CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	
University of Louisville Hospital **Provider** **vs.** **BlueCross BlueShield Association/ National Government Services** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period ending: December 31, 1999** **Review of:** **PRRB Decision No. 2010-D51** **Dated: September 29, 2010**

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 § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. The CMS' Centers for Medicare (CM) and the Intermediary submitted comments requesting that the Administrator reverse the Board's decision. The Provider also commented, requesting that the decision be affirmed. Accordingly, the case is now before the Administrator for final administrative decision.

ISSUE AND BOARD DECISION

The issue was whether the Intermediary properly reduced the Provider's number of resident full-time equivalents (FTEs) used for purposes of Medicare direct graduate medical education (GME) and indirect graduate medical education (IME) payment based on its contention that the Provider did not meet the written agreement requirement for counting resident time spent in nonprovider settings in 42 C.F.R. §§ 412.105 and 413.86.

The Board reversed the Intermediary's adjustment, holding that the Provider satisfied the written agreement requirement for counting resident time spent in a nonhospital setting in accordance with the regulatory provisions at 42 C.F.R. §§412.105 and 413.86. The Board stated that the appeal presents the issue of whether residents' time spent training at nonprovider sites can be excluded solely because the written agreement, which was made

effective to the beginning of the cost reporting period, was executed at the end of the cost reporting period for which resident time is claimed. Finding that the Provider met all of the statutory and regulatory requirements, the Board concluded that such time should not be excluded. The Board found that the plain language of the regulations regarding GME and IME is silent as to the issue of the timing of execution of the written agreement and does not prohibit retroactive written agreements. Furthermore, the Board found that the intent of the Secretary is to allow for retroactive agreements. The Board noted that when the Secretary first implemented the written agreement requirement in 1989 for purposes of GME only, the Secretary intended to permit retroactive written agreements, because the rule was made effective retroactively to residents' training on or after July 1, 1987. When the Secretary amended the regulations in 1998 and 1999, the purpose of the written agreement requirement was to ensure that the hospitals actually incurred all, or substantially all, of the costs of the programs in the nonhospital setting.

The Board reasoned that permitting the written agreements between hospitals and nonhospital sites to have retroactive effect to the beginning of a cost reporting period is consistent with interpretations of the regulations by the Secretary, including correspondence. The Board found that the position of the Intermediary is inconsistent with the Secretary's policy in related agreements situations; namely, as part of conditions of participation at 42 C.F.R. §489.13 where agreements can be made effective retroactively up to one year before execution. The Board stated that, where the Secretary requires a prospectively executed written agreement, the regulations have explicitly imposed this requirement, e.g., written agreements for affiliated Provider groups for purposes aggregating residency caps. The Board also distinguished its prior decisions on this issue, stating that, unlike its prior decisions, the only issue in this case is the timing of the execution of the written agreement. Finally, the Board concluded that Kentucky principles of contract law (where the Provider is located) specifically allows parties to a contract to agree to predate a contract and provides that such contract will have a binding effect.

SUMMARY OF COMMENTS

The CM commented, requesting reversal of Board's decision. The CM stated that the regulation at 42 C.F.R. §413.78(d)(2) (redesignated from 42 C.F.R. §412.105) requires, for cost reporting periods beginning on, or after, January 1, 1999, and before October 1, 2004, there be a written agreement among the hospital and nonhospital site stating that the hospital will incur the costs of the resident’s salary and fringe benefits while training at the nonhospital site. The phraseology “will incur” is utilized because the written agreement must be completed prior to the Provider incurring the costs of the resident's training at the nonhospital site. Notably, the signature for the written agreement is past the effective date provided for in the regulatory provision, i.e. January 1, 1999. The CM stated that the argument of the Provider that the Medicare statute does not require a written agreement is

irrelevant because the regulations implementing §1886(h)(4)(E) of the Act mandating a written agreement for purposes of counting resident time at nonhospital sites was in effect during the cost reporting period at issue. The CM stated that the written agreement was not signed by all parties until December 20, 1999.

