PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D82

PROVIDER -
Stormont-Vail Regional Medical Center
Topeka, Kansas

Provider No. 17-0086

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Kansas

DATE OF HEARING-

Cost Reporting Period Ended -
September 30, 1987

CASE NO. 94-2577

INDEX

ISSUE:

Was the Intermediary's reopening of the Medicare cost report to reduce reimbursement for indirect medical education expense proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Provider is a not-for-profit acute care hospital located in Topeka, Kansas. On April 9, 1990, the Provider received a Notice of Amount of Program Reimbursement (NPR) for its fiscal year ended September 30, 1987.[1] On August 22, 1990, the Provider received a Notice of Reopening of Cost Report for the same cost report year.[2] The reason given by the Intermediary for the reopening was "Secretary of Health and Human Services determination-- Implementation of Medical Education Costs". The August 22, 1990, Notice of Reopening made no indication of a potential adjustment to indirect medical education (IME) payments. Subsequent correspondence from the Intermediary, as evidenced by letters dated August 25, 1992,[3] September 18, 1992,[4] April 5, 1993,[5] and June 22, 1993,[6] indicated that adjustments were being made to direct medical education (GME) payments in accordance with 42 C.F.R. § 413.86.

On July 26, 1993, the Provider received a "Notice of Correction--Medicare Program Reimbursement" for the September 30, 1987 cost report, adjusting indirect medical education payments in accordance with 42 C.F.R. § 413.86.[7] The explanation cited by the Intermediary was "Indirect Med. Ed. to adjust IME per GME revisions". The adjustment resulted in a $51,108 decrease in reimbursement to the Provider from the original Medicare cost report. The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. § 405.1835-.1841, and has met the jurisdictional requirements of those regulations. The Provider is represented by Mr. Larry W. Morris, Director of Corporate Third Party Reimbursement. The Intermediary is represented by Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

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1 Provider Exhibit II

2 Provider Exhibit III

3 Provider Exhibit IV

4 Provider Exhibit V

5 Provider Exhibit VI

6 Provider Exhibit VII

7 Provider Exhibit VIII

Relevant Medicare Regulatory Background:

The primary issue in this case focuses upon the applicability of the Medicare regulation for determining direct graduate medical education payments, 42 C.F.R. § 413.86, and its application
to adjustments made to the Provider's reimbursement for indirect medical education costs which are computed under 42 C.F.R. § 412.105. Background on both sections is provided to fully understand this appeal.

In April of 1986, Congress enacted the Comprehensive Omnibus Budget Reconciliation Act of 1986, Public Law No. 99-272 ("Act"). Among other changes, the Act converted direct graduate medical education reimbursement from a pass-through basis to a per-resident reimbursement indexed to a base year. The Secretary did not adopt regulations implementing the Act until September 1989. 42 C.F.R § 413.86(e)(1) then directed intermediaries to implement a new payment system for direct medical education expenses according to the 1986 amendments. Under the new system, a base year was selected and reaudited. Direct graduate medical costs in that base year were divided by the average number of full-time-equivalent residents working in all areas of the hospital complex, except for certain excluded parts. This calculation constitutes the per resident amount. An update of this rate is multiplied by the full-time equivalent number of interns and residents for subsequent periods to determine the amount of Medicare direct graduate medical education payments.

The payment methodology the Secretary has provided to determine payments for indirect medical education costs is codified at 42 C.F.R. § 412.105. Hospitals receive indirect medical education payments as determined by their individual intern and resident-to-bed ratios, which count is computed in accordance with 42 C.F.R. § 412.105. To figure the individual intern and resident-to-bed ratio, the number of full-time equivalent interns and residents enrolled in the hospital's educational programs must be determined. The determination of the number of full-time equivalent interns and residents for the cost reporting period under appeal in this case is determined by 42 C.F.R. § 412.105(f), which provides in part:

> [c]ount of residents for cost reporting periods beginning before July 1, 1991. For cost reporting periods beginning before July 1, 1991, in order to have the residents included in the count under paragraph (a)(1) of this section, the following requirements must be met:
>
> (1) The residents must be enrolled in a teaching program approved under 42 C.F.R. § 413.85 of this chapter. . .
>
> (2) The hospital must submit an annual report to its fiscal intermediary. The report must include the following information:

> (I) A listing, by specialty, of all residents assigned to the hospital and providing services to the hospital on September 1 of that year. If September 1 falls on a weekend or a Federal holiday, the next business day is used for purposes of the count of residents.

