PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2010-D28

PROVIDER –
Benedictine Hospital
Kingston, New York

Provider No.: 33-0224

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services – New
York (formerly Empire Medicare
Services)

DATE OF HEARING –
March 17, 2010

Cost Reporting Period Ended -
December 31, 2000

CASE NO.: 05-0289

INDEX

ISSUE:

Whether the Intermediary properly adjusted the Provider's Family Practice residency program direct graduate medical education (DGME) and indirect medical education (IME) full-time equivalent (FTE) count for the fiscal year ended December 31, 2000.

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 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 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 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.

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 graduate medical education (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 resident 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

[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).

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 years 2000 and 2001, the regulations governing IME reimbursement were codified at 42 C.F.R. §412.105(f) (2000). The regulations state in pertinent part:

> 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:
>
> (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.
> (C) Effective for discharges beginning on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency program is counted towards the determination of full-time equivalency if the criteria set forth at §413.86(f)(4) are met.

The regulations governing the direct GME reimbursement at 42 C.F.R. §413.86(f)(4) state in pertinent part:

> For 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 - -
>
> (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.

(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.

The issue in this case involves the interpretation of the above regulations for the proper accounting of FTEs in the GME calculation.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Benedictine Hospital (Provider) is a 222-bed community hospital located in Kingston, New York. In 1983, the Provider and Kingston Hospital (another New York hospital) jointly established the Mid-Hudson Family Health Institute, Inc. (Institute). The Institute is a not-for-profit corporate entity that is separate from its affiliated teaching hospitals. The Institute operates a diagnostic and treatment center as well as an accredited residency program that trains medical school graduates to become board-certified family physicians. During the period from July 1983 through March 2001, the Provider executed a series of three agreements with the Institute under which the Provider agreed to cover the Institute's deficits, provide cash flow and assume the eventual responsibility for the management and cost of the residency program. In fiscal year 2000, the residency program had approximately 20 participants who split their time between the Provider, Kingston Hospital and various off-site family practice clinic locations. For that year, the Provider claimed 9.41FTEs on its cost report for the time spent by the residents at the Provider and off-site clinics.[2] In its FY 2000 NPR, National Government Services – New York (Intermediary) excluded the time spent by the Provider's interns and residents at non-provider settings operated by the Institute for failure to comply with the written agreement requirements set forth in 42 C.F.R. §413.86(f)(4)(ii). At issue is whether the Provider's collective agreements satisfied the requirements of the regulation.

The Provider appealed the denial to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Provider was represented by Roy W. Breitenbach, Esq. of Garfunkel, Wild & Travis, P.C. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., of Blue Cross Blue Shield Association.

STIPULATIONS OF THE PARTIES

The Parties agreed that the facts and circumstances of this case were identical to those already addressed by the Board in Kingston Hospital v. BlueCross BlueShield Association/National Government Services – New York ; PRRB Hearing Dec. No. 2009-D41 (September 23, 2009). The Parties requested that the Board make its determination in this case based upon its earlier decision. To that end, the Parties stipulated in pertinent part to the following:

* * * * *

1. The Provider and the Intermediary consent to a hearing on the record due to the similarities between this appeal and a previous appeal for Provider Kingston

[2] Stipulations of the Parties, ¶ 11; see also Exhibit I-4.

Hospital ("Kingston"), Provider No. 33-0004, which was heard on October 17, 2008, case numbers 05-0350 and 06-0452. [3]

2. Benedictine is a 222-bed community hospital located in Kingston, New York.

3. In July 1983, Benedictine, together with Kingston, also located in Kingston, New York, jointly established the Mid-Hudson Family Health Services Institute, Inc. (the "Institute'), a New York not-for-profit corporation with the approval of the New York State Health Department. The Institute was licensed pursuant to Article 28 of the New York Public Health Law to, among other things, operate the Mid-Hudson Family Practice Residency Program (the "Residency Program"). Ex. I-9.

4. On June 17, 1983, the Provider entered into an agreement with Kingston, captioned the "Undertaking," agreeing to fund any deficit of the Institute. More specifically, Kingston and Benedictine agreed to "contribute to the Institute, on at least an annual basis as (sic) adequate cash flow to the Institute in order to assure the Institute's financial liability." *Id.*

5. The Undertaking was entered into "to induce the Public Health Council to approve the Institute's application, and to assure that the Institute will have adequate financial resources and sources of future revenue…." *Id*.

6. Thereafter, on July 1, 1999, the Provider entered into an agreement with Kingston and the Institute. Ex. I-11.

7. During the relevant time period, the Residency Program had approximately 20 residents who split their time between Benedictine, Kingston, and various off-site family practice clinic locations. These residents spent their time in patient care activities. Ex I-7 at 2.

8. In correspondence dated March 29, 2005, Ms. Catherine Legg, Director of Financial Planning, Benedictine Hospital, represents that "Total funding provided by the hospitals [Kingston and Benedictine] [to the Institute] amounted to $ 2,074, 518. Provider's Position Paper dated March 29, 2005; Ex. I-3.

9. In 2000, the FTEs claimed by Benedictine for the time spent by residents providing services at Benedictine and various off-site family practice clinic locations were 9.41. Ex. I-4.

10. In the 2000 NPR, the Intermediary determined that the time spent by the Provider's interns and residents rotating at non-provider settings operated by the Institute would be excluded for the purposes of Medicare direct graduate medical education (GME) and indirect medical education reimbursement (IME). The

[3] The appeals for Kingston, FYE 12/31/00 (05-0359) and 12/31/01 (06-0452) addressed identical issues and were combined into one hearing.

Intermediary found that the Provider had not complied with the provisions of 42 C.F.R § 413.78(d).

11. On October 17, 2008, the Board heard Kingston's appeal of the Intermediary's denial of FTEs for residents rotating through the Institute's Residency Program during FYE 12/31/00. The facts underlying Benedictine's appeal, e.g., the formation of the Institute, the rotation of residents between Kingston, Benedictine and off site programs operated by the Institute, and the Undertaking, have already been presented to the Board. A live-hearing of Benedictine's appeal would be almost entirely duplicative. Indeed, with the exception of the number of FTEs the Intermediary rejected, there are no facts pertinent to Benedictine that have not already been heard in the Kingston appeal.

PROVIDER'S CONTENTIONS:

The Provider argues that, even if the Secretary did have the authority to impose a requirement for a written agreement, the Intermediary failed to excuse the Provider from compliance with that requirement in accordance with the provisions of Section 713 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.[4] The Section provides that:

> [d]uring the 1 year period beginning on January 1, 2004, for purposes of [determining indirect medical education and direct graduate medical education reimbursement provisions], the Secretary shall allow all hospitals to count residents in osteopathic and allopathic family practices programs in existence as of January 1, 2002, who are training at non-hospital sites, without regard to the financial arrangement between the hospital and the teaching physician practicing in the non-hospital site to which the resident has been assigned."

The Provider contends that the Secretary interprets Section 713 to excuse the written requirement for (1) all training that occurred in calendar year 2004; and (2) all training that incurred before 2004, if the reimbursability of that training was determined by one of the fiscal intermediaries during 2004.[5] The Secretary's specific instructions state:

> When settling cost reports during January 1, 2004 through December 31, 2004 (Calendar Year (CY)(2004), a hospital that seeks to count allopathic or osteopathic family practice FTE residents training in a nonhospital setting(s) is allowed to count those FTEs for IME and direct GME purposes even in instances where the written agreement between the hospital and a teaching physician or a non hospital site does not mention teaching physician

[4] Public Law 108-173.
[5] See Centers for Medicare and Medicaid Services, One Time Notification manual, Publication 100-20, Transmittal No. 61 (March 12, 2004).

