in accordance with 42 CFR 413.86(f)(4) as the hospital did not incur all or substantially all of the cost of the training in that setting."] The reopening notice was for purposes of making adjustments to the FTE count contained in the Notice of Program Reimbursement (NPR).[15] That is, the matter at issue was the FTE count related to the rotation

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[13] 72 Fed. Reg. 26870, 26968 (May 11, 2007).

[14] Pub. L. 111–148

[15] *See* Intermediary's Exhibit I-3.

at KCMS. Therefore, the Administrator finds that the Intermediary is not barred from raising the issue of the written agreement requirement. The Administrator finds that the two criteria frame the basis for the disallowance of the FTEs rotating at KCMS, the nonhospital site at issue in this case. The Administrator also agrees with CM that the Providers must meet all of the regulatory requirements for counting residents in a nonhospital setting to be determined to meet the § 1886(h)(4)(E) requirements regarding "all or substantially all" of the costs for the training program in that setting. The fact that the regulatory written agreement requirement was not specifically set forth as the reason for the disallowance of the FTEs does not bar the lack of a written agreement as a further basis for the adjustment.

Next, with respect to the written agreement requirement, the Administrator finds that for the cost years in dispute the Providers did not have written agreements with the nonhospital setting as required under 42 C.F.R. § 413.86(f). First, the Agreement does not address resident training at the nonhospital setting, but only addresses training in the hospital itself. Further, the Agreement does not state that the hospital is incurring the cost of the resident's salary and fringe benefits while training at the nonhospital setting, and it does not speak to teaching physician's cost.[16]

The Administrator finds that the written agreement requirements described at § 413.86(f) should be executed by the Providers and the nonhospital setting, identify the off site location, specify that the hospital will incur the cost of the resident training at the off site location, and what that cost will be. The Agreement relied upon by the Providers in this case, does not include any of the required information.

The respective Providers, did not present a written agreement to show a contractual agreement between the Providers and the nonhospital setting to incur "all or substantially all" of the cost of the nonhospital setting. The record also shows that neither hospital could establish that in fact it incurred "all or substantially all" of the cost of the nonhospital setting.[17] There is no detail in the budget or financial statements as to how the funds are

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[16] *See* Providers' Exhibit P-25. Master Affiliation Agreement p. 3. ("As outlined in the Bylaws of Michigan State University Kalamazoo Center for Medical Studies, Section 1.04, Borgress Medical Center shares joint and equal responsibility for providing the corporation with sufficient financing to carry out its programs.") *See also* Master Affiliation Agreement p. 5. ("As outlined in the Bylaws of Michigan State University Kalamazoo Center for Medical Studies, Section 1.04, Borgress Medical Center shares joint and equal responsibility for providing the corporation with sufficient financing to carry out its programs.")

[17] *See* Intermediary's Exhibit 2. KCMS Bylaws Article 1 Section 1.04. Financing. ("The Hospital Members shall share joint and equal responsibility for providing the Corporation with sufficient financing to carry out its purposes as negotiated on a yearly basis.") *See also* Providers' Exhibit P-25. Master Affiliation Agreement p. 3. ("As outlined in the Bylaws of Michigan State University Kalamazoo Center for Medical Studies, Section 1.04, Bronson

allocated by program. The Providers themselves concede that they cannot document the cost of the offsite training by residency program.[18]

The Administrator finds that for the cost years involved, to meet the "all or substantially all" requirement, each provider must establish that it paid "all or substantially all" of the training cost for each particular residency training program, not that it paid "all or substantial all" of the costs of its portion shared with another provider. The applicable statute and regulations explicitly specify that "the hospital" must "incur[]" not some of the costs of the nonhospital portion of the training program, but rather "all, or substantially all, of the costs." The fact that these provisions refer to one, single hospital, as opposed to "the hospitals," "multiple hospitals," or to "one or more hospitals" indicates that Congress and the Secretary had in mind that one hospital would shoulder the full financial responsibility for the costs of training the residents in nonhospital sites within a program.

