CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Providence Sacred Heart Medical Center **Provider**	**Provider Cost Reimbursement Determination for Cost Year Ending: December 31, 2004, December 31, 2005 and December 31, 2006**
vs.	**Review of:**
Noridian Healthcare Solutions,LLC	**PRRB Dec. No. 2018-D28**
Medicare Contractor	**Dated: March 20, 2018**

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 mandated 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 Medicare Administrative Contractor (MAC) submitted comments, requesting that the Administrator uphold the Board's decision in this case. The Center for Medicare (CM) submitted comments, requesting that the Administrator uphold the Board's decision. The Provider commented, requesting that the Administrator reverse the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue was whether the MAC properly disallowed reimbursement for direct graduate medical education (GME) and indirect medical education (IME) costs in the non-hospital setting by reducing the Provider's full-time equivalent (FTE) resident counts to exclude resident time spent in the non-hospital settings.

The Board rejected the Provider's contention that, because it paid and claimed a proportional share of the costs of the Family Medicine and Internal Medicine programs, it incurred "all or substantially all" of the program costs. The Board referenced the controlling regulations for the cost year at issue at 42 C.F.R. §413.86 (now designated at 42 C.F.R. §413.78), which refer to "the hospital," i.e., a single hospital. The Board also

recognized that several courts have considered the issue of whether "all or substantially all" of the program costs means all of the costs or a share of the costs of training at the nonprovider setting and all concluded that a single hospital must incur "all or substantially all" of the costs to receive the Medicare reimbursement. The Board further determined that section 5504 of the Affordable Care Act (ACA) did not provide for a retroactive relief from this rule. As part of the August 22, 2014 *Federal Register*, CMS clarified that the changes made by §5504(a) and (b) only apply prospectively as of July 1, 2010 and do not apply to a hospital that had an appeal(s) pending as of March 23, 2010 regarding a direct GME or IME issue from a cost reporting period beginning prior to July 1, 2010. The Board further concluded that §5504 is not applicable to the appeals at issue because the appeals involve fiscal years which began prior to July 1, 2010. The Board concluded that the MAC properly reduced the Provider's direct GME and IME FTE resident counts to exclude FTE resident training time in nonhospital settings.

SUMMARY OF COMMENTS

The MAC commented, requesting that the Administrator uphold the Board's decision as the PRRB reached the correct conclusion and decision. The PRRB decision recognized that its decision in *Eastern Maine Medical Center*, PRRB Dec. No. 2014-D10 was inapposite to its decision here, but indicated that *Eastern Maine* was issued prior to CMS clarification. However, the Board's decision failed to mention the Administrator's decision and its reasoning in overturning *Eastern Maine*. Thus, the MAC requested that the Administrator affirm the Board decision consistent with the Administrator's decision and reasoning in *Eastern Maine.*

The Center for Medicare (CM) agreed with the Board's finding that the MAC properly reduced the Provider's FTE counts to exclude time spent in nonhospital settings. The CM stated that, as discussed in the August 22, 2014 *Federal Register*, the provisions of §5504(a) and (b) are prospective and are not to be applied prior to July 1, 2010, irrespective of whether a hospital may have had a jurisdictionally proper appeal pending as of March 23, 2010, on an IME or direct GME issue from a cost reporting period occurring prior to July 1, 2010 (79 Fed. Reg. 50119). Consequently, CM recommended that the Administrator uphold the Board's decision.

The Provider commented, requesting that the Administrator reverse the Board's decision. The Provider argued that the Board did not address certain arguments that were made and the Board incorrectly also relied on the District Court decision in *Borgess Med. Ctr. v. Sebelius*, rather than the D.C. Circuit Decision in that case. The Circuit Court did not adopt the portions of the lower court's decision on which the Board relied in its Decision. Rather, the Circuit Court did not confirm application of the "single hospital" concept relied upon by the Board.

The Provider also continued to strongly disagree with the arguments made by CMS to support its refusal to apply the provisions of §5504 of the Affordable Care Act, which permitted multiple hospitals to support the costs of the non-hospital teaching site and

specifically permitted the application of the §5504 provisions to jurisdictionally proper appeals pending as of the date of the enactment of the Affordable Care Act. The Provider's appeals were so pending and the Provider's costs of supporting the residency at non-hospital sites should have been allowed.

The Provider specified the additional arguments that the Board did not address in its decision as follows: The Board did not address the procedural issues involving the MAC's assertion of a new basis for reducing the Provider's direct GME FTE court for the first time in its Preliminary Position Papers. (See Page 2, Section LB. of the Post-Hearing Brief, including Footnote 1.) The Provider argued that the related parties' nature of the relationship between the Provider and the residency sponsor essentially made the Provider the entity bearing the costs of the non-hospital teaching site and therefore it met the necessary criteria of bearing all or substantially all of the costs. The Board also ignored the fact that the Provider was part of an affinity group sharing residents with other IEHSA hospitals, a sharing activity that CMS actively encouraged during the FYEs 2004-2006, the periods at issue in the decision. (See Page 6, Section V.A.l, Page 10 at Section V.A.3, and Page 14, Section V.A.6.) The Board did not address the multiple distinctions existing between the Provider's case and prior decisions referenced by the Board in its decision. (See Pages 13-14, Section V.A.6.

