PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D27

PROVIDER –
Kaleida Health
Buffalo, New York

Provider No.: 33-0005

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services

DATE OF HEARING –
July 16, 2010

Cost Reporting Period Ended -
December 31, 1998

CASE NO.: 08-1474

INDEX

ISSUES:

Whether the Intermediary's adjustment of the Provider's direct Graduate Medical Education per resident amount was proper.

Whether the Intermediary properly excluded research time the Provider alleges was related to patient care from the Full Time Equivalent resident count for direct Graduate Medical Education and Indirect Medical Education.

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 et seq. 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 administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FI) and Medicare administrative contractors (MAC). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. 42 U.S.C. § 1395h, 42 C.F.R. §§ 413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. 42 C.F.R. § 413.20. The 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 reimburses a teaching hospital for its share of costs associated with direct graduate medical education (GME) and indirect medical education (IME). 42 U.S.C. §§ 1395ww(h) and 1395ww(d)(5)(B). In brief, the direct GME payment is the product of a hospital's average per resident amount (PRA), derived and updated from a 1984 base period, multiplied by the hospital's number of interns and residents in approved GME programs during the payment year, multiplied by the hospital's Medicare patient load. The Medicare patient load is a fraction representing the percentage of a hospital's total patient days (denominator) attributable to Medicare patients (numerator).

The IME payment compensates teaching hospitals an additional payment for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. 42 U.S.C. § 1395ww(d)(5)(B). The additional payment, known as the IME adjustment, is based on the indirect teaching adjustment factor, calculated using the hospital's ratio of full-time equivalent (FTE) residents to beds.

[1] FIs and MACs are hereinafter referred to as intermediaries.

The issues in dispute concern adjustments to the Provider's PRA and FTE counts.

Per Resident Amount (PRA)

In 1986, Congress enacted a separate prospective payment system for direct GME costs for all cost reporting periods beginning on or after July 1, 1985. 42 U.S.C. § 1395ww(h)(2). Central to this new payment system was the determination of the base-period average PRA. The PRA is determined by dividing the hospital's base year GME costs by the average number of FTE residents working at the hospital in the base year. The GME base year is the hospital's fiscal year beginning during the federal fiscal year 1984. 42 U.S.C. § 1395ww(h)(2)(A). The PRA then serves as the base figure in the formula to calculate graduate medical education reimbursements for 1985 and future cost years. 42 U.S.C. §§ 1395ww(h)(2).

In 1989, the regulations implementing the new direct GME payment methodology were promulgated. 42 C.F.R. § 413.86.[2] In pertinent part, the regulations specify the calculation of the PRA as follows:

> (e) *Determining per resident amounts for the base period – (1) For the base period*. (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:
>
> > (A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, graduate medical education costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and graduate medical education costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.
> >
> > (B) Divide the costs calculated in paragraph (e)(1)(i)(A) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (e)(1)(i)(A) of this section) for its cost reporting period beginning on or after October 1, 1983 but before

[2]In 2004, the direct GME regulation at 42 C.F.R. § 413.86 was amended and redesignated to 42 C.F.R. §§413.75 through 413.83 (69 Fed. Reg. 49254 August 11, 2004). This decision will refer to 42 C.F.R. § 413.86 the regulation in effect during the fiscal year at issue.

October 1, 1984.

42 C.F.R. § 413.86 (e)(1) (1998).

The regulations also identify exceptions to the above provision. 42 C.F.R. § 413.86(e)(4) (1998). These exceptions include: if a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period; and, if a hospital's base-period cost reporting period reflects GME costs for a period that is shorter than 50 weeks or longer than 54 weeks.

Full Time Equivalent (FTE) Resident Counts

Historically, for direct GME and IME purposes, a resident's time was counted towards the FTE for the time spent training in the hospital. In 1986, Congress authorized Medicare reimbursement for direct GME costs for time spent in outpatient settings providing that:

> [A]ll the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

42 U.S.C. §§ 1395ww(h)(4)(E).

In 1997, Congress authorized reimbursement for IME. 42 U.S.C. § 1395ww(d)(5)(B)(iv).

