PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D39

PROVIDER -
E.W. Sparrow Hospital
Lansing, Michigan

Provider No.: 23-0230

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC

DATE OF HEARING -
August 25, 2005

Cost Reporting Period Ended -
December 31, 2000

CASE NO.: 04-0644

INDEX

ISSUE:

Whether the Intermediary properly determined the full-time equivalent (FTE) intern and resident count for purposes of computing the Provider's indirect medical education adjustment (IME) and the direct graduate medical education (DGME) payment.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. 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 providers under Medicare law and interpretative 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 portion 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.

Medicare reimbursement is governed by section 42 U.S.C. §1395x(v)(1)(A) of the Social Security Act (Act). In part, the statute provides that the reasonable cost of any service shall be the cost actually incurred excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services.

Effective with cost reporting periods beginning on or after October 1, 1983, short-term acute care hospitals became subject to Medicare's Prospective Payment System (PPS). Under this system, Medicare's payment for hospital inpatient Part A operating costs is made on prospectively determined rates and applied on a per discharge basis; Medicare discharges are classified into diagnostic related groups (DRGs) and a hospital-specific payment rate is assigned to each DRG with respect to resource use or intensity. Hospital inpatient operating costs include general routine service costs, ancillary service costs, and intensive care-type unit service costs, but exclude certain other costs such as GME expenses and organ acquisition costs. In addition, an add-on payment or adjustment is made under PPS for IME.

In general, a PPS hospital's Direct GME costs are determined by multiplying its "updated per resident amount," a hospital-specific rate that had been determined from a base period (42 U.S.C. §1395ww(h)(2)(A), by the actual number of FTE residents in an approved medical residency training program that worked at the facility pursuant to 42 U.S.C. §1395ww(h)(4). These costs are then apportioned to Medicare based upon a hospital's ratio of Medicare inpatient days to total inpatient days. Implementing regulations at 42 C.F.R. §413.86(f)[1] provide specific rules for counting FTE residents.

Authority for the IME adjustment is found at 42 U.S.C. §1395ww(d)(5)(B). In general, the statute explains that a hospital's adjustment for IME is calculated by multiplying its total DRG prospective payments by the indirect teaching adjustment factor applicable to its cost reporting period.[2] Implementing regulations at 42 C.F.R. §412.105(f) provide the rules for counting FTE residents for IME purposes.

The time residents spend working in non-provider settings in connection with approved programs may be included in a hospital's FTE resident count for both IME and DGME if certain requirements are met. 42 C.F.R. §413.86(f)(4) states:[3]

> [f]or portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in non-provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met-
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> (i) The resident spends his or her time in patient care activities.
>
> (ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.
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> (iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

E.W. Sparrow Hospital (Provider) is a short-term acute care facility located in Lansing, Michigan. During its cost reporting period ended December 31, 2000, the Provider participated in approved graduate medical education programs and was entitled to

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[1] Effective October 1, 2004, this regulation was split into nine sections. The current section is 413.78.

[2] The indirect teaching adjustment factor is equal to c(((1+r) to the n^{th} power)1), where "r" is the ratio of the hospital's FTE interns and residents to beds and "n" equals .405.

[3] The IME regulations adopt these requirements at 42 C.F.R. §412.105(f)(1)(ii)(C).

reimbursement for its Direct GME costs as well as an IME adjustment. United Government Services, LLC (Intermediary) audited the Provider's cost report and made adjustments reducing the number of FTE residents claimed by the Provider. Specifically, the Intermediary reviewed a sample of interns and residents claimed by the Provider, the sample generated an error rate that was then extrapolated to the universe of residents used in the Direct GME and IME calculations. The Intermediary's disallowances are categorized as follows:

1) .5299 FTEs for resident rotations occurring at the Provider's facility rather than non-provider settings

2) .1312 FTEs for resident rotations supervised by physicians employed by the Provider

3) .4643 FTEs for written agreements requirements, and

4) .5849 FTEs for resident rotations to Michigan State University facilities.[4]

The Provider appealed the Intermediary's adjustments to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The estimated amount of Medicare reimbursement at issue is approximately $113,000.

