PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D10

PROVIDER –
Eastern Maine Medical Center
Bangor, Maine

Provider No.: 20-0033

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
NHIC, Corp., c/o National Government
Services, Inc.

DATE OF HEARING -
December 13, 2012

Cost Reporting Periods Ended -
September 27, 2003 and September 25, 2004

CASE NOs.: 06-1337 and 07-1505

INDEX

ISSUE:

Whether the Medicare Administrative Contractor erred by excluding outside rotations from the Provider's Graduate Medical Education and Indirect Medical Education full time equivalent count?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services. The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to qualified individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare Administrative Contractors ("MACs"). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulations and interpretative guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant accounting period and the portion of those costs allocated to the Medicare program.[3] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement ("NPR").[4] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of the NPR.[5]

The Medicare program reimburses teaching hospitals for their share of costs associated with direct graduate medical education ("GME") and indirect medical education ("IME"). The calculation for reimbursement requires a determination of the total number of full time equivalent ("FTE") residents in the teaching programs. The Medicare statute entitles a hospital to count the time its residents spend in patient care activities in non-hospital settings on or after July 1, 1987 for purposes of calculating GME reimbursement stating as follows:

> 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

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[3] 42 C.F.R. § 413.20.
[4] 42 C.F.R. § 405.1803.
[5] 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

> are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.[6]

Likewise, for discharges occurring on or after October 1, 1997, the statute entitles a hospital to count the time its residents spend in patient care activities in non-hospital settings for IME reimbursement purposes:

> 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.[7]

CMS issued implementing regulations which required a hospital to have a written agreement with the non-hospital site documenting the hospital's assumption of all, or substantially all, of the training costs for the non-hospital site.[8] Specifically, these regulations specified the following:

> (4) For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonprovider settings . . . in connection with approved programs may be included in determining the number of FFTE residents in the calculation for 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 teaching activities.
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> (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.[9]

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[6] 42 U.S.C. § 1395ww(h)(4)(E) (2003).

[7] *Id.*

[8] 42 CFR § 413.86(f)(4) (2002). In 2004, CMS redesignated 42 C.F.R. § 413.86(f)(4) as redesignated as 42 CFR § 413.78(d) without changing the regulatory language. *See* 69 Fed. Reg. 48916, 49235, 49258 (Aug. 11, 2004).

[9] 42 C.F.R. § 413.86(f)(4) (2002).

These regulations further define "all or substantially all of the costs for the training program in the nonhospital setting" as:

> [T]he 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.[10]

The same requirements were also incorporated by reference in the IME regulations.[11]

Section 5504 of the Patient Protection and Affordable Care Act ("ACA")[12] amended 42 U.S.C. § 1395ww(h)(4)(E) to reduce the costs that hospitals must incur for residents training in nonhospital sites in order to count the FTE residents for purposes of Medicare GME payments. Specifically, § 5504(a) amended the statute to allow a hospital to count all the time that a resident trains in a nonhospital site so long as the hospital incurs costs of the residents' salaries and fringe benefits for the time that the resident spends training in the nonhospital site and removed the language requiring hospitals to have a written agreement with the non-hospital setting and the reference to compensation for supervisory teaching activities. Further, § 5504(b) made similar changes to 42 U.S.C. § 1395ww(d)(5)(iv) to apply these changes to IME reimbursement as well.[13]

Finally, ACA § 5505(a)(4) amended the statute to include the following documentation requirement:

> Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.

The provisions in ACA §§ 5505(a) and (b) were codified and specified therein that they were effective prospectively on or after July 1, 2010.[14] ACA § 5505(c) is an uncodified provision that addresses certain additional permissible and nonpermissable applications of ACA §§ 5505(a) and (b) as follows:

> (c) 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

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[10] 42 C.F.R. § 413.86(b) (2002).
[11] 42 C.F.R. § 412.105(f)(1)(ii)(C) (2003).
[12] ACA, Pub. L. 111-148, § 5505, 124 Stat. 119, 659-660 (Mar. 23, 2010). The Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub L. 111-152, 124 Stat. 1029 (Mar. 30, 2010) amended certain ACA provisions; however, HCERA is not relevant to this case as it did not amend ACA § 5505.
[13] 75 Fed. Reg. 46385 (Aug. 3, 2010).
[14] ACA § 5505(a) was effective for cost reporting periods on or after July 1, 2010 and ACA § 5505(b) was effective for discharges occurring on or after July 1, 2010.

> indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).[15]

On November 24, 2010, CMS issued a final rule to implement ACA § 5504(a) and (b) through regulations located at 42 C.F.R. §§ 413.78(g) and 412.105(f)(1)(ii)(E) respectively ("November 2010 Final Rule").[16] Similarly, the final rule promulgated 42 C.F.R. § 413.78(g)(6) to implement ACA § 5504(c) and this regulation states:

> The provisions of paragraph (g)(1)(ii), (g)(2), (g)(3), and (g)(5) of this section cannot be applied in a manner that would require the reopening of settled cost reports, *except* those cost reports on which there is a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.[17]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Eastern Maine Medical Center ("Provider") is a nonprofit, short-term, acute care hospital located in Bangor, Maine. The Provider's fiscal year ("FY") ends September 30th. During the time at issue, the Provider's designated intermediary was Associated Hospital Service of Maine ("AHS") and National Government Services, Inc. succeeded AHS as the Provider's designated MAC (collectively referred to as "Intermediary").

The Provider entered into written agreements with various physicians in which it was agreed that the physicians would voluntarily supervise residents without compensation from the Provider while the residents were engaged in patient care activities.[18] The agreements were effective from September 29, 2002 to September 27, 2003 which roughly coincides with the Provider's FY 2003 and September 28, 2003 to September 25, 2004 which roughly coincides with the Provider FY 2004.

The Intermediary audited the rotation schedules and agreements and disallowed 369 weekly rotations or 7.1 FTEs for FY 2003 and 144 weekly rotations or 2.77 FTEs for FY 2004. Based on additional documentation submitted by the Provider, the Intermediary revised these disallowances. In addition, the Provider conceded that an additional 6 weekly rotations or 0.12 FTEs for FY 2003 and 11 weekly rotations or 0.21 FTEs for FY 2004 should be removed from the subject appeal.[19] As a result of the Intermediary revisions and the Provider concessions, the remaining weekly rotations or FTEs at issue are 156.85 weekly rotations or 3.02 FTEs for FY2003 and 62.6 weekly rotations or 1.21 FTEs for FY 2004. The Intermediary disallowed the remaining FTEs based the lack of a written agreement as required by the statute, the agreement

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[15] ACA § 5504(c).
[16] 75 Fed. Reg. 71800, 72134 (Nov. 24, 2010) (excerpt included at Provider Exhibit P-11 at 59-72 (Case No. 07-1505)).
[17] (Emphasis added).
[18] Provider Exhibit P-7 (Case No. 06-1337); Provider Exhibit P-7 (Case No. 07-1505).
[19] Provider's Supplemental Position Paper at 11-12 (Case No. 07-1505).

failed to state the amount of compensation, or because the teaching physician volunteered his/her time supervising the residents.[20]

The Provider appealed the Intermediary's final determination, specifically regarding the GME and IME FTE counts, to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-1841.

The Provider was represented by William H. Stiles, Esq., of Verrill Dana, L.L.P. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's reduction of its resident FTEs to exclude time spent by the residents in non-provider settings is improper for several reasons. First, the Provider believes that the Intermediary improperly interpreted the regulation when it disallowed the resident rotations because the teaching physician volunteered his/her time rather than being compensated and by insisting that the physician had to sign the written agreement before the start of the rotations.[21] The Provider maintains that the Intermediary imposed CMS' requirements regarding written agreements and generally disallowing volunteer teaching physicians which were not adopted until after the cost reporting periods at issue in this case.[22]