For direct GME purposes, the regulation determining the total number of FTE residents for GME payments was codified at 42 C.F.R. § 413.86(f) and states in pertinent part:

> (f) *Determining the total number of FTE residents.* Subject to the weighting factors in paragraphs (g) and (h) of this section, the count of FTE residents is determined as follows:
>
> > (1) Residents in an approved program working in all areas of the hospital complex may be counted.
> >
> > (2) No individual may be counted as more than one FTE. Except as provided in paragraphs (f)(3) and (4) of this section, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

42 C.F.R. § 413.86(f)(1)(2) (1998).

For IME purposes, the regulation determining the total number of FTE residents was codified at 42 C.F.R. § 412.105(f), and states in pertinent part:

> (f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1,1991*. (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) ... 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 occurring 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 training program is counted towards the determination of full-time equivalency if the criteria set forth at § 413.86(f)(4) are met.

42 C.F.R. § 412.105(f)(1)(i)-(ii) (1998).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Kaleida Health ("Provider") is a Medicare certified teaching hospital located in Buffalo, New York. On March 31, 1998, three teaching hospitals, Buffalo General Health System (also known as Buffalo General Hospital and referred to as "Buffalo General"), The Children's Hospital of Buffalo ("Children's), and Millard Fillmore Hospital ("Millard") and one non-teaching hospital, DeGraff Memorial Hospital ("DeGraff"), merged into Chilmilgen Corporation (renamed CFG Health System). CFG Health System was later renamed Kaleida Health. On April 1, 1998, CMS issued a tie-in notice to the Provider assigning Kaleida Health the provider number previously assigned to Buffalo General, the largest merging hospital[3] and retired the provider numbers of

[3] Provider's Exhibit P-5. *See,* Stipulation No. 9.

Children's, Millard and DeGraff. Empire Medicare Services[4], ("Intermediary") issued notices to the Provider, instructing that when filing its cost reports, it was to use the Buffalo General base year PRA updated for inflation.[5]

On September 18, 2007, the Intermediary issued an NPR for cost report period ending December 31, 1998, adjusting, among other things, the Provider's direct GME PRA using a weighted average of the base period 1984 PRAs for Buffalo General, Children's and Millard.[6] The Intermediary also made some adjustments to the weighted FTE resident counts.[7] The Provider appealed the Intermediary's final determination to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-1841. The Provider was represented by Ellen V. Weissman, Esq. and Robert J. Lane, Jr. Esq. of Hodgson Russ, LLP. The Intermediary was represented by Arthur E. Peabody, Jr., Esq. of Blue Cross and Blue Shield Association.

PARTIES' STIPULATIONS:

The parties agree to the following stipulations,[8] in part:

- CMS issued a tie-in notice effective April 1, 1998 assigning the provider number of Buffalo General to the Chilmilgen Corporation (CGF Health System, hereinafter "CGF"), later Kaleida Health. (Exhibit P-5.)
- CMS retired the provider numbers of Children's and Millard at the time it issued the tie-in notice, assigning the Buffalo General provider number to CGF, later Kaleida Health.
- A non-teaching hospital, DeGraff Memorial Hospital ("DeGraff"), was also part of the merger into Kaleida Health. DeGraff's provider number was also retired when CMS issued the tie-in notice assigning the provider number of Buffalo General to Kaleida Health.
- In assigning a single provider number to CGF, later Kaleida Health, CMS acknowledged the representation of the New York Department of Health that CGF had become the owner/operator of Buffalo General, Children's, Millard, and DeGraff and that the new entity would be known as CGF and function as a single hospital with a single provider number. CGF was later renamed Kaleida Health.
- In selecting the Buffalo General provider number as the number to be assigned to Kaleida Health, CMS followed its policy of assigning the provider number of the larger of the merging facilities. (Exhibit PA-5.)
- Buffalo General was the larger of the merging facilities, in terms of beds, total expenses, total charges, total Medicare reimbursement, and total FTE resident in approved residency programs. (Exhibits P-6 and P-7.)
- The Intermediary issued notices annually to Kaleida Health, before the due date for filing each cost report, notifying it to use the Buffalo General base year per resident amount ("GME PRA"), updated for inflation, in filing its cost reports for FYE 12/31/98- FYE

[4] In March 2008 National Government Services was designated the Jurisdiction 13 Medicare Administrative Contractor (MAC).
[5] Provider's Exhibit P-8. *See*, Stipulation No. 12.
[6] Provider's Exhibits P-1, P-2, adjustment no. 288, and P-10. *See*, Stipulation No. 13.
[7] Provider's Exhibit P-2 adjustment nos. 270, 271 and 272.
[8] Stipulation, signed by the Intermediary on July 7, 2010 and by the Provider on July 8, 2010.

