PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D43

PROVIDER -
Tulsa Regional Medical Center
Tulsa, Oklahoma

Provider No.: 37-0078

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Chisholm Administrative Services
(f/k/a Blue Cross of Oklahoma)

DATE OF HEARING -
January 24, 2008

Cost Reporting Periods Ended -
December 31, 1999 through December 31, 2003;
July 31, 2004

CASE NOs.: 04-1792; 05-2073; 05-2074;
05-2154; 06-0010; 06-0300

INDEX

ISSUE:

Whether the Intermediary properly adjusted the Provider's indirect medical education full-time equivalent (FTE) cap?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement to 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 and 413.24.

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.

In addition, 42 C.F.R. §405.1885 permits an intermediary to reopen its determination and revise any matter in issue on its own motion, CMS' motion, or the motion of the provider. However, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination.

Since the inception of the Medicare program, Congress always allowed the cost of training physicians, based on the premise that ". . . these activities enhance the quality of care in an institution." [1] In 1983, Congress recognized that teaching hospitals incur indirect operating costs that would not be reimbursed under the prospective payment system or by the Direct Graduate Medical Education (DGME) payment methodologies and 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

[1] 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).

that are associated with the presence and intensity of resident training in an institution but which cannot be specifically attributed to, and does not include, the costs of resident 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. The Balanced Budget Act of 1997 (BBA-97) placed a limitation on resident FTEs for purposes of determining the IME payment by amending 42 U.S.C. §1395ww(d)(5)(B)(v). This provision established a "cap" based on FTEs in the 1996 cost report period (the base year).

The issue in this case involves the application of the three-year limitation on reopenings and the interpretation of the regulation for the proper accounting of FTEs.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Hillcrest Healthcare System (Hillcrest) is an Oklahoma nonprofit, charitable corporation which acquired the assets of Tulsa Regional Medical Center (TRMC) on January 1, 1999. Hillcrest became the sole member of Hillcrest Riverside, Inc., a not for profit corporation, d/b/a Tulsa Regional Medical Center (Provider) which owned and operated TRMC from January 1, 1999 to July 31, 2004. The Provider is an osteopathic acute care teaching hospital that is located in Tulsa, Oklahoma.

For the fiscal periods ended December 31, 1999 through 2002, the Provider calculated its IME reimbursement utilizing an IME cap of 85.67 FTEs.[2] For the periods 1999-2001, Blue Cross of Oklahoma (Intermediary) adjusted the cap upward to 104.15 FTEs based upon the Provider's settled cost report for 1996 and issued a Notice of Program Reimbursement for each year. The base year 1996 cost report was filed by the Provider's prior owners. The Provider subsequently filed its cost reports for FYEs December 31, 2003 and July 31, 2004 using the Intermediary's adjusted 104.15 cap.

In 2004, CMS' conducted an examination of the FYE 2000 cost report and workpapers under its Audit Quality Review Program. CMS also received the 1996 cost report and workpapers for IME/GME calculation. CMS' found that the Intermediary had applied an incorrect IME base year cap (104.15 FTEs) for FYEs 1999-2001. The Intermediary revisited the 1996 year and determined that the proper FTE count should be 85.79.[3] In early 2005, the Intermediary reopened the cost reports for FYEs 1999-2001 to incorporate the corrected FTE cap. The Intermediary also settled the 2002, 2003 and 2004 cost reports using the same reduced cap.

The Provider challenged the authority of the Intermediary to reopen the 1996 cost report beyond the 3 year limitation[4] as well as the use of the reduced cap in all of the years where it was applied by the Intermediary (1999-2004).

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[2] Tr. p. 61.
[3] Provider Exhibit P-9, pgs. 3-4.
[4] 42 C.F.R. §405.1885(a).

The Provider appealed the Intermediary's determinations to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Provider was represented by Peter Leone, Esq., of McDermott, Will and Emery, LLP. The Intermediary was represented by James R. Grimes, Esq., of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly reopened and audited the settled 1996 cost report. The Intermediary issued its final NPR for the 1996 base year on November 30, 2000. The NPR incorporated the Provider's 104.15 IME FTE count as filed on Worksheet S-3 of its cost report. The Provider questioned the accuracy of the 104.15 FTEs in subsequent correspondence, but the Intermediary persisted in its application and use in subsequent cost reporting periods. In early 2005, the Intermediary reopened the FYE 1996 cost report. The Provider contends that the reopening is beyond the 3 year limitation and that the NPR cannot be adjusted. The Provider argues further that since the Intermediary accepted 104.15 IME FTE count in its final NPR, the cap for subsequent years is properly set at 104.15 FTEs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary disputes both the logic and conclusion of the Provider's argument. The Intermediary argues that while 104.15 FTEs were reported on Worksheet S-3, that number did not automatically flow into the computation of IME reimbursement for earlier cost reporting years. The Intermediary contends that it settled the FYE 1996 cost report with an FTE count of 88.14 for IME from Worksheet E, Part A as required by CMS Form 2552-92. The Intermediary argues, therefore, that the correct IME cap was properly set at 88.14 FTEs.

CMS' quality review of the FYE 2000 NPR found that the Intermediary incorrectly applied the direct GME cap to the IME calculation. CMS recommended that the Intermediary revise subsequent cost reports that were still subject to reopening. The Intermediary argues that its application of the corrected FTE in subsequent years is not a reopening of the 1996 cost report. On its 1996 cost report, the Provider's IME reimbursement was calculated using 85.67 FTEs which was relatively close to the audited/ settled count of 88.14 IME FTEs. The Intermediary argues there is no justification for using 104.15 FTEs for IME purposes.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions and the evidence presented at hearing finds and concludes that the Intermediary's adjustment to the Provider's IME reimbursement was consistent with the Secretary's regulations, but that it should be modified.

42 U.S.C. §1395ww(d)(5)(B)(v) imposes the limitation on resident FTEs for purposes of determining the IME payment and states in pertinent part[5]:

> 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 1, 1996.

The evidence contained in the record indicates that there were two cost reporting periods ending in 1996. The first period ended 1/10/96 and the second ended 5/31/96.[6] The language of the statute appears to require the use of the 5/31/96 reporting period. However, the Intermediary chose to use the 1/10/96 cost reporting period in its calculations stating:

> FYE 1/10/96 was the last cost report audited or reviewed by Intermediary as provider was owned by Columbia and Columbia reports were placed on hold. We will use information from the 1/10/96 NPR for 1996 FTE data.[7]

Neither the parties nor CMS contested the use of 1/10/96 year, therefore the Board's analysis will be based on the 1/10/96 fiscal period.

The primary issue in dispute is whether the IME base year FTE cap is properly derived from Worksheet S-3 or Worksheet E, Part A. Neither the statute nor the regulation identifies where within the cost report the IME FTEs are to be found. The cost report reports the IME FTE count on Worksheet S-3. However this worksheet is for statistical reporting purposes and is not used in the calculation of IME reimbursement. The IME reimbursement determination is calculated on Worksheet E, Part A, line 3. The number of IME FTEs is an essential component of the IME reimbursement calculation. It is undisputed that the 104.15 FTEs reported on Worksheet S-3 incorrectly related to the GME cap and that the IME base year payment was computed using 88.14 FTEs.

This case is complicated by the Intermediary's application in subsequent years, over the objections of the Provider, of the incorrect 104.15 IME FTE cap. The Intermediary informed the Provider that the 104.15 FTE cap was correct because it had been used in the base year. When the Intermediary reopened FY 1999 and reduced the IME FTE cap to 85.79, the Provider argued that this constituted a reopening of the FY 1996 cost report more than 3 years after the date of the NPR.

The Intermediary's application of the wrong number from the 1996 cost report to fiscal years 1999 through 2001 does not constitute a 1996 cost report redetermination of the

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[5] See also: 42 C.F.R. §413.86(4).
[6] Intermediary Supplemental Position Paper, p.4.
[7] Intermediary Supplemental Position Paper, Exhibit I-3, p. 4

IME FTE cap. The number used for the 1996 calculation (88.14 FTEs) of the IME reimbursement is the number "determined" in the 1996 cost report. Consequently, the Intermediary's action in December 2004 was not a reopening of the 1996 cost report but, rather, an application of the correct 1996 base year FTE cap to the FYs 1999-2001. Accordingly, the Board finds that the 3 year reopening limitation was not violated by the Intermediary's action.

The Board further finds that for IME reimbursement purposes the 88.14 FTEs should be used versus the 85.79 FTEs that had been adjusted by the Intermediary.[8] The 88.14 is the number that was determined in the 1996 base period and was correctly based upon a 365 day calendar year (1/1/95-12/31/95).[9] Therefore the reduction based upon the 375 day fiscal year was not appropriate.

The Board recognizes that the Provider may have relied on the Intermediary's 104.15 number to plan and budget its FTEs in future years and that this reliance was detrimental to the Provider's operations. However, the Board is bound by the statute and regulations. The statute and regulation require the Board to use the actual number of residents in the hospital. The Board finds the actual number of IME FTEs is the 88.14 FTEs utilized in the calculation of the final determination of IME reimbursement.

DECISION AND ORDER:

The Intermediary's adjustment reducing the Provider's Indirect Medical Education costs is modified. The correct IME FTE cap is 88.14 FTEs.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews-Powell, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 30, 2008

[8]Intermediary Supplemental Position Paper Exhibit I-4.
[9]Intermediary Supplemental Position Paper Exhibit I-2.