PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D4

PROVIDER -
Hallmark Health System, Inc.
Everett, Malden, Melrose and Medford,
Massachusetts

Provider No.: 22-0070

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services-Maine
(f/k/a Associated Hospital Service)

DATE OF HEARING -
November 7, 2006

Cost Reporting Period Ended -
September 30, 2001

CASE NO.: 04-1796

INDEX

ISSUE:

Whether the Intermediary's determination of the Provider's dental intern and resident count for purposes of calculating its direct and indirect medical education adjustment was accurate.

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.

Medicare reimburses teaching hospitals for their share of costs associated with direct graduate medical education (DGME) and indirect medical education (IME). The calculation for reimbursement requires a determination of the total number of full-time equivalent (FTEs) residents in the teaching programs. The Medicare statute at 42 §U.S.C. 1395ww(h)(4)(E) entitles a hospital to count the time its residents spend in patient care activities in non-hospital settings on or after July 1, 1987 for purposes of calculating DGME reimbursement. The statutory provisions prescribe the content of the implementing regulations as follows:

> 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.

Likewise, for discharges occurring on or after October 1, 1997, the Medicare statute at 42 U.S.C. §1395ww(d)(5)(B)(iv) entitles hospitals to count the time its residents spend in patient care activities in non-hospital settings for IME reimbursement purposes:

> 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.

CMS issued implementing regulations 42 C.F.R. §413.86 (for DGME payments) and 42 C.F.R. §412.105 (for IME payments). The regulations additionally mandated that the hospital have a written agreement with the non-hospital site documenting the hospital's assumption of all or substantially all training costs at the non-hospital site. Medicare DGME regulations at 42 C.F.R. §413.86(f)(4) thus permitted a hospital to claim the time residents spend at a nonprovider setting if the residents trained in an approved program and:

(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.

The same requirements were also incorporated by reference in the IME regulations at 42 C.F.R. §412.105(f)(1)(ii)(C).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Hallmark Health System, Inc. (Provider) is a 368-bed, non-profit, general acute care, teaching hospital located on four separate campuses in Everett, Malden, Melrose and Medford, Massachusetts. The Provider included 65.82 DGME and 70.32 IME dental

resident FTEs on its FYE 9/30/2001 cost report.[1] All of the FTEs included for the dental residents related to non-hospital rotations. Associated Hospital Services[2] (Intermediary) audited the dental FTEs and found that they did not meet the written agreement requirement of 42 C.F.R. §413.86 and 42 C.F.R. §412.105. The Intermediary, therefore, disallowed all FTEs related to the dental residents.

The Provider appealed the Intermediary's disallowance to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Provider is represented by Jeffrey L. Heidt, Esquire, of Ropes and Gray, LLP. The Intermediary is represented by Arthur E. Peabody, Jr., Esquire, of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that during FY 2001, it operated dental residency programs through an academic affiliation with the School of Dental Medicine at Harvard University and the School of Dental Medicine at Tufts University (Schools). The Provider asserts that it appropriately claimed time spent by the dental residents in training at the Schools and their clinics on its Medicare cost report for purposes of DGME reimbursement because the Provider strictly complied with the governing Medicare regulations in effect at the time.

The Provider explained that its Chief Medical Officer was approached around April of 2001 by a Tufts faculty member who also served on the Provider's Board with the "idea of a dental residency program."[3] The Provider's reimbursement staff then contacted the appropriate staff at Tufts and Harvard to obtain a better understanding of their dental residency programs. The three entities met in the spring/summer of 2001 to discuss the financial implications of an affiliation and to share some preliminary estimates regarding the programs.[4] The Provider also contacted the local intermediary in the summer of 2001 to obtain some assurance that the proposed affiliation or program would meet the Medicare regulatory requirements. The Provider alleges that the Intermediary confirmed that the type of program in question did meet the Medicare regulatory requirements, as long as it was set up properly. [5]

The Provider then negotiated agreements with the dental schools and, on September 28, 2001, entered into a Memorandom of Understanding (MOU) that was a summary of the agreements that had been reached as of that date.[6] This document had an effective date of October 1, 2000, the first day of the cost reporting period at issue. The MOU stipulated that the Provider would incur specific costs of the Schools graduate dental

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[1] This was the first year the Provider included dental residents on its cost report. The Provider had previously established GME programs in family practice and cardiology. See, Intermediary's revised final position paper, page 21.