Further, CM argued that there is no comparison between Medicare GME affiliation agreements and written agreements for the purpose of training at nonhospital sites. CM noted that GME affiliation agreements provide for a temporary cap transfer from one hospital to another, and since residency-training programs operate on a July through June training year, it is appropriate to specify that the written agreement for purposes of counting resident training time at nonhospital sites, which indicates where such training will be conducted, be submitted before the start of the training year. Conversely, in the case of written agreements allowing hospitals to count resident training time at nonhospital sites, the agreement to pay for the costs of the training at that particular site can occur at any point during the year.

Moreover, CM maintained that, when CMS implemented the written agreement requirement in 1989, the provision was made retroactively effective to training occurring on or after July 1, 1987. The retroactive implementation date is due to the nonhospital site provision that was included as part of the Omnibus Budget Reconciliation Act of 1986.[1] The CM concluded, stating that the adjustments of the Intermediary to exclude resident training time during Fiscal Year 1999 at the dental school were proper.

The Intermediary commented, requesting reversal of the Board's decision. The Intermediary argued that back-dating the agreement may have been binding between the parties to the argument, but CMS was not a party to the agreement. Thus, CMS' rights and obligations can only be driven by when the agreement came into existence.

The Provider commented, requesting affirmation of the Board's decision, relying on the reasoning set forth in its post-hearing brief

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Generally, direct Graduate Medical Education (GME) and Indirect Medical Education (IME) payments are intended to compensate teaching hospitals for the direct and indirect

[1] Pub. Law 99-509 (1986).

costs of interns and residents in graduate medical education programs. Both GME and IME payments depend, *inter alia*, on the number of residents. Congress has delegated broad authority to the Secretary to implement a policy on the count of full time equivalent (or FTE) residents for purposes of calculating direct GME and IME payments. In section 1886(d)(5)(B) of the Act, for IME payments the statute does not specify how FTE counts should be determined, and the plain language in the statute under section 1886 (h)(4) of the Act for direct GME, indicates that the Secretary "shall establish rules" for payment of direct GME consistent with the statute.[2]

Prior to the Omnibus Budget Reconciliation Act (OBRA) of 1987, the law did not permit the counting of residents' time in nonhospital settings. 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 (nonhospital sites) for purposes of graduate medical education (GME).[3] Section 1886(h)(4)(E) of the Act sets forth the Secretary's rules stating that:

> E) Counting time spent in outpatient settings.—Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

Congress, through this provision expanded the Secretary's authority to allow the counting of resident FTEs "without regard to the setting" which was not authorized prior to the statutory change. As the House Report 99-727 shows, this was done in response to the general concerns regarding resources for primary care training throughout the health care sector. The House Report stated that:

> Under current Medicare regulations a resident's time spent in ambulatory setting is counted towards the full-time equivalency only if the setting is organizationally part of the hospital where the resident training program is located. If the resident is assigned to a free-standing setting, such as a family practice center or clinic or a freestanding ambulatory surgery center, no Medicare payments are allowed for the time spent there. Since it is difficult to find sufficient other sources of funding for the costs of such training, assignments to these settings are discourage. It is the committee view that

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[2] Section 1886(h)(4)(A) of the Act states that "the Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time equivalent residents in an approved medical residency training program."

[3] Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509.

> training in these settings is desirable because of the growing trend to treat more patients out of the inpatient hospital setting and because of the encouragement it gives to primary care.
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> The Committee bill would change the current regulation by providing that all of the time that a resident spends in activities related to patient care is to be counted towards full time equivalency without regard to the settings in which the activities take place, so long as the hospital is incurring costs for that resident's training. Payments would continue to be made only to the hospital, they would not be made directly to the independent freestanding units. Such units would have a financial arrangement with the teaching hospital, under which the hospital incurs costs for such items as the resident's salary and stipends, the faculty supervisors or administrators of the residency program or other items that are represent included under direct medical education.
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> As discussed in the Committee Report on the structural changes made in COBRA (H. Rep. 99-265, Part 1 pp 66-73) primary care training programs have more difficulty obtaining resources than other programs, and they are more vulnerable to the cost-cutting measures currently being employed throughout the heath care sector. As a result, opportunities for primary care training might be curtailed for reasons having nothing to do with the training and career interest of residents or the relative scarcity or surplus of particular specialties and subspecialties. The two changes in the Committee bill are designated to reinforce and enhance the objectives of the changes made by COBRA.[4]

