PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D33

PROVIDER –
Mayo Clinic Indirect Medical Ed.
Cost 86 Group

Provider Nos. - Various

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Noridian Government Services

DATE OF HEARING-
December 4, 2001

Cost Reporting Periods Ended - Various

CASE NO. 91-0550G

INDEX

ISSUE:

Was the Intermediary's adjustment to Indirect Medical Education costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Mary's Hospital and Rochester Methodist Hospital ("Providers") are acute care teaching facilities located in Rochester, Minnesota. During the subject cost reporting periods the Providers were reimbursed under Medicare's Prospective Payment System ("PPS") for inpatient hospital services. This means that for inpatient services the Providers were reimbursed based upon a standard rate per discharge for a patient's particular diagnosis or Diagnosis Related Group ("DRG") as opposed to being reimbursed based upon reasonable cost.

As with other hospitals reimbursed under PPS, the Providers received payments in addition to their DRGs. These payments were based upon "pass-through" items such as capital-related costs and graduate medical education (GME) expenses. Also, as teaching facilities, the Providers received additional program reimbursement for the indirect costs of their teaching programs designated as the adjustment for indirect medical education ("IME"), which is at issue in this case.

In general, the amount of program funds paid to a hospital for IME is determined according to a formula which first determines the ratio of interns and residents that worked at a facility to the number of its beds. This ratio is then applied to the federal portion[1] of the facility's DRG reimbursement to determine the IME amount.

With respect to the subject cost reporting periods, Blue Cross Blue Shield of Minnesota ("Intermediary")[2] effected adjustments to the federal portion of the Providers' DRG reimbursement for the purpose of determining the Providers' IME payments. Specifically, the Intermediary reduced the DRG amounts by payments made to the Mayo Clinic under an Amendment to the Social Security Act referred to herein as the 602(k) waiver. These adjustments served to reduce the Providers' IME reimbursement.

The Intermediary reflected the subject adjustments in a Notice of Program Reimbursement ("NPR") issued for each of the subject cost reporting periods. The Providers appealed the

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[1] Medicare's prospective payment system was implemented over a four year transition period. During this time DRG rates were comprised of two parts. One part, the "federal portion," was developed from a data base of historical cost and statistical data, and the other part, the "hospital specific portion," was developed from each hospital's own/individual operation.

[2] Noridian Government Services is the Providers' current Intermediary.

Intermediary's adjustments to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and met the jurisdictional requirements of those regulations. The amount of program funds in controversy is approximately $ 4,160,000.[3]

The Providers were represented by David M. Glaser, Esq., of Fredrikson & Byron, P.A. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

BACKGROUND

During the cost reporting periods at issue, fiscal years ended December 31, 1984 through June 30, 1986, the Providers were independent from the Mayo Clinic ("Clinic"). However, while the Providers furnished a full range of inpatient and outpatient services, they were principally tertiary care hospitals serving the Clinic. The Providers' medical staff consisted only of physicians who practiced at the Clinic and, in addition to physician services, the Clinic also provided certain ancillary services to the Providers' patients.

Prior to the implementation of PPS, Medicare reimbursed the Clinic directly under Medicare Part B for the ancillary services it furnished the Providers' inpatients. However, PPS required, in most cases, that ancillary services provided to inpatients be reimbursed under Medicare Part A as part of a provider's DRG reimbursement.

Under PPS, Medicare Part A reimbursement for the operating costs of all inpatient hospital services, as defined at 42 U.S.C. § 1395ww(a)(4) and including specifically the cost of ancillary services, is paid according to the DRG in which a Medicare patient is classified. Neither the actual cost of inpatient services nor the manner in which hospitals furnish them to Medicare beneficiaries is normally relevant to the amount of reimbursement under PPS, which expressly prohibits hospitals from "unbundling" inpatient services through agreements with outside suppliers who would bill Medicare for such services under Part B separately from the DRG payments to the hospital under Part A. 42 U.S.C. §§ 1395ww(d)(1), 1395y(a)(14), 1395cc(a)(1)(H). Pursuant to 42 U.S.C. § 1395y(a)(14) and 42 U.S.C. § 1395cc(a)(1)(H), frequently referred to as the "rebundling" provisions, hospitals may make arrangements for services with other organizations, but the hospital must pay for those services from its PPS payments; no separate billing of Medicare is permitted.
During the PPS transition period, however, certain eligible providers could obtain a waiver permitting continued separate billing for ancillary services under Medicare Part B. Specifically,

[3] See Appendix. Stipulation of Undisputed Facts at 15.

section 602(k) of the Social Security Amendments of 1983 ("602(k) waiver") states:

> [t]he Secretary of Health and Human Services may, for any cost reporting period beginning prior to October 1, 1986, waive the requirements of sections 1862(a)(14) [42 U.S.C. § 1395y(a)(14)] and 1866(a)(1)(H) [42 U.S.C. § 1395cc(a)(1)(H)] of the Social Security Act in the case of a hospital which has followed a practice, since prior to October 1, 1982, of allowing direct billing under part B of title XVIII of such Act for services (other than physicians' services) so extensively, that immediate compliance with those requirements would threaten the stability of patient care. Any such waiver shall provide that such billing may continue to be made under part B of such title but that the payments to such hospital under part A of such title shall be reduced by the amount of the billings for such services under part B of such title. If such a waiver is granted, at the end of the waiver period the Secretary may provide for such methods of payments under part A as is [sic] appropriate, given the organizational structure of the institution.
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> (2) In the case of a hospital which is receiving payments pursuant to a waiver under paragraph (1), payment of the adjustment for indirect costs of approved educational activities shall be made as if the hospital were receiving under part A of title XVIII of the Social Security Act all the payments which are made under part B of such title solely by reason of such waiver.
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> (3) Any waiver granted under paragraph (1) shall provide that, with respect to those items and services billed under part B of title XVIII of the Social Security Act solely by reason of such waiver--
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> (A) payment under such part shall be equal to 100 percent of the reasonable charge or other applicable payment base for the items and services; and
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> (B) the entity furnishing the items and services must agree to accept the amount paid pursuant to subparagraph (A) as the full charge for the items and services.

Social Security Amendments of 1983, § 602(k), Pub. L. 98-21, 97 Stat. 65, 165 (1983), as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), § 9112, Pub. L. 99-272, 100 Stat. 82, 163 (1986) (adding subsections (2) and (3))(emphasis added).

The Providers applied for and received the 602(k) waiver. As a result, from January 1, 1984 through December 31, 1986, the Clinic received direct payment under Medicare Part B for ancillary services furnished to the Providers' inpatients, and these Part B payments were deducted from the Providers' DRG payments under Part A as required by the 602(k) waiver.[4] The Providers and Intermediary submitted a joint Stipulation of Undisputed Facts. Within that document the parties agree that the issue in this case is the calculation of the Providers' IME

[4] Providers' Opening Brief at 2.

payments. Generally, the Providers argue that their IME calculation should result in the same payment amounts from Medicare that would be received by non-602(k) waiver hospitals for the same payment factors. The Intermediary generally argues that the Providers' IME calculations should reflect the full offset of the 602(k) waiver payments from their DRG amount.

PROVIDERS' CONTENTIONS:

The Providers contend that they are entitled to the same amount of IME reimbursement regardless of their status under the 602(k) waiver.[5] The Providers argue that the 602(k) waiver was never intended to penalize providers financially; rather, it was enacted to help certain providers who previously had "so extensively" billed under Part B that "immediate compliance" with the new PPS requirements of exclusive billing under Part A "would threaten the stability of patient care." Section 602(k) of Pub. L. 98-21. By granting a brief waiver period during which such providers could continue to submit bills under both Part A and Part B, the 602(k) waiver gave them some breathing room to make the transition to PPS. The waiver sought to ensure that no financial windfalls would result to anyone by requiring the Part A payments to be reduced by the amount of the Part B billings so that the two payments would add up to the same amount as the single Part A payment that would be made if no waiver had been granted.[6]

The Providers contend that refusing to treat IME the same as GME and capital-related costs is inequitable and contrary to the purpose of the 602(k) waiver.[7] The Providers explain that on August 24, 1984, the Centers for Medicare & Medicaid Services' ("CMS") (formerly the Health Care Financing Administration ("HCFA")) Chicago Regional Office ("RO") issued a letter regarding this matter.[8] This letter explains that under PPS, pass-through costs such as capital and GME continue to be reimbursed on a reasonable cost basis and, therefore, are not included in prospective payments. The letter goes on to recognize that for a 602(k) waiver hospital, "offsetting the total amount of the supplier's nonphysician charge against the

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5 Transcript ("Tr.") at 13.

6 Providers' Opening Brief at 10.

7 Providers' Opening Brief at 11.

8 Exhibit I-1. Tr. at 22.

prospective payment amount will result in an underpayment to the hospital, since a portion of the charge is related to capital and direct medical education." HCFA Letter, August 24, 1984. Accordingly, "in the interest of equity," the letter further explains that 602(k) waiver hospitals such as the Providers may reduce their Part B payment offset by capital and GME expenses. Id. at 2. The reduction in the Part B offset resulted in a corresponding increase in the Providers' Part A payment recovery, and thus enabled the Providers to recover the full amount of the pass-through costs as Congress intended. However, CMS refused to accord similar treatment to IME and would not permit the Providers to apply the IME adjustment factor to the full federal portion of their DRG payments, but instead required the Clinic's Part B payments to first be netted out. Id. at 3.

The Providers argue that excluding the federal portion of Part B payments made to the Clinic from the calculation of their IME reimbursement is inconsistent with the treatment afforded capital-related costs and GME expenses. The Providers assert that CMS acknowledged, with respect to these other categories of pass-through costs which are also excluded from inpatient operating costs and separately reimbursed to hospitals, that Part B payments made under the waiver should be reduced to reflect these costs before deducting these amounts from the Providers' PPS payments, to assure full reimbursement to the Providers. Because a portion of the Part B payments made to the Clinic under the waiver is related to capital and GME, offsetting the total amount of the Part B payments against the PPS amount will result in an underpayment to the Providers with respect to these other pass-through costs. Yet, no similar adjustment has been made for IME. CMS asserts that because the Providers' interns and residents are employed by the Clinic, the Providers do "not incur indirect medical education costs in the ancillary departments where the ancillary services are provided by the Clinic." Id.