> compensation, specifies only a nominal amount of compensation, or states that the teaching physician is "volunteering" his/her time training the residents.[6]

The Provider contends that its FY 2000 cost report was settled by the Intermediary during calendar year 2004 and the Section 713 exception, therefore, applies.

Notwithstanding its argument relative to the legal validity of the written requirement or the availability of the Section 713 exception, the Provider contends that it satisfied the requirements of 42 C.F.R. §413.86(f)(4). There is no dispute that residents spent their time in patient care activities and therefore met the requirement of 42 C.F.R. §413.86(f)(4)(i).[7] At issue is the existence of an agreement that accommodates the requirements of the regulations and supports the reimbursement of costs incurred by the Provider.[8] The Provider argues that it entered into a series of agreements with the Mid-Hudson Family Health Services Institute, the terms of which evidence the Provider's obligation to incur the costs of the residency program. The Provider executed the first agreement (called the Undertaking) in 1983.[9] Under its provisions, the Provider and Kingston Hospital jointly and severally guaranteed sufficient funds to meet the deficits of the Institute and provide cash flow to assure its viability. The agreement was under the auspices of the New York State Department of Health's oversight. The Provider, through periodic payments to maintain the Institute's cash flow, and payments to cover year-end shortfalls, was effectively responsible for paying all of the salaries and fringe benefits of the residents allocated to its resident count. Accordingly, the Provider contends that under governing regulations the Undertaking is sufficient to satisfy the written agreement requirement of 42 C.F.R. §413.86(f)(4)(ii).

The Provider also argues that its subsequent agreements with the Institute further demonstrate its operational control and financial responsibility for the residency program. The Provider executed a second agreement in 1999.[10] Under its terms, the Institute committed its continuing compliance with the ethical precepts of Benedictine Hospital while Kingston Hospital retained its original financial responsibilities and became the residency site for several disciplines.[11]

The Provider executed a final agreement in 2001with the Institute. It then left the program and Kingston Hospital notified the State of New York that it was assuming full responsibility for the entire residency program.

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[6] Id at ¶ I-B-3a
[7] Stipulation of the Parties, ¶9.
[8] See 42 C.F.R. §413.86(f)(4)(ii) and (iii).
[9] Exhibit I-9.
[10] Exhibit I-11.
[11] Id.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider did not satisfy the requirements for a written agreement that are established under 42 C.F.R. §413.86(f)(4). The Intermediary argues that 42 C.F.R. §413.86(f)(4)(ii)[12] provides that for time spent by residents training in a nonhospital setting to be included in the FTE resident count, a written agreement must be in place between the hospital and the nonhospital site providing that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the nonhospital site. The hospital must also provide reasonable compensation to the nonhospital site for supervisory teaching activities and the written agreement must specify that compensation amount. The Intermediary contends that each of the three agreements offered by the provider in satisfaction of the requirement is deficient. The 1983 "Undertaking" is not an agreement with the non-provider setting (i.e., the Institute) and fails to specify that the hospital is responsible for the salaries of participating residents and the cost of supervisory teaching.[13] Further, the agreement only requires the Provider to cover deficits in circumstances where costs exceed revenues. Absent such circumstances, the Provider has no financial responsibility to support the Institute. Accordingly, the 1983 Undertaking agreement is not a binding commitment to fund the residency program prior to its commencement or before rotations begin.

The Intermediary argues that under the 1999 Agreement financial responsibility for residents' salaries and fringe benefits still remains with the Institute.[14] Further the agreement is silent relative to which party would have the financial responsibilities for supervisory educational activities, i.e. the costs of supervising the residents.

The third agreement was executed by the Kingston Hospital and became effective July 1, 2001 and marked the end of the Provider's involvement with the Institute and its programs. Accordingly, this agreement was executed too late to apply to the fiscal year (2000) under appeal.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The twofold issue before the Board is whether the requirements for a written agreement that are established under 42 C.F.R. §413.86(f)(4) are applicable to the facts and circumstances of this case and, if so, have they been met.

