CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
University Medical Center **Provider** **vs.** **Blue Cross/ Blue Shield Association** **Blue Cross & Blue Shield of Arizona** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 06/30/98 and 06/30/99** **Review of:** **PRRB Dec. No. 2005-D36** **Dated: April 12, 2005**

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) (l) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). Comments on Issue No. 1 were received from the Intermediary. Comments on Issue Nos. 1 and 2 were received CMS' Center for Medicare Management (CMM). The parties were then notified of the Administrator's intention to review the Board's decision. Comments on Issue Nos. 1 and 2 were also received from the Provider. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

For the fiscal periods in dispute, the Provider, a non-profit acute care teaching hospital, claimed payment for the direct and indirect costs of its graduate medical education training programs. The Intermediary reviewed the Provider's cost reports for its fiscal years ending (FYE) June 30, 1998 and June 30, 1999, and made adjustments reducing the Provider's full-time equivalent (FTE) count for time spent by residents in research and for time spent by residents who took vacation while on rotation to other hospitals. With respect to time residents spent in research activities, the Intermediary reduced the Provider's resident count for purposes of the Indirect Medical Education (IME)

adjustment by 10.06 FTEs in 1998 and by 4.96 FTEs in 1999.[1] With respect to time spent by residents on vacation while at other providers, the Intermediary reduced the Provider's resident count for purposes of the IME adjustment by .02 FTEs in 1998 and by 4.87 FTEs in 1999 and by a similar number of FTEs for Direct Graduate Medical Education (GME) in these periods.[2]

ISSUE AND BOARD'S DECISION

Issue No. 1 is whether the Intermediary's adjustment, reducing the Provider's IME full-time equivalent (FTE) resident count for time spent by residents in research activities, was proper.

The Board held that the Intermediary's adjustment, excluding research time from the FTE resident count used to calculate the Provider's adjustment for IME, was improper. The Board held that 42 C.F.R. §412.105(f) did not exclude research time from the IME resident count, nor did it require resident time to be related to patient care. The Board determined that the regulation allowed research time spent by residents to be included in the IME calculation if the residents were enrolled in an approved teaching program and were assigned to either the area of the hospital subject to the inpatient prospective payment system (IPPS) or the hospital's outpatient department. Therefore, since the residents at issue were enrolled in an approved GME program and they worked in either the portion of the Provider's facility subject to PPS, or an outpatient area, the Intermediary's adjustments were improper. The Board noted that its findings were consistent with the court's ruling in Riverside Methodist Hospital v. Thompson, No. C2-02-94 (S.D. Ohio, July 31, 2003) (Riverside). Finally, the Board held that the 2001 amendment to the IME rule excluding nonpatient related care research time from the resident count represented a change in policy that could not be applied retroactively to the subject 1998 and 1999 cost reporting periods.

Issue No. 2 is whether the Intermediary's adjustment reducing the Provider's Direct GME and IME resident FTE count for time spent by residents on vacation while on rotation to another hospital was proper.

The Board upheld the Intermediary's adjustment excluding vacation time from the Provider's FTE resident count used to calculate both GME and IME. The Board held that the critical factor in this case with respect to vacation time was “consistency” and as long as the Intermediary accounted for vacation time in the same manner with

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[1] Provider’s Post-Hearing Brief at 6.
[2] Id. at 27.

each provider, it was permissible for the Intermediary to disallow vacation time from the FTE resident count for both IME and GME.

SUMMARY OF COMMENTS

Issue No. 1

The Intermediary commented requesting that the Administrator review and reverse the Board's decision. The Intermediary argued that the Board incorrectly found that since the residents were enrolled in an approved medical education program and worked in an IPPS or outpatient portion of the hospital, time spent in research was allowable. The Intermediary maintained that the regulations and programs instructions require that time spent by a resident in research that is not associated with the direct care and treatment of a patient is not includible in the FTE count.

CMM submitted comments requesting that the Administrator reverse the Board's decision. CMM disagreed with the Board's determination that time spent by residents engaged in research not related to patient care should be included for IME purposes. CMM noted that the Provider's rotation schedules distinguished between resident rotations assigned to the Inpatient PPS, the outpatient areas of the Provider and research. CMM also argued that the regulation cannot be read in isolation. CMM stated that the regulation must be read in context with other regulations. When read in conjunction with the other regulations, it shows that Medicare never intended to pay for non-patient care activity. In addition, a plain reading of §412.105(f)(l)(ii), requires that a resident be “assigned to” either the inpatient PPS or outpatient areas of the hospital in order to be counted. Thus, since the residents, when involved in research, are not assigned to either the inpatient PPS or outpatient areas of the hospital, time spent by residents assigned to research should not be included in the IME adjustment.

CMM further stated that the Board inappropriately drew conclusions from Riverside Methodist Hospital because the FTE resident time at issue in Riverside was time spent in journal clubs and seminars, not research activities. Furthermore, the costs associate with research activities that were over and above usual patient care were not allowable under the reasonable cost system of reimbursement. Finally, CMM disagreed with the Board's determination that policy set forth in the August 1, 2001, Federal Register represented a change in policy that cannot be applied retroactively. CMM stated that there are longstanding regulations concerning research, and §412.105(f)(l)(iii)(B) is simply the codification of existing policy in the IME regulation text.

The Provider submitted comments requesting that the Administrator affirm the Board's decision. The Provider argued that the Board's decision to count residents' research time was correct because the time residents spent in the research rotation satisfied the clear and unambiguous language of the regulation. The Provider also argued that the Intermediary's "direct patient care" requirement argument is without legal support, as held by the Board and a Federal court in Riverside Methodist. In addition, the Provider argued that its residents met the statutory requirements of the IME regulation for inclusion in the FTE count; that the basic rules of statutory construction support the Board's conclusion; and that the Board was correct to find that the 2001 amendment to the IME regulation was a substantive rule change, not a "clarification."

Issue No. 2

CMM submitted comments, concurring with the Board's determination, on alternative grounds than that of consistency. CMM noted that CMS' longstanding policy prohibits one hospital from claiming the time by residents training at another facility. Therefore, the Intermediary properly disallowed the residents' vacation time from the Provider's FTE counts, since that FTE time was not spent training at the Provider, nor was those FTEs assigned to the Provider during the vacation in question.

The Provider also submitted comments requesting that the Administrator reverse the Board's decision. The Provider argued that the decision should be reversed because the Intermediary's method for determining which hospital is permitted to claim residents' vacation time fails to logically and accurately account for the nature of such time and the manner in which the costs for such time are borne.

DISCUSSION

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

Prior to 1983, Medicare reimbursed providers on a reasonable cost basis. Section 1861(v)(l)(a) of the Act defines "reasonable cost" as "the cost actually incurred, excluding therefrom 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)(l)(a) 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.

The Secretary promulgated regulations which explained the principle that reimbursement to providers must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.[3] Reasonable cost 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 a provider's costs 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.

Section 223 of the Social Security Act of 1972 amended section 1861(v)(l)(A) to authorize the Secretary to set prospective limits on the cost reimbursement by Medicare.[4] These limits are referred to as the "223 limits" or "routine cost limits" (RCL), and were based on the costs necessary in the efficient delivery of services. Beginning in 1974, the Secretary published routine cost limits in the Federal Register. These "routine cost limits" initially covered only inpatient general routine operating costs.

In 1982, in an effort to further curb hospital cost increases and encourage greater efficiency, Congress established broader cost limits than those authorized under section 1861(v)(l)(A), the existing routine cost limits. The Tax Equity and Fiscal Responsibility Act (TEFRA) added section 1886(a) to the Act, which expanded the existing cost limits to include ancillary services operating costs and special care unit operating costs in addition to routine operating costs. Pursuant to section 1886(l)(a)(ii) of the Act, these expanded cost limits, referred to as the "inpatient operating cost limits," applied to cost reporting periods beginning after October 1, 1982.

Under reasonable cost, the allowable costs of educational activities included trainee stipends, compensation of teachers and other direct and indirect costs of the activities as determined under Medicare cost finding principles. These costs were not subject to the routine costs limits.

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[3] See e.g. 42 C.F.R. §413.9.

[4] Pub. Law 92-603.

The Secretary promulgated the regulation at 42 C.F.R. §413.85 which permits reimbursement for the costs of "approved educational activities."[5] This regulation defines approved educational activities as "formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution.

Under the routine cost limits, Medicare also paid for the increased indirect costs associated with a hospital's approved graduate medical education program through an indirect teaching adjustment.[6] Thus, since its inception Medicare has recognized the increased operating costs related to a provider's approved graduate medical education programs.

The regulations governing research cost, under the "reasonable cost" system of reimbursement were found at 42 C.F.R. §405.422 et. seq. and stated that the "[c]osts

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[5] 42 C.F.R. §413.85 (b) (1998). This language has been in effect since the beginning of the Medicare program although it was formerly designated 42 C.F.R. 405.421(1977) and 20 C.F.R. §405.421 (1967).

[6] 45 Fed. Reg. 21584 (April 1, 1980)(indirect teaching adjustment under pre-TEFRA cost limits); 46 Fed. Reg. 33637 (June 30, 1981)("*A Revised Adjustment to the Limits for Increased Costs Due To Approved Internship and Residency Programs.* … The current schedule of limits on hospital inpatient general routine operating costs permits each hospital's otherwise applicable limit to be increased by 4.7 percent for each .1 increase (above zero) in the hospital's intern-and-resident to bed ratio. We included this adjustment to account for increased routine operating costs that are generated by approved internship and residency programs, but are not allocated to the interns and residents (in approved programs) or nursing school cost centers on the hospital's Medicare cost report. Such costs might include, for example, increased medical records costs that result from the keeping, for teaching purposes, of more detailed medical records than would otherwise be required. Because our analysis of the data we used to develop the new limits shows that hospital inpatient operating costs per discharge tend to increase in proportion to increases in hospital levels of teaching activity, we have adopted a similar adjustment to the new limits ….. The increase in the percentage amount of the adjustment (from 4.7 percent to 6.06 percent) results from the fact that total inpatient operating costs, which include special care unit and inpatient ancillary costs, are more heavily influenced than routine costs by changes in the level of teaching activity. In our opinion, this adjustment accounts for the additional inpatient operating cost which a hospital incurs through its operation of an approved intern and resident program." (Emphasis added.)

incurred for research purposes over and above usual patient care, are not includible as allowable costs."[7] The regulation at 42 C.F.R. §405.422(b)(2) further stated that:

> Where research is conducted in conjunction with and as a part of the care of patients, the costs of usual patient care are allowable to the extent that such costs are not met by funds provided for the research…[8]

In 1983, §1886(d) of the Act was added to establish the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital services furnished to Medicare beneficiaries.[9] Under IPPS, providers are reimbursed their inpatient operating costs based on prospectively determined national and regional rates for each patient discharge, rather than on the basis of reasonable operating costs. Under §§1886(a)(4) and (d)(1)(A) of the Act, the costs of approved medical education activities were specifically excluded from the definition of "inpatient operating costs" and, thus, were not included in the PPS hospital-specific, regional, or national payment rates or in the target amount for hospitals not subject to PPS. Instead, payment for approved medical education activities costs were separately identified and paid as a "pass-through," i.e., paid on a reasonable cost basis.[10] Later, for the cost years at issue, the direct costs of the approved graduate medical education program were paid under the methodology set forth at Section 1886(h) of the Social Security Act. These provisions were promulgated at 42 C.F.R. 413.86 (1997).

However, Congress recognized that teaching hospitals might be adversely affected by implementation of inpatient PPS because of the indirect costs of the approved graduate medical education programs. These may include the increased department overhead as well as a higher volume of laboratory test and similar services as a result of these programs which would not be reflected in the IPPS rates.[11] Thus, under §1886(d)(5)(B) of the Act, hospitals subject to IPPS, with approved teaching programs, receive an additional payment to reflect these IME costs.[12] The statute states that:

> The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs

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[7] See 31 Fed. Reg. 14814 (Nov. 22, 1966). See 42 C.F.R. §405.422, re-designated 42 C.F.R. §413.5(c)(2), and now at 42 C.F.R. 412.90).

[8] Id.

[9] Pub. Law 98-21 (1983).

[10] Section 1814(b) of the Act.

[11] See 50 Fed. Reg. 35646, 35681 (1985).

[12] This IME payment is distinguished from the direct medical education costs.

> under the regulations (in effect as of January 1, 1983) under subsection (a)(2)….

The regulation at 42 C.F.R. §412.105 governs 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.[13] The resident must be enrolled in an approved teaching program. In addition, the regulation at 42 C.F.R. 412.105(f)(ii) explains that in order to be included in the FTE count, the resident must be assigned to one of the following areas:

> (A) The portion of the hospital subject to the prospective payment system portion of the hospital;
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> (B) The outpatient portion of the hospital;
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> (C) Effective for discharges occurring on or after October 1, 1997, the time spent by residents in a nonhospital setting in patient care activities under an approved medical residency training program is counted towards the determination of full-time equivalency.[14]

Notably, when §1886(d) of the Act was amended to address the additional costs that teaching hospitals incur in treating patients, the Secretary discussed this new formula for IME payments and explained that:

> Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals receive an additional payment for the indirect costs of medical education computed in the same manner as the adjustments for those costs under regulations in effect as of January 1, 1983. Under [the] regulations [then set forth at 42 C.F.R. §412.118], we provided that the indirect costs of medical education incurred by teaching hospitals are the increase operating costs (that is, patient care costs) that are associated with approved intern and resident programs. These increased costs may reflect a number of factors; for example, an increase in the number of tests and procedures ordered by interns and residents relative to the number ordered

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[13] 42 C.F.R. §412.105(a)(1)(1997). See 49 Fed. Reg. 234 (1983) which noted that this additional payment is computed in the same manner as the indirect teaching adjustment under the notice of hospital cost limits published September 30, 1982 (47 Fed. Reg 43310).

[14] 42 C.F.R. §412.105(f) (1)(1997).

> by more experienced physicians or the need of hospitals with teaching programs to maintain more detailed medical records. [Emphasis added.][15]

Moreover, in a final rule implementing changes to direct GME reimbursement, the Secretary further explained:

> We also note that section 1886(d)(5)(B) of the Act and section 412.115(b) of our regulations specify that hospitals with "indirect cost of medical education" will receive an additional payment amount under the prospective system. As used in section 1886(d)(5)(B) of the Act, "indirect costs of medical education" means those additional operating (that is, patient care) costs incurred by hospitals with graduated medical education programs.[16] [Emphasis added.]

Thus, from the beginning of its implementation of the Congressional directives regarding medical education costs, Medicare has only paid for costs related to patient care even within the context of the increased costs associated with approved medical education programs.[17] Consistent with the Act and the regulations, the above principles were set forth in the Provider Reimbursement Manual (PRM) at §2405.3F.2 and state that a resident must not be counted for the IME adjustment if the resident is engaged exclusively in research. (Rev. 345, Aug 1988)

In this case, the Provider argues that during the subject cost reporting periods, the regulation at §412.105(f) did not specifically exclude research time from inclusion in the IME count or require that training be related to patient care. The Provider also argues that, since the residents are in an approved residency program, the time residents spend performing research as part of an approved residency program should be included in the IME calculation based upon the pertinent statute and controlling regulations.[18]

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[15] See 51 Fed. Reg. 16772 (May 6, 1986).

[16] See 54 Fed. Reg. 40282 (Sep. 29, 1989)

[17] The Administrator notes that the Secretary's longstanding policy of requiring hospitals to identify and excluded time spent by residents involved exclusively in research for purposes of the IME count adjustment was clarified at 42 C.F.R. §412.105(f) (1) (iii) (B) (2001). See 66 Fed. Reg. 39896 (Aug. 1, 2001).

[18] Time spent by residents in exclusively research with respect to GME is not at issue. Such time is similarly not allowed under GME payments, however, the costs so associated were removed from the base year costs used to calculate the average per resident amount.

The record shows that the Provider's rotation schedules listed each resident's name, month, and the “service area” (i.e., ward, clinic, etc.) to which the resident was assigned during that month. Among the “service areas” that the Provider listed were ED (Emergency Department), ICU (Intensive Care Unit), PICU (Pediatric Intensive Care Unit), Radiation Oncology, Inpatient Psychiatry, and Outpatient Psychiatry. The record also shows that the “service area” specified for the residents' time at issue was “Research.”

Applying the foregoing Medicare law and policy to the facts of this case, the Administrator finds that historically under the reasonable cost system of reimbursement, costs associated with research activities that were not related to patient care were not reimbursed and allowed. This exclusion extended to the indirect education (or teaching) adjustment paid under reasonable cost limits for the higher operating costs incurred by hospitals with medical education programs. The Administrator further finds that the indirect teaching adjustment methodology used under the reasonable cost limits was adopted under §1886(d)(5)(B) of the Act. Under both the reasonable cost and IPPS methodology, only the indirect costs of teaching programs relating to patient care (operating costs) is intended to be reimbursed by Medicare. Thus, the time spent by the residents exclusively in research (not related to patient care) is excluded from the IME FTE count.

In this case, the record shows that the research time was not related to patient care and thus is properly excluded from the IME FTE count. In addition, with respect to the time at issue, the record shows that the residents were not assigned to either the IPPS area, the outpatient area of the hospital, or a nonhospital setting in patient care activities. Instead the residents were assigned to “research.” Therefore, the residents' time at issue also fails to meet the criteria of 42 CFR 412.105(f)(ii) which is also necessary for inclusion in the IME FTE count.

With respect to Issue No. 2, the Administrator concurs with the Board's determination, but on alternative grounds. The regulation at 42 C.F.R. §412.105(f)(1)(iii) for IME and 42 C.F.R. §413.78(b) (2004) for direct GME, states that “A hospital cannot claim the time spent by residents training at another hospital.” Accordingly, the Administrator finds that because the residents were on rotation at another provider, the Intermediary properly disallowed the related residents' vacation time from the Provider's FTE counts.

DECISION

The decision of the Board on Issue No. 1 is reversed. The decision of the Board on Issue No. 2 is affirmed consistent with the foregoing opinion.

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

Date: 6/7/05 /s/

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Deputy Administrator
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