As to the court cases relied upon by the Board, the Provider noted the following: The D.C. Circuit in the *Borgess Med. Ctr. v Sibelius* case did not adopt that portion of the decision on which the Board relies relating to the "single hospital" notion. Rather, the Circuit Court relied upon the lack of an appropriate written agreement. (See Pages 13-14, Section V.A.6.) Accordingly, there is no D.C. Circuit decision adopting the "single hospital" concept as to non-hospital teaching sites.

There is also no mention of the *North Dakota GME/IME Group* cases, in which the District Court in *Medcenter One Health Systems,* 666 F. Supp. 2d 1043 (D.N.D. 2009). agreed with the Provider's position. That decision was reversed on other grounds by the Circuit Court in *Medcenter One Health Systems v. Leavitt,* 635 F.3d 348 (8'11 Cir. 2011). (See Pages 12-13 at Section V.A. 5.) The Provider is located in the Ninth Circuit and there is currently no Ninth Circuit Court of Appeals decision on the non-hospital teaching sites. Accordingly, the Provider requested that the Administrator reverse the Board and recognize the Provider's costs associated with the non-hospital teaching sites at issue in these appeals.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. The Administrator has reviewed the Board's decision. All comments timely submitted have been taken into consideration.

Since the inception of Medicare in 1965, the program has shared in the costs of educational activities incurred by participating providers. 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.[1] Under section 1886(h) of the Act and the implementing regulation at 42 CFR 413.86 (redesignated to 42 C.F.R. §413.75, et seq, Subpart F), Medicare reimburses hospitals for the costs of direct GME. 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 IME.

GME Payments

Effective July 1, 1987, the Social Security Act was amended to allow hospitals to count the time residents spend training in sites that are not part of the hospital (referred to as ''nonprovider'' or ''nonhospital sites'') for purposes of direct GME payments under certain conditions. Section 1886(h)(4)(A) of the Act)[2] provides 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.''

Section 1886(h)(4)(E) of the Act states that the Secretary's rules concerning computation of FTE residents for purposes of GME 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.)

Regulations implementing this provision were published in the September 29, 1989 final rule.[3] Relevant to the cost years in this case, the implementing regulation at 42 C.F.R. §413.86(f)(4) (2003) and later redesignated without substantive change to 42 C.F.R. §413.78(d) (2004)[4], states that:

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[1] See e.g. section 1886(h)(5) of the Act.; 42 C.F.R. §413.85(b)

[2] Section 9314 of the Omnibus Budget Reconciliation Act of 1986 (OBRA '86) (Pub. Law 99–509).

[3] 54 Fed. Reg. 40,292. Effective for cost reporting periods 2003 and 2004.

[4] In 2004, the regulation at 42 C.F.R. § 413.86(f)(4) was redesignated to 42 C.F.R. § 413.78(d). See 69 Fed. Reg. 48,916, 49,235, 29,258 (Aug. 11, 2004).

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

Paragraph (e) was added effective for portions of cost reporting periods occurring on or after October 1, 2004, and for cost reporting periods beginning before July 1, 2007, that included the same language of subparagraph (3) requiring that the hospital incur all or substantially all of the costs of the training program in the nonhospital site.[5]

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[5] 42 C.F.R. §413.78 (e): " For portions of cost reporting periods occurring on or after October 1, 2004, and for cost reporting periods beginning before July 1, 2007, 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:
(1) The resident spends his or her time in patient care activities, as defined in §413.75(b).
(2) The hospital must incur all or substantially all of the costs of the training program in a nonhospital setting(s) (in accordance with the definition under §413.75(b)).
(3) The hospital must comply with one of the following:
(i) The hospital must pay all or substantially all of the costs of the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the third month following the month in which the training in the nonhospital site occurred.
(ii) There is a written agreement between the hospital and the nonhospital site that states 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."

The phrase "all or substantially all" in 42 C.F.R. §413.86(f)(4), now designated as 42 C.F.R. § 413.75(b)(1) is defined as:

> All or substantially all of the costs for the training program in the nonhospital setting means— (1) Effective on or after January 1, 1999 and for cost reporting periods beginning before July 1, 2007, 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 (GME).[6]

The definition of "all or substantially all" of the costs was clarified pursuant to the Federal Fiscal Year (FFY) 1999 IPPS final rule (July 31, 1998). The Secretary explained that:

> 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. 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. (Emphasis added.)

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.