The Providers maintain that under the rationale applicable to capital-related costs and GME, the amount of Part B payments made to the Clinic should be adjusted for IME costs, as well, before these amounts are offset against the Providers' PPS payments. CMS has declined to do this purportedly because of duplicate reimbursement for IME costs. However, no duplication would occur because the Providers' DRG payments are reduced by the Part B payments to the Clinic. The Part B payments to the Clinic do include a component for IME costs. However, since the Intermediary has based the Providers' IME payments on a reduced federal rate and made no adjustment for payment of the Clinic's IME component of the Part B offset, the accounting developed through audit does not properly match the services with the payments. In effect, the Intermediary has required the Providers to bear the cost of the Clinic's IME payments. This different treatment of IME costs has no rational basis. Pass-through costs, including both direct and indirect medical education costs, are reimbursed separately from PPS payments. As noted above, Part B payments made under the 602(k) waiver do not represent payment for pass-through costs but are made as payment for services that are covered as inpatient hospital services and are reimbursed as part of the DRG payments.

The Providers assert that the Intermediary is mistaken in its belief that they will be overpaid if

credited with the portion of the DRG that was paid directly to the Clinic.[9] The Providers explain that IME reimbursement is designed to compensate hospitals for the added costs incurred when services are provided by residents. House Report No. 98-25, Part 1, p. 140. The Intermediary acknowledges that this report indicates that the chief goal of IME is to reimburse hospitals for the costs of diagnostic tests ordered by residents as part of their training. Id. However, unless the Board rules for the Providers, the Providers will not receive any compensation for the costs of these services.

Specifically, a hospital that is not using the 602(k) waiver receives DRG payments. The hospital's IME payment is calculated by multiplying the DRG payments by a percentage determined through a formula. When a hospital elects the 602(k) waiver, the hospital's DRG payments are reduced, dollar for dollar, by the amount of money paid to the clinic under the 602(k) waiver. Therefore, every time a resident orders a test performed by a clinic the DRG payments to the hospital are reduced. Since IME is based on DRG payments, if the Intermediary's position prevails each test ordered by a resident would reduce the Providers' IME allowance. The Intermediary's position would create an incredible irony--each test ordered by a resident would reduce the very payment intended to compensate the Providers for operating a residency program.

Assume, for example, two hospitals performed $100,000 in diagnostic tests. The DRG payments to each hospital, before any adjustments for the 602(k) waiver, is $1 million. Assume also that both hospitals have an IME factor of .33, and that both hospitals operate identical residency programs. The only difference between the two hospitals is that Hospital A obtains all of its ancillary services "under arrangements" while Hospital B is highly integrated with a clinic and elects to use the 602(k) waiver. As a result, Hospital A receives its full DRG and then pays the organization that provides its ancillary services under arrangements. Hospital B's ancillary services are billed directly by the clinic and deducted from the DRG payments made to the hospital. In short, the only difference between the two hospitals is that Hospital A wrote a check for $100,000 to a clinic to provide diagnostic tests under arrangements, whereas HCFA deducted $100,000 from the payments to Hospital B and forwarded the payment directly to the clinic. The result in this example is that Hospital B receives substantially less IME reimbursement as follows:

	Hospital A	Hospital B
DRG Payment	$1,000,000	$1,000,000

[9] Providers' Post Hearing Brief at 2.

Provider's Payment to Ancillary Supplier	100,000	100,000
Intermediary's 602(k) Adjustment		(100,000)
Net DRG Reimbursement	$1,000,000	$900,000
IME Factor	.33	.33
IME Payment	$330,000	$297,000

In this example, despite identical costs, Hospital B loses 10 percent of its IME reimbursement. The Providers see no legal or logical reason for payments made directly to a clinic under the 602(k) waiver to be treated differently than payments a provider makes to a clinic or other organization that supplies services under arrangement.

The Providers acknowledge but reject CMS' argument that IME costs are not the same type of pass-through costs as capital-related costs and GME because reimbursement of IME is addressed specifically in one section of the statute while GME costs are not. See 49 Fed. Reg. 267-268 (Jan. 3, 1984) (suggesting that the statutory basis for paying IME is different from that for GME costs). This interpretation is not supported by statute or regulation. Provisions at 42 U.S.C. § 1395ww(a)(4) exclude the "costs of approved educational activities" from PPS payments under 42 U.S.C. § 1395ww(d) without distinguishing between direct and indirect costs. Likewise, the regulation then applicable to reimbursement for educational activities states that reimbursement shall be made for the "direct and indirect costs of the activities." 42 C.F.R. § 405.421 (g). See also H.R. Rept. No. 98-25, supra at 140, 1983 U.S. Code, Cong. & Ad. News at 359 (drawing no distinction between direct and indirect medical education costs).

The Providers contend that reducing the federal portion of their DRG payments before applying the IME adjustment factor is inequitable and contrary to the purpose of the 602(k) waiver.[10] The Providers explain that the Intermediary, in calculating their IME reimbursement, applied the IME adjustment factor to the federal portion of their Part A DRG reimbursement after reducing those DRG payments by an amount equal to the federal portion of the amounts paid to the Clinic under Part B for inpatient services pursuant to the 602(k) waiver. The Providers contend that the IME adjustment factor should be applied to the full amount of the federal portion of their Part A DRG reimbursement without any reduction for any portion of the Part B payments to the Clinic.

The Providers assert that IME is reimbursed separately under PPS from DRG payments for inpatient services. By reducing the federal portion of the Providers' DRG payments before calculating IME reimbursement, the Providers have been forced to subsidize IME costs from

[10] Providers' Opening Brief at 14.

other sources contrary to the statutory directive that DRG payments to hospitals under 42 U.S.C. § 1395ww(d) pay for the: "operating costs of inpatient hospital services" as defined by section 1395ww(a)(4). This definition explicitly excludes the costs incurred by hospitals for "approved educational activities," with no distinction drawn between direct and indirect medical education costs. Payments made to the Clinic under Part B pursuant to the 602(k) waiver were intended to be payments that would have been made, but for the waiver, to the Providers for ancillary services, which are specifically included in the term "operating costs of inpatient hospital services." Id.

The Providers argue, therefore, that according to the statutory definition of "operating costs of inpatient hospital services," the Part B payments to the Clinic subtracted from their DRG payments could not include amounts for approved educational activities. Therefore, it was inappropriate for the Intermediary to reduce their reimbursement for IME costs by excluding the amount of the federal portion of the Part B payments to the Clinic from the federal portion of the DRG payments they would otherwise have received, because the proportionate amount of the Part B payments used to reduce the federal portion of the DRG payments should have nothing to do with the Providers' educational activities. These Part B payments to the Clinic substitute for DRG payments under Part A that would have otherwise been made to the Providers. Therefore, the Intermediary's argument that duplicate reimbursement would result if the IME adjustment factor were applied to the total federal portion of the DRG payments to the Providers without any reduction is inaccurate.

The Providers argue that in reality the opposite is true. The Intermediary does not deny that the Providers incurred IME costs that are reimbursable by Medicare. However, the Intermediary contends that the Providers are not entitled to reimbursement for these costs to the same extent as other hospitals. The Part B payments made to the Clinic under the 602(k) waiver were based on the Clinic's reasonable charges. The Clinic did not submit any bill for reimbursement of any portion of the Providers' IME costs. The Intermediary has provided no evidence that educational costs, particularly indirect costs, incurred by the Providers should be considered part of the Clinic's Part B charges for purposes of offset against Part A operating payments.

The Providers also assert that to the extent that a portion of the Part B payments to the Clinic included some IME costs, under the Intermediary's treatment these costs have been borne by the Providers through the reduction of their DRG payments and not by the Medicare program.[11] That is, the Medicare program did not reimburse the Clinic for its IME costs, if any, but rather the Providers paid these costs through the reduction of their DRG payments pursuant to the 602(k) waiver. The Providers argue that reducing their reimbursement for IME based upon the amount of Part B payments to the Clinic causes them to bear these costs twice and reduces the amount of Medicare reimbursement to which they are entitled. Consequently, the Intermediary's calculation of the Providers' IME reimbursement is proportionately less than that paid to other hospitals providing the same volume of inpatient services to Medicare patients (assuming that

[11] Providers' Opening Brief at 16.

the IME adjustment factors are equal). Excluding the federal portion of the Part B payments from the calculation of the Providers' IME reimbursement penalizes the providers for operating under the 602(k) waiver.

The Providers assert that Congress did not intend to penalize hospitals that were entitled to the 602(k) waiver. Rather, Congress intended to protect such hospitals in order to insure the continuity of patient care. The waiver expressly permits the exemption of certain hospitals from the "rebundling" provisions of 42 U.S.C. §§ 1395y(a)(14) and 1395cc(a)(1)(H), because the rebundling requirements "could threaten the financial stability of some institutions." Id. S. Rept. No. 98-23, at 50, reprinted in 1983 U.S. Code, Cong. & Ad. News 143, 190 (Mar. 11, 1983). Congress intended the 602(k) waiver to be available where the rebundling requirements would result in a "'significant hardship on the part of the hospital." H.R. Rept. No. 98-25, 98th Cong:; Sess., at 137, reprinted in 1983 U.S. Code, Cong. & Ad. News 219, 356 (March 4, 1983). Thus, the Intermediary's position is not only inaccurate when applied to the facts, it is also inconsistent with Congressional intent.

In all, the Providers assert that CMS and the Intermediary fail to recognize that they incur indirect costs for medical education programs just like other hospitals, such as additional staff time for working with interns and residents, regardless of whether or not the Providers or another organization is the employer. Also, additional tests and laboratory procedures are frequently ordered in the course of educational activities. While the Clinic bears the costs of these tests directly, the Providers bear them indirectly through the reductions in their DRG payments by the amount of Part B payments made to the Clinic for inpatient services. Thus, there is no logical or factual basis for the contention of CMS or the Intermediary that the Providers do not incur indirect medical education costs in the ancillary departments where the ancillary services are provided by the Clinic.

The Providers also contend that Congress made it clear that payments made to the Clinic under the 602(k) waiver should not affect the calculation of their IME reimbursement.[12] Specifically, the Providers assert that section 9112(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") clarified the 602(k) waiver by adding paragraph 2, which states:

> (2) In the case of a hospital which is receiving payments pursuant to a waiver under paragraph (1), payment of the adjustment for indirect costs of approved educational activities shall be made as if the hospital were receiving under Part A of title XVIII of the Social Security Act all the payments which are made under part B of such title solely by

[12] Providers' Opening Brief at 17. Tr. At 29.

> reason of such waiver.