Furthermore, the regulations define the phrase "[a]ll or substantially all of the costs for the training program in the nonhospital setting" as "the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries fringe benefits attributable to direct graduate medical education." The fact that the definition refers to the salaries and fringe benefits of "the residents," without any qualifying or limiting language, suggest that it refers to the salaries and fringe benefits of all the residents training at the nonhospital sites in connection with a particular training program (not just to that subset of residents who are assigned to or associated with the claimant hospital). As such, the Administrator concludes that Providers did not meet the regulatory requirements for claiming the FTE residents during off-site residency training.

Finally, in their position paper, the Providers argued that KCMS is a related party to both Providers. As such, KCMS should be viewed as the alter ego of the Providers. All costs incurred by KCMS relating to the residency rotations at nonhospital sites should be deemed to be costs incurred by the Providers. Furthermore, the written agreement between the Providers and KCMS is equivalent to written agreements between the Providers and the nonhospital sites. The Providers also argued that after the Intermediary's audits and issuances of Notice of Program Reimbursement (NPR), they are entitled to rely on the Intermediary's approval of the nonhospital site rotations. Until 2007, the Intermediary

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Methodist Hospital shares joint and equal responsibility for providing the corporation with sufficient financing to carry out its programs."). *See also* Providers' Exhibit P-26, KCMS Financial Reports, note 7. These reports only outline the financial agreement between the Providers and the nonhospital site with respect to providing patient diagnosis and treatment on a contractual basis.

[18] *See, e.g.,* Transcript of Oral Hearing (Tr.) at p. 118.

allowed the FTE rotations to the nonhospital sites as claimed without requesting a written agreement or proof of costs pertaining to the FTE rotations.

The Administrator does not agree. First with respect to the related party issue, the fact that the Providers are related to KCMS has no bearing on the written agreement requirement. The Administrator finds that when the Secretary promulgated the written agreements requirement in 1998, the fact that providers where related had no bearing on the written agreement requirement. In response to one commenter's question in the final rule, the Secretary stated:

> With regard to the cost of related parties under § 413.17, our policy was not to include costs associated with training in nonhospital clinics in the per resident amount even though certain direct GME costs of related parties could have been allowable. We also do not believe that § 413.17 has applicability to our proposed policy. We are requiring a written agreement between hospitals and nonhospital sites for purposes of this final rule, even where the hospital and nonhospital site are related organizations under § 413.17.[19] (Emphasis added.)

Next with respect to the Providers' contention that the Intermediary cannot disallow counting residents because the Intermediary allowed the Providers to count those FTEs over a number of prior years. The Administrator finds the fact that the Intermediary allowed these cost as claimed in the past does not prohibit the Intermediary from correction of this error in the cost reporting periods in contention. Regardless of the prior approval, once the legal error was discovered, the Intermediary had a responsibility to correct the error as it did not have the authority to pay inconsistent with the regulation. When a Provider receives a windfall through an intermediary's error, it does not bind the agency to continue such a payment in the future.

Accordingly, as there is no written agreement between the Providers and the nonhospital setting indicating that the either of the respective Providers (Bronson Methodist Hospital or Brogess Medical Center) "will incur the cost of resident[s'] and fringe benefits while the resident[s] [are] training in the nonhospital site[s]" or that either of the respective providers (Bronson Methodist Hospital or Brogess Medical Center) are "providing reasonable compensation to the nonhospital site[s] for supervisory teaching activities" the Providers' cannot include the resident's time spent at the nonhospital setting in the Providers' FTE count. In addition to the Providers not being able to prove that they incurred all or substantially all of the cost of at the nonhospital setting the Providers' cannot include the resident's time spent at the nonhospital setting in the Providers' FTE count.

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[19] 63 Fed. Reg. 40,954, 40,996 (July 31, 1998).

DECISION

The Administrator reverses the decision of the Board with respect to Issue No. 1, in accordance with the foregoing opinion. The Administrator summarily affirms Issue No. 2.

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

Date: 11/22/11

/s/

Marilyn Tavenner
Principal Deputy Administrator and Chief Operating Office
Centers for Medicare & Medicaid Services