CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Queen of the Valley Hospital **Provider** **vs.** **Blue Cross Blue Shield Association** **National Government Services, LLC-CA** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 12/31/96** **Review of:** **PRRB Dec. No. 2008-D6** **Dated: November 2, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). Comments were received from CMS' Center for Medicare Management (CMM). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from the Provider. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider is a 325-bed general service acute care hospital located in West Covina, California. In years prior to fiscal year ending (FYE) December 31, 1996, the Provider had a fully executed affiliation agreement with the University of California at Irvine (UCI) to help train residents in UCI's pediatric residency program. The Agreement terminated on June 30, 1995, and although an extension was signed by the Provider and Magan Clinic, it was not signed by UCI.[1]

[1] Intermediary's Exhibit I-3; Provider's Supplemental (PS) Exhibit PS-1.

On its FYE 12/31/96 as-filed cost report, the Provider reported a total of 1.00 full-time equivalent (FTE) for direct graduate medical education (GME) and indirect medical education (IME) purposes. Through audit adjustments numbers 5 and 36, the Intermediary eliminated all GME reimbursement, including the 1.00 FTE claimed.[2] However, the Intermediary, through audit adjustment number 4, allowed 0.54 FTE for IME purposes. By letter dated August 23, 2005, the Provider timely added the issue of whether audit adjustment number 4 is proper.

ISSUE AND BOARD'S DECISION

The Issue is whether the Intermediary improperly allowed 0.54 intern and resident FTE for IME purposes on the Provider's fiscal year ending (FYE) December 31, 1996 Medicare cost report.

The Board held that the Intermediary improperly included 0.54 FTEs in the Provider's IME FTE resident count. Relying on both the oral and written testimony, the Board found that no UCI residents were on rotation at, or assigned to, the Provider during 1996. Rather, the Board found that the evidence indicated that in 1996, the residents in question were engaged in an "elective" rotation at the Magan Clinic. Furthermore, had the UCI residents been training at the Provider, the training would not have been permitted because the residents would have been operating outside of their approved residency program because the Provider was not participating in an approved residency program. Finally, the Board also disagreed with the Intermediary's written agreement argument because Medicare IME regulations do not require a written agreement.

SUMMARY OF COMMENTS

CMM submitted comments requesting that the Administrator reverse the Board's decision. CMM disagreed with the Board's determination that the Intermediary improperly included 0.54 FTEs in the Provider's IME FTE resident count. Relying on the regulations found at 42 C.F.R § 413.86(f)(ii) CMM argued that "a hospital cannot claim the time spent by residents training at another hospital."[3] Therefore, if there is legitimate training occurring at the hospital, the hospital should count the residents training there for Medicare IME payment purposes. In this case the record shows that regardless of whether the UCI residents were participating in a Magan Clinic rotation, the UCI residents were participating in rounds at the Provider. Therefore, that portion of the residents' time should be part of the Provider's IME

[2] Intermediary's Exhibits I-1 and I-5.

[3] Recodified at 42 C.F.R. § 413.78(b) (2004). See also 69 Fed. Reg. 49254 (Aug. 11, 2004).

FTE count and not the IME FTE count of UCI. Furthermore, the Board's statement that the Provider was not participating in an approved residency program is irrelevant. Medicare counts residents for direct GME programs and IME payment purposes based on whether the program in which the residents are training is an approved program. Neither the Act nor the regulations at 42 C.F.R. § 413.86 (b) make any mention of an approved program being limited to an approved training site.

The Provider commented requesting that the Administrator affirm or decline to review the Board's decision. The Provider argued that the Board correctly decided that the Provider's IME FTE count was zero (0) because no residents were on rotation at the Provider. The evidence and the testimony of Provider's witnesses demonstrated that, for FYE 12/31/96, the Provider simply did not train residents at its hospital. The mere fact that residents might have followed Dr. Whiting on his rounds of hospital patients in an unscheduled manner does not count as being assigned for a formal rotation to the Provider and does not support claiming them for IME purposes. Regardless of what may have been appropriated in prior years, the Intermediary should not have allowed 0.54 FTE for IME purposes.

Finally the Provider argued that, even if somehow there were residents on rotation at the Provider, the Provider was not an institution approved to be part of the official training program under the rules of the Accreditation Council for Graduate Medical Educations. Therefore, any residents training at the Provider were necessarily outside the scope of the approved program and therefore should not be counted for IME purposes.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits.[4] The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Pursuant to § 1861(v) (1) (a) of the Act, providers are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. Section 1861(v)(1)(a) of the Act, defines "reasonable cost" as "the cost actually incurred, excluding from any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included…." Section 1861(v)(1)(a)

[4] The Administrator notes that the transcript of the December 13, 2006 hearing in this case is inadvertently incomplete with respect to the direct testimony of Kathleen Van Allen. See Stipulation Regarding Testimony at Hearing.

of the Act, does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters.

Consistent with the Act, the regulation at 42 C.F.R. § 413.9 establishes the principle that reimbursement to providers must be based on the reasonable costs of covered services, which are related to beneficiary care. This includes "all necessary and proper cost incurred in furnishing the services." Necessary and proper costs are costs, which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Accordingly, if the provider's cost include amounts not related to patient care, or costs that are specifically not reimbursable under the program, those costs will not be paid by the Medicare program.

Historically, Medicare has recognized the increased costs related to a provider's approved graduate medical education programs. Congress recognized that teaching hospitals might be adversely affected by implementation of the prospective payment system (PPS) because these indirect costs, which may include increased department overhead as well as a higher volume of laboratory test and similar services,[5] would not be reflected in the PPS rates.[6] Thus, under § 1886(d) (5) (B) of the Act, hospitals subject to PPS, with approved teaching programs, receive an additional payment to reflect the IME costs.[7]

For the cost reporting periods at issue, 42 C.F.R. § 412.105 governed IME payments to Medicare providers. The regulation states that CMS "makes an additional payment to hospitals for indirect medical education costs" in part by determining the ratio of the number of FTE residents to the number of beds.[8] The regulation also sets forth the criteria for counting full-time equivalent residents for costs reporting periods beginning on or after July 1, 1991. It states in relevant part:

> (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.[9]

Finally, the regulation states that:

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[5] See 50 Fed. Reg. 35646, 35681 (1985).
[6] Id.
[7] This IME payment is distinguished from the direct medical education costs.
[8] 42 C.F.R. § 412.105(a) (1) (1996).
[9] 42 C.F.R. § 412.105(g)(ii)(1996).

> (iii) Full-time equivalent status is based on the total time necessary to fill a residency slot. No individual may be counted as more than one full-time equivalent. If a resident is assigned to more than one hospital, the resident counts as a partial full-time equivalent based on the proportion of time worked in any of the areas of the hospital in paragraph (g)(1)(ii) of the section, to the total time worked by the resident…..[10] (Emphasis added).

In this case, the Provider argued that no residents were on rotation at, or assigned to, the Provider during FYE 12/31/96. Therefore, its initial claim of 1.00 FTE was incorrect, and the Intermediary's recognition of .54 FTE was also wrong. The Provider further argued that, even if any UCI Pediatric Program residents were physically located within the Provider during FYE 1996, such residents were not on official rotations or otherwise assigned to any department of the Provider. Moreover, even if there were residents assigned to the Provider or on rotation at the Provider, they would not have been a part of an approved residency program given that the Provider was not an approved training site in 1996 for UCI Pediatric Program. Finally the Provider argued that GME/IME must be treated consistently. If GME was disallowed, IME must be handled the same.

The Administrator finds that the regulation at 42 C.F.R. § 412.105(g)(iii) states that "[n]o individual may be counted as more than one full-time equivalent. If a resident is assigned to more than one hospital, the resident counts as a partial full-time equivalent based on the proportion of time worked in any of the areas of the hospital…" (Emphasis added). The record shows that the residents in question were participating in rounds (i.e., activities related to patient care) at the Provider.[11] Therefore, the Administrator finds that, since the residents were participating in rounds at the Provider, the portion of the residents' FTE associated with that time must be part of the Provider's IME FTE count and not the IME FTE count of another hospital. Accordingly, the Administrator finds that the Intermediary properly included 0.54 FTEs for the Provider's 1996 FYE IME count was proper.[12]

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[10] 42 C.F.R. § 412.105(g)(iii)(1996).

[11] Transcript of Oral Hearing at 133.

[12] The issue of the GME count was not pursued by the Provider and thus is not addressed in this decision.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF THE HEALTH AND HUMAN SERVICES

Date: **12/20/07**

/s/
Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services

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