12/31/03. (Exhibit P-8.)

- Medicare paid Kaleida, on an interim basis, using the Buffalo General base year GME PRA, updated annually for inflation, for FYE 12/31/98- FYE 12/31/ 05. Final settlement of the cost report for each year was based on updating a weighted average GME PRA calculated using base year data.
- On September 18, 2007, in issuing the Notice of Program Reimbursement ("NPR") for FYE 12/31/98 for Kaleida Health, the Intermediary adjusted the GME PRA it had previously utilized to make interim payments to Kaleida Health. (Exhibit P-2, Adjustment #288.)
- Adjustment #288 also has an impact on Kaleida Health reimbursement for each year after FYE 12/31/98, since the Intermediary has used this adjusted GME PRA, updated for inflation, for each year since FYE 12/31/98.
- The Intermediary calculated a revised GME PRA for Kaleida Health using a weighted average of the 1984 base year GME costs and base year FTE residents for each of Buffalo General, Children's and Millard. (Exhibit P-10.)
- The Buffalo General base year GME PRA is $51,604.73. (Exhibit P-11.)
- The Millard base year GME PRA is $39,070. (Exhibit P-13.)
- The Children's base year GME PRA is $26,702.79. (Exhibit P-22.)
- The weighted average base year GME PRA calculated by the Intermediary for Kaleida Health is $40,503.92. (Exhibit P-10.)
- The weighted average GME PRA for Kaleida Health calculated by the Intermediary, updated to 1998 by the trend factors for each of primary care and non-primary care, was $63,149.46 and $59,796.97, respectively, for a full fiscal year. For the nine month period covered by the cost report at issue in this case, 4/1/98 – 12/31/98, the weighted average GME PRA for Kaleida Health calculated by the Intermediary, updated to 1998 by the trend factors for each of primary care and non-primary care, was $47,362.09 and $44,847.72, respectively.
- The Intermediary has used this weighted average GME PRA for Kaleida Health, updated for inflation, in calculating all cost reports settled after FYE 12/31/98.
- The Intermediary also notified Kaleida Health it should use this weighted average GME PRA, updated for inflation, in filing future cost reports.
- Buffalo General had 150.17 FTE residents during the 1984 base year. (Exhibits P-12, 20 and 21.)
- The Buffalo General base year GME PRA of $51,604.73 was established through settlement of a PRRB case (Case No. 91-2852M). (Exhibit P-11.)
- Prior to settlement of PRRB Case No. 91-2852M, the Buffalo General base year GME PRA was $40,835.44 (Exhibit P-12.)
- Millard had 76.4.FTE residents during the 1984 base year. (Exhibits P-14, 20 and 21.)
- The Millard base year GME PRA of $39,070 was also established through settlement of a PRRB case (Case No. 91-2849M). (Exhibit P-13.)
- Prior to settlement of PRRB Case No. 91-2849M, the Millard base year GME PRA was $32,315.05. (Exhibit P-14.)
- New York State's reimbursement system was operating under a waiver from the Medicare program during 1984. (Exhibit P-16.)
- Under the terms of this Medicare waiver, GME costs reported on the 1984 Medicare cost

report had no impact on a New York hospital's Medicare reimbursement for 1984, since New York hospitals were, instead, reimbursed for all payors under the New York Prospective Hospital Reimbursement Methodology ("NYPHRM"). (Exhibit P-16.)