In this regard, the Provider argues that § 9314 of the Omnibus Budget Reconciliation Act of 1986[23] and the implementing regulations[24] contemplated the inclusion of time spent in non-hospital settings if there was a written agreement between the hospital and outside entity that stated only that the resident compensation for non-hospital training time be paid by the hospital. CMS, the Provider argues, initially interpreted the statutory phrase as payment of the resident's compensation only and that the hospital was not required to pay the outside entity for the supervision of residents.[25] CMS later amended this regulation in response to statutory changes in IME payments in the Balanced Budget Act of 1997[26] which the allowed the hospital to include the time a resident spends in non-hospital settings on or after January 1, 1999 if the following requirements were met:

> (ii) The written agreement between the hospital and 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

[20] *Id.* at 4. *See also* Intermediary Supplemental Position Paper at 7, 10-11 (Case No. 07-1505).
[21] Provider's Supplemental Position Paper at 4 (Case No. 07-1505).
[22] Provider's Consolidated Post-Hearing Brief at 6.
[23] Pub. L. No. 99-509, 100 Stat. 1874, 2005 (1986).
[24] 42 C.F.R. § 413.86(f)(1)(iii)(1996).
[25] Provider's Supplemental Position Paper at 5 (Case No. 07-1505).
[26] Pub. L. No. 105-33, 111 Stat. 251 (1997).

nonhospital site for supervisory teaching activities.[27]

This amendment, the Provider argues, merely requires the hospital to state the amount of compensation to the supervising physician, not to require that the supervising physician actually be paid for his/her services. Further, even if this regulatory change did require compensation to the supervising physician, in practice CMS continued to allow physicians to volunteer their time. The Provider cites the preamble of the 1999 regulations and language in Program Memorandum A-98-44[28] which states in pertinent part:

> The hospital may count the resident for indirect and direct medical education in this situation if the written agreement indicates that the physician is voluntarily supervising residents and the nonhospital site does not incur graduate medical education costs.

The Provider maintains that it satisfied CMS' requirement regarding written agreements and that these agreements stated that the physicians were volunteering their time as required. The Provider further argues that the Medicare Prescription Drug, Improvement and Modernization Act[29] imposed a moratorium on the written agreement requirement. This law stated:

> During the one year period beginning on January 1, 2004, for purposes of [calculating the reimbursement owed hospitals for medical residents training in non-hospital settings], the Secretary shall allow all hospitals to count residents in ...family practice programs...without regard to the financial arrangement between the hospital and the teaching physician practicing in the non-hospital site to which the resident has been assigned.

This moratorium allowed the Provider to obtain reimbursement for outside rotations that would otherwise be disallowed for lack of a written agreement between the hospital and the non-hospital site for training that occurred in calendar year 2004 and before if the intermediary determined reimbursement for that training in 2004.[30]

Further, the Provider argues, the enactment of ACA § 5504 settles this dispute once and for all. The Provider argues that all disallowed rotations for both FYs 2003 and 2004 are allowable under ACA §§ 5504(a) and (b) which applies to GME and IME reimbursement, respectively. The Provider contends the ACA eliminated the requirement for written agreements and allowed GME and IME reimbursement if the Provider incurs "the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting."[31]
Although ACA §§ 5504 (a) and (b) are effective for cost reporting periods beginning on or after

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[27] 42 CFR 413.86(f)(4)(ii)(1999) (copy included as Provider Exhibit P-10 (Case No. 07-1505)).
[28] Copy included as Provider Exhibit P-12 (Case No. 07-1505).
[29] Pub. L. No. 108-173, § 713, 117 Stat. 2066, 2340-2341 (2003) (copy included as Intermediary Exhibit I-38 (Case No. 06-1337)). *See also* Medicare Learning Network Transmittal No. MM3071, "MMA-Changes to the FY 2004 Graduate Medical Education (GME) Payments as Required by the Medicare Modernization Act of 2003 (MMA), P.L. 108-173" at 2-3 (Mar. 12, 2004) (copy included as Intermediary Exhibit I-39).
[30] Provider's Supplemental Position Paper at 9-10 (Case No. 07-1505).
[31] Provider's Consolidated Post-Hearing Brief at 7.