[2] Associated Hospital Services is now known as National Government Services- Maine.

[3] Transcript, page 37.

[4] Transcript, pages 37-42. The Provider met with the Schools prior to contacting Mr. Wheeler, a manager with the Intermediary, in the summer of 2001.

[5] Transcript, page 43.

[6] See, fully executed copy dated 9/28/01. Provider's consolidated Post-Hearing Brief Exhibit P-66.

residency programs including residents' stipends and benefits and the cost of supervisory teaching time, as detailed on Schedule A. Schedule A represents an estimate of Medicare GME receipts and how the proceeds would be disbursed to each dental school and to the Provider. The MOU called for the Provider to hold money in escrow contingent upon reaching a final agreement among the parties. The MOU was then superseded by a more comprehensive GME Agreement dated November 29, 2001. This document also had an effective date of October 1, 2000.[7]

The Provider argues that it met the four Medicare regulatory requirements for claiming the time spent by dental residents in rotations at non-hospital sites as set forth at 42 C.F.R. §413.86(f)(4) and 42 C.F.R. §412.105(f)(1)(ii)(C). The Provider asserts that it met the first requirement, in that the dental residents were enrolled in an approved GME program. The Provider claims that the programs were approved by the Commission on Dental Accreditation of the American Dental Association, and that the Intermediary has not challenged the Provider's compliance with this provision.

The Provider asserts that it met the second requirement of the Medicare regulations in that the residents spent their time in patient care activities. The Provider submitted documentation post-hearing[8] that was maintained by the Schools and identified specific activities that the dental residents were engaged in. The Provider argues that those schedules clearly document that the residents were spending their time in patient care activities. The Provider also referenced correspondence from CMS addressing the interpretation of "patient care activities" in relation to the time residents spend in non-hospital sites as support that the activities identified in its rotation schedules were related to patient care.[9] The Provider claims that all days in which the resident spent some portion of the day providing direct care to patients in clinics involved in other patient care oriented activities or other program requirements should be counted toward the FTE total.[10]

The Provider asserts that it met the third requirement of the Medicare regulations, in that it had entered into two written agreements with the non-hospital entities. For FYE 2001 the Provider and the Schools entered into two related agreements concerning the dental residency programs: 1) the summary MOU dated September 28, 2001[11] and 2) the more comprehensive GME Agreement dated November 29, 2001.[12] The Provider claims that each of these agreements independently met the written agreement requirement of the Medicare regulations.

The Provider argues that both the MOU and the GME Agreement were effective October 1, 2000, the first day of the cost reporting period in question and covered the entire cost reporting period ended September 30, 2001. Each written agreement provided that the

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[7] See, Provider Exhibit P-23 and Intermediary's Exhibit I-25.
[8] Exhibit's P-72 and P-73
[9] Exhibit P-79
[10] Provider's Post Hearing Brief, page 39.
[11] See, Consolidated Post-Hearing Brief Exhibit P-66.
[12] Exhibit P-23 and Exhibit I-25

Provider would incur specific costs of the Schools' dental residency programs with respect to those dental residents who would be included in the Provider's FY 2001 cost report. Each written agreement further provided that the costs incurred by the Provider were the specific costs addressed by the Medicare regulations, namely the cost of the dental residents' stipends and benefits, if any, and the cost of the supervisory teaching time of the dental school faculty. The Provider also asserts that the parties to each agreement were bound by its respective terms for the duration of the agreement.

The Provider argues that the dates that the MOU and the GME Agreement were signed are irrelevant, as the contracts were effective October 1, 2000, the first day of the cost reporting period. The Provider states that it appropriately complied with contract law and generally accepted accounting principles (GAAP) in claiming residents pursuant to the DGME regulations, absent any contemporaneous regulation or administrative guidance to the contrary. The Provider also asserts that no such contrary regulation or administrative guidance existed here. The DGME regulations did not place any significance on the execution date of the agreement implementing the dental residency affiliation and contemporaneous administrative guidance from CMS was consistent with contract law and GAAP in honoring the effective date of the agreement.[13]

The Provider asserts that it met the fourth and last requirement of the Medicare regulations in that the Provider incurred "all or substantially all" of the costs associated with the training of the dental residents at the Schools. The Provider asserts that it met that obligation by reimbursing the Schools for the residents' stipends and fringe benefits and the portion of the cost of faculty salaries and fringe benefits attributed to supervisory teaching duties.[14] The MOU and the GME Agreement include estimates of those costs incurred by the Schools that would be reimbursed by the Provider. The Provider did not have invoices to support the costs paid by the Provider to the Schools, but the Provider has supplied post-hearing affidavits from the Schools to document that the costs paid to the Schools for "supervisory teaching time" and residents stipends were used for that purpose.[15]

INTERMEDIARY'S CONTENTIONS:

The Intermediary asserts that the Provider failed to meet the criteria set forth in 42 C.F.R. §413.86 in order to include the dental residents from the Schools. The Intermediary contends that neither the MOU nor the GME Agreement entered into by the Provider met

[13] The Provider is referring to correspondence written by then CMS Administrator Nancy-Ann Min DeParle to the Association of American Medical Colleges, included at Exhibit P-19, which they claim states that the written agreements do not have to be provided to the Intermediary prior to the effective date of the regulations (1/1/99).

[14] Schedule A of the MOU and GME agreement identifies an amount paid to each school for faculty salaries and for resident stipends. See, Exhibit P-66 and Exhibit P-23.

[15] Schedule A of the MOU and GME Agreement identifies that the Provider paid Harvard $435,300 for faculty salaries. The affidavit of Mary Cassesso, Dean of Administration and Finance for the School of Dental Medicine at Harvard University at P-76, page 8, indicates that only $295,159 of faculty salaries actually related to supervisory teaching costs. The affidavit admits that the "estimate" used in the MOU and GME agreement was overstated.

the written agreement requirements of 42 C.F.R. §413.86(f)(4)(ii). The Intermediary argues that the MOU signed two days prior to the end of the cost reporting period is not a contract, but at best, an agreement to enter into a contract in the future, if then. The MOU language clearly demonstrated the contingency of the arrangement, as it specifically stated in Section 3.2, "If no definitive subsequent agreement is reached between the parties within 60 days of the signing of this MOU, the Schools agree to return the money held in escrow accounts to the Health System immediately upon receipt of written request from the Health System."[16]

The Intermediary argues that although the effective date of the MOU and the subsequent GME Agreement of October 1, 2001, covers the year at issue, they disregard the plain language of the regulation, which requires that the agreement be entered into before resident rotations begin. 42 C.F.R. §413.86(f)(4)(ii) states: "The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salaries. . ." (emphasis added). "Will incur" rather than has "incurred" indicates that the agreement will be entered into prior to the Provider incurring the costs of the residency program. The Provider failed to enter into a definitive, enforceable agreement within the relevant fiscal year or before the time that the dental residents began their "rotations." The Provider, at best, would not be able to begin counting the dental residents in question until November 29, 2001, the date of the definitive GME Agreement.

The Intermediary also argues that the Provider has not demonstrated it met the requirement that, "the resident spends his or her time in patient care activities." 42 C.F.R. §413.86(f)(4)(i). Neither the MOU nor the GME Agreement specifies that the residents will spend their time in patient care activities. The Intermediary requested detailed rotation schedules from the Provider on two occasions, first during the original audit and then during discovery, but the Provider submitted only a resident listing based on the first request and refused to submit the rotation schedules based on the discovery request. The Provider has finally submitted documents post-hearing[17] that it purports to be rotation schedules; however, those documents indicate that residents spent time in activities such as classwork and research that are not related to patient care.