The Provider also argues that, even if the Secretary did have the authority to impose a requirement for a written agreement, it should be exempted from compliance with that requirement in accordance with the provisions of Section 713 of the Medicare

[12] Now 42 C.F.R. §413.78(d)
[13] Exhibit I-10.
[14] Id.

Prescription Drug Improvement and Modernization Act of 2003. The Board's examination of Section 713 indicates that it spoke exclusively to supervisory teaching costs in cases where the agreement between the hospital and the non-provider setting failed to specify physician compensation for supervisory teaching activities. In this case, there is no agreement evidencing the Provider's responsibility to cover the costs of residents' salaries and fringe benefit or any category of supervisory teaching costs. Accordingly, the Board concludes that the Provider does not qualify for relief under Section 713.

Notwithstanding the legal validity of the written requirement or the availability of the Section 713 exception, the Provider argues that it satisfied the requirements of 42 C.F.R. §413.86(f)(4). There is no dispute that residents spent their time in patient care activities and, therefore, met the requirement of 42 C.F.R. §413.86(f)(4)(i). The Provider argues that it entered into a series of agreements that evidence the Provider's obligation to incur the costs of the residency program as required by 42 C.F.R. §413.86(f)(4)(ii) and that it incurred `all or substantially all of the costs associated with that program as required by 42 C.F.R. §413.86(f)(4)(iii). The Intermediary counters that the agreements fail to comply with the fundamental elements required under the regulation. The issue for the Board is whether the existing agreements satisfy the requirements of the regulations.

After examining the three agreements executed by the Provider, the Board finds the initial 1983 agreement was not an agreement between the Provider and the Mid-Hudson Family Health Institute but, rather, an agreement between the Provider and Kingston Hospital to establish the Institute. It is therefore not an agreement between the Provider and the nonhospital site required by the regulation. Although the agreement indicates that the Provider will contribute funds to meet any deficits and provide adequate cash flows, it makes no provision for the costs of the residents' salaries and fringe benefits while the resident is training in the nonhospital site.[15] It is also silent relative to the compensation the hospital is providing to the nonhospital site for supervisory teaching activities. Both are required elements under 42 C.F.R. §413.86(f)(4)(ii).

The Board's examination of the 1999 agreement indicates that Kingston Hospital will assume educational and supervisory responsibility for residents training within the hospital.[16] However, the agreement places responsibilities for the residents' salaries and portions of their fringe benefits with the Institute.[17] This arrangement does not meet the requirements at 42 C.F.R. §413.86(f)(4)(ii) and renders this agreement deficient.

The 2001 agreement ended the Provider's involvement in the program. The Board finds that the agreement is not applicable to the fiscal periods in dispute

The Provider also contends that it covered substantial portions of the costs of the family practice residency training program for time spent by residents in the non-provider settings through its periodic cash flow payments and by the additional payments made to

[15] Exhibit I-9.
[16] Exhibit I-11, ¶5.
[17] Id, ¶8.

the Institute to cover operating deficits and other shortfalls in the Institute's financing. The Board does not dispute that the Provider absorbed some measure of the costs generated by the residency program. However, the agreements that exist in support of the resident program indicate that the responsibility for the residents' salaries and fringe benefits rests with the Institute. The Provider's responsibilities are dependent upon financial deficiencies in the Institute's operation. The Board was not provided evidence of the nature of costs that were absorbed by the Provider and what amounts related to inpatient or outpatient care, or to training costs at the nonhospital site. Absent this documentation the Board can not conclusively determine compliance with the requirements. Further, even if the Provider absorbed the entire cost of the program, the regulations do not recognize actual cost absorption as an alternative means of compliance with its other requirements.

DECISION AND ORDER

The regulations at 42 C.F.R. §413.86(f)(4) were appropriately applied to the Provider's circumstances. The Provider is not in compliance with requirements for a written agreement. The Intermediary's adjustments reducing the Provider's direct graduate medical education and indirect medical education full-time equivalent counts were proper.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Keith E. Braganza, C.P.A.
John G. Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: May 18, 2010