Id.

Once the resident-to-bed ratio is determined, that ratio and the empirically-based payment formula are used to determine the hospital's indirect medical education adjustment factor (or percentage of add-on). Finally, the adjusted basic price for the patient's case is multiplied by the indirect medical education adjustments factor to calculate the indirect medical education payment.

PROVIDER'S CONTENTIONS:

The Provider contends that the methodology in 42 C.F.R. § 412.105(f) is clearly different from the methodology in 42 C.F.R. § 413.86 to determine the number of intern and resident full-time equivalents; and nowhere in 42 C.F.R. § 412.105 is reference made to 42 C.F.R. § 413.86. Therefore, the Intermediary should have relied exclusively on 42 C.F.R. § 412.105, (which was not changed by the newly implemented regulation at 42 C.F.R. § 413.86), to compute payments for indirect medical education costs.

The Provider asserts that the Intermediary's application of HCFA Memorandum BPO-F12 is erroneous. The passage cited by the Intermediary states that intermediaries are to calculate the average per resident amount for each hospital where interns and residents are in approved GME programs for direct medical education payments. The Intermediary failed to acknowledge that both methods (GME and IME) for determining the counts of interns and residents require interns and residents to be working in an approved GME program. 42 C.F.R. § 413.86 and 42 C.F.R.
§ 412.105. The specific reference for indirect medical education is located at 42 C.F.R. § 412.105(f), which requires that "[t]he residents must be enrolled in a teaching program approved under 42 C.F.R. § 413.85." Id. The Intermediary's position that indirect medical education is inherently linked with the Provider's involvement with direct medical and indirect medical education costs is only correct in that both methods require interns and residents to be involved in a teaching program. Accordingly, the Provider contends the Intermediary cited an incorrect authority for its position.

The Provider cites Loma Linda Community Hospital v. Ætna Life Insurance Company, PRRB Dec. No. 93-D50, June 24, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,576, as a case wherein the Board found that the provisions of 42 C.F.R. § 412.118 (now § 412.105) articulate the specific instructions for determining the indirect medical education cost adjustment. In that case, the intermediary used the Medicare regulations at

42 C.F.R. § 412.118 (now 412.105), to compute the count of interns and residents. The Board held that the Intermediary used the correct regulation when calculating indirect medical education cost.

The Provider also contends that the August 22, 1990 Notice of Reopening received from the Intermediary does not meet the legal requirements for notices of reopening contained in Medicare Regulations, and the Provider Reimbursement Manual (HCFA Pub. 15-1) § 2932. Specifically, 42 C.F.R. § 405.1887, in relevant part, provides:

> (a) [a]ll parties to any reopening. . . shall be given written notice of the reopening. When such reopening results in any revision in the prior decision notice of said revision or revisions will be mailed to the parties with a complete explanation of the basis for revision....
>
> (b) In any. . . reopening, the parties to the prior decision shall be allowed a reasonable period of time in which to present any additional evidence or argument in support of their position.

Id.

In addition, HCFA Pub. 15-1 § 2932 provides, in pertinent part, as follows: " [t]he provider or other party will be advised in the notice as to the circumstances surrounding the reopening, i.e., why it was necessary to take such action, and the opportunity to comment, object, or submit evidence in rebuttal." Id.

The Provider contends that the August 22, 1990 Notice of Reopening failed to inform the Provider of the reasons why the cost report was being reopened. Further, the Provider was not given the opportunity to comment, object, or submit evidence in rebuttal. Thus, the Intermediary's actions do not comply with the applicable Medicare regulation or with HCFA Pub. 15-1 instructions.

The Provider also contends that one of the fundamental requirements of due process is that a notice must be given which is reasonably calculated to afford the parties their right to present objections. See Mullane v. Central Hanover Bank and Trust Company, 339 U.S. 306, 314 (1950). The notice must be " reasonably calculated to convey the required information" and it must take into account "the particularities and peculiarities of the case." Id. at 314-15. The explanation in the August 22, 1990, Reopening Notice did not convey the required information to apprise the Provider of its rights to object. Further, the Provider had no reasonable expectation that its September 30, 1987 cost report would be adjusted for indirect medical education expense as the Provider was informed by the Intermediary that the adjustment errors to the September 30, 1987 cost report for indirect medical education expenses would be corrected when it was reopened. Thus, the Provider contends that the requirements of due process set forth in Mullane have not been met. As a result, the Provider

contends the August 22, 1990 Notice of Reopening was invalid, which should negate the Intermediary's adjustments to indirect medical education costs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly adjusted the number of residents used in calculating the Provider's indirect medical education payment under the appropriate provisions of the applicable Medicare regulations, and the manual instructions set forth in HCFA Pub. 15-1.

The Intermediary contends that its reference to medical education in the NPR properly included indirect medical education. HCFA Memorandum BPO-F12 dated February 12, 1990, concerning the instructions implementing Program payments for graduate medical education states at page 4, item 2:

> [n]ext, intermediaries are to calculate the average per resident amount for each hospital where interns and residents in approved GME programs worked. This would include all hospitals that claimed GME costs or an adjustment for indirect medical education.

Id.

Also, the Federal Register dated September 29, 1989, page 40286 et seq. which includes discussions of both direct and indirect medical education indicates:

> our regulation specifies that hospitals with "indirect costs of medical education" will receive an additional payment amount under the prospective payment system. As used in section 1886(d)(5)(B) of the Act, "indirect costs of medical education" means those additional operating (that is, patient care) costs incurred by hospitals with graduate medical education programs.

Id.

The Intermediary contends that indirect medical education is inherently linked with the Provider's involvement with direct medical and indirect medical education costs, and it has routinely considered GME and IME adjustments at the same time with its providers. An IME payment is only made because of the Provider's involvement with medical education. In fact, 42 C.F.R.
§ 412.105 is entitled, "Special treatment: Hospitals that incur indirect costs for graduate medical education programs." In the instant case, the Intermediary found that its count for GME purposes under 42 C.F.R. § 413.86 was also applicable to the IME calculation under 42 C.F.R.

§ 412.105(f). That regulation states in part: "[b]ased on its review of a hospital's documentation concerning the hospital's count of interns and residents under this section, the intermediary may adjust the resident-to-bed ratio for purposes of the final indirect medical education payment." Id.

The Intermediary notes that, contrary to the Provider's argument, the number of residents used for the IME calculation was based on instructions set forth in 42 C.F.R. § 412.105 and HCFA Pub. 15-1, § 2405.3. In the Provider's situation, the count of residents is the same for both calculations, as it is based on the identical residents. Furthermore, the Provider did not offer alternative documentation to support a different number, under the provisions of 42 C.F.R.
§ 413.24(c).

The Intermediary further contends that the Provider's argument regarding an absence of due process (which would serve to negate the Intermediary's actions) is without merit. In the Administrator's decision in Grim-Smith Hospital and Clinic, Inc. v. Blue Cross and Blue Shield of Missouri, PRRB Dec. 93-D37, May 13, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,439, rev'd. HCFA Admin., July 9, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,670, the Intermediary's failure to include specific language addressing the particulars set forth in HCFA Pub. 15-1, but not specifically required under the reopening regulations at 42 C.F.R. §§ 405.1885-1887, did not amount to a due process violation. Thus, the Administrator found no purpose for remanding the case. As the Federal court explained in Edwards v. Sullivan, 937 F.2d 580, 586 (11th Cir.1991), "[f]inding a flaw in the notice, however, does not automatically require the case to be remanded. We must determine whether [the plaintiff] was prejudiced . . . . [Our concern] is whether the record reveals evidentiary gaps which result in unfairness or prejudice. . . ." Id.

