PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D9

PROVIDER -Atlantic 97 Residents in Nonhosp Setting Grp
Atlantic Health System 99 IME Group
Atlantic Health System 00 FTE Calc Grp

Provider Nos.: Various

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Riverbend Government Benefits Administrator

DATE OF HEARING -
August 25, 2006

Cost Reporting Periods Ended -
Various

CASE NOs.: 01-3592G; 02-2153G and 03-0960G

INDEX

ISSUE:

Whether the Intermediary properly calculated the Providers' 1996 Indirect Medical Education (IME) base year Full-Time Equivalency (FTE) cap specifically regarding residents rotating to nonhospital settings.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program provides health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services (Secretary) is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payments for those services. The Centers for Medicare and 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 the program's administration. CMS has entered into contracts with insurance companies known as fiscal intermediaries to maintain the program's payment and audit functions. Intermediaries determine payment amounts due providers of health care services (e.g., hospitals, skilled nursing facilities, and home health agencies) under Medicare law and interpretative guidelines issued by CMS.

At the close of its fiscal year, each provider submits a cost report to its intermediary showing the costs it incurred during the period and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and notifies the Provider in a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's determination may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The Medicare Act at section 1886(d)(5)(B) provides that teaching hospitals that have residents in approved graduate medical education (GME) programs receive an additional payment for each discharge of Medicare beneficiaries to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. The additional payment, known as the indirect medical education (IME) adjustment, is determined by calculating the hospitals' ratio of residents to beds.

The Balanced Budget Act of 1997 (BBA) made several major changes to the reimbursement methodology for IME. Specifically, the Act established a cap on the number of full-time equivalent (FTE) interns and residents a hospital could count based upon how many the hospital had as of December 31, 1996:

> In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or non hospital setting may not exceed the number . . . of such full time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996 . . .

42 U.S.C. §1395ww(d)(5)(B)(v). Additionally, another provision of the Act changed the way that FTEs may be counted with respect to residents that rotate to nonhospital settings for training. The updated law provides as follows:

> 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.

42 U.S.C. §1395ww(d)(5)(B)(iv).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case involves two commonly owned acute care teaching hospitals: Morristown Memorial Hospital and Overlook Hospital (Providers). Morristown Memorial Hospital is located in Morristown, New Jersey and Overlook Hospital is located in Summit, New Jersey. There are four fiscal years at issue for each provider: fiscal years ended December 31, 1997, December 31, 1998, December 31, 1999 and December 31, 2000.

Riverbend Government Benefits Administrator (Intermediary) issued NPRs for each of the Providers' above-stated fiscal year ends. In each of the Providers' NPRs, the Intermediary adjusted the base year cap and consequently the rolling average[1] to reflect the FTE cap as it was determined for the hospitals' most recent cost reporting period ending on or before December 31, 1996. These adjustments reflected the exclusion of Interns and Residents FTEs for rotations to nonhospital settings in the IME calculation.[2]

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[1] Section 1886(h)(4)(G)(iii) of the Act, as added by section 4623 of the BBA, provides that for the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count for payment purposes equals the r of the weighted FTE count for that cost reporting period. For cost reporting periods beginning on or after October 1, 1998, section 1886(h)(4)(G) of the Act requires that hospital's direct medical education weighted FTE count for payment purposes equal the average of the actual weighted FTE count for the payment year cost reporting period and the preceding 2 cost reporting periods.

[2] Prior to the Balanced Budget Act of 1997, 42 C.F.R. §412.105 (g)(1)(ii)(C) identified that IME FTEs were limited to those rotations which were in the portion of the hospital subject to PPS, in the outpatient

The adjustments resulted in a cumulative reduction of Medicare reimbursement of approximately $1,146,299.

The Providers appealed the adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835- 405.1841.[3] The Providers were represented by Kevin Lenahan, CPA, of Atlantic Health System. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Providers contend that in enacting 42 U.S.C. §1395ww(d)(5)(B)(iv) which allows a provider to claim FTEs for interns or residents in approved training programs who spent time in patient care activities in nonhospital settings for discharges occurring on or after October 1, 1997, Congress intended to create a monetary incentive for hospitals to rotate residents from the hospital to no hospital settings. The Providers contend that the simultaneous change of the statute to limit the number of FTEs that can be claimed to those reported on a hospital's most recent cost report period ending on or before December 31, 1996 completely eviscerates the "monetary incentive" to which the Providers are entitled under 42 U.S.C. §1395ww(d)(5)(B)(iv). The Providers assert that the result of the change to 42 U.S.C. §1395ww(d)(5)(B)(v) is inconsistent with Congressional intent and should therefore be eliminated.

The Intermediary asserts that the plain language of the law speaks for itself and purposely does not allow for a revision to the base year FTE cap to include FTEs relating to rotations to nonhospital settings in the IME calculation. The Intermediary contends that if Congress had intended to allow for revision to the base year cap for changes made prospectively, the law would reflect that intent. In addition, the Intermediary identifies a May 12, 1998 Federal Register that responds to a commenter's concern over the establishment of the cap and the commentator's belief that the cap disadvantages providers who had already been training residents in nonhospital settings. CMS responded that the intent of the statutory change was to create an incentive for additional primary care training in future periods, and that ". . . hospitals that had previously established residency training in nonhospital settings did so in response to the existing incentives at the time."[4] The Intermediary asserts that the adjustments made were proper and in accordance with the plain language of the statute.

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department of the hospital or at an entity receiving a grant under section 330 of the Public Health Service Act and under the control of the hospital. FTEs related to rotations in nonhospital settings were not included in the IME count for discharges prior to October 1, 1997.

[3] The Provider concedes that there is no financial impact for the FYE 12/31/99 and 12/31/00 cost reports for Overlook Hospital. The Board acknowledges that each year stands on its own and must meet jurisdictional thresholds. However, as the adjustments in contention in this case relate to the rolling average and may have impact in later cost reporting years, the Board has accepted jurisdiction over each Provider and all cost reporting periods covered in the appeals.

[4] See Exhibit I-8, page 12 of 38, Intermediary's Final Position Paper for case number 01-3592G.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence and the parties' contentions, the Board finds and concludes as follows:

The Provider would have us invalidate a clear statutory mandate, an action that is beyond the Board's authority. Moreover, the Board disagrees with the Providers' assertion that Congressional intent of the BBA-97 as it relates to IME reimbursement was not realized due to inconsistency in two subsections of the same statute: 42 U.S.C. §1395ww(d)(5)(B)(iv) and 42 U.S.C. §1395ww(d)(5)(B)(v). The base year FTE cap does not preclude a provider from reaping the benefits of the change in another part of the statute that allows, after October of 1997, inclusion of FTEs for residents and interns training at nonhospital provider locations if the provider is under its base year cap. Therefore, Congress' failure to allow for the IME cap to be adjusted does not eviscerate the monetary incentive providers could have obtained by the change in the law as the Providers contend. The Intermediary's determination was required by law and is correct.

DECISION AND ORDER:

The Intermediary properly calculated the Providers' 1996 IME base year FTE cap in accordance with 42 U.S.C. §1395ww(d)(5)(B). The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: December 14, 2006

Suzanne Cochran
Chairperson