July 1, 2010 and discharges on or after July 1, 2010, respectively, the Provider contends that § 5504(c) provides the following additional application of these provisions to pending appeals:

> 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 . . . [IME and GME costs].[32]

Provider maintains that it appealed the payment for the "Direct Costs of Graduate Medical Education ("GME") and Indirect Medical Education ("IME") (Adj #s10, 19, 31 and 50)" on March 24, 2006[33] and that it had a jurisdictionally proper appeal pending as of the date of enactment of the ACA.[34] The Provider argues that Congress would not have inserted a specific provision referencing a "jurisdictionally proper appeal pending as of the date of enactment of the Act" if it was not intended to apply to existing appeals at the time of the enactment.[35] While Congress set a prospective effective date of July 1, 2010, it also created a retroactive application for those providers who had a history of appealing the very issue in the subject appeals.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the remaining disallowed FTEs fall into four categories.

1. Written agreements were signed by the parties after the non-provider rotation started.
2. There was no written agreement at all.
3. Written agreements noted physician as volunteer but identified by Provider as salaried or compensation basis unknown.
4. Resident was away, 100% offsite, agreement was not signed, or teaching physician name was missing from rotation schedule.

The Intermediary asserts that the regulation requires that a written agreement be executed and, therefore, in existence for every day for which the Provider wishes to have the resident's time counted.[36] The regulation at 42 C.F.R. § 413.78(d) requires that the agreement be executed prior to the commencement of the rotations. The written agreement between the hospital and non-provider setting must state that the hospital "*will incur* the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site…"[37] The Intermediary maintains that the use of the word "will" is clear evidence that the agreement must be entered into prior to the commencement of the fiscal year in which residents will be rotated to non-provider settings or before the hospital may begin to count residents training at the non-hospital site.[38]

The Intermediary also relies on a federal court decision in *University Medical Center v.*

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[32] *Id.*
[33] *See* Provider Exhibit P-2 at 2 (Case No. 07-1505).
[34] Provider's Consolidated Post-Hearing Brief at 7.
[35] *Id.* at 8.
[36] Intermediary's Supplemental Position Paper at 6 (Case No. 07-1505).
[37] (Emphasis added.)
[38] Intermediary's Supplemental Position Paper at 5-6 (Case No. 07-1505).

Sebelius[39] in which the Court found that the Secretary's interpretation of the requirement that the written agreement be in place prior to start of rotations was "plausible" and must be given substantial deference.[40]

Regarding the voluntary nature of the supervising physician, the Intermediary argues that a number of written agreements failed to comply with the requirement set forth in the Program Memorandum A-98-44 for "volunteer" physicians. The Intermediary maintains that the statute requires a hospital to pay "all or substantially all" of the training costs in a non-hospital setting and that the regulations define "all or substantially all" of the costs to include not only all the residents' salaries and fringe benefits, but also, the portion of the costs of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.[41] In support, the Intermediary cites a June 13, 2003 CMS letter which states "the determination of the teaching physician GME costs is dependent upon the teaching physician's salary and percentage of time he/she devotes to activities related to the residency program at the non-hospital site" and provides an example which required proration of a salaried physician's time spent on teaching activities.[42]

Additionally, the Intermediary argues that the Provider's written agreements violate federal regulation if the agreement fails to specifically state the compensation paid for supervisory teaching activities. The Intermediary points to specific language in the Program Memorandum A-98-44 stating as follows:

> ...[F]ew unique situations where the nonhospital site has no supervisory costs and the physician is voluntarily participating in training. For instance, the resident may be training in a physicians' private office. In this situation, the physician may receive all compensation through fee for service arrangements. . . . If the physician agrees to participate in training without compensation, the written agreement must indicate that . . . .

The Intermediary contends that the ACA contains no retroactive provision to address the issue at hand and that CMS was very clear in the November 2010 Final Rule preamble through its response to commenters stating:

> *Response*: There appears to be a misreading of our interpretation of section 5504(c). 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), ... 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

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[39] 856 F. Supp. 2d 66 (D.D.C. 2012) (copy included at Intermediary Exhibit I-23 (Case No. 07-1505)).
[40] *Id.* at 83-84.
[41] Intermediary Supplementary Position Paper at 8 (Case No. 07-1505).
[42] *Id.* at 8-9; Intermediary Exhibit I-15 (Case No. 07-1505).