The Intermediary contends, that in the case at hand, the Provider has not been restrained in any way from pursuing its administrative remedies, and has not suffered any harm in terms of its ability to develop its position fully on the record. It simply wants an additional payment based on a technicality that it perceives in the notice of reopening.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law- Title XVIII Social Security Act:

§ 1886(d)(5)(B)	-	Exceptions and Adjustments to PPS

2. Regulations - 42 C.F.R:

§ 405.1835-.1841	-	Board Jurisdiction

§ 405.1885-.1887	-	Reopening a Determination or Decision
§ 412.105 (Formerly § 412.118)	-	Special treatment: Hospitals that incur indirect costs for graduate medical education programs
§ 412.105(f)	-	Determining the total number of full time equivalent residents
§ 413.24(c)	-	Adequacy of cost information
§ 413.85	-	Cost of educational activities
§ 413.86	-	Direct graduate medical education payments
§ 413.86(e)(1)	-	Determining per resident amounts for the base period

3. Program Instructions- Provider Reimbursement Manual, Part 1, HCFA Pub. 15-1:

§ 2405.3	-	Adjustment for Indirect Cost of Medical Education
§ 2932.	-	Notice Related to Reopening and Correction

4. Case Law:

Loma Linda Community Hospital v. Ætna Life Insurance Company, PRRB Dec. 93-D50, June 24, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,576, aff'd in part and rev'd in part, HCFA Administrator September 15, 1995, Medicare and Medicaid Guide (CCH)
¶ 41,766.

Mullane v. Central Hanover Bank and Trust Company, 339 U.S. 306 (1950).

Grim-Smith Hospital and Clinic, Inc. v. Blue Cross and Blue Shield of Missouri, PRRB Dec. 93-D37, May 13, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,439, rev'd. HCFA Admin. July, 9, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,670.

Edwards v. Sullivan 937 F.2d 580 (11th Cir. 1991).

5. Other:

Comprehensive Budget Reconciliation Act of 1986. Public Law No. 99-272.

HCFA Memorandum BPO- F12.

Federal Register September 29, 1989, page 40286.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board finds that there are two key considerations which must be addressed to resolve the issue at hand. The first is whether the Intermediary reopening was proper. If proper, the Board must then determine if the Intermediary used the correct calculations in determining the number of residents used for the indirect medical education calculation.

With respect to the first issue, the Board finds that the Intermediary timely reopened the Provider's Medicare cost report, for the fiscal year ended September 30, 1987, to adjust the medical education costs for both direct and indirect medical education payments. The Board notes the reason given by the Intermediary in its notice of reopening was "Implementation of Medical Education Costs." This was subsequently followed by a revised NPR which indicated that the adjustment to indirect medical education resulted from GME revisions.

The evidence further reflects that the Intermediary relied on two valid sources to implement its Program payments. Specifically, the instructions in HCFA Memorandum BPO-F12 dated February 12, 1990, and the language in the Federal Register dated September 29, 1989, provide support for the Intermediary's position that indirect medical education is inherently linked with a provider's direct graduate medical education costs.

The Board also notes that 42 C.F.R. § 405.1887 provides that parties to a determination are to be allowed a "reasonable" amount of time to present any additional evidence or arguments in support of their position. In the instant case, no evidence was presented by the Provider to refute the Intermediary position that GME and IME payments are linked.

Regarding the second consideration, the Board finds evidence that the Intermediary did, in fact, use 42 C.F.R. § 412.105 and HCFA Pub. 15-1 § 2405.3 (the appropriate instructions) to determine the number of residents used for the IME calculation. The Board also notes that, in the case at hand, the count of residents turned out to be the same for both the GME and IME calculations. Again the Board finds that the Provider did not offer any alternative calculations or additional evidence, as allowed by 42 C.F.R § 405.1887, to refute the Intermediary's findings.

The Board rejects the Provider's argument that fundamental requirements of due process were not met, which would serve to render the reopening invalid. The Board is persuaded by the HCFA Administrator's decision in Grim-Smith. In that case, the Administrator noted that the Intermediary's failure to adhere to the strict notice requirements in HCFA Pub. 15-1 does not amount to a procedural violation which would warrant so severe a remedy as invalidating the Intermediary's adjustments. In the case at hand, the record indicates the Provider has had an opportunity to submit evidence, to present objections, and to raise pertinent legal arguments in connection with the reopening. Thus, the Board finds that the fundamental requirements of due process as set forth in Mullane have been met in this case.

DECISION AND ORDER:

The Intermediary's reopening of the Provider's Medicare cost report was timely and in accordance with Medicare regulations. The Intermediary adjustment to reduce Medicare reimbursement for indirect medical education costs is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: August 10, 1997

FOR THE BOARD:

Irvin W. Kues
Chairman