# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D28

**PROVIDER –**
Providence Sacred Heart Medical Center

Provider No.: 50-0054

**vs.**

**MEDICARE CONTRACTOR –**
Noridian Healthcare Solutions, LLC.

**HEARING DATE –**
July 27, 2017

Cost Reporting Periods Ended –
December 31, 2004, December 31, 2005, December 31, 2006

**CASE NOS.:** 08-1553, 09-1533, 09-2222

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## ISSUE:

Whether the Medicare Contractor improperly disallowed reimbursement for direct graduate medical education ("GME") and indirect medical education ("IME") costs in the non-hospital setting by reducing the Provider's full-time equivalent ("FTE") resident counts to exclude resident time spent training in non-hospital settings.[1]

## DECISION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly reduced the Provider's GME and IME FTE resident counts to exclude resident time spent in non-hospital settings.

## INTRODUCTION:

Providence Sacred Heart Medical Center ("Sacred Heart" or "Provider") is an acute care hospital located in Spokane, Washington. Sacred Heart's assigned Medicare Contractor, Noridian Healthcare Solutions, LLC (referred to as the "Medicare Contractor") reduced the Provider's reimbursement for graduate medical education by reducing its FTE resident counts in Notices of Program Reimbursement for ("NPRs") for 2004, 2005 and 2006.

On April 15, 2009,[2] Sacred Heart timely appealed the Medicare Contractor's final determinations to the Board and met the jurisdictional requirements for a hearing. The Board conducted a telephonic hearing on July 27, 2017. Sacred Heart was represented by Kathleen Houston Drummy of Davis Wright Tremaine LLP. The Medicare Contractor was represented by Edward Lau, Esq. of Federal Specialized Services.

## STATEMENT OF FACTS:

Inland Empire Hospital Services Association ("IEHSA")[3] operated two clinical facilities Family Medicine Spokane ("FMS") and Internal Medicine Spokane ("IMS") as part of its residency programs. These clinics are located on Sacred Heart's campus and were considered "non-hospital settings" as that term is used in 42 C.F.R. § 413.78 (d)-(e). IEHSA employed and compensated all residents training in its residency programs, including those training at the Provider, as well as other provider and non-provider sites including the FMS and IMS facilities. Likewise, IEHSA compensated, either through employment or contractual arrangements, all physicians providing professional services, training, and supervision at FMS and IMS.[4]

Prior to each July, IEHSA established an estimated budget and allocated the budgeted costs between the participating hospitals based on the projected number of residency rotations

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[1] Transcript ("Tr.") at 7.
[2] Provider's Final Position Paper at 1.
[3] IEHSA had two distinct members – Sacred Heart and Empire Health Services. Empire Health Services consisted of Deaconess Medical Center and Valley Hospital and Medical Center.
[4] *See* Stipulations at ¶ 6.

assigned to each hospital.[5] Sacred Heart's share of budgeted IEHSA costs for the Family Medicine program was approximately 60% for FYE 2004, FYE 2005, and FYE 2006[6]. Two other hospitals, Deaconess Medical Center ("DMC") and Valley Hospital and Medical Center incurred 34.2% and 5.3%, respectively, of the total Family Medicine program costs.[7]

Sacred Heart's share of IEHSA's budgeted costs for the Internal Medicine program was approximately 50% for FYE 2004, FYE 2005, and FYE 2006, with DMC incurring the other 50%.[8] IEHSA billed Sacred Heart monthly to cover the projected costs of the residents, teaching physicians, and other unfunded operating costs of IEHSA.[9]

The Medicare Contractor reduced Sacred Heart's reimbursement for its graduate medical education, disallowing the resident's time spent training in the non-hospital settings because Sacred Heart did not incur "all or substantially all" of the costs of the Family Medicine and Internal Medicine residency training programs.[10] Sacred Heart disagrees with this reduction to its GME and IME FTE residency counts.

## DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Sacred Heart argues that the statutes in place during the relevant cost reporting periods allowed reimbursement to hospitals for medical residency costs for patient care in a non-hospital setting, even when such costs were shared among two or more hospitals. Sacred Heart contends that CMS misinterprets the governing statute to require a "single hospital" to incur all or substantially all of the cost in a non-hospital setting.[11]

Sacred Heart asserts that Congress allowed reimbursement of graduate medical costs in non-hospital settings to provide a financial incentive (i.e. additional reimbursement) to provide hands-on, primary care medical training, by moving residency training outside the hospital and into the private practice or clinic setting. The Provider claims the "single hospital" policy, prohibiting more than one hospital from sharing the costs of non-hospital resident training, deters hospitals, particularly rural hospitals, from training residents in non-hospital family practice settings.[12]

Sacred Heart maintains that the Medicare Contractor allowed it to claim non-hospital resident FTEs at IEHSA sites for the last decade and that no changes in the applicable statutes or rules justifies the Medicare Contractor's new position.[13] Accordingly, Sacred Heart properly documented that it incurred all or substantially all of the costs by claiming its proportional share

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[5] *See* Stipulations at ¶ 7.
[6] The 60% estimate is after removing resident rotations that are not counted for cost reporting purposes or that relate to the Rural Training Track rotations. See Stipulations at ¶ 11.
[7] *See* Stipulations at ¶ 11.
[8] *See* Stipulations at ¶ 12.
[9] *See* Stipulations at ¶ 7.
[10] Medicare Contractor's Final Position Paper at 9.
[11] *See* Provider's Final Position Paper at 21-23.
[12] *See* Provider's Final Position Paper at 21.
[13] *See* Provider's Post Hearing Brief at 13.

of the FTEs training in the non-hospital setting, fully consistent with Congressional intent underlying the GME and IME programs, and CMS' rules and regulations.[14]

Finally, Sacred Heart asserts that Congress expressly revoked the single hospital policy when it enacted Sections 5504(a) and (b) of the Patient Protection and Affordable Care Act of 2010 ("ACA"),[15] and explicitly allowed this change to all then-pending, jurisdictionally proper appeals. Sacred Heart contends that its appeal was a jurisdictionally proper appeal pending before the Board on the date of the ACA enactment, March 23, 2010, and that it is entitled to relief under the law.

**REQUIREMENT FOR PAYMENT OF ALL OR SUBSTANTIALLY ALL OF THE GME PROGRAM COSTS**

The Board disagrees with Sacred Heart's contention that, because it paid and claimed a proportional share of the Family Medicine and Internal Medicine programs that it met the statutory requirement that it "incurred all or substantially all of the costs." For GME/IME reimbursement purposes, 42 U.S.C. §§ 1395ww(h)(4)(E) and 1395ww(d)(5)(B)(iv) entitle a hospital to count the time its residents spend in patient care activities in non-hospital settings, if "***the hospital*** incurs all, or substantially all, of the costs *for the training program* in that [nonhospital] setting."[16] During the fiscal years at issue, federal regulations located at 42 C.F.R. § 413.86(b) (2003)[17] defined the term "all or substantially all of the costs for the training program in the nonhospital setting" to mean "the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education."

In this case, Sacred Heart stipulated that IEHSA paid the medical education costs incurred in connection with the Family Medicine and Internal Medicine programs (*i.e.*, the training programs) and that Sacred Heart and the other hospitals were billed monthly for these costs. The Board finds that this financial arrangement did not strictly comply with longstanding federal statute and regulation and that the Medicare Contractor's GME/IME adjustments for interns and residents rotating to non-hospital settings was proper.

Several courts have considered the issue of a hospital incurring "all or substantially all of graduate medical education costs" in non-hospital settings, usually in the context of whether a written agreement adequately documented the fact[18] rather than, as raised in this case, whether the "all or substantially all" requirement actually means all of the costs or some indeterminate

[14] *See* Provider's Final Position Paper at 16.
[15] Pub. L. No. 111-148, 124 Stat. 119, 559-660 (Mar. 23, 2010). The Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010) amended certain ACA provisions; however, HCERA is not relevant to this case as it did not amend ACA § 5504.
[16] (Emphasis added.)
[17] With respect to cost reporting period on or after October 1, 2004, § 413.86(b) was redesignated as § 413.75(b) without any substantive changes pertinent to this appeal.
[18] *Cottage Health System v. Sebelius*, 631 F.Supp.2d 80 (D.D.C. 2009); *Borgess Med. Ctr v. Sebelius*, 966 F.Supp.2d 1 (D.D.C. 2013); *Covenant Med. Ctr. v. Sebelius*, 994 F. Supp 2d 862 (E.D. Mich. 2014), aff'd in unpublished opinion, *Covenant Med. Ct. v. Burwell*, 603 Fed Appx 360 (6th Cir. 2015); *Eastern Maine Medical Ctr. v. Burwell*, 159 F. Supp.3d 109 (D. Me., 2016);

share of the costs of graduate medical education in a nonprovider setting. To the extent that they have addressed it, these courts found that a single hospital must bear all or substantially all of the costs—i.e. cannot split these costs with other hospitals—in order to obtain Medicare reimbursement.

In *Integris/Deaconness 2005 Nonprovider Setting IME/GME CIRP Group Oklahoma City v. Novitas,* 2016-D14 (June 7, 2016), the Board has also taken the position that "Payment of merely a proportional share of cost does not meet the full set of requirements mandated by 42 U.S.C. §§ 1395ww(h)(4)(E) and 1395ww(d)(5)(B)(iv) or 42 C.F.R. § 413.78(e)(2)."[19] The Board's position was in sync with the Court's opinion in *Borgess Med. Ctr v. Sebelius* which stated: "since Congress did not specifically speak to the issue of whether the 'all or substantially all' language precluded the sharing of costs between two or more hospitals, it was a proper exercise of CMS' authority to interpret the statutory language in the restrictive manner it as prescribed"[20] and noted that Secretary held this interpretation as far back as 1998.[21] In this case, Sacred Heart admits that it shares the cost of the Family Medicine and Internal Medicine programs with other hospitals.[22] This proportional share does not meet the requirements of 42 U.S.C. §§ 1395ww(h)(4)(E) and 1395ww(d)(5)(B)(iv) or 42 C.F.R. § 413.86(f)(4)(iii).[23]

**FINDINGS RELATING TO THE APPLICATION OF ACA § 5504**

ACA § 5504(a) amended 42 U.S.C. § 1395ww(h)(4)(E) to allow a hospital to count all the time that a resident trains in a nonhospital site so long as the hospital incurs the costs of the residents' salaries and fringe benefits for the time that the resident spends training in the nonhospital site. As part of this amendment, it removed the language requiring hospitals to have a written agreement with the non-hospital setting and the reference to compensation for supervisory teaching activities. ACA § 5504(b) made similar changes to 42 U.S.C. § 1395ww(d)(5)(B)(iv) to apply these changes to IME reimbursement as well. Both §§ 5504(a) and (b) specify that they are effective prospectively for cost reporting periods or discharges on or after July 1, 2010.[24]

ACA § 5504(c) addressed certain additional permissible and non-permissible applications of ACA §§ 5504(a) and (b) by stating the following:

> (c) The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as

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[19] *Integris* at 5.
[20] *See Borgess* at 7.
[21] The Court cited language in 63 Fed.Reg. 40954, 40986 (July 31, 1998).
[22] Stipulations at ¶ 11 and ¶ 12.
[23] In its *Integris* decision, the Board also noted that one of CMS' principles of GME/IME reimbursement is that the impact of Medicare payment of these costs "does not redistribute costs and community support" for these programs and that, by funding GME and IME costs, "Congress intended hospitals to facilitate training in nonhospital sites that would not have occurred *without the hospital's sponsorship.*" Unless the hospital incurs all or substantially all of the costs for the training program, it is possible that the nonhospital could simply be shifting costs of training residents in nonhospital sites that were previously funded from other community sources.
[24] By its terms, ACA § 5504(a) was effective for GME for cost reporting periods on or after July 1, 2010 and ACA § 5504(b) was effective for IME for discharges occurring on or after July 1, 2010.

> of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).[25]

As part of the final rule published on November 24, 2010 (the "November 2010 Final Rule"), CMS promulgated regulations at 42 C.F.R. §§ 413.78(g) and 412.105(f)(1)(ii)(E) to implement ACA § 5504.[26] In particular, 42 C.F.R. § 413.78(g)(6) echoes ACA § 5504(c) because it reads:

> The provisions of paragraph (g)(1)(ii), (g)(2), (g)(3), and (g)(5) of this section cannot be applied in a manner that would require the reopening of settled cost reports, *except* those cost reports on which there is a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.[27]

As part of the preamble to the final rule published on August 22, 2014 (the "August 2014 Final Rule"), CMS included a section entitled "Clarification of Policies on Counting Resident Time in Nonprovider Settings Under Section 5504 of the Affordable Care Act."[28] In this section, CMS discussed at length the "longstanding substantive standard" which allowed hospitals to count FTE's for residents' training time if the one single hospital which sponsored the residency and then claimed GME and IME FTE's for the program also incurred all or substantially all of the costs for the training. CMS refers readers to final rules from 1998, 2003 and 2007.[29]

Regarding the retroactivity of newly granted latitude in claiming FTE's as per ACA §§ 5504(a) and (b), CMS stated: "The introductory regulatory language of 413.78(g) explicitly states that paragraph (g) governs only 'cost reporting periods beginning on or after July 1, 2010.' . . . [W]hereas earlier cost reporting periods are governed by other preceding paragraphs of 413.78."[30] Further, CMS explicitly clarified that retroactive application of the amendments was neither intended nor permitted to pending appeals before the Board:

> Accordingly, we believe that it is apparent that the provisions of sections 5504(a)(3) and (b)(2) of the Affordable Care Act are not to be applied prior to July 1, 2010, irrespectively of whether a hospital may have had a jurisdictionally proper appeal pending as of March 23, 2010 on an IME or direct GME issue from a cost reporting period occurring prior to July 1, 2010.[31]

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[25] ACA § 5504(c).
[26] 75 Fed. Reg. 71800, 72134-36 (Nov. 24, 2010).
[27] *Id.* at 72262 (emphasis added).
[28] 79 Fed. Reg. 49854, 50117 (Aug. 22, 2014).
[29] *See id.* at 50117-50122.
[30] *Id.* at 50118.
[31] *Id*. at 50119.

In summary, CMS explicitly and clearly maintains through its recent regulatory clarification at 42 C.F.R. § 413.78(g)[32] that the changes made in ACA §§ 5504(a) and (b) only apply prospectively beginning July 1, 2010 and do not apply to appeals that were pending as of March 23, 2010 and had a GME or IME issue from a cost reporting period beginning prior to July 1, 2010.

The Board concludes that ACA § 5504 is not applicable to the subject appeals because the fiscal years at issue in these cases began before July 1, 2010. While the Board recognizes that the decision in this case conflicts with its 2014 decision in *Eastern Maine Med. Ctr. v. Blue Cross Blue Shield Ass'n* ("*Eastern Maine*"),[33] the Board notes that CMS clarified the regulation subsequent to the Board's decision.

This legal conclusion is consistent with the Board's 2015 decision in *Lutheran Hosp. of Fort Wayne Indiana v. Wisconsin Physicians Servs.*[34] which relies on the 2015 decision of the U.S. Court of Appeals, Sixth Circuit in *Covenant Med. Ctr., Inc. v. Burwell* ("*Covenant*")[35] which upheld CMS' regulatory clarification precluding retroactive application of ACA § 5504 (a) and § 5504 (b) to fiscal years occurring prior to its issuance.[36]

**DECISION AND ORDER:**

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly reduced Sacred Heart's GME and IME FTE resident counts to exclude resident time spent in non-hospital settings.

**BOARD MEMBERS PARTICIPATING:**

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

**FOR THE BOARD:**

/s/
L. Sue Andersen, Esq.
Chairperson

**DATE:** March 20, 2018

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[32] *Id*. at 50117-50112, 50119 (amending 42 C.F.R § 413.78(g)(6)).
[33] PRRB Dec. No. 2014-D10 (June 2, 2014), *rev'd*, CMS Adm'r Dec. (July 23, 2014).
[34] PRRB Dec. No. 2015-D13 (Aug. 4, 2015), *declined review*, CMS Adm'r (Sept. 22, 2015). *See also Integris/Deaconess 2005 Non-Provider Setting IME/GME CIRP Grp. v. Novitas Solutions, Inc.*, PRRB Dec. No. 2016-D14 (June 7, 2016), *declined review*, CMS Adm'r (Aug. 1, 2016).
[35] 603 Fed. Appx. 360 (6th Cir. 2015) (involving FYs 1999 to 2006).
[36] *See id*.