> 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.[43]

The Intermediary further argues that the doctrine of *Chevron* deference[44] applies and that the Board does not have the authority to decide what § 5504 means but it need only to decide that the agency's interpretation is reasonable. It is not for the Board to "second guess" the agency's interpretation.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law, regulations and program instructions, the evidence presented, and the parties' contentions, the Board finds and concludes that the Intermediary's determination of the Provider's GME and IME payments was improper. The Board finds the Intermediary's interpretation is inconsistent with the plain language and manifest intent of the GME and IME statute and implementing regulations.

At the outset, the Board notes that ACA § 5504 made certain changes to the statutory provisions for the Medicare reimbursement of GME and IME and that these statutory provision are at issue in this case. Accordingly, what the Board must address is whether ACA § 5504 and the statutory changes made therein apply to the case before the Board.

ACA §§ 5504(a) and (b) specify that the ACA changes to IME and GME reimbursement are effective for cost reporting periods or discharges, respectively, beginning on or after July 1, 2010 without retrospective application. However, § 5504(c) also authorizes application of these changes to "jurisdictionally proper pending appeals as of the date of enactment of this Act."

The Board also reviewed the preamble to the November 2010 Final Rule and finds that the implementing regulation, 42 C.F.R. § 413.78(g)(6), specifies that ACA §§ 5504(a) and (b) apply to "cost reports on which there is a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010."

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[43] 75 Fed. Reg. at 72136.

[44] *Chervon v. Natural Resources Defense Council,* 467 U.S. 837 (1984).

This finding is supported by the discussion in the preambles to the proposed rule published on August 3, 2010 ("August 2010 Proposed Rule")[45] and the November 2010 Final Rule and the regulation adopted in the November 2010 Final Rule. In the preamble to the August 2010 Proposed Rule, CMS includes the following discussion on how it interpreted and intended to apply ACA § 5504(c):

> Section 5504(c) of the Affordable Care Act specifies that the provisions of sections 5504(a) and (b) shall not be applied in a manner that would require the reopening of settled cost reports except where the provider has a jurisdictionally proper appeal pending on the issue of direct GME or IME payments as of March 23, 2010 (the date of the enactment of Pub. L. 111-148). We are proposing to interpret "pending, jurisdictionally proper appeal on direct GME or IME payments" to mean that *in order for a hospital to request a change to its FTE count, direct GME or IME respectively, the "pending, jurisdictionally proper appeal" must be specific to direct GME or IME respectively.* For example in order for a hospital to increase its FTE count with regard to an ACA provision that is unique to IME (such as inclusion of the IME count of didactic time occurring in the hospital as specified by new section 1886(d)(5)(B)(x)(II)), the hospital's "pending, jurisdictionally proper appeal" must be on an IME issue; IME FTEs or the available bed count. However, if the hospital's "pending, jurisdictionally proper appeal" is on an issue that only affects direct GME payments, such as the initial residency period or the Medicare patient load, that appeal would not be sufficient in order for the hospital to increase its FTE count with regard to an ACA provision that is unique to IME, such as didactic time in the hospital setting.[46]

The examples included in the proposed rule make it clear that CMS intended to apply ACA §§ 5504(a) and (b) to "pending, jurisdictionally proper appeals." The November 2010 Final Rule includes the following reference back to the August 2010 Proposed Rule:

> Section 5504(c) of the Affordable Care Act specifies that the amendments made by the provisions of sections 5504(a) and (b) shall not be applied in a manner that would require the reopening of settled cost reports, for which there is not a jurisdictionally proper appeal pending on the issue of direct GME or IME payments as of March 23, 2010 (the date of the enactment of Pub. L. 111–148). In the August 3, 2010 proposed rule (75 FR 46385), we proposed to interpret ''pending, jurisdictionally proper appeal on direct GME or IME payments'' to mean that in order for a

[45] 75 Fed. Reg. 46170 (Aug. 3, 2010).
[46] *Id.* at 46385 (emphasis added.)

> hospital to request a change to its FTE count, for direct GME or IME, the ''pending, jurisdictionally proper appeal'' must be specific to direct GME or IME, respectively.

