CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Rush University Medical Center Center **Provider** **vs.** **BlueCross/BlueShield Association/ National Government Services, Inc. (formerly AdminaStar Federal, Inc.)** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 06/30/93 and 06/30/94** **Review of: PRRB Dec. No. 2012-D8 Dated: February 8, 2012**

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)). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. The Provider submitted comments requesting that the Administrator reverse the Board's decision on Issue No. 1 and Issue No. 2-C and affirm the Board's decision on Issue No. 2-A and Issue No. 2-B. The Center for Medicare (CM) also submitted comments, requesting that the Administrator affirm the Board's decision on Issue No. 1 and Issue No. 2-C, and reverse the Board's decision with respect to Issue No. 2-A and Issue No. 2-B. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

Issue No. 1 was whether the Intermediary properly calculated the number of interns and residents for fiscal year (FY) 1993 for purposes of the Provider's direct graduate medical education (DGME).

The Board upheld the Intermediary's adjustment excluding FTEs attributable to time spent by pathology residents on elective rotations. The Board concluded that the Provider failed to maintain adequate and verifiable documentation to support its claim that the elective resident(s) rotations in controversy were performed at the Provider's location. The Board found that both the original and revised rotation schedules failed to identify where the rotations took place. The Board also held, with respect to this issue, that the February 25, 2003 letter from the Department of Pathology chair was inadequate evidence as the letter was not contemporaneous, was unsworn; contained discrepancies with other evidence; was incomplete; and did not identify all the contested residents who had elective rotations.

Issue No. 2-A was whether the Intermediary's adjustments to the Provider's bed count, as used for purposes of the indirect medical education (IME) calculation, was proper.

The Board modified the Intermediary's adjustment. The Board held that a majority of the beds in controversy were taken out of service, thus, making them unavailable for inpatient care if needed. Based on testimony regarding the process of taking beds out of service and bringing them back in service, and the two types of contemporaneous evidence (memoranda relating to closures, and Room and Bed Master Price Index reports), the Board agreed with the Provider that it would take the Provider at least 72 hours to make the beds in controversy available. Therefore, the Board determined that the beds were not permanently maintained for lodging inpatients. For FYEs 1993, and 1994, for the most part, the Board, adopted the Provider's calculation with minor modifications.

Issue No. 2-B was whether, in calculating the Provider's bed count as used for purposes of IME calculation, there should have been a reduction for beds used for observation purposes.

The Board held that the available bed days should be decreased to exclude observation/recovery bed days even though the services rendered to patients in those beds may not have qualified as observation services for billing purposes. The Board found that the Provider was placing outpatient observation patients in hospital inpatient beds. The Board noted that in the August 1, 2003 *Federal Register*,[1] CMS stated that inpatient beds that are used for observation services must be excluded from the available bed count. Thus, the Board agreed with the Provider that the total hours those outpatient observation patients utilized inpatient beds should be removed from the available bed day calculation.

[1] 68 Fed. Reg. 45418-9 (Aug. 1, 2003).

Issue No. 2-C was whether, for purposes of the Provider's intern and resident count for IME, the Intermediary correctly disallowed research rotations for residents participating in an approved medical residency program at the Provider.

The Board upheld that the Intermediary adjustment removing the IME FTEs related to research rotation. The Board found that the Intermediary's adjustment was based upon the fact that the research rotation in controversy had not been shown to be directly related to treating particular patients. The Board acknowledged that Congress revised the rules for counting FTEs for IME purposes in the Affordable Care Act, stating that "the time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable."

SUMMARY OF COMMENTS

Issue No. 1: Number of DGME Pathology Residents in FYE June 30, 1993.

CM commented requesting that the Administrator uphold the Board's decision.

The Provider commented requesting that the Administrator reverse the Board's decision in this matter. The Provider argued that the 14 Pathology residents claimed in FY 1993 should be included in the Provider's resident count for DGME purposes because the rotation schedules submitted to support the claimed number of Pathology residents participating in an approved program at the Provider were contemporaneous. The Provider argued that, since its rotation schedule did not identify the pathology rotation as occurring at another provider, the rotation must have been performed at the Provider. Finally, the corroborating letters from the Pathology Department Chairman, were requested by the Intermediary during the mediation phase of this appeal and, thus, could not have been contemporaneous with the actual rotations. These letters only verify that all the elective rotations occurred at the Provider.

Issue No. 2-A: Provider's Bed Count as Used for Purposes of the IME Calculation.

CM commented requesting that the Administrator reverse the Board's decision. CM agreed with the Intermediary that the Provider failed to present adequate documentation to substantiate that the beds in controversy were taken out of service and made unavailable to the extent that they could not be converted for patient care use within a short period of time. Contrary to the instructions in the PRM 15-1, § 2405-3G, the Provider attempted to remove from the available bed count those beds that, in fact, only represent "day-today fluctuations in patient rooms and wards as beds are added to or taken out of service."

The Provider commented requesting that the Administrator affirm the Board's decision in this matter. The Provider stated that the Board properly applied 42 C.F.R. § 413.105(b) and CMS Pub. 15-1 §2405.3G in finding that the majority of the beds in controversy met the requirements for being unavailable and therefore should have been excluded from the Provider's bed count.

Issue No. 2-B: Provider's IME Bed Count Regarding Observation Beds.

CM commented requesting that the Administrator reverse the Board's determination regarding this matter. CM contended that the Provider has not satisfactorily documented the number of observation bed days to be subtracted from the available bed count.

The Provider submitted comments requesting that the Administrator affirm the Board's determination regarding this matter. The Provider disagreed with the Intermediary's contention that if services provided in observation beds could not be billed as observation services, then the bed days associated with the non-billable services could not be excluded from the Provider's bed count. The Provider argued that the Intermediary is impermissibly mixing concepts with its position. The Provider contended that Line 19 on Worksheet S-3 is used to report statistics that are used elsewhere in the cost report. It is not used to generate reimbursement to the Provider for observation bed services. Rather, that reimbursement is driven by separate claims procedures and criteria.

Issue No. 2-C: Research Activities.

CM commented requesting that the Administrator affirm the Board's decision to exclude the research FTEs from the IME count.

The Provider commented requesting that the Administrator reverse the Board's determination regarding this issue. The IME regulations only require that a resident be: (1) enrolled in an approved teaching program; and (2) assigned to work in the portion of the Provider subject to the prospective payment system or an outpatient department of the Provider. The Provider argued that there are no other requirements or standards that can be applied to research rotations from any reading of the IME regulations. In this case, the Provider argued that these two elements of the IME regulation have been met. Moreover, the Board has impermissibly applied an interpreted §5505(b) of the Affordable Care Act to retroactively exclude research activities not associated with the treatment or diagnosis of a particular patient. Finally, the Board chose to follow a Sixth Circuit Court of Appeals decision rather than follow an on-point decision from the Seventh Circuit Court of Appeals, which is the jurisdiction in which the Provider is located.

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.

Issue No. 1: Number of DGME Pathology Residents in FYE June 30, 1993.

Section 1886(h) of the Act, also direct the Secretary to make payment for DGME costs. During the fiscal years at issue in this appeal, the implementing regulations at 42 C.F.R. §413.86(f) established certain conditions that a provider must meet in order to include a resident in the full time equivalent (FTE) count. Specifically, the regulation at 42 C.F.R. §413.86(f)(2) provided that:

> (2) To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.
>
> > (i) The name and social security number of the resident.
> > (ii) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.
> > (iii) The dates the resident is assigned to the hospital and any hospital-based providers.
> > (iv) The dates the resident is assigned to other hospitals, or other freestanding providers, and any non-provider setting during the cost reporting period, if any.
> > (v) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation….

The Provider argued that the 14 Pathology residents claimed in fiscal year (FY) 1993 should be included in the Provider's resident count for DGME purposes because the rotation schedules submitted to support the claimed number of Pathology residents participating in an approved program at the Provider were contemporaneous. The Board upheld the Intermediary's adjustment excluding FTEs attributable to time

spent by pathology resident on elective rotations. The Board concluded that the Provider failed to maintain adequate and verifiable documentation to support its claim that the elective resident rotations in controversy were performed at the Provider's location. The Board found that both the original and revised rotation schedules failed to identify where rotations took place.

Applying the applicable Medicare law and policy to the facts of this case, the Administrator agrees with the Board's determination that the Provider failed to maintain adequate and verifiable documentation to support its claim that the elective resident rotations were performed at the Provider's location. Under 42 C.F.R. §§ 413.20 and 413.24, a provider has the burden of maintaining adequate documentation to support its claimed costs and enable the Intermediary to determine the amount payable. The Administrator agrees with the Board that the February 25, 2003 letter from the Department of Pathology Chair was inadequate evidence as it was not contemporaneous, contained discrepancies with other evidence and did not identify all the contested residents who had elective rotations. Accordingly, the Board's determination with regard to the Pathology Residents for FYE 1993 is affirmed.

Issue Nos. 2-A, 2-B, 2-C

Prior to 1983, Medicare reimbursed providers on a reasonable cost basis. Section 1861(v)(1)(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)(1)(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.

Acting under such authority, the Secretary promulgated the regulation at 42 C.F.R. §413.85 which permits reimbursement for the costs of "approved educational activities."[2] 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 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. Thus, since its inception Medicare has recognized

[2] 42 C.F.R. §413.85(b)(1993). 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).

the increased costs related to a provider's approved graduate medical education programs. The Secretary also promulgated the regulation at 42 C.F.R. §413.9 which 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.

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 incurred for research purposes over and above usual patient care, are not includible as allowable costs."[3] 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 cost of usual patient care are allowable to the extent that such costs are not met by funds provided for the research….[4]

From the beginning of the program, the PRM has provided at §500 et seq., the principle that costs incurred for research purposes over and above usual patient care, are not includable as allowable costs.[5] Section 502.2 defines usual patient care as:

> [T]he care which is medically reasonable, necessary, and ordinarily furnished (absent any research programs) in the treatment of patients by providers under the supervision of physicians as indicated by the medical condition of the patients. Also, this definition intends that the appropriate level of care criteria must be met for the costs of this care to be reimbursable. Such care is represented by items and services (routine and ancillary) which may be diagnostic, therapeutic, rehabilitative, medical, psychiatric, skilled nursing, and other related professional health services.[6]

Section 504.2 sets forth rules for accounting for usual patient care costs incurred in conjunction with research. Section 504.2 states that:

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[3] *See* 31 *Fed. Reg.* 14814 (Nov. 22, 1966).
[4] *Id.*
[5] Provider Reimbursement Manual § 500.
[6] *Id.* at § 502.2.

> Usual patient care costs incurred in conjunction with research must be specifically identified in those situations where a portion of the research funds is applicable to usual patient care costs. (See Exhibit 1 for the method to be used in identifying usual patient care costs.) In these instances, providers must maintain statistics on research patients for each research project to identify the patients and the patient days and ancillary charges applicable to the usual patient care furnished by the providers….

As reflected in Section 504.2 and Exhibit 1, CMS has historically identified patient care related research costs by using patient days and ancillary charges which by definition would relate to billable patient care services for a particular individual.

Under the routine cost limits, under §1886(a)(2) of the Act, Medicare also paid for the increased indirect costs associated with a hospital's approved graduate medical education program through an indirect teaching adjustment.[7] Thus, since its inception Medicare has recognized the increased *operating* costs related to a provider's approved graduate medical education programs through an indirect teaching adjustment.[8] Notably, research costs have never been includable as allowable operating costs.

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[7] Section 1886(a)(2) states that the Secretary shall provide "for such…adjustments to, the limitation…as he deems necessary to take into account - (A) …. Medical and paramedical educational costs …."

[8] 45 Fed. Reg. 21584 (April 1, 1980)(indirect teaching adjustment under pre-TEFRA cost limits); 46 Fed. Reg. 33637 (June 30, 1981)("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 … 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.)

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 "pass-through," i.e., paid on a reasonable cost basis.[10]

Congress recognized that teaching hospitals might be adversely affected by implementation of IPPS because these indirect costs, which may include increased department overhead as well as a higher volume of laboratory test and similar services,[11] would not be reflected in the IPPS rates.[12] Thus, under §1886(d) (5)(B) of the Act, hospitals subject to IPPS, with approved teaching programs, receive an additional payment to reflect the IME costs.[13] Section 1886(d)(5)(B) of the Act provides that teaching hospitals subject to IPPS shall receive an additional payment for the indirect costs of medical educations. This payment is designed to cover the increased operating or patient care costs that are associated with approved intern and resident programs and which are not separately identifiable on the cost report or accounting statement. These increased costs may reflect a number of factors such as an increase in the number of tests and procedures ordered by the intern or resident as compared to a more experienced physician, higher staffing ratios, the need of hospitals with teaching programs to maintain more detailed medical records than other hospitals, and the presence of a more severely ill patient population.[14] Thus, under §1886(d)(5)(B) of the Act, hospitals subject to IPPS, with approved teaching

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[9] *Pub. L.* 98-21 (1983).
[10] Section 1814(b) of the Act.
[11] *See* 50 *Fed. Reg.* 35646, 35681 (1985).
[12] *Id.*
[13] This IME payment is distinguished from the direct medical education costs.
[14] *See* 51 *Fed. Reg.* 16772, 16775 (1986). *See also* Committee of Conference Report on the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), No. 99-453, 99th Congress, 1st Session, p. 455 (December 19, 1985).

programs, receive an additional payment to reflect these IME costs.[15] 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 under the regulations (in effect as of January 1, 1983) *under section (a)(2)* [i.e., under the reasonable cost routine cost limits] …. (Emphasis added.)

The amount of payment is based on a hospital's ratio of full-time equivalent interns and residents to bed size.[16] The regulation governing this provision is set forth at 42 C.F.R. §412.105 (1993), stating that to determine the IME adjustment CMS uses the following procedures:

> (a) *Basis data.* [CMS] determines the following for each hospital:
>
> (1) The hospital's ratio of full-time equivalent residents, except as limited under paragraph (g) of this section, to the number of beds (as determined under paragraph (b) of this section)….
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> (b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

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:

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

[16] *See* 50 Fed. Reg. 35646, 35678 (1985). *See also* Report of the Senate Budget Committee on COBRA 1985, No. 99-146, 99 th Congress, 1 st Session, p. 291 (September 30, 1985) which, in summarizing the current law, states that: "In addition to the DRG payment, teaching hospitals are paid amounts designed to compensate them for certain costs that are indirectly attributable to their teaching activities. The amount of this indirect teaching adjustment is based on the ratio of the hospital's residents and interns to the number of its beds." (Emphasis added.)

> (A) The portion of the hospital subject to the prospective payment system portion of the hospital;
>
> (B) The outpatient portion of the hospital;
>
> (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.[17]

Further, the preamble to the final rule for "Changes to the Inpatient Hospital Prospective Payment System" for 1986[18] states, regarding the definition of available beds, that:

> For purposes of the prospective payment system, "available beds" are generally defined as adult or pediatric beds (exclusive of newborn bassinets, beds in excluded units, and custodial beds that are clearly identifiable) maintained for lodging inpatients. Beds used for purposes other than inpatient lodgings, beds certified as long-term, and temporary beds are not counted. If some of the hospital's wings or rooms on a floor are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied.

CMS in discussing this new formula for IME payments 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, <u>patient care costs</u>) 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 by more experienced physicians or the need of hospitals with teaching programs to maintain more detailed medical records. [Emphasis added.][19]

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[17] 42 C.F.R. §412.105(f)(1)(1997).
[18] 50 Fed. Reg. 35683.
[19] *See* 51 Fed. Reg. 16772 (May 6, 1986).

Moreover, in a final rule implementing changes to direct GME reimbursement, CMS 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 graduate medical education programs.[20] [Emphasis added.]

Consistent with the Act and the regulations, the above principles are set forth in the Provider Reimbursement Manual (PRM) at §2405.3F2 and state that a resident must not be counted for the IME adjustment if the resident is engaged exclusively in research. Section 2405.3.F of the PRM explains that:

> The term "interns and residents in approved programs" means individuals participating in graduate medical education programs approved as set forth in §404.1.A….
>
> It is recognized that situations arise in which it may be unclear whether an individual is counted as an intern or resident in an approved program for the purpose of the indirect medical education adjustment…. Intermediaries must not count an individual in the indirect medical education adjustment if any of the following conditions exist:
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> ….
>
> The individual is engaged exclusively in research….[21]

Consistent with the law, §2405.3(G) of the PRM stated that:

> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patients rooms or wards (i.e., not in corridors or temporary beds). Thus, beds are considered available only if the hospital put the beds into use when they are needed…. In the absence of evidence to the contrary, beds available at any time during the cost reporting period are presumed to be available during the entire cost reporting period. The hospital bears the burden of proof to exclude beds from the count.

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

[21] Transmittal Rev. 345 (August 1988).

To clarify certain points concerning the definition of available bed days in § 2405.3 of the PRM, Blue Cross and Blue Shield Association (BCBSA), issued Administrative Bulletin (Bulletin) 1841, 88.01, on November 18, 1988.[22] In the Bulletin, the Association stated that:

> Section 2405.3G also states that "beds in a completely or partially closed wing of the facility are considered available only if the hospital put the beds into use when they are needed." [CMS] makes a distinction here between a temporarily closed wing and a permanently closed wing. A wing is considered permanently closed if the area in which the beds are contained is not included in a hospital's depreciable plant assets subject to capital-related cost reimbursement during a cost reporting period, and no available bed days for these beds should be counted. In a situation where rooms or floors are temporarily unoccupied, the beds in these areas must be counted, provided the area in which the beds are contained is included in the hospital's depreciable plant assets, and the beds can be adequately covered by either employed nurse or nurses from a nurse registry. In this situation, the beds are considered "available" and must be counted even though it may take 24-48 hours to get nurses on duty from the registry.
>
> Where a room is temporarily used for a purpose other than housing patients, (e.g., doctors' sleeping quarters), the beds in the room must be counted, provided they are available for inpatient use on an as needed basis…

Finally, AB 1841, 88.01 states in part that: "Depending upon circumstances, it may not be appropriate to use all licensed beds in determining total available bed days."[23]

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 direct and indirect costs associated with approved medical education programs.

The Administrator finds 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.

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[22] Administrative Bulletin (AB) No. 1841, 88.01, November 18, 1988. This policy was first articulated in correspondence to the BCBSA on November 2, 1988.

[23] *Id.*

§412.105(f)(1)(iii)(B)(2001).[24] Consistent with longstanding policy, the regulation at 42 C.F.R. §412.105(f)(1)(iii)(B)(2001) specifically excluded all time spent by residents in research not involving the care of a particular patient by stating:

> The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable. …."[25]

Subsequently, the Affordable Care Act specifically prohibited the post-2001 inclusion in the IME FTE count of research time not associated with patient care. As noted by the Board, the Affordable Care Act explicitly left to the Secretary the discretion to determine research time not related to patient care is to be included prior to 2001.[26] Finally, in the 75 Federal Register dated November 24, 2010, CMS stated that research time that is not associated with the treatment or diagnosis of a particular patient, is not countable in the FTE count for purposes of the IME payment.[27]

Issue No. 2-A: Provider's Bed Count for Purposes of the IME Calculation.

The issue involves whether the Provider supplied sufficient documentation to support its claim that the beds in dispute were not "available" as the terms is used under the regulation and manual for inpatient use for purposes of calculating the IME payment. The Board held that a majority of the beds in controversy were taken out of service, thus, making them unavailable for inpatient care if needed. The Board relied upon testimony regarding the process of taking beds out of service and bringing them back in service, and two types of contemporaneous evidence (memoranda relating to closures, and Room and Bed Master Price Index reports). The Board agreed with the Provider that it would take the Provider at least 72 hours to make the beds in controversy available. Therefore, the beds were not permanently maintained for lodging inpatients. The Board modified the Intermediary's adjustment for FYE 1993, finding that the beginning bed count for 3 Pavilion was 22 ((instead of 20 as the Provider recorded) and, thus, the weighted bed average for that unit was 21.43

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[24] *See* 66 Fed. Reg. 39896 (Aug. 1, 2001).

[25] *See* 66 Fed. Reg. 39896 (Aug. 1, 2001) for full recitation of historical overview of policy herein incorporated by reference. For further discussions, *see also* 71 Fed. Reg. 47870, 48081-48093 (August 18, 2006).

[26] Section 5505(c)(3) of the Affordable Care Act. Pub. Law. No. 111-148. The Administrator also notes that Section 5505 of the Affordable Care Act provides that time spent in non-research didactic and scholarly activities may be included in the IME calculation effective retroactively to 1983 for open cost reports. However, the record would not support a finding that the time at issue in this case involves includable "non-research" didactic activities.

[27] *See* 75 Fed. Reg. 71800, 72144-46. (Nov. 24, 2010).

(instead of 20). The Board also recognized that the Intermediary conceded that 9 Kellog was unavailable due to construction after December 12. 1992, thus, overstating the bed count by 25.21 for FYE 1993. The Board also modified the bed count for FYE 1994, and found for 5 Kellog the starting count should be 34 beds as that was the ending count (based on the Provider's FY 1993 bed count and not the Intermediary FY 1993 bed count of 37) the previous year and should be used instead of the Provider's proposed FY 1994 bed count of 33 or the Intermediary bed count of 24. Thus, for 5 Kellog, the Board found the bed count should be weighted as 22.47 (based on 34 beds for 218 days, 10 beds for 25 days and 0 beds for 121 days) instead of the Provider's 19.76 beds for that unit or the Intermediary's 24 beds for that unit. (The Intermediary's numbers basically track the Board's except that the Intermediary did not find evidence that the 10 beds held for "bed crisis" were in fact taken out of service for the remainder of the cost year.).

1993 beds in dispute
Area/ Provider Bed Count/ Intermediary Bed Count/ difference
5 Pavilion — 2 — 1.46 — 0.54
8 Kellog 35.19 41.08 - 5.89
3 Pavilion 20 24-4
7SAtruim - 36—37—1
10 Kellog— 30.51—46—15.49
2 Pavilion— 22.51—24—1.49
5 Kellog — 34—37 3
9 Kellog 17.18—46—28.82
11 Kellog— 15.89—44—28.11
Total difference— 88.34

1994 beds in dispute
Area/ Provider Bed Count/ Intermediary Bed Count/ difference
3 Pavilion — 19.85 -20 —.15
5 Kellog 19.76 -24—4.24
7 Kellog 23.56 25— 1.44
9 Kellog 27.80—40—12.20
11 Kellog -32.19—35—2.8
Total difference—20.84

The contrast in the Intermediary and Provider's available bed counts are generally based on differences in several discrete factors: the beginning bed count for a unit; the treatment of discrete beds opened and closed through the cost year in an otherwise occupied unit; the treatment of whole units not being used for part of a year

due to budget/utilization; and the treatment of beds of a reopened post-construction unit.

Regarding the beginning bed count of a unit, the Administrator finds that, to the extent that the Provider may have relied, as a starting point, upon "budgeted beds"[28] such criteria would not be an appropriate measure for determining "available beds" and has been rejected in past cases.[29] Generally, in lieu of the budgeted beds as a beginning point in the unit bed count, the Intermediary relied on either the licensed beds, available beds as reflected in an immediate cost year or an extrapolation based on walk through observations. Tr. 183, 196, 200-201

Another disagreement is whether the available beds captured by the Provider's statistics reflect the day-today fluctuations in the bed size based on the placing and removing of beds in service in otherwise occupied units. (see, e.g., FYE 1993 5 Pavilion, 8 Kellog;, FYE 1994 5 Kellog, 7 Kellog, 10 Kellog, Tr. 237, 241) The Provider justifies these counts claiming that the beds were not available as they could not be prepared to be occupied in less than 72 hours in conformity with the AB Bulletin. The Provider witness testified that, inter alia, the Provider leased its beds and therefore could not return any beds to service before 72 hours. The Intermediary witness, in response, stated at the hearing that the Provider's alleged inability to place the beds in service in less than 72 hours still did not make the beds unavailable as a delay of 24 hours was not significant to the determination of whether the bed is available.[30] The Intermediary argued that the day-to-day fluctuation of bed size as shown in the Provider's documentation only reflected utilization/budget concerns and was not equivalent to "available beds."

In past cases, where a provider has alleged that it could not place beds in service in a timely manner to make them "available", such contentions were supported by contracts (i.e., staffing, equipment) that showed the contractual lead time necessary to obtain sufficient staffing, equipment, etc., to place the beds in service, or evidence that the beds/room/unit had been permanently converted to a non-inpatient use and oxygen, nurse call systems, etc., had been removed making it impossible to place a bed in service in that time frame. In this instance, the Provider relied upon witness testimony that in turn relies upon conversations, *inter alia*, with nurses that staffed

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[28] *Compare*, e.g., FYE 1993 Provider Exhibit P-16 "bed count" numbers to the Provider's "budgeted" bed numbers for certain areas such as 3 Pavilion, 10 Kellog, 2 Pavilion, 5 Kellog, 9 Kellog, 11 Kellog. The Provider did not submit a budgeted bed report for the FYE 1994 in Provider Exhibit P-11.

[29] See, e.g., County of Los Angeles v. Leavitt, 521 F.3d 1073 (9 th Cir. 2008).

[30] The auditor stated in workpapers for FY 2000 that it would allow the removal of beds from the count when it required "more than" 72 hours to return a bed to service.

areas at the time. Problematic is that such testimony is not supported by any audible documentation and is not being directly relayed by staff with firsthand knowledge.

Further, in contrast, there is contradictory documentary evidence as to how quickly the Provider's beds could be placed in service and made available in the otherwise occupied units. The record shows at least four memorandums requesting to have beds placed in service and that such beds were placed in service the same dates of the requests. Reviewing Provider Exhibit P-16, for the FY 1993 cost year, the record shows for 8 Kellog, a January 8, 1993 memorandum requesting six beds be opened (two of which indicated as "already there") and the Provider showing in the summary of the beds in dispute, dates of service 01/08/1993-01/12/1993; a January 12, 1993 memorandum requesting that two beds (indicated as already there in January 8 memorandum as Rooms 815 A and 833B) be opened "in the computer" system and showing dates of service 1/12/93-3/17/1993; and a March 17, 1993 memorandum showing a request to open 5 beds, showing dates of service of 3/17/1993-06/30/1993. For the FY 1994 cost year, Provider Exhibit P-11, shows a June 15, 1995 memorandum requesting that 4 beds in 3 Pavilion be placed back into service, which the Provider then indicates were put back into service that day as reflected in its summary of beds in dispute at P- 11, with dates of service 6/15/1995-6/30/1995. (The Provider withdrew those beds from the dispute. *See* Tr. 224). The Provider has no contemporaneous and audible documentation to support its contention that it would take at least 72 hours to place beds in service and its own records show that the Provider was able to consistently place beds in service the same day requested. Consequently, regardless of whether, as a matter of policy, a 72 hours delay in placing a bed in service is sufficient to make the bed unavailable, the Provider's own documentation indicates that beds in otherwise occupied areas, were able to be immediately placed in service upon request

In addition, the dispute involved whether beds were available when the unit was vacated, but not yet under construction (see, e.g., FYE 1993, 9 Kellog); whether beds were available in units post-construction (see, e.g., FYE 1994, 9 Kellog) or whether beds were available in units not being used prior to another unit closing for construction. (see e.g. FYE 1993, 11 Kellog) The Intermediary does not contend that beds in units under construction would be counted. Pursuant to a review of documents offered at the hearing, the Intermediary witness agreed that, for FYE 1993, 9 Kellog was closed for renovations starting 12/12/92. Based on the licensed bed number of 46 (instead of the Provider's starting point of budgeted beds of 38), the count would be reduced by 20.79 or a positive 25.21 (instead of the 46 beds used by the Intermediary or the 17.18 beds used by the Provider.)[31]

[31] Tr. at 240-241.

However, for that same unit 9 Kellog, for FY 1994, the renovation started in the FY 1993 cost year, was completed in September 1993 of the FY 1994 and 28 beds were put into service for the rest of the FY year. The Intermediary maintained that, as renovations were complete for 9 Kellog in September 1993, that 40 licensed beds could be considered available as the Provider had not demonstrated that they could not be used to maintain patients following the reopening of the unit.[32]

For 11 Kellog, (which was utilized in lieu of the 9 Kellog unit when 9 Kellog was under construction), the Provider proposed that 29 beds were opened for 11 Kellog effective December 12, 1992 (the 9 Kellog closing date.) However, the Intermediary reasonably determined that 11 Kellog was not shown to be unable to hold available beds prior to the date from the start of the FYE 1993 (and had not been permanently converted to other uses) and, thus, in the absence of other documentation, the licensed beds of 44 should be used. The evidence that the Provider points to for support only reflects budgeted and utilization concerns and not whether the area in fact could be used for available beds.[33]

The Administrator finds that the Intermediary reasonably relied on documentation of licensed beds, prior and subsequent cost year bed counts; walk-through observations and first hand discussions with staff to determine the correct beginning bed count for the disputed FYE 1993 and 1994 units. In addition, the Intermediary reasonably concluded that except when the Provider documented units closed for construction9as herein modified), the beds in the units at issue had not been otherwise permanently converted and could be timely made available for inpatient services. The Provider had the burden of proof to have beds removed from the bed count and did not provide sufficient documentation beyond a bed count based on budget and utilization which is not equivalent to "available beds." The Administrator affirms the Intermediary finding of the bed count, as herein modified for FY 1993, and the Intermediary finding of the bed count for FY 1994.

Issue No. 2-B: Provider's IME Bed Count Regarding Observation Beds.

The Board held that the available bed days should be decreased to exclude observation/recovery bed days even though the services rendered to patients in those

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[32] The Intermediary also pointed out that a letter at Exhibit P-11 p. 45 showed that the Intermediary may have mistakenly believed that 11 Kellog (a unit not raised in the FY 1994 dispute) was closed for all of the FY 1994, when it was only closed from January 1, 1994. However, as that issue was not raised and fully briefed prior to the hearing, the Administrator does not require a corresponding adjustment to reflect a correction of that apparent mistake for the available beds for that unit.

[33] (*See* e.g. Tr. 242.

beds may not have qualified as observation services for billing purposes. The Board found that the Provider was placing outpatient observation patients in hospital inpatient beds. The Board noted that in the August 1, 2003 Federal Register,[34] CMS stated that inpatient beds that are used for observation services must be excluded from the available bed count. Thus, the Board agreed, with the Provider that the total hours those outpatient observation patients utilized inpatient beds should be removed from the available bed day calculation.

Applying the applicable Medicare law and policy to the facts of this case, the Administrator disagrees with the Board's determination. First, the Administrator agrees that observation bed days should be removed from the available bed count. However, a review of the record shows that the Intermediary could not audit the documentation for accuracy, nor could the Intermediary determine whether the patient days in question reflected outpatient observation services, outpatient recovery services, or other unrelated services. Under 42 C.F.R. §§413.20 and 413.24, a provider has the burden of maintaining adequate documentation to support its claimed costs and enable the Intermediary to determine the amount payable. The Provider self-disclosed that it had billed certain services incorrectly as observation days and that the days reported by the Provider on worksheet S-3, Part I of the cost report as observation days do not, in fact, reflect only observation days. Without supporting documentation that the days at issue were in observations days (i.e., successfully billed as such) the Provider has not demonstrated that the patient days in question are actually observation days. Therefore, the Administrator finds that the Provider has not documented that the days in dispute are in fact "observation bed days" and that they must be subtracted from the available bed count.

Issue No. 2-C: Research Activities.

The Provider commented requesting that the Administrator reverse the Board's determination regarding this issue. The IME regulations only require that a resident be (1) enrolled in an approved teaching program, and (2) assigned to work in the portion of the Provider subject to the prospective payment system or an outpatient department of the Provider. The Provider argued that there are no other requirements or standards that can be applied to research rotations from any reading of the IME regulations. The Board upheld that the Intermediary adjustment removing the IME FTEs related to research rotation. The Board found that the Intermediary's adjustment was based upon the fact that the research rotation in controversy had not been shown to be related to treating particular patients.

[34] 68 Fed. Reg. 45418-9 (Aug. 1, 2003).

Applying the applicable Medicare law and policy to the facts of this case the Administrator agrees with the Board's determination and holds that research time that is not related to patient care for a particular patient is not included in the IME FTE count. The record in this case does not show that the research activities were related to the patient care of an individual. Under general Medicare reimbursement principles as reflected in section 1861(a) of the Act and 42 C.F.R. §413.9, costs incurred by a hospital must be related to patient care in order to be reimbursed by Medicare. 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 allowed,[35] which was continued in the treatment of FTEs under the cost limits and IPPS for the IME payment.[36] Thus, with respect to the FTEs at issue, only research time that is associated with the treatment or diagnosis of a particular hospital patient is to be counted for IME payment purposes. Accordingly, the Administrator finds that the Intermediary properly excluded research time from the IME FTEs not associated with the delivery of patient care for a particular patient from the Provider's IME calculation.

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[35] *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). "Cost incurred for research purpose, over and above usual patient care, will not be included." As reflected in Section 504.2 and Exhibit 1, CMS has also historically identified patient care related research costs by using patient days and ancillary charges which by definition would relate to billable patient care services for a particular individual.

[36] See also 66 Fed. Reg. 39896, 39897 (Aug. 1, 2001). The August 1, 2001 *Federal Register* is merely a clarification of long-standing Medicare policy on research and does not represent a change in policy that was applied retroactively to the subject cost reporting periods.

DECISION

Issue No. 1-A: The decision of the Board with respect to Issue No. 1-A, regarding the number of DGME Pathology residents in FYE June, 30, 1993, is affirmed in accordance with the forgoing opinion.

Issue No. 2-A: The decision of the Board with respect to Issue No. 2-A, regarding the Provider's bed count for purposes of the IME calculation, is reversed in accordance with the foregoing opinion.

Issue No 2-B: The decision of the Board with respect to Issue No. 2-B, regarding the Provider's IME bed count and observation beds, is reversed in accordance with the foregoing opinion.

Issue No. 2-C: The decision of the Board with respect to Issue No. 2-C, regarding the treatment of research activities for purposes of the IME payment, is affirmed in accordance with the foregoing opinion.

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

Date: 4/4/12

/s/

Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services