- In 1984, the Intermediary had distributed to New York hospitals a physician time allocation questionnaire which erroneously omitted the line for recording time spent supervising residents. (Exhibit P-17.)
- The Children's base year GME PRA of $26,702.79 was not established through settlement of its PRRB case (Case No. 91-2851M) contesting its base year per resident amount. (Exhibit P-22).
- Children's had also filed a timely PRRB appeal (Case No. 91-2851M) contesting the base year GME PRA assigned to it by the Intermediary. Children's withdrew this appeal.
- Children's had 112.85 FTE residents during the 1984 base year. (Exhibits P-20, 21 and 22.).
- Children's, Buffalo General, and Millard were all members of the Buffalo Medical and Dental Education Consortium (the "Consortium").
- Members of the Consortium also included Erie County Medical Center ("ECMC"), Mercy Hospital of Buffalo, Niagara Falls Memorial Medical Center, Roswell Park Cancer Institute, Sisters of Charity Hospital and the State University of New York ("SUNY") at Buffalo.
- The Consortium was the accredited sponsor of many of the approved residency programs operating at Buffalo General, Millard, and Children's. (Exhibit P-20 and P-21.)
- Children's Medicare utilization was less than 1%.
- Direct GME payment is the product of a hospital's base year GME PRA, updated for inflation, times its rate year number of FTE residents in approved residency programs, times the hospital's Medicare patient load.
- The methodology the Intermediary applied in the case of Kaleida Health was to treat the hospitals as if they had merged in the GME base year, adding the 1984 GME allowable cost of the three teaching hospitals and dividing this total by the sum of their 1984 FTE residents in approved residency programs.

Issue #1 – Per Resident Amount

PARTIES' CONTENTIONS:

The Provider contends that the Intermediary's adjustment to the PRA was improper for several reasons. First, the statute and controlling regulations in effect at the time of the merger contain no exceptions allowing CMS to redetermine an established PRA following a merger or other operational change.[9] The Provider urges the Board to apply the holding in a similar case, *Methodist Hospitals of Memphis v. Blue Cross Blue Shield Association ("Methodist"),* PRRB Dec. No. 2007-D50, Medicare & Medicaid Guide (CCH) ¶ 81,761 (July 19, 2007) *rev'd* Administrator Medicare & Medicaid Guide (CCH) ¶ 81,794 (Sept. 14, 2007).[10] In *Methodist,* the Board ruled that the GME statute and regulations do not authorize creating a weighted average PRA of merging hospitals, and instead requires CMS to use the PRA assigned to the surviving

[9] Provider's Final Position Paper at 11 and 12.
[10] *Id.* at 16; Transcript (Tr.) at 20.

hospital.

While the Board decision was reversed by the Administrator, the Provider maintains the Administrator's reasoning in *Methodist* is inapplicable to the facts of this case. In *Methodist*, the hospital was contesting the initial selection of a PRA for a post-merger hospital. In this case, the Provider is not contesting the PRA that it was assigned upon merger, but instead challenging as unlawful the revision to the PRA eight years following the merger.[11] In *Methodist*, the Administrator stated that the policy implemented by the Intermediary "is reasonable as it ensures that, where there is a merger, neither the hospital nor the Medicare program, will receive a windfall or be penalized, depending on the assignment of the provider number…." [12] In the instant case, if the Intermediary's adjustment stands, the Medicare program will gain a windfall and the Provider will be unfairly penalized. This is because through no fault of its own, Children's base year PRA was significantly understated; therefore using it to create a blended average PRA for Kaleida Health would compound this error for all future years. The Provider asserts that the Board is not bound by Administrator's decision in *Methodist* and because the decision was never appealed to the federal courts, the Board should reaffirm its reasoning and rely on its own ruling in *Methodist*.[13]

Second, the Provider contends that the Intermediary's apparent reliance on regulations issued after the merger is impermissible, as it constitutes retroactive rulemaking.[14] Specifically, it was not until 2006 and for mergers that occurred after October 1, 2006, that CMS amended its regulations and authorized redeterminations of PRAs when hospitals merge subsequent to the establishment of their base period PRAs. 71 Fed. Reg. 47870, 48076 (August 18, 2006). Since the Provider's merger occurred in 1998, it is not subject to these rules.

Third, for the cost reporting period under appeal, the Provider asserts that CMS did not issue any policy statements or interpretative rules on redetermining the 1984 base period PRA following a merger.[15] The Provider acknowledged CMS issued instructions entitled "Graduate Medical Education, Determining Average Per Resident Amounts, Section 1886 (h) of the Social Security Act, Questions and Answers "(Q & A), to the intermediaries strictly for purposes of conducting the base year GME audits between the 1984 base year and before the original PRA determination was made.[16] The Q & A at no. 17 addresses calculating a base year PRA for hospitals that merged. However, the instructions were not intended to apply to any redetermination of a PRA, after the original base period PRA determination was made and became final.

Finally, the Provider maintains that the Intermediary's adjustment is inconsistent with CMS general policy on Medicare reimbursement after changes of ownership. In this regard, following the merger, CMS terminated the provider numbers of Children's, Millard and DeGraff, and assigned Buffalo General' provider number to Kaleida Health.[17] By virtue of it being assigned Buffalo General's provider number, Kaleida Health succeeded to all of the terms and conditions

[11] Provider's Final Position Paper at 16 – 17.
[12] Provider's Response to MAC Final Position Paper at 7.
[13] Tr. at 21.
[14] Provider's Final Position Paper at 15.
[15] Provider's Final Position Paper at 14.
[16] Provider's Final Position Paper at 14- 15; Provider's Exhibits P-27 at 2; PA-8; Tr. 24 and 25.
[17] Provider's Final Position Paper at 19; Provider's Exhibit P-5.

of that provider number, including its PRA, Tax Equity and Fiscal Responsibility Act (TEFRA) target amounts, capital rates and cost-to-charge ratios. Accordingly, the Intermediary's adjustment of the base period PRA is inconsistent with the Medicare determination that the Provider was the successor of Buffalo General, for the notices of the PRAs and other reimbursement determinations issued to Kaleida Health.

The Intermediary contends that the adjustment to the Provider's PRA was proper. The Intermediary conceded that for the period under appeal, the regulations were silent as to determining a PRA following a hospital merger. Nevertheless, CMS's policy, as addressed in the Q & A No. 17 and dated November 8, 1990, establishes that the PRA following a merger is calculated by using the weighted average of the PRAs of the hospitals involved in the merger.[18] This policy was reiterated in the proposed rule issued May 12, 1998 and again in August 2006 Final Rule, and therefore establishes CMS's longstanding policy on calculating a PRA in the circumstances of a merger.

The Intermediary also contends that contrary to the Provider's assertions, *Methodist* is distinguishable from the instant case.[19] In *Methodist*, two hospitals merged with *Methodist* being the surviving hospital. In the instant case, there was no surviving hospital; instead four hospitals merged to create a new entity, Kaleida Health. The Intermediary acknowledged that the Provider was assigned Buffalo General's provider number; however, this was strictly for administrative purposes unrelated to the calculation of the PRA.[20] The Intermediary asserts that in calculating the Provider's PRA, one cannot ignore the fact that a merger is actually the result of multiple hospitals with pre-existing and statutorily derived PRAs joining together. The Intermediary acknowledged that the Children's base year PRA had an adverse impact on the Provider's weighted PRA; however, Children's elected to withdraw its appeal challenging its base year PRA.[21] Consequently, the Children's PRA stands as the official amount of record, and was properly included in calculating the Provider's weighted PRA.

Finally, the Intermediary asserts that it is undisputed that the GME payments based on Buffalo General's PRA were not final payments, and instead were interim payments.[22] As interim payments, they are subject to review and revision.

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 adjustment to the Provider's PRA was improper.

In this case, it is undisputed that the Provider was formed following the merger of DeGraff, a non-teaching hospital and Buffalo General, Children's and Millard, three teaching hospitals.[23] Following the merger and at CMS direction, the Provider was assigned Buffalo Hospital's

[18] Intermediary's Position Paper at 9 – 12; Tr. at 26 – 28.
[19] Intermediary's Post-hearing Brief at 2.
[20] Tr. at 32.
[21] Tr. at 29 – 30; Provider's Exhibit P-25.
[22] Tr. at 28, 110 and 111.
[23] Stipulation No. 3.

provider number. The Board notes that assignment and retiring of provider numbers in the event of a merger does not mean that the PRAs of the merging hospitals are also re-assigned or retired. According to CMS policy, the provider number is not changed merely because there was a merger of facilities or change in ownership.[24] Instead, when merged facilities operate as a single institution, as in the instant case, CMS will assign a single provider number to be used, in order to avoid misunderstanding on the part of the beneficiaries. CMS uses the provider number previously assigned to the larger of the merging facilities and retires the other provider numbers. There is nothing in this policy to suggest that the PRA associated with the surviving provider number is also re-assigned to the new entity.