In doing so, Congress was reacting to the pressures placed on the costs for primary care resident programs, independent from the Medicare program and reflective of cost cutting measures "currently being employed throughout the health care sector." That is, while Congress saw the increasing importance of primary care programs, the competitive health care environment was correspondingly likely not to recognize or prioritize those emerging training needs. In addition, in allowing for the count of FTEs in the nonprovider setting for GME purposes, Congress expected that there would be "financial arrangements" between the hospital and the freestanding units, under which the hospital would incur the residents' training costs.

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 Balanced Budget Act (BBA) 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,

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[4] House Report No. 99-727 at 69-70 (1986).

effective for discharges occurring on or after October 1, 1997.[5] Section 1886(d)(5)(B) of the Act states that:

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

The Secretary promulgated these respective provisions at 42 C.F.R. §412.105 and 42 C.F.R. §413.86, now redesignated at 42 C.F.R. §413.78. The regulation at 42 C.F.R. §412.105(f)(2)(ii)(C) states 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 training program is counted towards the determination of full-time equivalency if the criteria set forth in §413.78(c) or §413.78(d) of this subchapter, as applicable, are met.

For the cost reporting period at issue, the regulation at 42 C.F.R. §413.78 (as noted, formerly designated at 42 C.F.R. §413.86) provides, in pertinent part, that:

> (d) For portions of cost reporting periods occurring on or after January 1, 1999, and before October 1, 2004, 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

[5] In addition, concurrent with the enactment of the BBA 1997 IME "nonhospital setting" provision, congressional deference to the Secretary was expressed in the conference agreement that accompanied Pub. L. 105-33, which established a cap on the number of allopathic and osteopathic residents a hospital may count, which stated that: "[T]he Conferees recognize that such limits raise complex issues, and provide for specific authority for the Secretary to promulgate regulations to address the implementation of this provision." (H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess., 821 (1997). Accordingly, the Secretary has concluded that: "[I]n the absence of statutory specificity on determining FTE counts and the declared Congressional delegation of authority to the Secretary on the subject are clear indications that Congress has given the Secretary broad discretion to promulgate reasonable regulations in order to implement the policy on the counting of residents for direct GME and IME payments." 68 Fed Reg. 45346, 45447 (August 1, 2003) (FFY 2004 IPPS final rule).

> number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—
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> (1) The resident spends his or her time in patient care activities.
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> (2) 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.
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> (3) 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 §413.75(b).
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> (4) The hospital is subject to the principles of community support and redistribution of costs as specified in §413.81.(Emphasis added.)[6]

The implementing regulations require that, in addition to incurring all or substantially all of the costs of the program at the nonhospital setting, there must be a written agreement between the hospital and the nonhospital site. Notably in clarifying the definition of "all or substantially all" of the costs, pursuant to the Federal Fiscal year (FFY) 1999 final rule (July 31, 1998), the Secretary also responded to commenters concerned because of the terms of pre-existing agreements between hospitals and nonprovider settings not conforming to this requirement. The Secretary noted that:

> One commenter noted that some arrangements between hospitals and nonhospital settings for the training of residents predate the GME base year. This commenter stated that hospitals did not compensate nonhospital sites for supervisory teaching physician costs and it would not be fair to shift these costs to teaching hospitals. The commenter also stated that teaching hospitals have already entered into written agreements with nonhospital sites under the existing rules. According to the commenter, the proposed rule would necessitate renegotiation of thousands of agreements, imposing tremendous transaction costs upon the academic medical community. The commenter noted that if the agreements are not renegotiated prior to the effective date, the hospital will be unable to count the residents for direct

[6] Initially codified at 42 C.F.R. §413.86(f)(3) (effective July 1, 1987), and as later codified at 42 C.F.R. §413.86(f)(4) (redesignated as §413.78(d)), (effective January 1, 1999).

