PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D1

PROVIDER -
University Hospital
Denver, Colorado

Provider No.: 06-0024

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
TrailBlazer Health Enterprises, LLC

DATE OF HEARING -
October 24, 2008

Cost Reporting Period Ended –
June 30, 1996

CASE NO.: 01-2484

INDEX

ISSUE:

Whether the Intermediary's determination that the resident time was not spent in the hospital complex was proper and with respect to some residents, the resident time was adequately documented as occurring in the contested area.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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 providers under Medicare law and under interpretive guidelines published by CMS. 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

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 direct graduate medical education (DGME) reimbursement for residency program has provided 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 formed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting," 42 U.S.C. §1395ww(h)(4)(E).

The regulations in effect during the fiscal years at issue, for determining the total number of FTE residents for DGME payment purposes states:

> [T]he count of FTE residents is determined as follows:
>
> (i) Residents in a approved program working in all areas of the hospital complex may be counted
> (ii) No individual may be counted as more than one FTE. . . .

> (iii) On or after July 1, 1987, the time residents spend in non-provider settings . . . in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of the hospital's resident count if the following conditions are met:
>
> (A) The resident spends his or her time in patient care activities.
>
> (B) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

42 C.F.R. §1413.86(f)(1).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The University Hospital (Provider) is a general, short-term hospital located in Denver, Colorado. On October 24, 2008, the Provider and Blue Cross Blue Shield Association (Intermediary) filed the document titled Stipulation of Parties. Below are pertinent parts of those stipulations.

1. The Intermediary removed full-time equivalent residents (FTEs) from the Provider's FTE count for purposes of calculating the Provider's direct graduate medical education (DGME) payment under 42 U.S.C. §1395ww(h).
2. The Provider incurred all the costs of these 17.4502 FTEs, including paying the residents' stipends.
3. If the final decision establishes that the University of Colorado Health Sciences Center (UCHSC) constitutes part of the Provider's hospital complex, the Intermediary agrees that all other requirements for inclusion of 6.9321 FTEs (of the 17.4502 FTEs referred to in paragraphs 1 and 2) in the DGME FTE count have been met, and these will be added to the Provider's FY 1996 DGME FTE count.
4. If the final decision establishes that the UCHSC constitutes part of the Provider's hospital complex, the Intermediary agrees to add an additional 2.2236 FTEs.
5. If the final decision establishes that the UCHSC constitutes part of the Provider's hospital complex, the Intermediary agrees to add the remaining 8.7589 FTEs (of the 17.4502 FTEs referred to paragraphs 1 and 2) if the final decision establishes that the Provider's documentation establishes the location of these residents.
6. The Provider is owned by the State of Colorado.
7. The State General Assembly of Colorado has plenary authority over the Provider.
8. The Provider is operated by the University of Colorado Hospital Authority (UCHA), a corporate body and political subdivision of the State of Colorado.
9. The Board of Regents for the University of Colorado appoints all members of the UCHA, who serve as the Provider's Board of Directors.
10. During fiscal year ending June 30, 1996, three members of the UCHA were employees of the University of Colorado, including the President of the University of Colorado, the Chancellor of the UCHSC, and the President of the University of Colorado Hospital Medical Staff.

11. During fiscal year ending June 30, 1996, one of UCHSC's vice chancellors served as the Provider's Chief Executive Officer.
12. The University of Colorado operates a School of Medicine, which is part of UCHSC.
13. The mission of the Provider is to facilitate and support the education, research, and public service activities of the health sciences schools operated by the regents of the University of Colorado and to provide patient care, including care for the medically indigent, and specialized services not widely available elsewhere in the state and region.
14. The Provider is required to supply space and facilities for UCHSC's clinical programs.
15. The Provider, through the UCHSC and its School of Medicine, sponsors approved graduate medical education (GME) programs and assigns residents to train at hospital sites and non-hospital sites for specified time periods to fulfill accreditation requirements.
16. The Provider is the primary teaching site for UCHSC.
17. The Board of Regents of the University of Colorado appointed the UCHSC faculty, and only UCHSC faculty may have hospital privileges at the Provider.
18. During fiscal year ending June 30, 1996, the Provider and UCHSC were located in adjoining buildings on the "9th and Colorado Campus" in Denver, Colorado.

The Intermediary excluded 17.4502 DGME FTEs from the Provider's count, representing time spent by residents outside the main hospital building but within the UCHSC campus. Of these 17.4502 FTEs, the Intermediary also disallowed 7.9195 DGME FTEs for one or more of the following reasons relating to documentation: (1) the residents or exact location of the resident's assignment was not recorded on a rotation scheduled; (2) the documentation that the Provider furnished to support the resident assignment was complied after FY 1996. The disallowed resident counts resulted in a reduction in Medicare reimbursement of approximately $1.5 million.

The Provider was represented by Ronald S. Connelly, Esquire, of Powers, Pyles, Sutter & Verville, P.C. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that CMS has limited the FTE count for DGME to residents working in a "hospital complex, a term that is not defined. The UCHSC is part of the Provider's hospital complex. CMS stated that the DGME FTE count should be calculated consistently with the count used for the average per resident amount (APRA). (54 Fed. Reg. at 40,289-40,290 and 53 Fed. Reg. at 36,591-36,593).

During the Provider's APRA base year, the IME FTE count was determined based upon the employment status of the residents. 42 C.F.R. §405.477(d)(2)(v)(1983). Excluded from the count were residents who furnished services at another site or who replaced certified registered nurse anesthetists. HCFA Pub. 15-1 §2802.G. (8/93). "Site" refers to

other hospitals to prevent an intern or resident from being counted by more than one institution. The Provider argues that since the medical school is not a Medicare provider, it could not claim IME reimbursement and would not have counted interns and residents (I&Rs) for IME purposes.

The Provider further contends that CMS' comment that a medical school is not part of a hospital complex is inconsistent with the Agency statements at the time the GME regulation was adopted. The relationship between the Provider and the UCHSC constituted a single hospital complex in 1996. It functioned as a single complex. It shared one address. It functioned under common control. The U.S. Court of Appeals, First Circuit, held that an "area" as used in the Medicare regulations has a functional definition. Rhode Island Hospital v. Leavitt, No. 07-2673 (1st Cir., 2008).[1] Since the Provider's residents were engaged in research, which is an allowable functional "area" for DGME reimbursement, the residents should be considered working within the hospital complex.

The Intermediary contends that the area where the residents were assigned to do their training work was not part of the hospital complex. Residents that were engaged in research were not training in the hospital complex.[2] Research took place in the University of Colorado Health Science Center, not in the hospital complex. The fact that the Provider and medical school were intertwined does not automatically collapse them into a single entity under Medicare's related party principle. And the fact that residents were engaged in research at the medical school does not mean that the time was spent in the hospital complex.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law and program instructions, the evidence, and the parties' contentions finds and concludes that the Intermediary properly determined that the time residents spent in the University of Colorado Health Science Center (UCHSC) should not be included in either the Provider's DGME or IME counts. The relevant regulation applicable to the Provider's disputed FTE resident count is 42 C.F.R. §413.86 (f)(l)(i) which states:

> Residents in an approved program working in all areas of the hospital complex may be counted.

The Board does recognize that the Provider and the UCHSC were closely affiliated and worked together in providing care to patients. It is undisputed, however, that as of 1991 the Provider and UCHSC were set up as two separate legal structures. The Colorado legislature dictated how the two entities would work together. While working together, the entities were nevertheless separate operating entities. The Board finds that a hospital complex is determined based on physical layout. Corporate structures are not necessarily relevant in determining whether organizations are in fact hospital complexes.

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[1] Exhibit P-65.
[2] Transcript (Tr.) at 16.

CMS addressed the definition of a hospital complex in a September 21, 1988 Proposed Rule .[3] It stated:

> [t]his proposed rule would apply to graduate medical education (GME) costs in all hospitals and hospital-based providers and subproviders. Although providers other than hospitals may participate in approved GME programs that Medicare supports, the majority of these programs are concentrated in hospitals and health care complexes. The latter are complexes that include, in addition to a hospital, subproviders such as psychiatric units and other hospital-based providers such as skilled nursing facilities or home health agencies. The allowable costs of GME on which the resident amounts established by this proposed rule are based include GME costs attributable to nonhospital portions of a health care complex. These costs are not separable in such a manner as to permit per resident amounts based exclusively on the GME costs of the hospital. For example, it would not be unusual for a resident in family practice to see patients in both the acute care portion of a hospital and in the hospital-based skilled nursing facility on his or her daily rounds. To require a tracking of a resident's time in each entity of the hospital complex would not be practical. (Emphasis added).

Also, the cost report instructions in the Provider Reimbursement Manual (PRM), Part II, Section 304 had a similar definition since 1980. It states in part:

> HOSPITAL, HOSPITAL-SKILLED NURSING FACILITY COMPLEX AND SKILLED NURSING FACILITY STATISTICAL DATA
>
> Part I – General. –
>
> NAMES AND ADDRESSES, PROVIDER NUMBERS AND DATES CERTIFIED.
> Enter on the appropriate lines the names and addresses, provider of identification numbers and certification dates of the facility and its various components, if any. The following definitions apply when completing these cost reporting forms.
>
> HOSPITAL--An institution meeting the requirements of section 1861(e) of the "Health Insurance for the Aged and Disabled Act" and participating in the Medicare program, or a Federally controlled institution approved by the Secretary.
>
> SUBPROVIDER--A general hospital which has been issued subprovider identification numbers because it offers clearly different types of service, e.g., short-term acute and long-term tuberculosis.

[3] 53 Fed. Reg. 36,589, 36,590 (September 21, 1988)

> See PRM, Part I, chapter 23, for a complete explanation of separate cost entities in multiple facility hospitals.
>
> SKILLED NURSING FACILITY--An institution meeting the requirements of section 1861(j) of "Health Insurance for the Aged and Disabled Act" and participating in the Medicare program, or a Federally controlled institution approved by the Secretary.
>
> HOSPITAL-BASED SKILLED NURSING FACILITY--A distinct part and separately certified component of a hospital where skilled nursing and related services are provided.
>
> HOME HEALTH AGENCY--An institution meeting the requirements of section 1861(o) of the "Health Insurance for the Aged and Disabled Act" and participating in the Medicare program, or a Federally controlled institution approved by the Secretary. The remainder of the statistical data for a provider-based home health agency should be entered on form HCFA-1728A.
>
> SPECIAL PROVIDER-CONTROLLED FACILITY--A separate cost entity controlled and/or owned by one provider or jointly by more than one provider. This entity usually has its own administration, staff, building, location and financial autonomy. Examples include a provider-controlled comprehensive health center and a patient service facility financed and operated by two or more providers on a shared-cost basis. The services rendered are under the control of the provider (s) and are services usually covered for Medicare reimbursement by title XVIII statutory or regulatory provisions. A special provider-controlled facility could not participate in the Medicare program in the absence of the provider or providers to which it is related. (Emphasis added)

The Board finds the above references reasonably define what comprises a hospital complex and the Intermediary properly applied those references by not allowing the UCHSC residents to be included in the DGME and IME resident count.

It was not until 2006 that CMS for the first time equated the term "hospital complex" with the provider-based regulations at 42 C.F.R. §413.65. 71 Fed. Reg. 48,092-93 (Aug. 18, 2006). CMS went on to prohibit most medical schools from being included within the term "hospital complex": "To put it simply, a hospital is not a medical school, and a medical school is not a hospital."[4]

Based on the above, the Board finds that the pre-2006 regulations were reasonable in determining the nature of a hospital complex. The UCHSC is not part of the hospital complex.

[4] 71 Fed. Reg. 48,093 (August 18, 2006).

DECISION AND ORDER:

The Intermediary properly disallowed the UCHSC resident time spent in the DGME and IME counts. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD

Suzanne Cochran, Esquire
Chairperson

DATE: October 7, 2009