PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2004-D22

PROVIDER –
Chestnut Hill Hospital
Philadelphia, PA

Provider No. 39-0026

vs.

INTERMEDIARY –
Veritus Medicare Services/Blue Cross Blue Shield Association

DATE OF HEARING -
June 27, 2003

Cost Reporting Periods Ended
June 30, 1999
June 30, 2000

CASE NOS. 03-0063
03-0064

INDEX

ISSUE:

Were the Intermediary's adjustments disallowing direct graduate medical education (GME) and indirect medical education (IME) costs of the interns and residents full-time equivalent counts proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Chestnut Hill Hospital (Provider) is a two hundred-bed hospital located in Philadelphia, Pennsylvania. It operates a family practice residency program, wherein residents receive training in both hospital and outpatient settings. Physicians who have admitting privileges at the hospital participate as teaching physicians in the family practice program when requested to do so.

Medicare reimburses teaching hospitals for its share of costs associated with GME and IME. The calculation for reimbursement requires a determination of the total number of full time equivalent residents (FTEs) in the teaching program. This case arises from a dispute over the FTE count.

The Medicare Program's payment and audit functions are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by CMS.

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 what proportion of those costs are to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in 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.

During the audit of the Provider's June 30, 2000 Medicare cost report, the Intermediary adjusted the hospital's FTE count of residents to exclude time spent in non-hospital settings. The adjustment was made because the Provider did not have written agreements with the non-hospital entities as required by the Medicare regulations. The Intermediary also reopened the Provider's June 30, 1999 Medicare cost report to make the same adjustment. The impact on Medicare reimbursement is approximately $549,000.

The Provider appealed the Intermediary's adjustments to the Board and has met the jurisdictional requirements of 42 C.F.R. §§405.1835-.1841. The Provider was represented by Christopher L. Keough, Esquire, and Andrew D. Ruskin, Esquire, of Vinson & Elkins, L.L.P. James R. Grimes, Esquire, Blue Cross Blue Shield Association, represented the Intermediary.

Statutory and Regulatory Background

The Medicare Act provides, in relevant part:

> 42 U.S.C. §1395ww(d)(5)(B)(iv) – 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 non-hospital 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.
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> 42 U.S.C. §1395ww(h)(4)(E) – Counting Time Spent In Outpatient Settings. 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.

The Secretary's implementing regulation, 42 C.F.R. §413.86(f), determining the total number of FTE residents, provides in pertinent part:

> (iii) On or after July 1, 1987, the time residents spend in non-provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:
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> (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.

PARTIES' CONTENTIONS:

This dispute hinges on the regulation's requirement for a written agreement between the hospital and the outside entity in which the resident is working. The Intermediary asserts that there was no written agreement. The Provider responds that the requirement is met by reading together two documents: (1) the bylaws and, (2) the supervising physician's agreement to be bound by the bylaws. The Provider further contends that a Memorandum of Understanding (MOU) executed by the hospital and outside entities after the cost year in issue that specifically tracks the language of the regulation satisfies

the requirement. Alternatively, the Provider contends that the requirement for a written agreement exceeds the statute and frustrates its intent.

The Provider contends that the Medicare statute requires that time spent in a non-provider setting shall be included in the FTE resident counts for IME and GME so long as the hospital incurs all, or substantially all, of the costs of the residents' training in the non-hospital setting.[1] The Provider points out that there is no dispute that the Provider bears, and has always borne the costs of all of the residents' salaries and fringe benefits, including the compensation costs attributable to the out-rotations to the physicians' private offices.[2] The Provider further contends that the GME cost of physicians' supervision of the residents during the rotations is minimal at most.[3] Moreover, even if there were some costs that could have been attributable to the physicians' supervision of the Providers' family practice residents, the Provider maintains that such expense would be considered a Part B cost of direct patient care rather than a GME cost of residents' training.[4] Finally, even if there were any GME costs associated with physicians' supervision of the residents during their out-rotations, the Provider contends that the privileges and benefits granted to the physicians in consideration for their participation in the Provider's family practice program constitute more than adequate in-kind compensation.[5]

Given these circumstances, the Provider further contends that the crux of the dispute boils down to a question of form over substance: whether the Provider has adequate documentation of a written agreement to bear the costs which it has always incurred and did in fact incur for the years at issue here. In that regard, the Provider argues that the GME and IME regulations do not require an "agreement" that literally repeats verbatim the language of the regulation. The rules only require a written instrument that "indicate[s]" the parties' mutual assent that the hospital will incur the residents' compensation cost and pay reasonable compensation for the GME cost, if any, of the physicians' supervision of the residents in connection with their training in a non-provider setting.[6]

The Provider contends that each of the supervising physicians has agreed to the Bylaws and the Bylaws constitute an enforceable agreement under Pennsylvania law. Viewed in

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[1] 42 U.S.C. § 1395ww(h)(4)(E); 42 U.S.C. § 1395ww(d)(5)(B)(iv).

[2] Tr. at 41-42.

[3] Tr. at 41, 54, 55, 102, 122-23.

[4] This was clearly set forth in CMS policy guidance with respect to the determination of a hospital's allowable GME cost for its GME base year under 42 C.F.R. §413.86. HCFA Q&A's pg. 26 on Graduate Medical Education (Nov., 1990) (Provider Exhibit 8).

[5] As an alternative argument, the Provider states that even if this consideration did not meet the regulatory requirement, then implicitly the physicians have agreed to volunteer their services in accordance with applicable Medicare program policies. *See* Program Memorandum A-98-44 (Dec. 1, 1998), Intermediary Exhibit 7 (FY 1999) pg 11 of 27.

[6] 42 C.F.R. §§ 413.86(b) and (f)(4)(ii).

the context of the facts and circumstances presented here,[7] the Bylaws indicate the mutual understanding and assent of the physicians and the hospital that the Provider is solely responsible for all of the residents' salaries and benefits. It is undisputed that the Provider has written employment agreements with each of the residents, providing that the hospital will pay the residents' salaries and benefits during the term of their residency, which includes time spent rotating through the physician offices.[8] No part of the Provider's legal obligation to pay the residents' salaries and benefits is transferred to the physicians under any provision of the Bylaws. Thus, the Provider reasons, no one could reasonably construe the Bylaws to mean that the physicians have assumed the Provider's obligation to pay the residents' salaries and benefits.

The Bylaws also indicate that the Provider is furnishing reasonable in-kind compensation, specifically privileges, in consideration for the physicians' services to the residents. The Bylaws expressly state that appointment or reappointment to the staff is contingent upon the physician's agreement to "participate in the student and resident teaching program if requested to do so."[9] Thus, even the Intermediary has conceded that the Bylaws indicate the required quid pro quo.[10]

The Provider also points out that a memorandum of understanding (MOU) executed by the Provider and each of the supervising physicians in 2002, restates and clarifies their long-standing agreements under the Bylaws with respect to the physicians' supervision of the residents during the out-rotations.[11] And, except for its timing, the Intermediary agrees that the MOU meets all the regulation's requirements for a written agreement.[12] The Provider argues that it is of no consequence that the MOU relates to periods prior to its execution. The regulation itself calls only for an "agreement," and in accordance with the plain meaning and ordinary usage of that term, an "agreement" may relate to past rights or duties. Indeed, the Provider maintains that this case is indistinguishable from Barnes Hospital v. Mutual of Omaha, CMS Adm. Dec., July 5, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,592, wherein the CMS Administrator accepted the use of a 1992 MOU as a valid clarification of a 1984 payment arrangement governed by a 1964 agreement.

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[7] Further evidence of the mutual understanding of the parties can be gleaned from their conduct. Traditionally, courts look to the parties' course of conduct to shed light on any ambiguities in their agreement. Restatement second Contracts, § 223 (1981). In this case, the Provider has always incurred all of the residents' compensation since the inception of the family practice program in 1974, Tr. at 36, 41-42, and the Intermediary allowed the residents' time spent in the out-rotations for all prior cost reporting periods. Tr. at 65-66, 124, 152.

[8] Tr. at 41-42.

[9] Bylaws, Article IV, section 2, clause (e) (Provider Exhibit 3).

[10] Tr. at 230.

[11] Provider Exhibit 3; Tr. at 43-47, 79-80.

[12] Tr. at 269-70.

Because the Provider incurs substantially all of the costs of the residents' training during out-rotations, the Provider further maintains that the Intermediary's disallowance of the residents' rotations to the physicians' office is inconsistent with the plain meaning and intent of the Medicare Act. Moreover, the Provider contends that the requirement for a written agreement exceeds the statute, and the requirement that the Provider compensate the physicians for their supervision of the residents is arbitrary and capricious and not based upon substantial evidence.

The Provider also contends that the Board should reverse the Intermediary's reconciling adjustments R-1001, R-1004 and R1-007 because they: (1) went beyond the stated scope of the Intermediary's Notice of Reopening, (2) were "fraught with plain errors," and (3) were based upon a "factually incorrect assumption that the Provider's total resident count for all programs did not reconcile with its 'IRIS' report."[13]

The Intermediary contends that the Bylaws and the physician's agreement to be bound by them cannot satisfy the regulation. The Intermediary argues that the purpose of the regulatory requirement is to ensure that providers receive full reimbursement when residents spend a portion of their training time in another setting; but, in order to fully reimburse the provider and still protect against the possibility of double payment, the hospital and the non-hospital site must enter into a written agreement covering the costs of training residents at off-site facilities. The Intermediary maintains that the written agreement should explain the nature of the relationship between the hospital that wants to claim the costs of the residents' time and the outside entity where the resident is spending time. It should address the specific activity of an off-site residency training program, including the activities that will take place, where they will take place, and which party incurs the costs of that program. Therefore, the agreement should reflect that the residents will be engaged in patient care activities, that the hospital will be responsible for the salaries and benefits of the residents while they are at the non-hospital site, and describe the compensation paid to the non-hospital provider for supervisory teaching services (or state that no payment will be made for such services). It is only with that level of specificity that it becomes clear that the hospital is incurring substantially all of the costs of the residency training. Absent that information, not addressed by the Bylaws, the Intermediary contends that the Provider cannot include the residents' time spent at other facilities in the FTE count.

With regard to the fiscal year 1999 reopening adjustment, the Intermediary contends that it appears that an error was made in the original cost report/Notice of Program Reimbursement (NPR) relative to the GME count. Before implementing the adjustments for the family residency program, the Intermediary auditor had to first identify the components of the intern and resident counts used in the original NPR. The Intermediary compared the NPR FTE counts to the counts calculated using the Provider's workpapers as well as IRIS information submitted by the Provider and made reconciling adjustments.

[13] Provider's post-hearing brief at pages 4, 6 and 7.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, parties' contentions and evidence submitted finds that the Provider did not meet the requirement of the regulation at 42 C.F.R. §413.86 which requires a written agreement between the hospital and the outside entities. The thrust of the regulation is that the agreement must be in writing and specify who bears the costs. The Board finds the Bylaws did not address any of the regulatory requirements relating to who would be responsible for costs of medical training. Therefore, the Provider's argument that the Bylaws and the physician's agreement to be bound by the Bylaws collectively rises to the level of a written agreement is without merit. The Provider also suggests in its argument that a third document should be considered. The Provider described it as the hospital's agreement with the residents and as including a provision that the hospital would bear all costs. This document was not submitted to the Board, however, and was not considered.

The Board further finds that the 2002 MOU also fails to satisfy the regulation. Medicare reimbursement is determined on a cost year basis. The Board concludes that the agreement must be in place at the time of non-provider setting rotations in order to ensure proper payment and protect the Medicare program against the possibility of double payment. This finding is consistent with the Board's decision in Natividad Medical Center v. Blue Cross Blue Shield Association/United Government Services, LLC, PRRB Dec. No. 2003-D17, March 6, 2003, Medicare and Medicaid Guide (CCH) ¶ 80,698, decl'd . rev. CMS Administrator, April 17, 2003.

The Board does not agree that the Barnes decision authorizes use of the MOU in this case. Unlike the regulation here, in Barnes there was no law requiring a written agreement. In Barnes, the later agreement merely supplied evidence of the prior purpose of funds.

With regard to the Intermediary's reopening of the fiscal year 1999 Medicare cost report, the Board finds that the regulations at 42 C.F.R. §405.1885 and §405.1887 do not limit the Intermediary to any specific area. Any matter in an earlier determination can be revised. The Intermediary made adjustments to the FTE count contained in the NPR. The reason given for the adjustments was that the FTE count in the NPR did not agree with the Provider's IRIS report. At the hearing, the Board requested clarification as to the adjustments made by the Intermediary.[14] A review of the post-hearing briefs revealed that the Intermediary's adjustment may have been based on erroneous information taken from a "Summary Report by Residency Code" and used by the Intermediary to incorrectly conclude that the FTE counts allowed in the original settled cost report did not agree with the IRIS report. Accordingly, the Board remands this issue to the Intermediary to reassess the accuracy of its determination.

[14] Tr at p. 289-291.

The Board has also considered the Provider's March 24, 2004 letter[15] to the Board opining that section 713 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) would allow hospitals to count residents who are training at non-hospital sites, without regard to the financial arrangements between the parties. However, the Board finds this argument is without merit.

In the case at hand, the Board concludes that, at a minimum, there needs to be evidence of a written agreement between hospitals and their teaching physicians as required by 42 C.F.R. §413.86. This is supported by a recent CMS notice dated March 12, 2004 which was issued to clarify the cited MMA provision. That notice speaks to the existence of written agreements between hospitals, physicians, and non-hospital sites. Without a written agreement, the Board can not reach the conclusion advocated by the Provider.

DECISION AND ORDER:

The Intermediary's adjustments to the Provider's FTE count were proper and are affirmed. With respect to the fiscal year 1999 reconciling adjustments, the Board remands the issue to the Intermediary to verify the accuracy of its previous determination.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA
Anjali Mulchandani

DATE: May 6, 2004

FOR THE BOARD:

Suzanne Cochran
Chairperson

[15] Letter dated March 24, 2004 from Christopher L. Keough, Esq. to Suzanne Cochran, Chairman, Provider Reimbursement Review Board is a part of Board correspondence.