While the proposed rule did not include a regulatory provision to implement the uncodified ACA § 5504(c), the November 2010 Final Rule did (namely 42 C.F.R. § 413.78(g)(6)) and the Board is bound by this regulatory provision. This regulatory provision clearly implements the above preamble discussions to allow a provider with a "pending, jurisdictionally proper appeal" specific to GME or IME as of March 23, 2010 to have ACA §§ 5504(a) and (b) applied to them (*i.e.*, subsection (a) for a pending GME issue and subsection (b) for a pending IME issue).

For both FYs 2003 and 2004, the Provider had GME and IME issues pending on appeal as of March 23, 2010.[47] Accordingly, ACA § 5504(c) and 42 C.F.R. § 413.78(g)(6) are applicable to this consolidated case.

The Board notes that, contrary to the Intermediary's assertion, the preamble language in the November 2010 Final Rule cited by the Intermediary[48] focuses on the application of § 5504 to unsettled cost reports (*i.e.*, cost reports for which no NPR had been issued as of March 23, 2010) and reopening of cost reports for which there was no appeal pending as of March 23, 2010. The case at hand involves neither of these scenarios and, accordingly, it is not applicable to this case. Notwithstanding, the Board notes that the following language in the cited preamble discussion ties it back to the discussion the August 2010 Proposed Rule:

> [I]t [i.e., ACA § 5504(c)] 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 jurisdictional proper appeal pending.*[49]

More importantly, the Board notes that the Intermediary's interpretation of the cited preamble discussion would conflict with and cannot be reconciled with the plain reading of 42 C.F.R. § 413.78(g)(6). As the Board is bound by regulations pursuant to 42 C.F.R. § 405.1867, the Board must reject the Intermediary's interpretation.

Accordingly, the Board finds that the Provider has satisfied the requirement in ACA § 5504(c) because, as of March 23, 2010, both of the subject appeals were pending before the Board and GME and IME payments were specific issues on appeal as required by the regulation. Indeed, the GME and IME payment issue before the Board is the very one addressed by the statutory changes to made by ACA §§ 5504(a) and (b). As a result of this finding, ACA §§ 5504(a) and (b) must be applied to this case.

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[47] By letter dated March 24, 2006, the Provider filed an appeal with the Board for FY 2003, and Issue 3 for that appeal involved GME and IME FTE issues. Similarly, by letter dated March 23, 2007, the Provider filed an appeal with the Board for FY 2004, and Issue 2 for that appeal involved GME and IME FTE issues. For example, the issue statement for both of these appeals included the following statement: "The Intermediary failed to include certain resident FTE's for GME and IME in the non-hospital setting as reimbursable FTE's."

[48] *See supra* note 43 and accompanying text. In order to put this preamble discussion in the proper context it is important to read the "Comment" preceding this "Response." *See* 75 Fed. Reg. at 72136.

[49] (Emphasis added.)

The Board next considered the effect of applying ACA §§ 5504(a) and (b) to the case before the Board. The plain language of ACA §§ 5504(a) and (b) no longer requires a written agreement and that the provider must only meet the requirement of payment of the resident's stipend and fringe benefits during the time spent at the non-provider setting. Accordingly, as the written agreement is no longer required under ACA §5504, the Intermediary's concerns about whether the Provider had a proper written agreement for each rotation at issue becomes moot and the Board orders the Intermediary to audit the rotations under appeal in these cases to determine if the requirements of the statute, including the provisions of ACA § 5504, and regulations have been met as to the remaining rotations at issue. It is the Provider's responsibility to supply adequate documentation to the Intermediary to complete its review. The Intermediary will make a determination of allowable rotations and revise the Provider's Medicare cost reports for FYs 2003 and 2004 accordingly.

DECISION AND ORDER:

The Intermediary is directed to audit the Provider's disallowed rotation schedules for FYs 2003 and 2004 by applying ACA §§ 5504(a) and (b) to its review. Once the Intermediary has completed its review, it will revise the Provider's number of resident full-time equivalents used for purposes of Medicare GME and IME for FYs 2003 and 2004.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: JUN 02 2014