The Provider was represented by Kenneth R. Marcus, Esquire, of Honigman, Miller, Schwartz and Cohn, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel of Blue Cross Blue Shield Association.

Stipulation of the Parties

On February 17, 2006, subsequent to the Provider's hearing before the Board, the Provider and Intermediary submitted joint stipulations into the record. The Provider and Intermediary resolved their disagreements regarding the first two categories of disallowances discussed above. In part, the parties agreed that:[5]

▪ With respect to the dispute over the number of FTE resident rotations occurring at the Provider's facilities, 0.5356 FTEs should be added to the Intermediary's audit sample FTE count for purposes of determining the Provider's Direct GME payment, and 0.5356 FTEs should be added to the Intermediary's audit sample FTE count for purposes of determining the Provider's IME adjustment.

▪ With respect to the dispute over the number of FTE resident rotations supervised by physicians employed by the Provider, 0.1312 FTEs should be added to the Intermediary's audit sample FTE count for purposes of determining the Provider's Direct GME

[4] Provider's Supplemental Position Paper at 3. Provider's Post Hearing Brief at 9.
[5] See also Provider's Post Hearing Brief at 9.

payment, and 0.1312 FTEs should be added to the Intermediary's audit sample FTE count for purposes of determining the Provider's IME adjustment.

▪ The Intermediary acknowledges and agrees that it has received and reviewed all necessary documentation, and has obtained all necessary approvals regarding the agreements set forth in the stipulations, and therefore will apply the reduced error rates based upon the "add-backs" to sampled list to determine the Provider's resident FTE count for Direct GME and IME payments.

PARTIES' CONTENTIONS:

Written agreement requirements

The Intermediary contends that certain of the Provider's written agreements with non-provider settings (Exhibit P-3A) did not meet the requirements of 42 C.F.R. §413.86(f)(4). That is, the written agreements do not explain who is paying the residents' salaries and fringe benefits or how the teaching physicians will be compensated.[6] The Intermediary also contends that the "Volunteer Faculty Physician Supervision Agreements for Office-Based Rotations" included in Exhibit P-3A were not considered acceptable documentation because they were entered into after the subject cost reporting period.

The Provider contends that it complied with the written agreement requirements of 42 C.F.R. §413.86(f)(4) in that it entered into written agreements with each of its non-provider settings (Exhibit P-3A); it incurred the entire direct cost of the residents' compensation as evidenced by copies of W-2 forms at Exhibit P-4A; it was responsible for payment of the residents' professional liability insurance; and, as shown in the Volunteer Faculty Physician Supervision Agreements for Office-Based Rotations (referred to as the Long Form); and it compensated the teaching physicians in the form of continuing medical education credits.[7]

Rotations to Michigan State University facilities.

The Intermediary contends that the Provider's affiliation agreement with Michigan State University (University) does not comply with 42 C.F.R. §413.86(f)(4). This regulation requires that the written agreement between the Provider and the University indicate the costs incurred by the Provider to ascertain if, "all or substantially all of the costs for the training program in the nonhospital setting" (42 C.F.R. §413.86(b)), meaning the salaries and fringe benefits of the residents and a portion of the cost of the teaching physicians, were paid by the Provider.[8] The Intermediary asserts that the pertinent agreement (Exhibit P-5A at section 6.1.3) indicates that the Provider will pay the cost of the compensation package for the University's Family Practice Residency Director and a portion of the cost of the part-time Geriatrics and part-time Sports Medicine Directors.

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[6] Tr. at 166.
[7] Provider's Post Hearing Brief at 10-13.
[8] Transcript (Tr.) at 91.

The Intermediary points out that based on the residents' rotation schedules there are other teaching physicians in addition to these directors and the agreement does not address who these teaching physicians are and how they will be compensated.[9] The Intermediary adds that the Provider's agreement with the University was executed in August 2000, which is 8 months after the start of the cost reporting period at issue.

