PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D13

PROVIDER -
Rush-Presbyterian-St. Luke's Medical Center
(n/k/a Rush University Medical Center)
Chicago, IL

Provider No.: 14-0119

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
AdminaStar Federal-Illinois

DATE OF HEARING -
November 9, 2004

Cost Reporting Period Ended -
June 30, 1992

CASE NO.: 97-2986

INDEX

ISSUES:

1. Should the Provider's transplant surgery residents be included in the full-time equivalent (FTE) count for the purposes of both direct graduate medical education (DGME) and indirect medical education (IME) reimbursement?

2. To the extent transplant surgery residents are not included in the FTE counts for purposes of DGME and IME, is the Provider entitled to reimbursement for costs it incurred with such individuals pursuant to 42 C.F.R. §405.523?

3. In calculating the Provider's Disproportionate Share Hospital (DSH) payment, should all of the Medicaid Health Maintenance Organization (HMO) days, as reported by the Illinois Department of Public Aid, be included?

4. Was the Intermediary's disallowance of a portion of the depreciation expense claimed for the Atrium Pavilion proper?

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 to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. 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 administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal 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). 42 C.F.R. §405.1803. 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Rush University Medical Center (Provider) is a tertiary care teaching hospital located in Chicago, Illinois. The Provider is an Illinois not-for-profit corporation that has been certified for participation in the Medicare program since its inception in 1966. The Provider had approximately 824 licensed beds in 2002.[1]

The Intermediary[2] audited the Provider's fiscal year ended June 30, 1992 (FY 92) cost report and issued an NPR dated September 30, 1994. Dissatisfied with the Intermediary's findings and adjustments, the Provider filed an appeal with the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by James F. Flynn, Esquire, of Bricker & Eckler, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

Issues 1 and 2 – Transplant Surgery Program

Direct Graduate Medical Education (DGME)

Congress authorized payments to hospitals to reimburse them for the direct expenses incurred in providing training programs for physicians. 42 U.S.C. §1395ww(h)(5)(A). Specifically, the statute provides that a provider is entitled to count residents' participation in an "approved medical residency training program." Id. Congress defined the term "approved medical residency training program" as "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty . . ." 42 U.S.C. §1395ww(h)(5)(A).

The regulation implementing the DGME statute, 42 C.F.R. §413.86, defines "approved medical residency program" as a program that meets one of the following criteria: (1) Is approved by one of the national organizations listed in 42 C.F.R. §405.522(a) (which, in turn, includes the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association's committee, the American Dental Association's council and the American Podiatry Association's council), (2) May count towards certification of the participant in a specialty or sub-specialty listed in the current edition of either of the following publications: (i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and (ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.

The final rule creating the DGME regulation was promulgated on September 29, 1989. In the preamble to that rule, the Secretary stated:

> In addition to the changes required by section 1886(h) of the Act, we proposed to clarify what constitutes an approved program for the

[1] See Provider Exhibit 2, page 22.

[2] At the time of the intial audit of the fiscal year at issue, Health Care Services Corporation was the Provider's Interemdiary. However, AdminaStar Federal, Inc, now serves in that capacity.

> purpose of payment for direct GME costs. Program experience indicates that in the past there has been a problem in identifying approved teaching programs for certain medical subspecialties. These programs are sometimes called "fellowship" programs.

54 Fed. Reg. 40286, 40295 (Sept. 29, 1989). In retracing the history of Medicare's recognition of fellowship programs, the Secretary stated: "The Medicare program has generally treated fellowship programs as if they were accredited and paid for the services of residents in these programs as residents in approved programs." Id.

The Medicare regulations define the term "approved educational activities" to determine allowable costs. The term is defined in 42 C.F.R. §413.85(b) as follows:

> (b) Definition – Approved educational activities. Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed if required by State law. If licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

Indirect Medical Education (IME)

Since the inception of the Medicare program, Congress always recognized the cost of training physicians, based on the premise that " . . . these activities enhance the quality of care in an institution." (H.R. Rep. No. 213, 89th Cong., 1st Sess., 32 (1965); see also Report to the Congress, Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals, at 5 (Aug.1999).[3]

In recognition of the fact that teaching hospitals have indirect operating costs that would not be reimbursed under the prospective payment system or by the DGME payment methodologies, in 1983 Congress authorized an additional payment known as the indirect medical education (IME) payment, to hospitals with GME programs. 42 U.S.C. §1395ww(d)(5)(B). Specifically, the IME payment compensates teaching hospitals for higher-than-average operating costs that are associated with the presence and intensity of residents' training in an institution but which cannot be specifically attributed to, and does not include the costs of residents' instruction.