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[6] On May 11, 2007, after the cost years at issue in this case, the IPPS final rule (72 Fed. Reg. 26,949) explained the definition of ''all or substantially all" to mean at least 90 percent of the total costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of the teaching physician's salaries attributable to GME. With this definition, hospitals were not required to pay 100 percent of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the teaching physicians' costs attributable to GME at the nonprovider site. In addition, the May 11, 2007 rule modified the regulation text at § 413.78(f)(3)(ii) to specify the longstanding policy that the required written agreement between a hospital and a nonprovider site must be in place before residents begin training at the nonprovider site. That final rule also specified the information that must be included in the written agreement, and stated that the amounts specified in the written agreement may be modified by June 30 of the applicable academic year.

In again addressing the "all or substantially" requirement in the FFY 2004 IPPS rates, CMS explained that:

> Comment: Several commenters objected to the sentence in the preamble to the proposed rule that stated: "* * * a hospital is required to assume financial responsibility for the full complement of residents training in a nonhospital site in a particular program in order to count any FTE residents training there for purposes of IME." One commenter explained that there are a number of situations where a hospital is truly incurring the cost of having a resident at a site, but the hospital is not incurring the cost of the entire complement of residents. "For example, if two different hospital programs each elect to send residents to the same clinic, under the interpretation in the [proposed rule], neither of the two hospitals would be able to count any of the residents because neither of the two programs would incur the cost of the full complement of residents." Another commenter believed that "this change" runs contrary to other current Medicare policies that focus on the resident rather than the program. The commenter believed that both the direct GME and IME regulations "are replete with references to 'resident' rather than 'program'." The commenter believed that "residency program" is referenced only in the context of the requirement that, for residents to be counted for direct GME and IME payments, they must be part of an "approved program" (§ 413.86(f)(1)).
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> Response: We understand the concerns of the commenters about the requirement for a hospital to incur "all or substantially all of the cost" of training residents in a training program at a nonhospital site. However, we do not believe this is a change in policy. We believe that the policy that requires a hospital to incur the cost of "the program" in the nonhospital site has existed since the passage of the direct GME provisions, section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509), and the passage of the IME provision, section 4621(b)(2) of the Balanced Budget Act of 1997 (Pub. L. 105-33), that permitted hospitals to continue to count residents in nonhospital sites, for purposes of direct GME and IME payment, if the hospital incurred "all or substantially all of the cost" of residents training in the program. As we explained in the proposed rule, this policy is derived from the language of the IME and direct GME provisions of the statute on counting residents in nonhospital settings; both sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act state that the hospital must incur "all, or substantially all, of the costs for the training program in that setting." (Emphasis added.) Therefore, we believe a better reading of this language is that hospitals must incur all or substantially all

> of the cost for the full complement of residents in the training program at the nonhospital site. [7]

Finally, with respect to these provisions, the Secretary also addressed the effect of the related party rule as early as 1998 with respect to the written agreement requirement, stating that:

> With regard to the costs of related parties under §413.17, our policy was not to include costs associated with training in non-hospital 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 non-hospital sites even where the hospital and the non-hospital site are related organizations under §413.17. In practice, since we are requiring an agreement between hospitals and nonhospitals sites that are under common ownership or control the agreements are a formality. [8]

In addition, CMS further discussed the related party rule in the "Medicare Policy Clarifications on Graduate Medical Education Payments for Residents Training in Non-Hospital Settings" (April 2005), with respect to the cost incurred and the written agreement, stating that:

> Question 8) Must the hospital incur the teaching physician costs and have a written agreement with the nonhospital site if a) the nonhospital site is owned by the hospital, or b) the nonhospital site is owned by the same organization that owns the hospital?
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> Answer 8) In either scenario, the hospital *must incur the teaching physician costs,* and there must be a written agreement in place before the time the residents begin training in the nonhospital site ... *The hospital would need to demonstrate, under either ownership scenario, that it is paying all or substantially all of the costs of the training program by actually paying the nonhospital site through the hospital's accounts payable system.* (If the hospital and nonhospital site share a single accounting system, the hospital could demonstrate payment of the nonhospital site training program costs using journal entries that expense

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[7] *See*, 68 Fed. Reg. 45346, *45449-50 (Aug. 1, 2003)(Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates). The cost years in this case involve cost years ending December 31, 2004, 2005 and 2006. This language is explicitly recognized as not a change in policy. Moreover, it was published prior to the beginning of three of the four cost years involved.

[8] 63 Fed. Reg. 40986, 40996 (July 31, 1998)

> these costs in the hospital's GME cost center and credit the nonhospital site.)(Emphasis added.)

IME Payments

With respect to the indirect medical education or IME adjustment, 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 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:

> 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 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.