The Provider contends that its agreement with Michigan State University was effective January 1, 1999, and was executed during FYE 12/31/2000. The Provider points to section 6.1.5 of the agreement, in addition to Attachment C to show that the Provider was solely responsible for the compensation and professional liability of the residents. Moreover, section 6.1.3 of the agreement indicates that the Provider was solely responsible for the compensation of the Family Practice Residency Director, and for a portion of the costs of the Directors of the Geriatrics and Sports Medicine programs as mutually agreed to in writing.[10] In addition, the Provider submitted as evidence a certification by the Director of Medical Education, Michigan State University that the Provider compensates the University for the portion of time teaching physicians employed by the University spend training and supervising the Provider's residents.[11]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

Upon consideration of the Medicare law and guidelines, the parties' contentions, and the evidence presented, the Board finds and concludes as follows:

The Provider appealed four categories of disallowances made to its FTE resident counts for determining IME and Direct GME reimbursement.[12] Subsequent to the Board's hearing held on 8/25/2005, the parties administratively resolved two (2) of the above categories/components of the Intermediary's disallowances categorized as "Resident rotations occurring at the Provider's facilities rather than non-provider settings" and "Resident rotations supervised by physicians employed by the Provider." With respect to the two remaining categories of the Intermediary's disallowances, "Written agreement requirements" and "Resident rotations to Michigan State University facilities," the Board finds that the Intermediary properly determined the Provider's FTE resident counts.

In each of the two remaining categories of disallowances, the Intermediary determined that the Provider had not complied with 42 C.F.R. §413.86(f)(4) and 42 C.F.R. §412.105(f)(1)(ii)(C). The regulations require providers to have written agreements with each non-hospital setting where their residents spend time in connection with approved teaching programs. Moreover, the regulations are clear that the written agreements must indicate that the Provider will incur the cost of the residents' salaries and fringe benefits while training at the non-hospital site and the compensation the Provider is providing to the non-hospital site for supervisory teaching activities. The Provider did not have

[9] Tr. at 93.
[10] Provider's Post Hearing Brief at 15. See Exhibit P-5A at 5.
[11] Provider's Post Hearing Brief, Exhibit 2
[12] The disallowances pertain to a sample of FTE resident rotations reviewed by the Intermediary yielding an error rate that was extrapolated to the universe of the Provider's FTE residents.

written agreements with all teaching physicians that met the regulatory requirements, and it did not have a written agreement with Michigan State University which indicated the compensation the Provider furnished for supervisory teaching activities.[13]

With respect to resident rotations to individual physicians offices, which are the Intermediary's disallowances categorized as "Written agreement requirements," the Provider asserts that it entered into basic written agreements (referred to as the "Short Form") with each non-provider setting during the cost reporting period at issue, and subsequently entered into a more sophisticated form of written agreement (i.e., Long Form) with the same non-provider settings during FYE 12/31/2003.[14] The Provider asserts that the Short Form agreement states that each rotating resident is "a resident in good standing" which signifies that the Provider is responsible for paying the costs of the residents' salaries and fringe benefits. In addition, the Long Form agreements entered into with the teaching physicians memorialized the arrangement that existed in the subject cost reporting period which indicated that the Provider compensated the physicians in the form of continuing medical education credits.

The Board finds, however, that this documentation does not meet the requirements of 42 C.F.R. §413.86(f)(4). The regulation requires a written agreement exist that indicates the Provider will incur the cost of the residents' salaries and fringe benefits. Although, the Provider explains what it believes the statement a "resident in good standing" means, it does not plainly indicate that the Provider is paying the residents' compensation, which the Board finds to be the clear intent of the regulation. Similarly, the regulation requires the written agreement to indicate the compensation the Provider is furnishing the non-hospital sites for supervisory teaching activities. In this instance, the Provider's basic agreements are silent with respect to teaching physicians' compensation, and the more sophisticated agreements entered into in fiscal year 2003 are not contemporaneous.