The IME adjustment attempts to measure teaching intensity based on "the ratio of the hospital's full-time equivalent interns and residents to beds." Id. Thus, the IME payment amount is based, in part, upon the number of intern and resident FTEs participating in a provider's GME Program.

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[3] Provider's final position paper at page 9.

The regulation implementing the IME statute, 42 C.F.R. §412.105[4] (as it existed in FY 1992), defines an "approved teaching program" identically to the way the term "approved medical residency program" is defined in the DGME regulation, 42 C.F.R. §413.86(b).

In July, 1990, the Provider began offering a two-year Transplant Surgery Fellowship Program (Program). Since its inception, the Program has been accredited by the American Society of Transplant Surgeons (ASTS), for kidney and liver transplant training.[5] In order to be accredited by ASTS, a transplant surgery fellowship program must:

- Have a director who is certified by the American Board of Surgery or the American Board of Urology;
- Provide "an adequate volume of operative experience."
- Have 75 patients available for each transplant fellow to serve as the principal surgeon over the course of the [fellows'] training.
- For accreditation as a kidney transplant training program, each transplant fellow must perform at least 30 kidney transplants over the course of their fellowship.
- For accreditation as a liver transplant training program, each fellow must perform at least 45 liver transplants over the course of their fellowship.
- Exist within an organ procurement organization's boundaries that has at least 25 multi-organ procurements annually.

The Provider's abdominal transplantation service – the broader service of which the training Program is a part – is certified by the United Network for Organ Sharing (UNOS).[6] UNOS is the federal government contractor for the Organ Procurement and Transplant Network (OPTN). Congress established the OPTN when it enacted the National Organ Transplant Act in 1984.[7]

The ASTS is the nationally recognized authority for accreditation of abdominal transplant training programs. The ACGME does not accredit transplant surgery training programs. ASTS has an application process for request for accreditation of abdominal transplant surgery fellowship training programs.[8] A fellow must meet all ASTS requirements to be issued a certificate of completion.

In FY 92, four fellows participated in the Program. For purposes of DGME, those individuals' participation in the Program amounted to 1.54 FTEs. For purposes of IME,

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[4] Redesignated from 412.118 at 56 FR 43241, Aug. 30, 1991.
[5] See Provider Exhibit 4.
[6] Transcript (Tr.) at 30.
[7] Tr. at 33, 34, 37, 43. Provider's Post Hearing Brief at 5.
[8] See www.asts.org: See Fellowship Training: Application Procedures

their participation amounted to 3.07 FTEs. The Intermediary disallowed these individuals from both FTE counts because it believed the residents were not participating in an "approved program" under 42 C.F.R §413.86. The Provider and Intermediary (Parties) have agreed that if the Board rules that transplant surgery residents are not in an approved program, the Board should rule on whether such costs should be allowed as a part of a non-approved program under 42 C.F.R. §405.523.

Issue No. 3 - DSH Calculation:

Disproportionate Share Hospital (DSH) Adjustment

The Medicare program provides for an additional payment amount for subsection (d) hospitals which serve a significantly disproportionate number of low-income patients as defined in clause (v) of this section. 42 U.S.C. §1395ww(d)(5)(F). The formula used to calculate a provider's DSH adjustment is the sum of two fractions, often referred to as the Medicare proxy and the Medicaid proxy. The numerator of the Medicaid proxy is the number of hospital patient days for patients who were eligible for medical assistance under a State Plan approved under Title XIX, for such period, but not entitled to benefits under Medicare Part A; and the denominator is the total number of the hospital's patient days for such period. Id.: see also 42 C.F.R. §412.106(b)(4).

The Parties agree that Medicaid HMO days that can be supported by auditable documentation should be incorporated into the DSH calculation. However, one factual issue still remains that pertains to the correct number of Medicaid HMO days to be included in the Provider's FY 92 DSH calculation.

In FY 92, the Provider included a total of 1198 Medicaid HMO days in its DSH calculation – 912 from Chicago HMO, 172 from MedCare HMO and 114 from out-of-state HMOs.[9] At issue are 133 days out of the 172 Medicaid days paid by MedCare HMO. In order to determine how many Medicaid HMO days the Provider was entitled to claim, the Provider engaged a consulting firm, The Curtis Group, to review its Medicaid HMO days.

In response to its Freedom of Information (FOI) request, The Curtis Group received an 800 page report that listed claims paid for Medicaid HMO enrollees for all Illinois hospitals as reported to the Illinois Department of Public Aid (IDPA). This report included the HMO name, hospital name, admission and discharge dates and length of stay.[10] An excerpt of this report, pertaining to the Provider for the MedCare HMO, was presented to the Intermediary and exists in the record at Provider's Exhibit P-15 and Intermediary's Exhibit I-6. For FY 92, this report shows that 172 days were reported to IDPA as claims paid for MedCare HMO enrollees receiving care from the Provider.[11]

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[9] See, Provider's Exhibit 16, p. 2.
[10] Tr. 63-65.
[11] Id.