It is also undisputed that at the time of the transaction in this case, neither the statute nor the regulations explicitly addressed how to calculate the PRA in the event of a merger. The only agency authority or purported authority was contained in the Q & A issued on November 8, 1990. Without deciding whether the Q & A is indeed authority, the Board does not find it to be determinative in this case. The Provider is not contesting the assigned PRA. Instead it is contesting a revision to that PRA eight years following the merger and the accuracy of the data used in determining the revised PRA.

The Provider asserts that the assigned PRA was final and not subject to redetermination. The Board disagrees. The parties stipulated and the witness for the Provider acknowledged that the direct GME payments based on the Buffalo General's PRA were for periodic interim payments.[25] In accordance with CMS policy, by its definition, interim payments, which include GME payments are subject to retrospective adjustment based on a submitted cost report.[26]

As to the calculation of the PRA, the Board finds it appropriate to use a weighted average methodology in this case. The facts indicate that Kaleida Health is a successor of not only Buffalo General, but also a successor of Children's and Millard's hospitals. Consequently, using a weighted average PRA takes into account all of the merging hospitals PRAs. The Board notes however, that the Provider's PRA data is somewhat inaccurate. For example, as stipulated by the parties, a physician time allocation questionnaire issued by the Intermediary in 1984 erroneously omitted the line for recording time spent supervising residents.[27] The faulty questionnaire caused a misclassification of GME costs, resulting in an inaccurate PRA.

In calculating an accurate PRA, the Board finds the Circuit Court case, *Mercy Catholic Center vs. Thompson*, 380 F.3d 142 (3d Cir. Aug. 18, 2004) ("*Mercy*") instructive. Similar to this case, *Mercy* involves the determination of the PRA. In *Mercy*, to assure maximum accuracy of the PRA, intermediaries were required to re-audit all hospitals' 1985 graduate medical education costs. *Mercy* at 146. The Court noted that the Secretary acknowledged that some hospitals would no longer have the records required to support a reclassification of costs; and therefore allowed the intermediaries to accept time records from subsequent time periods as proxy. *Id.* The Board finds that for this case, and consistent with *Mercy*, the most accurate data available is

[24] CMS Pub. 100-07 State Operations Manual, § 2779F (Rev. 1, 05/021/04) (Eff. 06/01/04). Although the date of the policy is subsequent to the cost reporting period at issue, the Provider has offered this as the authority, and neither party has contested the applicable of this policy statement.
[25] Stipulation No. 12; Tr. at 110, 111.
[26] CMS Pub. 15-1, Provider Reimbursement Review Manual - Part 1 § 2405.2.
[27] Stipulation No. 31.

required to determine the PRA. This is necessary in order to "catch errors that, if perpetuated, could grossly distort future reimbursements." *Mercy* at 154 (citing *Regions Hospital v. Shalala*, 522 U.S. 448, 457-58 (1998)).

The Board reverses the adjustment and remands the case to the Intermediary to re-calculate the PRA using a weighted average methodology. The Intermediary is instructed to use the data from most recently settled cost reports of the merged hospitals. *See*, Medicare Program, Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates, 71 FR, 47870, 48073 (August 18, 2006). In the preamble, the Secretary acknowledged that it had become administratively burdensome in accessing the base year information to calculate the weighted average PRAs for merged hospitals, especially when considering such data was over 20 years old. *Id.* Therefore in this case, and consistent with *Mercy*, the Board finds that to assure maximum accuracy of the PRA, it is appropriate for the Intermediary to use the most recent cost reporting data available to calculate the Provider's PRA.

