PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D31

PROVIDER –
Atlantic 97 FTE Cap for IME Calculation Group

Provider Nos.: 31-0015, 31-0051

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ Riverbend Government Benefits Administrator

DATE OF HEARING -
February 13, 2007

Cost Reporting Period Ended -
December 31, 1997

CASE NO.: 01-3521G

INDEX

ISSUE:

Whether the cost report instructions improperly apply the indirect medical education (IME) full-time equivalent (FTE) cap to discharges prior to October 1, 1997.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper 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 proportion 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 the inception of the Medicare program, Congress has allowed hospitals' costs for operating programs for residents' training based on the premise that " . . . these activities enhance the quality of care in an institution." [1] In 1983, Congress recognized that teaching hospitals have indirect operating costs that would not be reimbursed under the prospective payment system or by the Direct Graduate Medical Education (DGME) payment methodologies, and it authorized an additional payment known as the Indirect Medical Education (IME) payment to hospitals with GME programs. 42 U.S.C. §1395ww(d)(5)(B). Specifically, the IME payment compensates teaching hospitals for higher-than-average operating costs that are associated with the presence and intensity of residents' training in an institution but which cannot be specifically attributed to, and does not include, the costs of residents' instruction. The IME adjustment attempts to measure teaching intensity based on "the ratio of the hospital's full-time equivalent

[1] H.R. Rep. No. 213, 89th Cong., 1st Sess., 32 (1965); see also Report to the Congress, Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals, at 4 (Aug.1999).

interns and residents to beds." Id. Thus, the IME payment amount is based, in part, upon the number of intern and resident FTEs participating in a provider's GME Program.

The Balanced Budget Act of 1997 (BBA-97) placed a limitation on resident FTEs for purposes of determining the IME payment by amending section 1886(d)(5)(B)(v)of the Act as follows:

> In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or non-hospital setting may not exceed the number of such full time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 1, 1996.

This appeal involves the implementation of the above statutory limitation through the cost report instructions.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This group appeal was formed by Morristown Memorial Hospital and Overlook Hospital (collectively the "Providers"), which are acute care hospitals located in the state of New Jersey. For the cost report period ended 12/31/97, the Providers used their total actual FTE counts (109.41 at Morristown; 93.14 at Overlook) to calculate their IME payments from January 1 through September 30, 1997. Riverbend Government Benefits Administrator (Intermediary) applied CMS Pub. 15-2 §3630 (the cost report form CMS-2552-96 instructions) to develop a weighted average for the same period. There is no dispute that the Intermediary properly applied the reporting instructions. At issue is whether the cost report instructions, as written, improperly apply the IME FTE base year cap to discharges prior to October 1, 1997.

PROVIDERS' CONTENTIONS:

The Providers argue that the plain language of the statute applies the 1996 FTE cap to discharges on or after October 1, 1997. Nothing in the statute requires or permits the intermediary to use a weighted average of total FTEs to account for discharges prior to October 1, 1997. Further, the plain language of the law requires the use of the full actual 1997 residents count for calculating the IME payments for the period from January 1, 1997 through September 30, 1997.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Providers' methodology uses the total FTE count for the entire cost reporting period (January 1, 1997 – December 31, 1997). Consequently, it does not account for the change in the regulation, in that, the FTE count at 9/30 is not the same as at 12/31. The cost report instructions properly apply the FTE cap to only those

discharges on or after 10/1/97, and the methodology used is consistent with the regulatory changes of BBA-97.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, finds and concludes that the Intermediary's calculation of the Providers' IME reimbursement was improper.

The central dispute in this case is whether the cost report instructions, as written, improperly apply the 1996 IME FTE base year cap to discharges prior to October 1, 1997. The Board examined both the instructions and their application to determine whether discharges prior to October 1, 1997 were impacted by the base year cap.

The Board's examination indicated that the Intermediary developed a weighted average FTE count for the fiscal year and incorporated it into the calculations of the Providers' IME factor. The Intermediary then applied the IME factor to the total DRG payments to arrive at the allowable IME payment amount. The Board notes that while the Intermediary's methodology is consistent with the cost report instructions at CMS Pub. 15-2 §3630, the application of the weighted average FTE count to total DRG payments subjects payments for discharges prior to October 1, 1997 to the FTE cap. Such application is inconsistent with the provisions of the BBA-97 and, consequently, the Board must conclude that the cost report instructions are flawed.

The Intermediary used the Provider Statistical and Reimbursement Report (PS&R) in its calculations. The PS&R split the discharges that occurred before October 1 from those that occurred on or after October 1. The Board finds no reason to weight the FTE count when actual figures are readily available. The Board concludes that the plain language of the statute requires the use of the total uncapped FTE count in the calculation of the IME ratio for discharges prior to October 1, 1997 and that the resulting factor should then be applied to the actual DRG payments for discharges for that same period.

DECISION AND ORDER:

The Intermediary's calculation of the Providers' IME reimbursement was consistent with the cost report instructions at CMS Pub. 15-2 §3630. However, the cost report instructions subject payments for discharges prior to October 1, 1997 to the FTE cap and are inconsistent with the provisions of the BBA-97.

The plain language of the statute requires the use of the total uncapped FTE count in the calculation of the IME ratio for discharges prior to October 1, 1997 and that resulting factor should then be applied to the actual DRG payments for discharges for that period. The Intermediary's adjustments for fiscal year 1997 are reversed, and this case is remanded to the Intermediary for recalculation consistent with the Board's decision.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

DATE: May 9, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

APPENDIX A LIST

Atlantic Health System 1997 IME Calculation
Case Number: 01-3521

Schedule of Providers

Provider Number	Provider Name	FYE
31-0015	Morristown Memorial Hospital Morristown, New Jersey	12/31/97
31-0051	Overlook Hospital Summit Union, New Jersey	12/31/97