COBRA, Pub. L. No. 99-272, 100 Stat. 82, 163 (1986), § 9112(a).

The Providers acknowledge but reject the Intermediary's reliance upon COBRA section 9112(b) which provides that section 9112(a) would be effective for cost reporting periods beginning after January 1, 1986. The Providers assert that in an earlier Position Paper the Intermediary agreed that the amended 602(k) waiver provision would compel calculation of IME reimbursement in the manner the Providers contend. However, the Intermediary now errs in reversing its position by assuming that section 9112(a) represented a change from prior law. The Providers assert that the legislative history makes it clear that section 9112(a) was a clarification designed to ensure that the receipt of a 602(k) waiver would not disadvantage a provider in recovering its IME costs. Section 9112(a) was not meant to change the law but to ensure that intermediaries applied the law as Congress had originally intended without financial penalty to the hospitals who had received 602(k) waivers. Thus, the method of calculation required by section 9112(a) should also apply to cost reporting periods prior to those specified in COBRA.

The Providers maintain that section 9112(a) of COBRA originated in the Senate as bill S. 1730. The intent behind section 9112(a) was explained in the Senate Finance Committee's Report on S. 1730, as follows:

> [t]he provision would clarify that the split payment provisions [the waiver] was [sic] only intended to provide a temporary billing accommodation for certain hospitals and that the indirect teaching adjustment should be applied as if the entire PPS payment had been made under Part A.

S. Rept. No. 99-1/46, 99th Cong., 2d Sess. at 294, (Sept. 27, 1985) reprinted in 1986 U.S. Code, Cong. & Ad. News 251, 261 (emphasis added).

Thus, COBRA section 9112(a) was not intended to change the law applicable to the calculation of IME reimbursement for hospitals where the waiver applied. Rather, the purpose of section 9112(a) was to clarify the manner in which reimbursement was calculated under the waiver as enacted in 1983, notwithstanding the effective date provided in section 9112(b).

The Providers acknowledge the law's clarification that after January 1, 1986, the Intermediary treats payments to the Clinic as if they were payments to the Providers. The Providers argue, however, that regardless of why the law contains an effective date there are four facts that confirm Congress' intent that the IME amendment serves as a restatement of existing law and not as a new law.[13] First, the legislative history refers to the IME amendment as a clarification. Congress did not refer to the amendment as a reversal of the law or as a new law, but deemed it a clarification. The IME amendment was not designed to change IME reimbursement; it aimed to

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[13] Providers' Post Hearing Brief at 5.

correct the Intermediary's mistaken belief that IME was to be treated differently than GME and capital costs.

Second, if the Intermediary's position is correct then Congress intended to allow only organizations whose fiscal years begin in January through September to receive IME reimbursement. The IME amendment's effective date says it applies to fiscal years starting on or after January 1, 1986, and the waiver's sunset is fiscal years starting on or after October 1, 1986. The Intermediary's position necessitates this illogical result.

Third, the Congressional Budget Office's ("CBO") analysis makes it clear that Congress expected the amendment to result in program expenditures in each fiscal year from 1986 through 1990.[14] The Intermediary is claiming that the IME amendment only applied to fiscal year 1986. If that were true the governmental outlay would have all occurred in one, or at most, two fiscal years. The fact that the outlay was to occur over five or more years confirms that Congress expected the amendment to cover all years that the waiver was in place.

Specifically, the Intermediary noted that the CBO's discussion of the amendment describes the estimated outlay as $3 million. S. Rep. 99-146 at 408 (1986) reprinted in 1986 U.S.C.C.A.N. 42, 367. The Intermediary observed that this was somewhat close to the estimated financial impact for one year of the IME adjustment requested by the Providers and suggested that this may support the Intermediary's contention that corrected IME payments were to be made only for the fiscal year 1986. However, this argument is flawed because the CBO actually estimated that there would be at least $5 million in expenses, with $1 million projected in each of the five years from 1986 through 1990. Id at 361. It appears that the $1 million dollar estimate was actually too low, but the point is that the CBO was estimating expenses incurring over multiple years, which would not occur if the IME amendment was only valid for fiscal years beginning in the nine months from January 1, 1986 through September 30, 1986.

The summary of the provision states:[15]

Section 710. Indirect Teaching Adjustment Related to Independent Clinic Activities.

> This section **clarifies** the method for calculating indirect teaching adjustments for Mayo Clinic affiliated hospitals. As a result payments to those hospitals are increased by $3 million during 1986 through 1988.

S. Rep. 99-146 at 408 (1986) Reprinted in 1986 U.S.C.C.A.N. 42, 367 (emphasis added).

However, and as noted above, the chart accompanying the summary shows $5 million dollars in

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[14] See also Providers' Reply Position Paper and Exhibit P-26.

[15] Id.

expenditures occurring $1 million a year from 1986 through 1990.

The Providers also argue that this congressional provision contains two factors which clearly demonstrate Congress' intent. First, the provision explains that it is a "clarification." Accordingly, it should apply to all interpretations of the 602(k) waiver, not just to those after a certain date. Second, the only logical explanation for Congress' anticipation of expenditures in 1986 through 1990 is that Congress anticipated that payments would be made in each of those years as cost reports for the earlier years, including 1984 and 1985, the years in dispute are settled.

Fourth and finally, there is no logical or regulatory reason to believe that IME should be handled differently than the other pass-through costs such as GME and capital. The Intermediary concedes that GME and capital costs are not reduced simply because some DRG payments were directed to the Clinic. Therefore, the Intermediary included payments made directly to the Clinic when calculating GME and capital costs. When a resident ordered a test, that test directly reduced the Providers' DRG payments because all ancillary payments to the Clinic directly reduced DRG payments to the Provider. The Providers incurred the expense. Unless the Intermediary makes the adjustment requested by the Providers they will have been penalized for electing the waiver. When it was originally passed, the 602(k) waiver did not include any discussion of IME reimbursement. The Providers believe this happened because the waiver was not intended to affect it. The IME amendment was necessary only because the Intermediary chose to treat IME differently than other pass through costs. As a result, Congress passed the IME amendment to restate its original intent.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments, which calculated the Providers' IME reimbursement after the offset of payments made to the Clinic, are proper.[16]

The Intermediary contends that its position regarding this matter is supported by the controlling regulations. Specifically, 42 C.F.R. § 412.118, the IME regulation in effect as of October 1, 1986, describes the basic data for the IME calculation as follows:

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[16] Intermediary Supplemental Position Paper at 4. Intermediary Post Hearing Statement at 4. Tr. at 44.

> [t]o determine the indirect medical education costs, HCFA uses the following procedures:
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> (a) *Basic data*. HCFA determines the following for each hospital:
>
> (1) The hospital's ratio of full-time equivalent interns and residents, except as limited under paragraph (g) of this section, to number of beds (as determined in paragraph (b) of this section).
>
> (2) The hospital's total DRG revenue based on DRG-adjusted prospective payment rates (for transition period payments, the Federal portion of the hospital's payment rates), including outlier payments determined under Subpart F of this part but excluding additional payments made under the provisions of Subpart G of this part. For cost reporting periods beginning on or after January 1, 1986, for purposes of this section, the total DRG revenue is not offset for payments made to outside suppliers under § 489.23 of this chapter for nonphysician services furnished to beneficiaries entitled to Medicare Part A.

42 C.F.R. § 412.118(a)(1) and (2).

Under appeal in this case are two cost reporting periods ended December 31, 1984 and 1985, respectively, and two other cost reporting periods ended June 30, 1985 and June 30, 1986, respectively. The regulatory directive not to make the contested offset is effective at the earliest for a cost reporting period that begins on January 1, 1986. Therefore, under the controlling regulation, the only permissible reading is that the contested offset should be made for earlier cost reporting periods such as those covered by this appeal. Accordingly, within the four corners of the regulation the Intermediary's determinations are correct.

The Intermediary explains that the statutory component of PPS reimbursement addresses the exception to the requirement that hospitals assume the costs for the non-physician component of ancillary services. The law, 42 U.S.C. § 1395y, also referenced as the 602(K) waiver provides:

> Sec. 602(k)(1) The Secretary of Health and Human Services may, for any cost reporting period beginning prior to October 1,1986, waive the requirements of sections 1862 (a)(14) and 1866(a)(1)(H) of the Social Security Act in the case of a hospital which has followed a practice, since prior to October 1, 1982, of allowing direct billing under part B of title XVIII of such Act for services (other than physicians' services) so extensively, that immediate compliance with those requirements would threaten the stability of patient care. Any such waiver shall provide that such billing may continue to be made under part B of such title but that the payments to such hospital under part A of such title shall be reduced by the amount of the billings for such services under part B of such title. If such a waiver is granted, at the end of the waiver period the Secretary may provide for such methods of payments under part A as is [sic] appropriate, given the organizational structure of the institution.

> (2) In the case of a hospital which is receiving payments pursuant to a waiver under paragraph (1), payment of the adjustment for indirect costs of approved educational activities shall be made as if the hospital were receiving under part A of title XVIII of the Social Security Act all the payments which are made under part B of such title solely by reason of such waiver.

42 U.S.C. § 1395y.

The Intermediary contends that the limitation in the regulation which requires the non-offset of funds paid to the Clinic is not immediately evident from the statute. The Intermediary goes on to explain, however, that it is evident from the legislative history.

Paragraph (2) of the 602(k) waiver provision was not part of the original legislation; rather, it was added by section 9112 of COBRA 1985, Public Law 99-272. The legislative history on the address to the original text of the 602(k) waiver states:

> 13. *Indirect teaching adjustment related to independent clinic activities*
>
> ***Present law***
>
> For the first three years of the prospective payment system (PPS), a special exception is applied to hospitals which had traditionally been allowed direct billing under part B so extensively that it would have been disruptive to immediately require them to bill for all such services under part A. These hospitals are, in effect, allowed to have part of their PPS payments paid through part B billings and the remainder paid to the hospital under part A. The Health Care Financing Administration has ruled that in such split payment cases, the indirect teaching adjustment would apply only to the portion of the medicare payment that is paid through part A.
>
> ***House Bill***
>
> No provision.
>
> ***Senate amendment***
>
> The conference agreement includes the Senate amendment, with the following modifications. Part A services billed under part B under a waiver granted under this authority will be paid at 100 percent of the reasonable charge (or other applicable basis of payment) and the entity billing such services under part B must accept such payment as payment in full. Payment of the indirect teaching adjustment as if all services were billed under the PPS payment methods in part A, will be effective with the first hospital cost reporting periods beginning on or after January 1, 1986. Payment of part A services billed under part B at 100 percent of reasonable charges and the requirement that the billing entity accept such payment as full payment will be effective for services provided

on or after 10 days following enactment.

Address-Social Security Amendments of 1983, § 602(k), Pub. L. 98-21.

The Intermediary asserts, therefore, that based upon the above integrated interpretation of 42 C.F.R. § 412.118(a)(1) and the underlying legislation, its IME calculations are appropriate.

The Intermediary disagrees with the Providers' argument that they are being treated inequitably and should be paid the same IME amount as a similar provider who directly incurs the costs of the services covered by the 602(k) waiver.[17] The Intermediary believes the Providers want the IME increment to be based upon costs they did not incur.

Specifically, if the premise of the IME payment is correct, then the payment to the Clinic for ancillary services furnished Medicare beneficiaries who are inpatients at the Providers' reflects the actual increase in services resulting from the extra tests ordered by the interns and residents; otherwise the IME premise is wrong. That is, the 602(K) waiver payments made to the Clinic, which were based on a per service measure, are higher than would be paid to a supplier in a non-teaching hospital assuming no rebundling.
In all, for the purpose of calculating the Providers' IME adjustment, ignoring the actual Clinic payments results in a double recognition of IME. That is, once when the increased volume of services is paid on a case by case basis to the Clinic, and then when the IME factor is applied to the unadjusted DRG payments made to the Providers.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law 42 U.S.C.:

§ 1395y et seq.	-	Exclusions From Coverage; Basic Guidelines
§ 1395cc(a)(1)(H)	-	Agreements With Provider of Services

[17] Intermediary Supplemental Position Paper at 7. Intermediary Post Hearing Statement at 6.

§ 1395ww(a)(4) for	-	Limits on Operating Costs Inpatient Hospital Services
§ 1395ww(d) et seq.	-	PPS Transition Period; DRG Classification System; Exceptions and Adjustments to PPS

2. Regulations - 42 C.F.R.:

§ 405.421(g) (redesignated at § 413.85)	-	Cost of Educational Activities
§ 405.1835-. 1841	-	Board Jurisdiction
§ 412.118 et seq.	-	Determination of Indirect Medical Education Costs

3. Other:

Social Security Amendments of 1983, § 602(k), Pub. L. 98-21, 97 Stat. 65, 165 (1983), as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), § 9112, Pub. L. 99-272, 100 Stat. 82, 163 (1986) (adding subsections (2) and (3)).

HCFA Letter, August 24, 1984.

House Report No. 98-25.

49 Fed. Reg. 267-268 (Jan. 3, 1984).

S. Rept. No. 99-1/46, 99th Cong., 2d Sess. at 294, (Sept. 27, 1985).

S. Rep. 99-146 at 408 (1986).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and post hearing briefs, finds and concludes as follows:

Rochester Methodist Hospital and Saint Mary's Hospital, the Providers in this case, are acute care teaching facilities located in Rochester, Minnesota. Prior to and throughout the subject cost reporting periods, the Providers maintained a close relationship with the Mayo Clinic. In part,

the Clinic furnished certain non-physician ancillary services to the Providers' patients. Prior to the implementation of PPS the Clinic billed the Medicare program directly for the services it furnished the Providers' patients. Moreover, during this time the Clinic was directly reimbursed by the program, under Medicare Part B, for these services.

Upon implementation of Medicare's prospective system, however, it became necessary for the Providers to obtain a waiver under section 602(k) of the Social Security Act in order for the Clinic to continue its direct billing practice. The waiver was necessary because, under PPS, Medicare Part A reimbursement for the operating costs of all inpatient hospital services, including ancillary services, is paid according to a patient's DRG, and statutory provisions pertaining to PPS prohibit hospitals from "unbundling" inpatient services through agreements with outside suppliers who would bill Medicare under Part B separately from the DRG payments.

The section 602(k) waiver obtained by the Providers, as originally promulgated, stated:

> [t]he Secretary of Health and Human Services may, for any cost reporting period beginning prior to October 1, 1986, waive the requirements of sections 1862(a)(14) [42 U.S.C. § 1395y(a)(14)] and 1866(a)(1)(H) [42 U.S.C. § 1395cc(a)(1)(H)] of the Social Security Act in the case of a hospital which has followed a practice, since prior to October 1, 1982, of allowing direct billing under part B of title XVIII of such Act for services (other than physicians' services) so extensively, that immediate compliance with those requirements would threaten the stability of patient care. Any such waiver shall provide that such billing may continue to be made under part B of such title but that the payments to such hospital under part A of such title shall be reduced by the amount of the billings for such services under part B of such title. If such a waiver is granted, at the end of the waiver period the Secretary may provide for such methods of payments under part A as is [sic] appropriate, given the organizational structure of the institution.

Social Security Amendments of 1983, § 602(k), Pub. L. 98-21, 97 Stat. 65, 165 (1983)(emphasis added).

At issue in this appeal is the effect the "reduction" in the Providers' Part A payments, as required by the section 602(k) statute quoted above, should or should not have on the Providers' adjustment for IME. As noted in the Procedural History of this case, the amount of program funds paid to a hospital for IME is directly dependent upon the amount of its Part A payments.