Issue # 2- Research Time and FTE Counts:

PARTIES' CONTENTIONS:

The Provider contends that the documentation presented shows that the time spent by residents performing research activities as part of an approved residency program should be included in the direct GME and IME FTE calculations.[28] Specifically, for direct GME purposes, the Provider maintains that the evidence substantiates that the research rotations were for residents in approved programs working in the hospital setting. As for IME purposes the documents show that the residents worked in the geographic area of the hospital subject to the inpatient PPS system. The Provider requests that the FTE resident count shown in Exhibit P-41 be added to the FTE resident counts.

The Intermediary contends that the Provider failed to furnish adequate documentation to substantiate the research time of the direct GME and IME FTE resident counts.[29] Specifically, for direct GME purposes the record does not establish that the research actually occurred in the hospital. For IME purposes, the record does not show that the research was directly related to patient care.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION

After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds and concludes that the Intermediary's adjustments to the direct GME and IME FTE counts related to a research rotation were improper.

With regard to the direct GME FTE counts, the Intermediary excluded the resident research time because the record did not demonstrate whether the research actually occurred in the hospital instead of in some adjacent research facility. Contrary to the Intermediary's contentions, the Board finds the regulations make no distinction in the areas of the hospital used to determine

[28] Tr. at 203 – 204.
[29] Tr. at 205 - 206.

FTE counts. Specifically, during the cost reporting period at issue, the regulation indicates, "Residents in an approved program **working in all areas of the hospital complex** may be counted." 42 C.F.R. § 413.86(f)(1). (emphasis added). The Board finds the documents presented show that the research was conducted on the hospital complex; and therefore should be included in the Provider's direct GME FTE count.[30]

As to the IME FTE counts, the Intermediary excluded the research time because the record does not show that such time was directly related to patient care. The Board finds that the regulation in effect during the cost reporting period at issue did not exclude research time from the IME FTE resident count, nor did it require resident time to be related to patient care. In pertinent part, the regulation states:

> (1) . . . 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.
>
> (C) Effective for discharges occurring 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 training program is counted towards the determination of full-time equivalency if the criteria set forth at § 413.86(f)(4) are met.
>
> 42 C.F.R. § 412.105(f)(1)(i) and (ii) (1998).

The Board notes that its finding is consistent with other court decisions. *Henry Ford Hospital System v. Sebelius* 680 F.Supp. 2d. 799 (E.D. Michigan) (Dec. 30, 2009) ("*Henry Ford Hospital System*"); *Riverside Methodist Hospital. v. Thompson*, 2003 WL 22658129 (S.D.Ohio July 31, 2003) ("*Riverside Methodist Hospital*"); *University Medical Center Corp. v. Leavitt*, 2007 WL 891195 (D.Ariz. March 21, 2007) ("*University Medical Center Corp.*"). In *Henry Ford Hospital Systems*, the district court held that the Secretary could not exclude residents engaging in

[30] Provider's Exhibits P-41, P-42 and P-43.

educational research from the Hospital's IME resident count under the 1996 version of 42 C.F.R. § 412.105(g)(1)(ii). *Henry Ford Hospital System* at 804. Next, in *Riverside Methodist Hospital* the court concluded 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." *Riverside Methodist Hospital* at 5. Lastly, in *University Medical Center Corp.* the court concluded:

> The 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.

University Medical Center Corp. at 9.

The record shows that the residents at issue 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.[31] Consequently, the Intermediary's adjustment removing IME FTE from the count was improper.

The Board reverses the adjustment and remands the case to the Intermediary. The Intermediary is instructed to evaluate the documentation contained in the record in verifying the resident's research time used to determine the FTE counts for direct GME and IME purposes.

DECISION AND ORDER

Issue # 1- Per Resident Amount

The Intermediary's adjustment to the PRA for Kaleida Health was improper. The issue is remanded to the Intermediary to recalculate the PRA by using a weighted average methodology of the three merged hospitals utilizing data available from the most recent cost reports.

Issue # 2- Research Time and FTE Counts

The Intermediary's adjustments reducing the Provider's GME and IME FTE resident counts for the time spent by residents in research were improper. The issue is remanded to the Intermediary to recalculate the GME and IME FTE resident counts by incorporating the time spent by residents in research activities that were part of their approved medical residency training program.

[31] *Id.*

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, C.P.A
John Gary Bowers, C.P.A.

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: APRIL 26, 2011