In the July 31, 1998 final rule[9], at §412.105(f)(1)(ii)(C) (cross-referencing §413.78), CMS specified the requirements that a hospital must meet in order to include the time spent by residents training in a nonprovider site in its FTE count for purposes of IME payments. 42 C.F.R. §412.105(f)(1)(ii)(C) stated:

> (C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities, as defined in §413.75(b) of this subchapter, 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), (d), (e), or (f) of this subchapter, as applicable, are met.[10]

Therefore, for purposes of counting residents in nonhospital settings for the IME adjustment, 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."

Section 5504 of the Patient Protection and Affordable Care Act

Section 5504(a) of the Patient Protection and Affordable Care Act[11] or ACA amended §1886(h)(4)(E) of the Act to reduce the costs that hospitals must incur for residents training in nonprovider sites in order to count the FTE residents for purposes of Medicare

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[9] 63 Fed. Reg. 40,954, 41,005.
[10] See *infra* for regulatory text of 42 C.F.R. §413.78 for the relevant cost years.
[11] Pub. L. 111-148 (March 23, 2010).

direct GME payments on a prospective basis. Section 5504(a) addressed §1886(h) regarding GME payments and in subsection (3)(ii) provides that:

> [E]ffective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

Section 5504(b)(2) of the ACA made similar changes to § 1886(d)(5)(B)(iv) of the Act for IME payment purposes, with the provision being effective for discharges occurring on or after July 1, 2010, for IME:

> Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted towards the determination of full-time equivalency if a hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

Section 5504(c) specifies:

> APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).[12]

Notably, §5504(a)(1) and (b)(1) concurrently amended the existing provisions of §§ 1886(h)(4)(E) and 1886(d)(5)(B)(iv), respectively. The existing provision of §1886(h)(4)(E) was amended to state that:

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[12] This application provision was added as a note to 42 U.S.C. 1395ww.

> COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Subject to subparagraphs (J) and (K), such rules shall provide that only time spent in activities relating to patient care shall be counted and that—
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> (i) *effective for cost reporting periods beginning before July 1, 2010*, all the time 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.)

Further, the existing provision of §1886(d)(5)(B) was amended to state:

> (iv)(I) *Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010*, 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. (Emphasis added.)

In the November 24, 2010 final rule[13] with comment period, CMS revised the regulations at §412.105(f)(1)(ii)(E) for IME and §§ 413.78(f) and (g) for direct GME to reflect the prospective changes made by §5504 of the ACA. Section 413.78(g) implements the statutory amendments set forth in §§5504(a)(3) and (b)(2) of the Affordable Care Act. The introductory regulatory language of §413.78(g) explicitly states that paragraph (g) governs only ‘‘cost reporting periods beginning on or after July 1, 2010.’’ Paragraph (g)(5) of §413.78 also expressly states that the paragraph is limited to ‘‘cost reporting periods beginning on or after July 1, 2010.’’ The IME regulations at § 412.105 were revised to reflect the statutory amendments, by incorporating by reference §413.78(g). Moreover, no change was made to the controlling regulation for the cost reporting periods at issue here, set forth at 42 C.F.R. §413.78(d).

In the comments section of the final rule, CMS responded to comments regarding the effective date:

> Another commenter claimed that the application provisions of section 5504(c) clearly apply the provisions of sections 5504(a) and (b) to cost reporting periods occurring before July 1, 2011 [sic]. The commenter asserted that because section 5504(c) expressly states that the provisions of this section ‘‘shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending’’ as of March 23, 2010, such nonprovider site

[13] 75 Fed. Reg. 71,800, 72,124-39.

> training time should be allowed for those cost reports, even though the provisions of sections 5504(a) are only effective as of July 1, 2010.

CMS pointed out that:

> The effective date of the provisions of section 5504 is clearly July 1, 2010. This date is unambiguously stated in the plain text of section 5504(a), which states that it is ''effective for cost reporting periods beginning on or after July 1, 2010.'' Similarly, section 5504(b) is ''effective for discharges occurring on or after July 1, 2010.'' Our discussion of section 5504(c) in the August 3, 2010 proposed rule (75 FR 46385) only intended to explain our interpretation of the phrase ''a jurisdictionally proper appeal pending'' in the context of the plain language of the statute. However, we are clarifying in this final rule that, as noted above, and unlike some other provisions of the Affordable Care Act, *section 5504 is fully prospective, with an explicit effective date of July 1, 2010*, for the new standards it creates. Nothing in section 5504(c) overrides that effective date. Section 5504(c) merely notes that the usual discretionary authority of Medicare contractors to reopen cost reports is not changed by the provisions of section 5504; it simply makes clear that Medicare contractors are not required by reason of section 5504 to reopen any settled cost report as to which a provider does not have a jurisdictionally proper appeal pending. It does not require reopening in any circumstance; and the new substantive standard is, in any event, explicitly prospective. We believe if Congress had wanted to require such action or to apply the new standards to cost years or discharges prior to July 1, 2010, it would have done so in far more explicit terms. (Emphasis added.)

Thus, §413.78(g) is applicable only to cost reporting periods beginning on or after July l, 2010. Earlier cost reporting periods are governed by the preceding paragraphs of § 413.78.

Despite the clear effective dates, with respect to the applicability of §5504(c) of the ACA and §413.78(g)(6) of the regulations to periods prior to July 1, 2010, in the May 15, 2014 proposed rule[14], CMS noted:[15]

> Upon revisiting the existing regulation text, we determined that § 413.78(g)(6) was not written in a manner that is as consistent with section 5504(c) of the Affordable Care Act and reflective of our reading of that provision and our policy as it could be…In this proposed rule, we are reiterating our existing interpretation of the statutory amendments made by sections 5504(a), (b), and (c) of the Affordable Care Act and also

[14] 79 Fed. Reg. 27,978.
[15] Id. at 28,153-54.

proposing to clarify the regulation text implementing these provisions by revising the language at § 413.78(g)(6) to read more consistently with the language in section 5504(c) of the Affordable Care Act and to ensure no further confusion with respect to the applicability of section 5504(c) of the Affordable Care Act and § 413.78(g)(6) of the regulations.

When we proposed to implement section 5504(c) in the August 3, 2010 proposed rule (75 FR 46385) and when we implemented section 5504(c) in the November 24, 2010 final rule with comment period (75 FR 72136), we had to consider what new meaning it was adding to sections 5504(a) and (b) of the Affordable Care Act because unlike, for example, section 5505 of the Affordable Care Act which has a effective date prior to enactment of the Affordable Care Act and, therefore, would apply to prior cost reporting periods, section 5504's applicable effective date for the new standards it creates was July 1, 2010, a date that came after enactment of the Affordable Care Act and was fully prospective…We continue to believe that Congress was clear in amending sections 1886(h)(4)(E) and 1886(d)(5)(B)(iv) of the Act to provide for new standards to be applied *only prospectively, effective for cost reporting periods beginning on or after, and discharges occurring on or after, July 1, 2010.* We also continue to believe that the plain meaning of section 5504(c) of the Affordable Care Act is that the Secretary is not required to reopen a cost report when there is no jurisdictionally proper appeal pending as of March 23 2010, the date of the enactment of the Affordable Care Act, on the issue of payment for IME and direct GME. Therefore, we believe that section 5504(c) of the Affordable Care Act is merely a confirmation of the Secretary's existing discretionary authority in one particular context, and that sections 5504(a) and (b) of the Affordable Care Act and their effective dates become all the more prominent, and are not affected by section 5504(c).

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[W]e continue to believe the language in paragraph (g)(6) (along with the remainder of paragraph (g)) only applies to cost reporting periods beginning on or after July 1, 2010 and does not apply retroactively to cost reporting periods beginning before July 1, 2010. We had intended that the language under § 413.78(g) do no more than simply paraphrase the language in section 5504(c) of the Affordable Care Act.

Accordingly, we believe that it is apparent that the provisions of sections 5504(a)(3) and (b)(2) of the Affordable Care Act are *not to be applied prior to July l, 2010, irrespectively of whether a hospital may have had a jurisdictionally proper appeal pending as of March 23, 2010, on an IME*

> *or direct GME issue from a cost reporting period occurring prior to July 1, 2010.* (Emphasis added.)[16]

In the August 22, 2014 *Federal Register*, (79 Fed. Reg. 50118) CMS again stated that the provisions of section 5504 were prospective and only apply to cost reporting periods beginning, and discharges occurring on or after July 1, 2010 (79 Fed. Reg. 50119):

Conclusions

The Provider argued that during the cost years at issue (FYs 2004, 2005, and 2006), the law allowed for reimbursement for training at nonhospital sites, including when the nonhospital site training costs were shared among two or more hospitals. The Provider stated that requiring a single hospital to incur "all or substantially all" of the costs discourages hospitals, especially rural hospitals, from training residents in nonhospital family practice settings, which is contrary to Congress' intent. The Provider noted the MAC allowed it to claim residents at the same nonhospital sites for the last decade and no changes in the statute or regulations support the MAC's new position that a disallowance is required. The Provider stated it properly documented that it incurred "all or substantially all" of the costs by claiming its proportional share of residents training at the nonhospital setting. The Provider argued that §5504(a) and (b) of the Affordable Care Act revoked the requirement that a single hospital must incur "all or substantially all" of the costs and that this change also applies to hospitals that had a jurisdictionally proper appeal pending March 23, 2010. The Provider stated that its appeal was a jurisdictionally proper appeal pending before the Board March 23, 2010 and therefore § 5504(a) and (b) should apply.

The Board on review disagreed with the Provider's contention that because it paid and claimed a proportional share of the costs of the Family Medicine and Internal Medicine programs that it incurred "all or substantially all" of the costs. The Board referenced the controlling regulations for the cost years at issue at 42 C.F.R. §413.86 (redesignated to §413.78), which refer to "the hospital," i.e. a single provider. The Board noted that several courts have considered the issue of whether "all or substantially all" of the costs means all of the costs or a share of the costs of training at the nonprovider setting and all concluded that a single hospital must incur "all or substantially all" of the costs to receive the Medicare reimbursement.

The Provider contended in its comments to the Administrator that the related party rules under 42 C.F.R. §413.17 means that the costs incurred by the related party are in fact incurred by the hospital and therefore, the hospital meets the requirement that it pay all or substantially all of the program costs. It also maintained that the Board did not address the fact that the Provider was a member of affiliation group which meant it shared

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[16] Consequently, §413.78(g)(6) was further clarified by repeating again in §413.78(g) that: "Cost reporting periods beginning before July 1, 2010 are not governed by paragraph (g) of this section."

residents and which was encouraged by CMS. The Provider distinguished the various cases already decided in the courts from the facts presented in this case, which the Board failed to do when it relied upon certain court cases. The Provider also continued to disagree with CMS' insistence that ACA was not retroactive and not applicable in this case.

In this case, Inland Empire Hospital Services Association (IEHSA) was a corporation established between the members, Empire Health Services and [Providence] Sacred Heart Medical Center (the Hospital) to provide "collaborative, community benefitting health care" including to promote and conduct and sponsor educational activities related to the Internal Medicine Residency Program and the Family Medicine residency program [17] The IEHSEA operated two clinical facilities, Family Medicine Spokane (FMS) and Internal Medicine Spokane (IMS), as part of its residency programs. The clinics were located on the Hospital's campus and were considered "nonhospital settings" as that term is used in 42 C.F.R. §413.78 (d) through (e).

The IEHSA employed and compensated all residents training in its residency programs, including those training at the Provider, as well as other provider and non-provider sites including the FMS and IMS facilities (the nonhospital settings). IEHSA compensated, either through employment or contractual arrangements, all of the physicians providing professional services, training, and supervision at the nonhospital clinics. IEHSA established an estimated budget and allocated the budgeted costs between the participating hospitals based on the projected number of residency rotations assigned to each hospital. The Provider's share of budgeted IEHSA costs for the Family Medicine program was approximately 60 percent for FYE 2004, FYE 2005, and FYE 20066. Two other hospitals, Deaconess Medical Center (DMC) and Valley Hospital and Medical Center incurred 34.2 percent and 5.3 percent, respectively, of the total Family Medicine program costs. The Provider's share of IEHSA's budgeted costs for the Internal Medicine program was approximately 50 percent for FYE 2004, FYE 2005, and FYE 2006, with DMC incurring the other 50 percent. IEHSA billed Sacred Heart monthly to cover the projected costs of the residents, teaching physicians, and other unfunded operating costs of IEHSA.[18]

The MAC disallowed the resident's time spent training in the non-hospital settings because the Provider did not incur "all or substantially all" of the costs of the Family Medicine and Internal Medicine residency training programs. The Hospital disagreed with this reduction to its GME and IME FTE residency counts.

All or Substantially All Requirement

The Administrator agrees with the Board's conclusions regarding the Provider's contention that, because it paid and claimed a proportional share of the Family Medicine

[17] Provider Exhibits 4 and 5.
[18] *See* Stipulations.

and Internal Medicine programs, it met the statutory requirement that of incurring all or substantially all of the costs. As the Board recognized, for GME/IME reimbursement purposes, section 1886 (h)(4)(E) and 1886(d)(5)(B)(iv) entitle a hospital to count the time its residents spend in patient care activities in non-hospital settings, if "the hospital" (singular) incurs all, or substantially all, of the costs for the training program in that [nonhospital] setting." During the fiscal years at issue, regulations located at 42 C.F.R. § 13.75 defined the term "all or substantially all of the costs for the training program in the nonhospital setting" to mean "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."

In this case, as the Board properly found that IEHSA paid the medical education costs incurred in connection with the Family Medicine and Internal Medicine programs *(i.e.*, the training programs) and that the Provider and the other hospitals were billed monthly an apportioned amount based on the number of its residents, for these program costs. The Board correctly found that this financial arrangement did not comply with Federal statute and regulation and therefore, that the Medicare Contractor's GME/IME adjustments for interns and residents rotating to non-hospital settings was proper.

In its comments to the Administrator, the Provider argued that the related party principle is applicable in this case and was not specifically addressed in the Board decision. The regulation at 42 C.F.R. §413.17 provides that the costs applicable to services, facilities, and supplies *furnished to the provider by organizations* related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. The Provider argued that the related party (IEHSA) incurred all or substantially all of the program costs and, under the related party rules, the Provider itself therefore has "incurred all or substantially all" of the costs.