> and indirect GME, and this will have a lasting effect because of the 3 year averaging rules. Another commenter stated that there are many complex contractual arrangements between hospital based programs and nonhospital sites regarding the placement, training and patient service utilization of residents, and any change in Medicare GME payment policy could have significant and unknown impacts on these current training structures.
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> Response: The GME provisions of this final rule will be effective January 1, 1999. All other provisions of this final rule are effective October 1, 1998. By making a later effective date for the GME provisions, hospitals 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.[7]

Consequently, the Secretary contemplated that the hospitals would have the opportunity to negotiate and have in place by January 1, 1999, written agreements that met the necessary criteria for inclusion of the FTEs in the hospital residents counts.

The Administrator finds that the record demonstrates that the Provider's agreement was signed and fully executed on December 20, 1999. However, the Provider counted the time of dental residents and interns on the subject cost report from the period January 1, 1999 through December 31, 1999. In order to count the time that residents spend in a nonhospital setting, the Administrator finds that the Provider must demonstrate it incurred all or substantially all of the costs of its medical education program and have a contemporaneous written agreement in effect at the time the residents rotate through the clinics. Thus, the Intermediary properly limited the FTEs to the period December 20, 1999 through December 31, 1999 which was contemporaneous with the execution of the agreement. The Administrator concludes that the Provider did not meet the regulatory requirements to include the FTEs for purposes of its IME or GME adjustment for the period January 1, 1999, through December 19, 1999.[8]

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[7] 63 Fed. Reg. 40986, 400995 (July 31, 1998).

[8] The Provider argued, *inter alia*, that correspondence from the Administrator De Parle supports its contention that, for a written agreement to be in effect, and hence be properly executed, it need not be in place before the training commences, i.e., at the beginning of the cost-reporting period. The letter on its face makes no such statement but rather states that the written agreement need not be sent to the Intermediary by the effective date but rather is to be maintained in the provider's records to support the claiming of the FTEs. In

The plain language of the regulation requires that the the written agreement between the hospital and the nonhospital site must state, inter alia, 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.[9] This prospective requirement that a written agreement be in place is also consistent with the Secretary's response to commenters, in the July 1999 final rule, that the agreement is to have been negotiated and put in place prior to the January 1, 1999 effective date of the clarifying regulatory change.[10] Finally, this requirement is also consistent with Medicare general record keeping principles as set forth at section 1815 of the Act[11] and 42 C.F.R. §§413.9 and 413.24. Contemporaneous verifiable documentation is a basic and a long-standing principle in Medicare law and a policy that is consistent with the Secretary's responsibilities to ensure the proper expenditure of Trust fund monies.

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addition, the Provider suggests that an OIG Report accepted the post-dated agreement, however, reviewing for the written agreement dates was not the subject of the audit, the cost years involved were 200-2002 and OIG makes 'recommendations.'

[9] The original 1989 implementation of the written agreement requirement was effective for training occurring on or after July 1, 1987, due to the nonhospital site provision effective date as included as part of the Omnibus Budget Reconciliation Act of 1986. The Secretary may also have reasonably presumed that certain providers already had agreements in place that would meet the requirements that pre-dated the enactment of OBRA 1987 or the nonhospital setting provision in the regulation. See, e.g, commenters statement at 63 Fed. Reg. 40986, 400995 ("some arrangements between hospitals and nonhospital settings for the training of residents predate the GME base year.") Regarding the aggregation of caps agreement deadline set forth in the regulation, the explicit execution date in the regulation for an agreement is because of the universal July 1-June 30 nature of training programs. In contrast no such universal date applies in this case.

[10] The Administrator also finds that State contract law is not controlling over Medicare payment rules.

[11] *See*, e.g., Section 1815(a) which states that: [N]o payment shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts dues such provider …."

DECISION

The Board's decision is reversed in accordance with the foregoing opinion.

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

Date: 11/30/10

/s/
Marilynn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services