In addition to the IDPA report, the Intermediary required that the Provider also document the patients' names or ID numbers and obtain eligibility screens for each of the paid claims on the IDPA report.[12] The Provider presented this additional information for 39 of the 172 days which the Intermediary allowed after its review.[13] The Intermediary did not allow the remaining days because the Provider could not provide eligibility screens to support that these claims were for Medicaid eligible patients. Several problems prevented the Provider from obtaining all of the Medicaid eligibility screens. The primary problem was that the IDPA report did not contain patient identifying information.[14]

Issue No. 4 - Atrium Depreciation:

Under 42 C.F.R. §413.24, adequate cost information must be obtainable from the provider's financial and statistical records to support a claim for payment for services furnished to Medicare beneficiaries. This requirement of adequacy implies that the data be inaccurate, in sufficient detail and capable of being audited.

The Provider made improvements to its main hospital building; this new structure was known as the Atrium Pavilion. The Atrium Pavilion assets were placed in service in fiscal year (FY) 1982 and assigned a 40-year estimated useful life.[15] During FY 1984, however, the Provider changed methodology for estimating the useful lives for building additions from a composite to a "componentized" methodology to calculate depreciation expense.[16] This change in methodology had not been expressly approved by the Intermediary.[17] Under this method, the Atrium Pavilion used a 10-year estimated useful life. Id. Therefore, the Atrium Pavilion should have been fully depreciated during FY 1992.[18]

Due to a miscalculation in the revised depreciation schedule, the Provider failed to claim the appropriate amount of depreciation expense related to the Atrium Pavilion from FYEs 6/30/82 through 6/30/91. At the end of FYE 6/30/92, after the normal annual depreciation expense was claimed an un-depreciated balance of $300,783 remained in the Atrium Pavilion asset account. The Provider claimed the balance remaining in the account at the end of FY 92 on its FYE 6/30/92 cost report as additional depreciation expense.[19] The Intermediary disallowed the difference between on full year's worth of depreciation expense and what was claimed by the Provider on the as-submitted cost report.[20]

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12 Tr. at 69.
13 See Note 6 of Provider's Exhibit P-16.
14 See Intermediary's Exhibit I-6 or Provider's exhibit P-15.
15 Tr. at 96.
16 In general, the component depreciation method allows individual parts or elements of a building or improvement to be separately depreciated. In component depreciation, each component has its own class life and recovery period.
17 See Provider's Exhibit 17; Tr. 96-97.
18 Tr, at 97.
19 See Provider's Exhibit 1.
20 See Provider's Exhibit 18.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, evidence presented, parties' contentions and post-hearing briefs, finds and concludes the following.

Issues No. 1 & 2 - Transplant Surgery Program

The Board finds that the allowability of the Provider's fellowship program in transplant surgery, which was accredited by ASTS, rests upon the directions provided by the Secretary in the preamble to the Medicare regulations that were issued on September 29, 1989. Specifically, Federal Register at 54 FR 40286 (Sept. 29, 1989)[21] rule sets forth changes in Medicare policy for payment of DME costs in approved residency programs. These changes implement Section 1886(h) of the Social Security Act, which was added to that section by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 and amended by section 9314 of the Omnibus Budget Reconciliation Act of 1986. Part 8 of the preamble offers clarification of what constitutes an approved program for the purposes of payment for direct GME costs. The preamble states that . . . "Congress has shifted the emphasis from the accreditation of the program to the acceptability of the training for the purpose of attaining certification in a specialty or subspecialty."[22] However, the existing reference in section 1861(b)(6) of the Act regarding approved programs did not change. The Secretary defined in the regulation at 42 C.F.R. §413.86(b) an approved residency program in medicine, osteopathy, dentistry and podiatry for cost reporting periods beginning on or after July 1, 1985.

Effective with this final rule, a medical residency program was considered approved if it: (1) was approved by one of the national accrediting bodies set forth in section 1861(b)(6) of the Act; or (2) may count toward certification in a medical specialty or subspecialty cited in the 1985-1986 Director of Residency Training Programs published by the American Medical Association; or (3) was approved by the ACGME as a fellowship program in geriatric medicine. Essentially, Congress still required the Secretary to establish which programs would be approved and what bodies would approve them.

Based on the plain reading of 42 C.F.R. §413.86(b) the Board observes that the transplant surgery fellowship is not a medical subspecialty specifically allowed by the above regulation in effect during the cost reporting period at issue. The regulation in effect during FYE 6/30/92 defines an approved medical residency program as a program that meets one of the following criteria: (1) is approved by one of the national organizations listed in §405.522(a); (2) may count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications: (i) the Directory of Graduate Medical Education Programs published by the American Medical Association…; or (ii) the annual Report and Reference Handbook published by the American Board of Medical Specialties (ABMS)….; (3) is approved by the ACGME as a fellowship program in geriatric medicine. Neither the ACGME nor the ABMS had

[21] See Provider Exhibit No. 7.
[22] Id at p. 3.

recognized transplant surgery as a medical subspecialty in the period under appeal. Although, ASTS accredits abdominal transplant surgery programs and fellows, it is not an accrediting body recognized by the Medicare program for purposes of payment. Therefore, the transplant surgery program is not an approved medical residency program and time spent by fellows in the program is not includable in the DGME or IME FTE counts.

The Board also notes that the Provider's transplant program does meet the requirements of a non-approved educational program under 42 C.F.R. §405.523. As such, the costs incurred (salary and salary-related fringe benefits) are allowable. The Board remands this issue to the Intermediary to review the Provider's claimed cost under this regulatory provision.

Issue No. 3 - Medicaid HMO Days

The essence of this issue is what is considered adequate documentation to support the entire 172 MedCare HMO days that the Provider argues should be included in its DSH calculation. The Provider argues that the accuracy of the MedCare report was supported by eligibility screens that were obtainable from the IDPA System. 39 out of 172 screens were provided to and accepted by the Intermediary in support of its accuracy. Finally, the Provider argues that the IDPA report is sufficient to support the Provider's claim that all 172 MedCare HMO days were proper for inclusion in the DSH calculation. The Intermediary counters that its experience with using IDPA reports for Medicare HMO day purposes has resulted in a high incidence of errors. Therefore, it required, as part of its review, eligibility screens for all MedCare HMO claims reported on IDPA's listing.

The Board finds that the regulation at 42 C.F.R. §413.24 requires providers to present adequate documentation to support costs claimed for Medicare reimbursement purposes. The Board further finds that the Intermediary has the responsibility to require additional corroborating evidence where it determines that the supporting documentation provided is inadequate. The Board has reviewed the record to determine what documentation was submitted in order to determine its reliability. Based on its review, it finds the evidence presented, both documentary and testimonial, to be insufficient to make a determination as to the adequacy of the Provider's documentation. Since 42 C.F.R. §413.24 clearly puts the burden of proof on the Provider to support its claimed costs, the Board concludes that the Provider has not met this burden, and that the Intermediary's adjustment was appropriate.

Issue No. 4 – Atrium Depreciation

The Board finds that there is no dispute regarding the facts (historical cost, depreciable life, etc.) relating to this issue. Essentially, both parties agree that depreciation of the Atrium Pavilion should have ceased by FYE 6/30/92, the year at issue. Further, both parties admit that an error occurred in the depreciation calculation when the Provider changed its useful life calculation from a composite life to a component-based life. The Board finds that the Intermediary was technically correct in disallowing the "extra"

depreciation claimed by the Provider in FYE 6/30/92. The appropriate response would have been to reopen prior year cost reports, but this was not permissible due to the 3 year time limit. However, the Board finds that based on the Provider's observation, this Intermediary had a practice of allowing multi-year adjustments in one cost reporting period. These usually involved circumstances where it adjusted depreciation claimed that benefited the Medicare program and the procedure was done out of administrative convenience.

Based on this practice and the fact that the error was found well beyond the point when costs reports could have been reopened, the Board concludes that based on the need for administrative consistency, the Intermediary should have allowed the Provider's remaining unclaimed and unreimbursed depreciation.

DECISION AND ORDER:

Issues No. 1 & No. 2 - - Transplant Surgery Program

The transplant program is a non-approved teaching program reimbursable under 42 C.F.R. §405.523. The Intermediary properly disallowed these costs under an approved program under 42 C.F.R. §413.86. Further, this issue is remanded to the Intermediary to determine the accuracy of claimed costs under 42 C.F.R. §405.523. The Intermediary adjustments are modified.

Issue No. 3 - - Medicaid HMO Days

The Provider did not adequately document MedCare HMO days that were included in the DSH calculation. The Intermediary's adjustment is affirmed.

Issue No. 4 - - Atrium Depreciation

The Provider properly included unclaimed depreciation expense in its FYE 6/30/92 cost report in light of the facts and circumstances relating to an error in calculating depreciation in prior years. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING

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

DATE: January 19, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson