PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D19

PROVIDER –
North Dakota 99-01 Adjustment of FTE GME/IME Group

Provider Nos.: 35-0002 and
35-0015

INTERMEDIARY –
BlueCross BlueShield Association/
Noridian Administrative Services

DATE OF HEARING –
July 11, 2007

Cost Reporting Periods Ended -
December 31, 1999, December 31, 2000 and June 30, 2001

CASE NO.: 04-1995G

INDEX

ISSUE:

Whether the Intermediary properly disallowed reimbursement for direct graduate medical education (DGME) and indirect medical education (IME) costs in the non-hospital setting by reducing the Provider's full-time equivalent (FTE) resident counts.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Since 1986, the statute authorizing DGME reimbursement for residency programs has provided that "all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting." Social Security Act (SSA) §1886(h)(4)(E), 42 U.S.C. §1395ww(h)(4)(E). In 1997, Congress authorized reimbursement for residents in nonhospital settings for IME as well. SSA §1886(d)(5)(B)(iv).

During the fiscal years at issue, the regulations established three conditions, two of which were also required by statute, that a Provider must meet in order to count residents' training time in non-hospital settings for DGME and IME payment purposes:

(i) The resident spends his or her time in patient care activities.

(ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

(iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

42 C.F.R. § 413.86(f)(4) (1999).[1] *See also* 42 C.F.R. § 412.105(f)(1)(ii)(C) (2000) (incorporating the above DGME standards by reference to IME). With respect to subparagraph (iii), the regulations provide a definition for "all or substantially all of the costs for the training program in the nonhospital setting" as follows:

> All or substantially all of the costs for the training program in the nonhospital setting means 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.

42 C.F.R. § 413.86(b)(3).

Furthermore, CMS published in the preamble to the 2003 final rule the following comment and response:

> *Comment:* Several commenters objected to the sentence in the preamble to the proposed rule that stated " . . . a hospital is required to assume financial responsibility for the full complement of residents training in a nonhospital site in a particular program in order to count any FTE residents training there for purposes of IME."
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> *Response:* We understand the concerns of the commenters about the requirement for a hospital to incur "all or substantially all of the cost" of training residents in a training *program* at a nonhospital site. However, we *do not* believe this is a *change* in policy. We believe that the policy that requires a hospital to incur the cost of "the program" in the nonhospital site has existed since the passage of the direct GME provisions, section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509),

[1] 42 C.F.R. §413.86(f)(4)(iii) was added effective October 1, 1999. All other quoted regulations were consistent throughout the periods in controversy.

> and the passage of the IME provision, section 4621(b)(2) of the Balanced Budget Act of 1997 (Pub. L. 105-33), that permitted hospitals to continue to count residents in nonhospital sites, for purposes of direct GME and IME payment, if the hospital incurred "all or substantially all of the cost" of residents training in the program.
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> *****
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> However, we believe the statutory provisions cited above require hospitals to assume the cost of the full complement of residents training in the program at the nonhospital sites in order to count any FTE residents training at that site. . . .

68 Fed. Reg. 45,346, 45,449-50 (Aug. 1, 2003)(emphasis in original).

The dispute in this case concerns CMS' interpretation of the phrase "all or substantially all of the costs for the training program" as expressed in the preamble above.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Medcenter One Health Systems and St. Alexius Medical Center (the Providers) are hospitals located in the Bismarck, North Dakota area. Both Providers train residents participating in a three-year family practice residency program operated in conjunction with the University of North Dakota Medical School (University). Both of their programs include resident training at the Bismarck Family Practice Center (FPC), an unrelated nonhospital setting also located in Bismarck, North Dakota. Medcenter claimed FTEs for its residents' time at the FPC in its fiscal year ended (FYE) December 31, 1999 and 2000 cost reports. St. Alexius Medical Center also claimed FTEs for its residents' time at the FPC in its FYE June 30, 2001 cost report. Noridian Administrative Services (the Intermediary) reopened the Providers' cost reports in March 2006, see Exhibit I-5, to disallow the FTEs claimed by the Providers for time spent by its residents at FPC. The Providers filed timely appeals to the Provider Reimbursement Review Board (Board) and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841.

The Providers, in cooperation with the University, train medical residents in the practice of primary care and family medicine through the FPC. During the fiscal years at issue, the FPC trained approximately 15 residents annually.

Pursuant to a series of written agreements, which are not at issue in this appeal,[2] the University ran the day-to-day operations of the resident training program, including the FPC, and the Providers incurred the costs of that training through fixed quarterly payments and year-end payments, the amounts of which varied annually and were calculated based on the FPC's

[2] The Intermediary conceded that the Providers met the "written agreement" requirement set forth in 42 C.F.R. §413.86(f)(4). See, Tr. at 33 and Intermediary Supplemental Position Paper at page 4.

annual operating losses. For each fiscal year at issue, the Providers shared the costs of the FPC and each claimed a share of the FTEs rotating through the FPC on its respective cost report.

The Intermediary issued audit adjustments to the Providers disallowing the FTEs claimed by them for FYEs 12/31/99, 12/31/00 and 06/30/01. Though the basis of the Intermediary's adjustments initially varied, the Intermediary now defends the disallowance on the basis that because they shared the cost of the program, neither Provider can claim to have incurred all or substantially all of the costs of the entire training program.

The Provider was represented by Colleen M. Faddick, Esquire, and T. Jeff Fitzgerald, Esquire, of Faegre & Benson LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Providers note that prior to the fiscal years at issue in this appeal the Intermediary never disallowed any costs at the nonhospital setting using the "all or substantially all of the costs of training for [the nonhospital] setting" as its basis. The Providers contend that the Intermediary's position is a departure from: (1) the plain meaning and legislative intent of the DGME and IME payment statutes and rules, and (2) well-settled law prohibiting retroactive rule-making. The Providers also contend they both have paid all or substantially all of the costs of the training program for all of the residents rotating through the nonhospital setting.

The Providers indicate that neither the SSA nor the DGME and IME regulations promulgated at 42 C.F.R. §§ 413.86(f)(4) and 412.105(f)(1)(C)(ii) explicitly define "program" as it relates to reimbursement of FTEs in the nonhospital setting. Nevertheless, CMS stated in a 2003 preamble that the statutory provisions cited above require a hospital to assume the cost of the full complement of residents training in the program at the nonhospital sites in order to count any FTE residents training at that site.

The Providers contend that this interpretation is not supported by the plain language of the statute or legislative intent of the DGME and IME provisions to expand reimbursement in the nonhospital setting as reflected in the statute's legislative history. The Providers refer to the following from the legislative history.

> The Committee bill would change the current regulations by providing that all of the time that *a resident* spends in activities related to patient care is to be counted towards full-time equivalency . . . . so long as the hospital is incurring costs for *that resident's* training.[3] (emphasis added)

The Providers assert that the language used clearly shows that Congress intended that a provider be reimbursed for a resident's time in a nonhospital setting as long as the provider incurred the costs for that resident in that setting. The Providers also assert that CMS

[3] H.R. Rep. No. 99-727, at 70 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3607, 3660; *See also* Providers' Supplemental Position Paper, pp. 12 -15.

acknowledged that the statutory requirement is a departure from other GME policies that focus on the resident rather than the program. 68 Fed. Reg. 45,346, 45,450 (Aug. 1, 2003) (preamble to Final Rule).

The Providers also refer to an internal CMS document that suggests a reasonable reading of the statute would allow more than one hospital to share in the costs of nonhospital resident training.[4] The Providers assert that testimony at the hearing indicated that no fiscal intermediary has interpreted the word "program" in the statute to require that only one hospital incur the costs of residents' training in nonhospital setting, Tr. at 131-132, and that the Intermediary in this case has audited the Providers' DGME and IME FTE counts at the nonhospital setting for decades and has never interpreted or applied the statute in such a manner, Tr. at 99-100 and 120-123.

The Providers state that even if CMS' interpretation can be supported by the statute, the evidence indicates that CMS' interpretation is a change in the rule and practice and cannot be applied retroactively. CMS' position was stated for the first time in the preamble to a proposed rule in May, 2003. *See*, Exhibit P-19. Uncontested testimony and evidence presented at the hearing showed that before 2003, no fiscal intermediary was interpreting the statutes or regulations in that manner or applying this interpretation in their audits. *See*, Exhibit P-19, Tr. at 99-100, 120-122 and 131-132. The Providers argue that such a substantive change in policy and departure in practice must be promulgated as ordinary rule-making with the requisite notice and opportunity for comment. (Administrative Procedure Act, 5 U.S.C. §553(b) and (c)).

Finally, the Providers assert that each hospital has, in fact, paid an amount greater than "all or substantially all of the costs" for all of the residents training at the FPC. See, Exhibits P-26 and P-27. Each Provider paid more than the total costs of salaries, benefits, and physician supervision because each Provider shared in the total costs of operating the FPC, costs which include many other items such as the facilities, office supplies, and equipment. *See*, Exhibit P-7 (Residency Consortium, year-end financial statement, FYE 06/30/1999, detailing costs of FPC operations). Because the Providers each paid more than residents' salaries and benefits and supervising physicians' salaries, both actually paid "all or substantially all of the costs of training residents" at the nonhospital setting.

The Intermediary responds that the Providers do not satisfy the requirement in the statute and regulation that they incur all or substantially all of the costs of the training program at the nonhospital setting. The Intermediary refers to the preamble to the final rule, 68 F.R. at 45,449 (Aug. 1, 2003), cited above, in which CMS stated that hospitals must incur all or substantially all of the costs for the full complement of residents in the training program at the nonhospital site. While CMS acknowledged that this was a departure from other Medicare GME policies that focus on the resident rather than the program, CMS stated that it believed the statutory provisions require hospitals to assume the costs

[4] See Exhibit P-20 (noting "We could interpret [the statute] to mean that if the hospital is paying the salaries and fringe benefits and proportionate share of the teaching physicians' compensation for *any* number of residents training at the non-hospital site…the hospital can include this number in its GME/IME count."); *See also* ,Tr. at 134-139.

of the full complement of residents training in the program at the nonhospital site in order to count any FTE residents training at that site.

The Intermediary points out that the Providers each paid 50 percent of the cost related to the nonhospital setting (or FPC) and, therefore, neither met the requirement of paying all or substantially all of the costs.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Prior to 1986, providers could only count FTEs in an ambulatory setting if the setting was organizationally part of the hospital where the residents training program was located. *See*, H.R REP. 99-727, 1986 U.S.C.C.A.N 3607. If a resident was assigned to a free-standing setting such as a family practice center or ambulatory surgery center, no Medicare payments were allowed for the time spent there. Congress viewed training in these settings as desirable because of the growing trend to treat more patients out of the inpatient hospital setting and because of the encouragement it gives to primary care. In 1986, Congress changed this rule for DGME so that a provider could count all of the time of its residents without regard to setting so long as all of the residents' activities related to patient care and the provider incurred the cost of the residents' training. Id. In 1997, Congress allowed providers to count time residents spend training in nonhospital sites for IME purposes.

The issue in this case is whether the Providers have complied with the statutory and regulatory requirements to claim their FTEs in a nonhospital setting. More specifically, the question in this case centers on the interpretation of the language in the statute, and repeated in the regulation, that requires hospitals to incur all or substantially all of the costs of the training program at the nonhospital setting. CMS and the Intermediary take the position that the statutory language requires a hospital to incur all or substantially all of the costs of the entire training program at the nonhospital setting in order to claim any of the residents. Under this interpretation, if hospitals, as here, share the costs of the training program equally, neither can claim any of the residents. The Providers assert that the statute does not require an all or none interpretation and that each hospital can claim FTEs for the residents for whom that hospital incurs the costs of the residents' salary and fringe benefits and the supervising physicians' salaries attributable to training that resident.

The Board first examined the language in the statute to determine whether it specifically addressed the issue in this case. In 1986, the statute authorizing DGME reimbursement for residency programs provided that:

> The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

* * * * *

> Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

SSA §1886(h)(4)(A), (E).

In 1997, Congress authorized reimbursement for residents in nonhospital settings for IME:

> Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

SSA §1886(d)(5)(B)(iv).

With the 1997 amendments to the SSA, the statutory obligations concerning DGME and IME reimbursement for residents in a nonhospital setting were consistent.

Both statutes have the "all or substantially all" language but neither statute specifically defines the term "program." They do not state that a hospital must incur all or substantially all of the costs for the entire training program for all of the residents in order to claim any FTEs. Since the statute does not specifically address whether hospitals must incur all or substantially all of the costs for the "entire" program or just for their residents in the program, the Board finds that the statute does not determine which of the competing interpretations is correct.

We agree with Providers that the following language from the legislative history provides guidance in interpreting Congress' intent.

> The Committee bill would change the current regulations by providing that all of the time that *a resident* spends in activities related to patient care is to be counted towards full-time equivalency . . . so long as the hospital is incurring costs for *that resident's* training.[5] (emphasis added.)

The Providers assert that the language, "so long as the hospital is incurring costs for *that resident's* training," reflects Congress' intent that the program's cost be tied to the resident for which the hospital claims the FTE - not the entire program. The Board finds that the legislative

[5] See *ltd*. supra, note 3.

history does not directly address the question in this case even though it lends support to the Providers' position that the costs to be "substantially incurred" relate to the particular resident claimed. The committee language does not prohibit the sharing of costs, but neither does it prohibit the Intermediary's interpretation. The language in the legislative history is, therefore, not dispositive as to which interpretation is correct.

Therefore, the Board reviewed the regulations to determine whether they addressed the issue of paying for the costs of the entire program. During the fiscal years at issue, the regulations established three conditions that a provider must meet to count residents' training time in nonhospital settings for DGME and IME payment purposes:

> (i) The resident spends his or her time in patient care activities.
>
> (ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.
>
> (iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

42 C.F.R. § 413.86(f)(4) (1999). *See also*, 42 C.F.R. § 412.105(f)(1)(ii)(C) (incorporating the above DGME standards by reference to IME). With respect to subparagraph (iii), the regulations provide a definition for "all or substantially all of the costs for the training program in the nonhospital setting" as follows:

> All or substantially all of the costs for the training program in the nonhospital setting means 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.

42 C.F.R. § 413.86(b)(3).

It is undisputed that the conditions in 42 C.F.R. §413.86(F)(4)(i) and (ii) were met. The Board notes that the "all or substantially all of the cost" language in the regulation is similar to the language in the statute. Even though the regulation provides a definition of "all or substantially all of the costs for the training program in the nonhospital setting," it does not state that a hospital must incur all or substantially all of the costs for the entire training program for all of the residents. The Board concludes that the language in the regulation does not resolve which of the competing interpretations is correct.

Having found that neither the language in the statute nor in the regulation is dispositive, the Board must look to the policy that was actually in place during the periods in issue.

The Intermediary proffered the preamble to the 2004 Inpatient PPS (IPPS) final rule published in the Federal Register on August 1, 2003 in support for its position. CMS, in response to comments regarding a proposed rule, stated its policy on the issue in dispute as follows:

> . . . we believe that the statutory provisions cited above require hospitals to assume the cost of the full complement of residents training in the program at the nonhospital cites in order to count any FTE residents training at that site.

Clearly, the above policy supports the Intermediary's position regarding the FTEs at issue in this case. The Board finds that while CMS' policy is an allowable interpretation of the controlling statute, the statute does not require the Secretary's interpretation. In the same preamble, CMS also stated that it did not believe that its position on this issue was a change in policy. Notwithstanding CMS' assertion, the Providers presented evidence that intermediaries were not aware of the policy and had, in fact, allowed hospitals to claim FTEs for their share of the complement of residents training at the same nonhospital site if all of the costs of the residents was incurred by the hospital. Specific evidence includes correspondence from Mike Harty, Director, Strategic Government Initiatives for Blue Cross Blue Shield Association, (which handles the largest percentage of appeals for individual intermediaries nationwide for CMS.) See, Exhibits P-18 through 22, in which, Mr. Harty states "the first time this position was put in writing was in the Federal Register dated May 19, 2003. Before that time no [fiscal intermediary] was applying this position. In addition I have attached an internal CMM[6] document from OFM,[7] FSG,[8] Division of Provider Audit referring to CR 3071. CR 3071 was issued March 12, 2004. In this document it appears that OFM has questions regarding this policy. Their questions are as if this is the first time they have heard of it." Exhibit P-18 at 1b and 1c.

There was also testimony at the hearing from the Intermediary's witness that she had no knowledge of any such policy prior to 2006 and was not applying it. Tr. at 132-133. The record also indicated that the Intermediary in this case had audited the Providers' DGME and IME FTE resident counts at the nonhospital setting for decades and had never interpreted or applied the statute in such a manner. Tr. at 99-100 and 120-123.

In other correspondence, Mr. Harty states "the only one that took that strict interpretation was CMS. It wasn't until 2003 that it was clarified by CMS how the regulation was to be applied. (Looking at the [redacted] document even [redacted] wasn't fully aware of the policy.)" and "[a]lthough CMS said this was a clarification most if not all [fiscal intermediaries] FIs were not applying this policy." Exhibit P-22 at 1 and 3.

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[6] Centers for Medicare Management
[7] Office of Financial Management
[8] Financial Service Group

The internal CMM document noted by Mr. Harty states in relevant part:

> [W]e suggest that either in this CR or a Federal Register, CMM give examples of how providers/intermediaries should apply the requirements that "The hospital incurs all or substantially all of the costs for the training program in the non-hosptial setting." It is not clear whether a hospital must incur all or substantially all the costs for "all" the residents training in a specific non-hospital setting before it can count "any" resident in that setting. . . . However, 42 CFR 413.86(f)(4)(ii) states that in order to count a resident, the written agreement between the hospital and non-hospital site must indicate that the hospital will incur the cost of the "resident's salary and fringe benefits while the resident is training in the non-hospital sites" and the hospital is providing reasonable compensation to the non-hospital site for supervisory teaching activities. We could interpret this to mean that if the hospital is paying the salary and fringe benefits and proportionate share of the teaching physicians' compensation for any number of residents training at the non-hospital site (e.g., 5 even if 10 residents work at the site), the hospital can include this number (5 in this case) of residents in the GME/IME count.

Comments by OFM, FSG, Division of Provider Audit Re: E CR 3071 Changes to FY 2004 GME Payments as Required by the MMA. Exhibit P-20.

The Board observes that, at the very least, this component of CMS recognized that the interpretation suggested by the Provider was a valid reading of the rules.

Based on the evidence in the record, the Board concludes that, prior to publication of the 2004 IPPS final rule, CMS had not announced any policy interpreting the statute in the manner it sets out in the preamble; accordingly, its intermediaries were unaware of and were not applying this interpretation in their audits and it follows that Providers were not given notice of such a policy.

In summary, the Board finds that neither the statute nor regulation clearly requires the interpretation stated in the preamble to the 2004 IPPS Final Rule. The Board also finds that, in practice, this policy was not being interpreted in the manner of the preamble. Without communication from CMS of its policy during the period in dispute, the Board concludes that the only policy or interpretation providers could rely on was the intermediaries' practice which was to permit hospitals to share the costs of training programs. The policy to permit sharing was clearly conveyed to the Provider through years of acceptance during audits and we give weight to CMS policy in effect during the period in controversy. Even though CMS claimed the policy stated in the referenced preamble was not a change, the overwhelming weight of evidence shows differently.

The Board finds and concludes that the Providers are permitted to share costs provided they meet all of the other requirements of the regulations. The Intermediary did not dispute that the services provided by the residents were related to patient care as required

by C.F.R. §413.86(f)(4)(i). The Intermediary conceded that the written agreement requirement of 42 C.F.R. §413.86(f)(4)(ii) was also met.[9] The evidence showed that the Providers paid in excess of the costs required to be paid by 42 C.F.R. §§413.86(b)(3) and (f)(4)(ii). See, Exhibits P-26 and P-27. Based upon the Providers' meeting the regulatory and policy requirements in existence during the fiscal years in controversy, the costs are allowable.

Finally, the Board notes that even if CMS' interpretation of the statute may be permitted prospectively, it is inconsistent with the larger intent of the legislation. The purpose of the change in the statute was to allow FTEs in non-hospital settings to encourage providers to have their residents participate in outpatient treatment and primary care.

DECISION AND ORDER:

The Board finds that the Providers met the requirements of the statutes, regulations, and policies in effect during the cost years at issue in order to claim FTEs in the nonhospital setting. The Intermediary adjustments disallowing the Providers' FTEs at the nonhospital setting are reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, CPA
Anjali Mulchandani-West, CPA
Yvette C. Hayes
Michael D. Richards, CPA

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: February 26, 2008

[9] See, Tr. at 33, and the Intermediary supplemental position paper at page 4.