PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D4

PROVIDER -
Royal Oaks Hospital
Windsor, Missouri

Provider No.: 26-4020

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
TriSpan Health Services

DATE OF HEARING -
May 29, 2008

Cost Reporting Periods Ended -
December 31, 1999; December 31, 2000

CASE NOs.: 05-0917 and 05-0916

INDEX

ISSUE:

Whether the Intermediary properly declined to establish a per-resident amount (PRA) and full-time equivalent (FTE) cap applicable to Provider's graduate medical education (GME) costs.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the eligibility of a Medicare provider for reimbursement for GME costs. All citations to regulations are to those in effect during 1999 and 2000, unless otherwise indicated.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§ 1395-1395ggg. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (HHS) charged with the Medicare program's administration. 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 interpretative guidelines published by CMS. See 42 U.S.C. §1395(h); 42 C.F.R. §421.100 (2007); 42 C.F.R. §413.86.

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 NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §§ 405.1835-405.1841.

The Medicare Program reimburses teaching hospitals for their share of costs associated with direct graduate medical education (DGME). The calculation and reimbursement requires a determination of several factors, including (1) the total number of full-time equivalent residents in the teaching program; (2) the FTE "cap" applicable to each provider, established by the section 4623 of the Balanced Budget Act amending the Social Security Act, see 42 U.S.C. §1395ww(h)(4)(F); and (3) the "average per resident amount" (APRA), a hospital-specific rate determined from a base period. 42 U.S.C. §1395ww(h)(2)(A).

In general, a hospital's direct GME costs are determined by multiplying its APRA times the number of FTEs that worked at the facility pursuant to 42 U.S.C. §1395ww(h)(4). These costs are then apportioned to Medicare based upon a hospital's ratio of Medicare inpatient days to total inpatient days. Implementing regulations at 42 C.F.R. §413.86(f) provide specific rules for counting FTE residents for GME.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Royal Oaks Hospital (Provider) is a 41-bed free-standing psychiatric hospital located in Windsor, Missouri. The Provider offers behavioral health services to children, adolescents and adults in a variety of settings, including inpatient, partial hospitalization and outpatient programs.

The University of Missouri-Columbia School of Medicine ("UMC") is a fully-accredited, four year medical school offering training in approximately sixty medical specialties and subspecialties. The UMC Department of Psychiatry has offered its child and adolescent psychiatry residency training program continuously since 1968.[1] The program is fully accredited by the Accreditation Council for Graduate Medical Education (ACGME). The program operates on an academic year beginning July 1 through June 30.[2] As of the end of 1995 the following institutions participated in the program: University and Childrens Hospital, Columbia; Mid-Missouri Mental Health Center, Columbia; Charter Hospital of Columbia; and Riverside Hospital and Counseling Center, Jefferson City.[3] The program provided for three resident fellow slots per academic year.[4]

Following the closure of Riverside Hospital, the Provider agreed to assume the rotations formerly assigned to Riverside.[5] The Provider's participation first received approval from ACGME on July 1, 1996.[6] Commencing in 1996**,** the Provider hosted three child psychiatry residents on a rotating basis with the other institutions participating in the program.[7]

During the relevant time periods, the regulations at 42 C.F.R. § 413.86(e)(4)(i) provided that:

> If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period.

The Provider reasoned that the above provision established 1997 rather than 1996 as its base year, since its cost reporting period ran from January 1, and 1997 was the first year in which it had residents on duty during the first month of a cost reporting period.[8] Based upon that

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[1] Transcript, p. 61.
[2] Exhibit P-9, p.1.
[3] Hearing Exhibit P-3.
[4] Hearing Exhibit P-9, p.1.
[5] Exhibit P-9, p. 2.
[6] Exhibit P-3, p. 1.
[7] Transcript. pp. 51, 71.
[8] Transcript, pp. 96-97.

understanding, the Provider did not include GME costs in its Medicare cost report for 1996.[9] The Provider claimed GME costs in 1998 and subsequent years.[10]

The Intermediary issued an NPR for Provider's 1999 cost report on September 8, 2004, and for Provider's 2000 cost report on September 27, 2004. The Intermediary adjusted Provider's unweighted resident FTE count to zero, which had the effect of disallowing all Provider's claimed GME cost. Provider timely appealed the 1999 and 2000 adjustments.

The Provider was represented by Bradley L. Williams, Esq., of Ice Miller LLP. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that regulations in effect during the cost reporting years in issue (1999 and 2000) do not specifically address the situation where one provider replaces another as a rotational training site in an ongoing graduate education program.[11] The Provider contends that the statutes governing GME reimbursement require that the Secretary, and by extension the fiscal intermediary, must establish a cap and APRA for each hospital which begins participating in a GME program for the first time.