The Administrator finds that the Board decision, while not specifically addressing 42 C.F.R. §413.17, in essence, found it was not applicable. More specifically however, the Administrator finds that the controlling regulation at issue does not provide an exception, pursuant to the related party rule, to the "all or substantially all" criteria.[19] The related

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[19] *Gozlon-Peretz v. United States*, 498 U. S. 395, 407 (1991). *Bloate v. United States*, 559 U.S. 196 (2010) ("[A] specific provision . . . controls ones of more general application.)" This is also consistent with the agency statements and prior Administrator decision in *Covenant* regarding the related party principle and the written agreement provision under 42 CFR 413.86, where the Provider argued that general rule of 42 CFR§ 413.17 allowed hospitals to claim reimbursement for "costs applicable to services, facilities, and supplies furnished" by a related party and nullifies he requirements of §413.86(f)(3) and (f)(4)(ii) for residency costs.) *See also* PM-98-44 addressing the related party rule with respect to the written agreement provision that related parties must have written agreements under §413.86(f)(3) and (f)(4)(ii); 63 Fed. Reg. 40, 954, 40, 996 (July 31, 1998). (As noted, in response to one commenter regarding the written agreement requirement in 1998, CMS stated that the final rule "requir[ed] a written agreement between hospitals and

party rules are generally used to determined allowable costs under the reasonable cost payment methodology of §1861 of the Act .which reimburses for Part A costs related to inpatient hospital care incurred by hospital and is used to prevent the payment of inflated purchased goods or services. due to the lack of an arms-length transaction [20] The purpose for the related party rule under reasonable cost rules[21] is separate from and not related to the objective of the IME and GME payments under §1886 of the Act

Even assuming, *arguendo*, the related party rule was relevant, the related party rules would not make allowable those costs that are otherwise not allowable costs. The nonhospital site costs incurred by the related party IEHSA attributable to the Provider are limited to the costs for the services, facilities, and supplies *furnished to the provider by the related organization* and not all of the costs incurred by the related party for the program (some of which were paid by other hospitals). Therefore, even applying this principle would not resolve the Provider's problem that it has not incurred all or substantially all of the *costs of the program*.

In addition, the Provider suggested the Board erred because it did not specifically address any distinctions between its case and the list of referenced court cases. The Provider also pointed out that there is no Ninth Circuit controlling law.[22] The Provider is located in the California and may file suit in the district court of the United States for the judicial

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nonhospital sites for purposes of this final rule, even where the hospital and nonhospital site are related organizations under §413.17.")

[20] Similarly, within the context of the related written agreement requirement, the Administrator stated in *Covenant Medical Center*, PRRB Dec No 2007-D55: "The Administrator finds that the related party rule, under reasonable costs, is to prevent inflated costs from being borne by the Medicare program. In the GME and IME context, a purpose of the written agreement is to show that the provider is financially responsible for paying the costs of the residents and supervising physicians. The related party rule does not ensure that the provider is in fact financially responsible to pay "all or substantially all" of the costs and, therefore, that the provider meets the statutory requirement. Rather, the related party rule is to ensure the payment of only reasonable costs by Medicare. Consequently, where the nonhospital setting involves a related party, the hospital is still required to have in place a written agreement with the nonhospital setting that meets the criteria of 42 CFR 412.86."

[21] This does not mean that the reasonable cost rules are not relevant to the payments made under §1886 of the Act. For example, CMS has discussed at length the relevance of the redistribution and community support rules prominent under the reasonable cost methodology to the IME and GME payments. *See e.g.*, Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates 68 Fed. Reg. 45346 (Aug. 1, 2003).

[22]Section 1878(f) states that: "[S]uch action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia…."

district in which the provider is located or in the District Court for the District of Columbia. However, there was no error on the part of the Board as there is no suggestion in the decision that the Board was treating the cited cases as binding and controlling case law for this Provider, but rather, the Board decision reasonably refers to them in the context of non-precedential guidance. This includes the Board's reference to the District Court decision in *Borgess Med. Ctr. v. Sebelius*. The D.C. Circuit Decision in that case did not overturn the District Court on the "all of substantially all", but rather decided it did need to reach the issue.