In general, the Intermediary argues that the reduction should be made before the calculation of the Providers' adjustments for IME. The Providers argue, in general, that the purpose and intent of the 602(k) waiver is to provide for the continuation of a billing arrangement that, if immediately disturbed, would "threaten the stability of patient care." Id. While the Providers do not dispute that the reduction is necessary to avoid duplicate program payments for inpatient services covered by the program's DRG payments, they maintain that the reduction should have no effect on payments made outside of the DRGs such as capital-related costs, direct graduate

medical education costs, and IME.
Regulations in effect during the subject cost reporting periods are found at 42 C.F.R. § 412.118 et seq. With respect to the composition of the DRG revenue factor used in the IME calculation, these regulations state:

> [t]otal revenue based on DRG-adjusted prospective payment rates (for transition period payments, the Federal portion of the hospital's payment rates), including outlier payments determined under Subpart F of this part.

42 C.F.R. § 412.118(a)(2).

Respectively, the Board finds that the controlling statute, as originally promulgated, does not specifically address the IME calculation. Similarly, the implementing regulations in effect also do not address this matter.

On August 24, 1984, the CMS Chicago Regional Office ("RO") issued a letter explaining that the amount of monies paid to the Clinic pursuant to the waiver should be adjusted, i.e., reduced, for the portion of the Clinic's charges applicable to capital-related costs and graduate medical education costs before they are offset against the Providers' Part A payments. According to the RO, these adjustments are necessary to avoid underpaying the Providers for "pass-through" costs that are excluded from DRG payments. This letter goes on to explain that the Providers do not incur IME costs in the ancillary departments where services are provided by the Clinic; therefore, the adjusted waiver payments made to the Clinic should be offset against the Providers' Part A payments before determining the Providers' IME payments. While the Board finds the RO's letter helpful in addressing some of the factors discussed in this case, the Board also finds the letter more interpretive in nature than authoritative.

However, subsequent to the date of the RO's letter, on April 7, 1986, Congress amended the 602(k) waiver by adding, in pertinent part, the following:

> (2) In the case of a hospital which is receiving payments pursuant to a waiver under paragraph (1), payment of the adjustment for indirect costs of approved educational activities shall be made as if the hospital were receiving under part A of title XVIII of the Social Security Act all the payments which are made under part B of such title solely by reason of such waiver. . . .
>
> (3)(b) EFFECTIVE DATES.— (1) Section 602(k)(2) of the Social Security Amendments of 1983 (as added by subsection (a)) shall apply to cost reporting periods beginning on or after January 1, 1986.

Consolidated Omnibus Budget Reconciliation Act of 1985, § 9112, Pub. L. 99-272, 100 Stat. 82, 163 (1986) (adding subsections (2) and (3)).

Accordingly, the Board finds the Intermediary's adjustments reducing the Providers' Part A inpatient reimbursement by the amount of the waiver payments made to the Clinic, prior to calculating the Providers' adjustments for IME, proper. The Board is bound by statutory authority. With respect to the instant case, section 602(k)(2) of the Social Security Amendments establishes cost reporting periods beginning on or after January 1, 1986, as the period in which the Providers' IME adjustments are to be determined based upon their entire Medicare Part A reimbursement absent any reduction for waiver payments made to the Clinic. Conversely, this statute effectively mandates that such offsets shall be made in all prior cost reporting periods, which includes the cost reporting periods at issue in this case.

The Board acknowledges the several arguments posed by the Providers regarding the purpose and intent of the statute's effective date. The Board finds, however, that the purpose and intent of this law are absolutely clear based upon a plain reading of the statute's language. The Board also notes that the establishment of the effective date was more than a perfunctory action on the part of Congress; rather, it was a deliberate and purposeful decision. As noted by the Intermediary, Congress states in the address to the original text of the section 602(k) provision, the following:

> ***Present law***
>
> For the first three years of the prospective payment system (PPS), a special exception is applied to hospitals which had traditionally been allowed direct billing under part B so extensively that it would have been disruptive to immediately require them to bill for all such services under part A. These hospitals are, in effect, allowed to have part of their PPS payments paid through part B billings and the remainder paid to the hospital under part A. The Health Care Financing Administration has ruled that in such split payment cases, the indirect teaching adjustment would apply only to the portion of the medicare payment that is paid through part A.
>
> ***House Bill***
>
> No provision.
>
> ***Senate amendment***
>
> The conference agreement includes the Senate amendment, with the following modifications. Part A services billed under part B under a waiver granted under this authority will be paid at 100 percent of the reasonable charge (or other applicable basis of payment) and the entity billing such services under part B must accept such payment as payment in full. Payment of the indirect teaching adjustment as if all services were billed under the PPS payment methods in part A, will be effective with the first hospital cost reporting periods beginning on or after January 1, 1986. Payment of part A services billed under part B at 100 percent of reasonable charges and the requirement that the billing entity accept such payment as full payment will be effective for services provided

on or after 10 days following enactment.

Address-Social Security Amendments of 1983, § 602(k), Pub. L. 98-21.

DECISION AND ORDER:

Payments made to the Clinic under the provisions of the section 602(k) waiver should be offset against, or used to reduce, the Providers' Medicare Part A reimbursement before the Intermediary calculates the Providers' adjustments for IME. The Intermediary's adjustments are affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esq.

Date of Decision: August 09, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman