PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D6

PROVIDER -
Greenville Hospital Center
Greenville, South Carolina

Provider No.: 42-0078

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Palmetto Government Benefits
Administrator

DATE OF HEARING -
December 16, 2008

Cost Reporting Period Ended -
September 30, 1996

CASE NO.: 08-0429

INDEX

ISSUE:

Whether the intermediary's disallowance of resident time spent in didactic activities for purposes of the indirect medical education adjustment was 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. 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.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The PPS statute contains a number of provisions that adjust reimbursement based upon hospital specific factors. 42 U.S.C. §1395 ww(d). This case involves one of those provisions.

In 1983, Congress recognized that teaching hospitals have indirect operating costs that would not be reimbursed under the prospective payment system or by the Direct Graduate Medical Education (DGME) payment methodology 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 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.

For fiscal 1996, the year at issue in this case, the regulations governing IME reimbursement were codified at 42 C.F.R. § 412.105(g) (1995).[1] The regulations state in pertinent part:

> (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purposes of determining the indirect medical education adjustment is determined as follows:
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> (i) The resident must be enrolled in an approved teaching program
> (ii) The resident must be assigned to one of the following areas:
> (A) The portion of the hospital subject to the prospective payment system;
> (B) The outpatient department of the hospital
> (iii) Full-time equivalent status is based on the total time necessary to fill a residency slot.

In 2001, CMS adopted a rule change to the IME regulation that expressly excluded time that was spent by residents in research unrelated to the care of a specific patient from the count of residents for IME. 42 C.F.R. §412.105(f)(1)(iii)(B). The new rule did not address didactic activities and did not exclude such activities from the count of FTE residents.

In 2006, the Secretary promulgated changes to the IME regulations that specifically required that residents spending time in patient care activities, in both hospital and non-hospital settings, be counted in the FTE resident count for IME. 42 C.F.R. §412.105(f)(1)(ii)(C). CMS quoted from the August 1, 2001 final rule (66 FR 39897) which states that, "we do not include residents in the IME count to the extent that the residents are not involved in furnishing patient care. . ." 71 Fed.Reg.47480, 48081 (Aug.18, 2006)[2]. The new regulatory provisions state, "[i]n order to be counted, a resident must be spending time in patient care activities, as defined in §413.75(b) of this subchapter." 42 C.F.R. §412.105(f)(1)(iii)(C) (2006)[3]. At the same time, CMS defined "patient care activities" for direct GME and IME purposes as "the care and treatment of particular patients, including services for which a physician or other practioner may bill." 42 C.F.R. §413.75(b) (2006)[4]

The issue in this case involves the interpretation of the regulation for the proper accounting of FTEs in the IME calculation.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Greenville Hospital Center (Provider) is an acute care facility located in Greenville, South Carolina. On 02/13/04, Palmetto Government Benefits Association (Intermediary) issued an NPR for the Provider's fiscal year 1996 cost report in which classroom time on the interns/residents rotation schedules was excluded from both the allowable time and the total time used in the calculation of FTEs for direct GME and IME. The approach was consistent with the

[1] This regulation was re-designated from 42 C.F.R §412.105(g) to §412.105(f). See 62 Fed.Reg. 45966, 46029 (Aug. 29, 1997).
[2] Exhibit P-17.
[3] Exhibit P-18.
[4] Exhibit P-19.

manner in which the Provider filed its cost report and treated didactic activities as general time, which, would be spread between allowable and non-allowable time based upon the direct hours included in the rotation schedules. As a result, the Provider would be negatively impacted for didactic activities only if there were non-allowable hours in the rotation for a given specialty. On 09/27/07, the Intermediary reopened the fiscal year 1996 cost report to remove the classroom time and other didactic activities from the allowable IME FTE count by including the hours designated as classroom time on the rotation schedules in the total time (denominator) and excluding the hours from the allowable time (numerator) of the FTE calculation. At issue is whether the Intermediary may properly disallow didactic time using the rules adopted by CMS in 2001 and 2006.

The Provider appealed the issue to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835- 405.1841. The Provider was represented by Thomas W. Coons, Esquire, of Ober, Kaler, Grimes and Shriver. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the time residents spend in didactic activities as part of an approved residency program is properly included in the IME calculation based upon the pertinent statute and controlling regulation. For fiscal year 1996, the regulations governing IME reimbursement required that the resident "must be enrolled in an approved teaching program" and "the resident must be assigned to one of the following areas: (A) The portion of the hospital subject to the prospective payment system [, or](B) [t]he outpatient department of the hospital."[5] It is undisputed that the residents at issue here met both of the requirements imposed by the regulations.[6] Further, the IME regulation also provides that "[f]ull-time equivalent status is based on the total time necessary to fill a residency slot."[7] The Provider contends therefore that time spent in didactic activities in an approved teaching program must necessarily be included in the count of FTE residents for IME purposes and offers the decision in Riverside Methodist Hospital v. Thompson[8] in support of its contention. In Riverside the Court found:

> [U]nder ACGME standards medical residents are *required* to spend a portion of their time attending seminars and engaging in the type of educational activities involved in this case. . . Thus by requiring residents to be enrolled in an approved educational program, . . . the regulation implicitly recognizes that "full-time" residents will spend some of their time in solely educational activities that are not directly related to providing hands-on patient care; yet nothing in the regulation indicates that time so spent should be deducted from the FTE resident count. Although the phrase "total time necessary to fill a residency slot" is not defined in the regulation, it can only reasonably be read to include time spent by residents participating in *required* educational activities . . . because such activities would be necessary to fill a residency slot. (Emphasis in original)

[5] 42 C.F.R. § 412.105 (g) (1)(ii)(A) & (B); see also Exhibit P-13.
[6] Stipulations of the Parties, ¶12.
[7] Id.
[8] Riverside Methodist Hospital v. Thompson, No. C2-02-94, (S.D.Ohio July 31, 2003.)

The Provider also contends that the Intermediary's disallowance is contrary to the plain language and purpose of the IME statute and argues that Congress did not intend to incorporate a hands-on patient care requirement for counting residents. As initially enacted in 1983, the IME statute required that the IME adjustment must be "computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983)."[9] The regulations make no mention of excluding any residents who were enrolled in approved teaching programs based upon the activity in which they engaged. The Provider argues that Congress did not intend to give the Secretary broad authority through these provisions to impose whatever conditions he desired and that the legislative history indicates that Congress included the indirect teaching formula in the statute so that "[t]here is no discretion on the part of the Secretary."[10]

The Provider also contends that the 2001 and 2006 amendments to the IME regulation cannot be viewed as a clarification of existing policy since they establish new restrictions and recordkeeping requirements. The Provider argues that these amendments cannot be applied to the subject cost reporting period because retroactive rule making is prohibited under the Administrative Procedure Act[11] and established Court decisions.[12]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that time spent by residents in didactic activities that are not directly related to the care of patients should be excluded from the IME resident count. The Intermediary argues that, although the Medicare program has traditionally sought to reimburse hospitals for the indirect costs associated with interns and residents treating patients in the hospital, certain costs related to medical residency training programs were considered unrelated to the care and treatment of patients. As such, they are not reimbursable costs under the program. The Intermediary argues that the Secretary's instructions at 71 Fed.Reg. 47,870, 48,082 (Aug.18, 2006)[13] restated the proper treatment of didactic time in the computation of the FTE count for IME purposes as follows:

> With respect to residency training in the hospital, our policy limiting the IME count to only time spent in patient care activities is rooted in the creation and the purpose of the IME adjustment. The IME adjustment is a payment to a teaching hospital for its higher costs of patient care.

The Intermediary contends that CMS' policy had always assumed that there must be a direct link between the costs that the IME payment addressed and patient care. The Intermediary argues further that the nexus between costs and patient care is consistent with the regulatory basis for Medicare payment.[14] The Intermediary argues that a resident who is attending a class or conference is not involved in the direct care of a patient but engaged in a didactic, non-patient care activity that is not recognized for purposes of the IME payment.

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[9] 42 U.S.C. §1395ww(d)(5)(B).
[10] H.R. Rep.No. 99-241(I), as reprinted in 1986 U.S.C.C.A.N. 579, 593. See Exhibit P-55
[11] 5 U.S.C. §553(b). See Exhibit P-61
[12] National Mining Association v. Department of Labor, 292 F.3d 849 (D.C. Cir 2002); Health Insurance Association of America, Inc., v. Shalala, 23 F.3d 412 (D.C.Cir. 1994).
[13] See Exhibit P-17.
[14] 42 C.F.R. §413.9.

The Intermediary further contends that the Medicare program does not recognize didactic activities for the same reason that it does not recognize research time in the IME adjustment process. In both cases the resident is not involved in patient care and is therefore not contributing to the higher cost of treating patients which is the basis of the IME payment. The Intermediary argues that the First Circuit Court of Appeals addressed this rationale in Rhode Island Hospital v. Leavitt.[15] There the Court focused on 42 C.F.R. §412.105(g)(l) in which the Secretary identifies the types of resident activities that Medicare will include in the FTE count. The Secretary argued that residents assigned to educational research activities are not assigned to a portion of the hospital subject to the prospective payment system. The Court concluded:

> Put simply, the Secretary's interpretation of the FTE regulation is not "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law 5 U.S.C. §706(2)(A)." We therefore "refuse to substitute our judgment" for that of the Secretary.[16]

The Court agreed that the legislative and administrative history indicates that the IME adjustment was intended to reimburse hospitals for the increased patient care costs associated with a teaching program due to factors such as increased diagnostic testing, increased numbers of procedures prescribed, higher staffing ratios and a more severely ill patient population. The Court also found that educational research expenses do not directly increase the costs that teaching hospitals incur in providing patient care.

The Intermediary argues that residents involved in classroom or didactic activities are not contributing to the increased costs of treating patients that are associated with the presence of residents treating patients in the hospital. As a result, the time should not be included in the FTE count used to calculate the IME payment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and stipulations, and the evidence contained in the record, the Board finds and concludes that the Intermediary's calculation of the Provider's IME reimbursement was improper.

The single issue in this case is whether the time spent by residents in didactic activities that are a part of an approved residency program should be included the IME calculations. The issue is not new to the Board. It addressed this issue in its decision in Univ. Med. Ctr. (Tucson, Ariz.) v. BCBS/Blue Cross and Blue Shield of Ariz,[17] finding that the regulation[18] in effect during the subject cost reporting period did not exclude research time from the IME resident count nor did it require resident time to be related to patient care. In pertinent part, the regulation states:

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[15] Rhode Island Hospital v. Leavitt; 548 F. 3d 29 (1st Cir. 2008) see Exhibit P-96.
[16] Id., at p.11.
[17] Univ. Med. Ctr. (Tucson, Ariz.) v. BCBS/Blue Cross Association and Blue Shield of Ariz., PRRB Dec. No. 2005-D36, Medicare and Medicaid Guide (CCH) ¶81,307 (Apr.12, 2005).
[18] 42 C.F.R. §412.105(f)

> (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:
>
> (i) The resident must be enrolled in an approved teaching program.
>
> (ii) In order to be counted, the resident must be assigned to one of the following areas:
>
> (A) The portion of the hospital subject to the prospective payment system.
>
> (B) The outpatient department of the hospital.

It is undisputed that the residents at issue in this case were enrolled in an approved GME program and that they worked in either the portion of the Provider's facility subject to PPS or an outpatient area. Therefore the Board finds that the time spent by the Provider's residents meets the regulatory requirement for inclusion in IME FTE count.

The Board notes that this finding is consistent with the court's findings in Riverside Methodist Hospital v. Thompson. [19] In part, the court concluded that the Secretary did not deny that, "the [IME] regulation as it was written at the time in question, does not by its plain language contain any requirement that the time spent by residents had to be spent in direct patient care in order to be counted."[20] The Board also notes that both its findings and the findings of the court in Riverside were affirmed by the court in University Medical Center Corp. v. Leavitt,. [21] There the court concluded:

> The [pre-2001] regulation is not ambiguous, and when considered in context with the historical intent of both the regulation and its governing statute, it is evident that all time spent by residents in research and other scholarly activities while they are "assigned to" the Hospital must be included when determining the Hospital's resident count for purposes of calculating the IME payment.

Additionally, the Board finds that the 2001 and 2006 amendments to the IME rule excluding non-patient care research time from the resident count and limiting includable time to time spent in the care and treatment of a particular patient represent changes in policy that cannot be applied retroactively to the subject 1996 cost reporting period. As the court in Riverside explained, the IME regulation is clear, in that the time spent by residents performing non-patient care related activities is not excluded from the resident count, and "if the Secretary desires to include a new

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[19] Riverside Methodist Hospital v. Thompson, No. C2-02-94 (S.D. Ohio, July 31, 2003) see also Exhibit P-6
[20] See Riverside, pg. 5.
[21] University Medical Center Corp. v. Leavitt, No. 05-CV-495 TUCJMR, (D.Ariz., March 21, 2007), p.9 see also Exhibit P-59.

requirement regarding excludable time, it must be done by amendment, and in compliance with the necessary administrative procedures for amending regulations."[22]

DECISION AND ORDER:

The Intermediary's adjustments reducing the Provider's IME FTE resident count for the time spent by residents in didactic activities that were required by the residents' approved medical residency program was improper. The determination of IME reimbursement is remanded to the Intermediary for recalculation incorporating the time spent by residents in didactic activities that were part of their approved medical residency program.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A
Keith E. Braganza, C.P.A
John Gary Bowers, C.P.A

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: November 25, 2009

[22] See Riverside, pg. 15.