The Provider points to Section 1886(h)(1) of the Social Security Act, as amended by the Medicare & Medicaid Budget Reconciliation Amendments of 1985, Section 9202(a), P.L. 99-272, 100 Stat. 151, 171-175. 42 U.S.C. §1395ww(h)(2)(F), which provides (emphasis added):

> In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this subchapter for a cost reporting period beginning during fiscal year 1984, the Secretary **shall**, for the first such period for which it has such a residency training program and is participating under this subchapter, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based upon approved FTE resident amounts for comparable programs.

The Provider contends that it participated in a GME program for the first time in 1996, and that under regulation 42 C.F.R. § 413.86(e)(4)(i) (1999), the Intermediary was required to determine an APRA and cap applicable to Provider.

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[9] Transcript, p. 17-18.

[10] Through oversight by its contractor, the Provider also did not claim GME costs on its 1997 cost report. On November 15, 1999, Provider submitted to the Intermediary an amended 1997 cost report which included GME costs (Transcript p. 92). By letter dated January 10, 2000, the Intermediary refused to accept the amended 1997 cost report, on the ground that "at the time of receipt on December 2, 1999 [sic], the cost report had already been finalized" (Provider Exhibit P-12) However, Intermediary's representative testified at the hearing that the 1997 cost report was not finalized prior to January 12, 2000 and that an NPR was not issued for that cost report until April 14, 2000 (Transcript, p. 97).

[11] Transcript, p. 14.

The Provider acknowledges that its agreement with UMC did not constitute an "affiliation agreement" as defined by regulation. However, the Provider contends that there is no statutory or regulatory requirement that hospitals providing GME under a common program must affiliate. The Provider relies on a statement from the preamble to the 1998 Final Rule.

> Hospitals that could qualify to be part of an affiliated group do not have to affiliate. . . . If a hospital does not affiliate, that hospital will remain subject to a cap based on its FTE count in its most recent cost reporting period ending on or before December 31, 1996.

63 Fed. Reg. 26337 (May 12, 1998). The Provider, relying on other language in this preamble, contends that it is entitled to its own cap and APRA (63 Fed. Reg. 26333):

> With regard to application of the cap for hospitals that become teaching institutions on or after January 1, 1995, and on or before August 5, 1997, our policy is that the hospital can receive an adjustment to its FTE cap for a new medical residency training program and can affiliate with hospitals that have existing medical training programs.

The Provider argues that, if the Intermediary's position is correct, no hospital could ever receive reimbursement for GME costs if it joined a program already in existence; unless it entered into an affiliation agreement which the Secretary has indicated is not required. The Provider contends that it participated in the UMC program, obtained accreditation, and incurred costs in training residents in compliance with the regulations as they existed at the time. The Provider contends that the statute as enacted by Congress controls its right to GME reimbursement.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider is not eligible for GME reimbursement, because it failed to claim GME costs on its 1996 cost report. As a result, the Intermediary claims that it is precluded from (1) establishing an FTE cap for the Provider, other than zero;[12] and (2) establishing an APRA other than zero.[13] The Intermediary further contends that, as a result, an FTE cap or APRA based on a 1996 Medicare cost report can never be established.

The Intermediary notes that the agreement between the Provider and UMC does not constitute a properly executed "affiliation agreement" under current 42 C.F.R. §413.75(b)(2004), formerly 42 C.F.R. §413.86(b)(1999). It argues that in order to participate in an affiliated group, all hospitals in the group must enter into a written affiliation agreement which covers, among other things, the total FTE caps for each hospital and how the aggregate cap will be distributed.[14] Because no affiliation agreement exists, the Intermediary contends that the Provider cannot participate in the proration of the aggregate FTE cap for the approved UMC-Child and

[12] Intermediary Second Revised Final Position Paper, May 21, 2008, p. 4.
[13] Intermediary Second Revised Final Position Paper, May 21, 2008, p. 7.
[14] Intermediary Second Revised Final Position Paper, May 21, 2008, p. 4

Adolescent Psychiatry program, but must rely on its own cap which the Intermediary insists must be zero.[15]

The Intermediary further contends that the Provider does not qualify for an adjustment to its FTE cap as a "new medical residency training program" under current 42 C.F.R. §413.79(e)(2004), formerly 42 C.F.R. §413.86(g)(6)(1999). It states that the Provider's participation in the UMC program did not constitute a "new program" as defined in the regulations, currently at 42 C.F.R. §413.79(l), formerly 42 C.F.R. § 413.86(g)(9)(1999) or (g)(12)(2000). That provision defines a "new medical residency training program" as "a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." The Intermediary points out that the UMC Child and Adolescent Psychiatry program has been in existence and has provided residency training since 1968 and thus cannot qualify as a new program. The Intermediary relies on a statement made by the Secretary in the preamble to the 1999 Hospital Inpatient Prospective Patient System: Final Rule, 64 Fed. Reg. 41519 (July 30, 1999), that the language "begins training residents on or after January 1, 1995" does not mean that it is the first time a particular hospital began training residents in a program on or after January 1, 1995, but the program was in existence at another hospital prior to January 1, 1995.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

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

Congress created the requirement for an FTE cap in the Balanced Budget Act of 1997, Public Law 105-33. Section 4623 of the BBA amended section 1886(h)(4) of the Social Security Act, 42 U.S.C. § 1395ww(h)(4), to add subsection (F). The same legislation also included new subsection (G), which required the Secretary to "prescribe rules for limiting and counting the number of interns and residents in medical residency training programs established on or after January 1, 1995." The Conference Report which accompanied the bill demonstrates Congressional awareness that "there are a sizeable number of hospitals that elect to initiate such programs (as well as terminate such programs) over any period of time," and concern that "within the principles of the cap that there is proper flexibility to respond to such changing needs . . . ." House Conf. Report No. 105-217, 105th Cong., 1st Sess. 821-22 (July 30, 1997).

The Provider contends it qualifies as a new medical residency training program under the regulations and therefore is entitled to an adjustment to its FTE cap. Regulations at 42 C.F.R. §413.86(g)(6) stated:

> If a hospital establishes a new medical residency training program as defined in paragraph (g)(9) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted . . .

In 1997, 42 C.F.R. §413.86(g)(7) defined a new medical residency training program as:

[15] Intermediary Second Revised Final Position Paper, May 21, 2008, p. 6.

> A medical residency training program that receives initial accreditation by the appropriate accrediting body on or after July 1, 1995.[16]

The language of the regulation was changed to read:

> A new medical residency training program that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995. [17]

The change to the regulation defining a new medical residency program was published in the Federal Register, Vol. 63, No. 91, Tuesday, May 12, 1998. The Secretary responded to commentors who questioned the advisability of just using the accreditation date for determination of a new medical residency program. Commentors noted that programs may not be able to get up and running for some time after the accreditation letter is issued. In revising the definition of a new medical residency program, the Secretary stated at page 26332:

> We recognize that hospitals that either received accreditation for a new medical residency training program or began training residents in the new program may have expended substantial resources during the accreditation process. We also recognize that hospitals usually do not begin training residents immediately upon receiving an accreditation letter. For these reasons, we believe it appropriate to consider a medical residency training program to be newly established if the program received initial accreditation or began training residents on or after January 1, 1995. We are modifying the regulation accordingly.

However, even under this expanded definition of a new medical residency program, the Provider's initial participation in the UMC Child and Adolescent Psychiatry Training Program after January 1, 1995 does not constitute a new medical residency training program. The Provider did not establish the program, but rather began participating in an existing residency program.[18] The UMC program was accredited in 1968.[19] The ACGME letter dated July 1, 1996 merely acknowledged the participation of the Provider in the conduct of the program. [20]The Secretary addressed the facts presented by the Provider's participation in the UMC program in the July 30, 1999 Federal Register. [21] The Secretary explained that the language "'begins training residents on or after January 1, 1995'," means that the program may have been accredited by the appropriate accrediting body prior to January 1, 1995, but did not begin training in the program until on or after January 1, 1995. The Secretary goes on to say "the language does not mean that it is the first time a particular hospital began training residents in a

[16] Transcript, p. 117.
[17]Prov. Exhibit P-5.
[18] Exhibit P-3; Transcript, p.67.
[19] Transcript, p. 61.
[20] Exhibit P-3.
[21] Exhibit I-8.

program on or after January 1, 1995, but the program was in existence at another hospital prior to January 1, 1995." [22]

The Provider has argued that the definition of a new medical residency training program should be determined on a facility-specific basis. However, the Intermediary contends the PRRB has already confronted this issue in *St. Joseph Community Hospital vs. Blue Cross & Blue Shield Association/AdminaStar Federal*, Dec. No. 2005-D71.[23] The Board held that

> The language of the regulation does not support a facility-specific based test. The regulation defines a new residency program as a "medical residency that received initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." The regulation is specific to the program, not the facility at which it is located.

Applying that reasoning to this case, the Board concludes that the Provider did not establish a new medical residency training program after January 1, 1995. The Provider became a new training site for an existing medical residency training program established and operated by the University of Missouri-Columbia School of Medicine.

DECISION AND ORDER:

The Provider did not establish a new medical residency training program after January 1, 1995, nor did it opt to enter into an affiliation with other participating institutions to allow for the proration of an aggregated FTE cap. Therefore the Intermediary properly computed and applied an FTE cap of zero to the Provider's FY 1999 and FY 2000 cost reporting periods. 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, Esq.
Chairperson

DATE: October 27, 2009

[22] Exhibit I-8.
[23] Exhibit P-10.