Further, the Provider stated that the Board ignored the fact that the Provider was part of an affiliation group sharing residents with other IEHSA Hospitals, a sharing activity CMS encouraged. The Hospital seems to be suggesting that the present of affinity agreements means that Hospitals were expected to share in a program with shared rotational arrangements. Under a Medicare GME affiliation agreement, hospitals form an aggregate cap, and individual hospitals' caps are adjusted within that aggregate cap. Thus, CMS determines if a hospital's FTE resident cap should be reduced on a hospital-specific basis. The fact the Medicare program allows for affiliation group "sharing of residents" and, under 42 C.F.R. §413.78(b), allows for partial FTEs to be claimed by multiple providers when the residents are rotating through a facility does not negate the specific language in the statute requiring a hospital to incur all or substantially all of the costs of the program in the *nonhospital* setting in order to count that FTE.[23]

Section 5504

The Administrator also finds that based on the statute and regulation, the Board was correct in determining that §5504(c) of the ACA does not allow for retroactive application of §§5504 (a)(3) and (b)(2). As such, the Board properly determined that the Intermediary correctly applied the law and regulations in effect. The Administrator determines that had Congress intended §5504 to be applied retroactively, it would have expressly stated this intent, as it did in other sections of the ACA.[24] Instead, in this case, Congress expressly prescribed that the statute is prospective for (a)(3) and (b)(2) for cost reporting periods (or discharges) beginning on or after July 1, 2010, and that the longstanding policy and rules continue to apply for cost reporting periods (and discharges) prior to July 1, 2010 under §§ 5504 (a)(1) and (b)(1) and §1886(d)(5)(E)(iv)(I) and §1886(h)(4)(E)(i). The statute states that for cost reporting periods before July 1, 2010 for GME and for discharges occurring after October 1, 1997 and before July 1, 2010 for IME, the residents' time in nonhospital setting went toward a

[23] The Provider also claimed that the MAC changed the basis for the disallowance in its preliminary position paper. The Administrator finds that the procedures in place requiring the sharing of preliminary position papers served its purpose of putting the parties on timely notice of the issues to be addressed.

[24] *See, e.g.*, Section 1556(c), ("The amendments made by this section shall apply with respect to claims filed under part B or C of the Black Lung Benefits Act…after January 1, 2005, that are pending on or after the date of enactment of this Act.") (Emphasis added.)

hospital's FTE count only "if the hospital incurs all, or substantially all, of the costs for the training program in that setting." "Effective for cost reporting period beginning on or after July 1, 2010" for GME and "for discharges occurring on or after July 1, 2010" for IME residents time in nonhospital settings[25] count towards a hospital's FTE count if the hospital simply "incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting." Congress expressly indicated in the statute the standards that are to be applied to the respective cost reporting periods and discharges.

Further, paragraph (c) established that, if there was no pending appeal concerning a final cost report when the ACA was enacted, that cost report will not be reopened. Notably, § 5504(c) *does not* establish *that if there was* a pending appeal concerning a final cost report when the ACA was enacted, *that the cost report must be reopened*; (*i.e.*, the ACA applied retroactively), contrary to the Provider's contention and the Board's findings.[26] As CM noted, nothing in §5504(c) overrides that effective date as §5504(c) merely recognizes that the usual discretionary authority of Medicare contractors to reopen cost reports is not changed by the provisions of §5504 and makes clear that Medicare contractors are not required by reason of §5504 to reopen any settled cost report as to which a provider does not have a jurisdictionally proper appeal pending. It does not require reopening under any circumstance as would be suggested by the Provider.

The Secretary has properly given effect to each part of the applicable statute in that time spent by residents in nonhospital settings for cost reporting periods commencing before July 1, 2010 would count towards a hospital's FTE count only if the hospital incurred all, or substantially all, of the costs for the training program. Time spent by residents in nonhospital settings for cost reporting periods commencing on or after July 1, 2010 would count if the hospital incurred all or substantially all of the costs of stipends and fringe benefits for the residents. Neither section would apply in a way that would require the reopening of a closed cost report for which there was not a pending appeal when the ACA was enacted.[27] Any other reading would nullify the standards set forth in §5504(a) and (b) with respect to §1886(h)(4)(E)(i) and (ii) and §1886(d)(5)(B)(iv)(I) and (II). In addition, the Secretary's regulation promulgated the same standard and language as the statutory provisions.

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[25] CMS recognized that §5504 of the ACA also changed the manner in which the Act refers to sites outside the hospital in which residents train as "nonprovider settings." 78 Fed. Reg. 50.495, 50,734 (Aug. 13, 2013). For purposes of the review for these cost years, the term "nonhospital" setting is used.

[26] This has been referred to as the fallacy known as "negating" or "denying the antecedent." *New England Power Generators Assn., Inc. v. FERC*, 707 F.3d 364, 370 (D.C. Cir. Feb. 15, 2013).

[27] In addition, as subsection (c) applies to the entirety of §§ 5504 (a) and (b), it does not require the Secretary to affirmatively reopen to confirm the correct application of the longstanding policy reaffirmed by Congress in its amendments to (a)(1) and (b)(1), although the Secretary has the discretion to do so under the regular reopening rules for this cost reporting periods prior to July 1, 2010.

DECISION

The Administrator affirms the decision of the Board in accordance with the foregoing opinion. The MAC's exclusion of the subject rotations from the Provider's Graduate Medical Education and Indirect Medical Education full time equivalent count was proper

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

Date: 5/22/2018

/s/
Demetrios Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services