The Board further notes that the Provider presented copies of Wage and Tax Statement forms (W-2s) showing that it paid the salaries of the residents at issue. While the Board finds the W-2s substantive evidence that the Provider paid the residents' compensation, they are not cast within the framework of a written agreement as required by the regulation.

The Board also notes what appears to be a discrepancy within the Provider's documentation.[15] Specifically, the written agreements are for residents other than those

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[13] The Board notes that CMS modified its policy regarding a hospital's need to have a written agreement with a non-provider site in order to have a resident's time included in its IME and Direct GME counts. Effective for portions of cost reporting periods occurring on or after October 1, 2004, hospitals could waive the written agreement requirement if they paid all or substantially all of the costs of the training program in a non-hospital setting on a timely basis. The Board believes this modification shows that the intrinsic value of the written agreement requirement applicable to non-hospital sites is extremely limited; however, the Board is bound to enforce the regulations in effect during the cost reporting period at issue (see re-codification at 42 C.F.R. §413.78(e)).

[14] Provider's Supplemental Position Paper at 10.

[15] The first page of Exhibit P-3A (Provider's Supplemental Position Paper) shows the names of the residents at issue and the portion of their FTE count disallowed by the Intermediary. Exhibit P-4A

addressed in the Intermediary's adjustment. Therefore, even if the documents presented by the Provider as its written agreements complied with 42 C.F.R. §413.86(f)(4), and were contemporaneous to the cost reporting period at issue, it appears the Intermediary's disallowance would still be warranted.

With respect to the Intermediary's disallowances categorized as "Resident rotations to Michigan State University facilities," the Provider refers to its affiliation agreement with the University found at Exhibit P-5A of its Supplemental Position Paper. The Provider asserts that section 6.1.3 of the agreement indicates the compensation it is furnishing to the University for supervisory teaching activities in accordance with 42 C.F.R. §413.86(f)(4). However, while section 6.1.3 of the agreement does address the Provider's representation to pay certain costs incurred by the University, a complete reading of the section shows that yet another agreement is needed to actually establish the terms and conditions of the Provider's relationship with the University. In pertinent part, section 6.1.3 of the agreement states:

> Sparrow will pay the cost of the compensation package for the full-time Family Practice Residency Director including but not limited to salary, benefits, and liability insurance, and will pay a portion of the cost of the part time Geriatric and part time Sports Medicine Directors as mutually agreed to in writing by Sparrow and MSU/CHM [Michigan State University/ College of Human Medicine]. <u>These terms and conditions shall be committed to writing in an agreement, signed by both parties, and shall define the employer, the compensation, the responsibilities, the evaluation process, and other items necessary to the operation of the program</u>. (Emphasis added.)

In addition, the Board notes that the Provider's agreement with the University addresses the compensation of the Director of the Family Practice Residency program and the Directors of the Geriatrics and Sports Medicine programs. However, the agreement does not address whether or not any other University faculty (members) actually conducted any teaching activities, which would be customary practice where a GME program is operated by a hospital but affiliated with an academic institution.

<u>DECISION AND ORDER</u>:

The Intermediary will add 0.5356 FTEs to its audit sample FTE count for purposes of determining the Provider's Direct GME payment, and 0.5356 FTEs to it audit sample FTE count for purposes of determining the Provider's IME adjustment resolving the parties' dispute over the number of FTE resident rotations occurring at the Provider's facilities.

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contains the W-2s applicable to these residents. However, the basic written agreements provided in Exhibit P-3A do not pertain to residents at issue.

The Intermediary will add 0.1312 FTEs to its audit sample FTE count for purposes of determining the Provider's Direct GME payment, and 0.1312 FTEs to its audit sample FTE count for purposes of determining the Provider's IME adjustment resolving the parties' dispute over the number of FTE resident rotations supervised by physicians employed by the Provider.

The Intermediary's adjustments to its FTE audit samples for resident rotations to non-provider/non-hospital settings and rotations to the Michigan State University facilities were proper and are affirmed.

BOARD MEMBERS PARTICIPATING:

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Dr. Gary B. Blodgett
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DATE: May 31, 2007

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