Additionally, the Intermediary argues that the terms of the MOU and the GME Agreement fail to meet the requirement that, "the hospital must incur all or substantially all of the costs for the training program in the nonhospital setting. . ." Both the MOU and the definitive GME Agreement indicate only "estimates" of costs for teaching physicians, not actual costs and there was no documentation provided until the post-hearing brief was submitted that outlined how the amount was determined.

In addition, the GME Agreement signed by the parties on November 29, 2001 specifies that the Schools were responsible for malpractice coverage of interns and residents under

[16]The definitive GME Agreement was dated (or entered into) November 29, 2001. Also, the checks written on September 28, 2001 to the Schools were not cashed by those parties until December of 2001 and January of 2002, well after the definitive GME Agreement was dated (or entered into).

[17] Provider Exhibit's P-72 through P-74.

the Schools' "blanket professional liability insurance coverage."[18] As the regulation requires the Provider to "incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site," and because the Provider is not incurring the malpractice costs, the Provider has not met this requirement of the regulation.

Finally, the Intermediary asserts that both agreements violate the principle of Medicare reimbursement barring the redistribution of costs. This principle prohibits shifting the cost of training residents from the educational institution to a hospital to obtain Medicare payment. The Intermediary maintains that although for purposes of DGME and IME, the redistribution concept does not appear to have been incorporated directly into a regulation until October 1, 2003, the concept of redistribution of costs appears in discussions of GME from at least 1989. It is undisputed that the residents do not spend any time at the Provider nor do they furnish services or any benefits to its patients. The Intermediary reasons that for a provider to claim DGME and IME for placing residents in a nonprovider setting, the provider must first have a related program in its facility. The Provider does not own, operate or manage the dental residency programs, and none of the dental residents rotate to the Provider. The Provider makes no contribution to the education of the Schools' dental residents except to "incur" various costs historically borne by Harvard and Tufts' dental schools. The arrangement results in an inappropriate redistribution of costs from the dental schools to the Provider, and therefore, the Provider should not be reimbursed for the time dental residents "spent outside the hospital."

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The circumstances here address a novel arrangement not previously addressed by the Board. The Board agrees with the parties that there are four criteria which must be met by the Provider in order for it to claim the residents in question. The first criterion, that the residents be trained in an approved teaching program, was not challenged by the Intermediary, and the Board, therefore, finds that the Provider has met that criterion.

Of the three remaining criteria which the Intermediary argues that the Provider does not meet, the Board will first address the written agreement requirement. It is undisputed that the MOU was not signed until September 28, 2001, two days prior to the end of the Provider's fiscal year and that the definitive GME Agreement which superseded the MOU, was not signed until November 29, 2001, or after the close of the relevant fiscal year. It is also undisputed that there was no obligation by the Provider at the start of the fiscal year to fund the dental programs at issue.[19]

The Provider asserts that although all the costs incurred related to the training of the residents at non-provider settings, the costs are allowable because they meet the written agreement requirements of 42 C.F.R. §413.86 and 42 C.F.R. §412.105.

[18] Exhibit P-23, Section 2.4.
[19] See transcript, page 159.

However, the MOU, by its own terms, is conditional:[20]

> Section 3.1 The Parties acknowledge that this MOU is only a summary of the agreements that have been reached among them as of the date of this MOU, and agree that they will diligently cooperate to develop a mutually agreed upon definitive agreement among them within 60 days of signing this MOU. The form and business term of such agreement shall be substantially the same as this MOU, subject to such changes as may be recommended by the parties' respective legal counsel. Upon execution by the parties, the definitive agreement shall replace this MOU.
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> Section 3.2 If no definitive agreement is reached among the parties within 60 days of the signing of this MOU, the Schools agree to return the money held in escrow accounts to the Health System immediately upon receipt of written request from the Health System.

The Board majority finds that the MOU does not address each of the criteria required by the regulation.[21] In addition, the MOU was not enforceable until further action was taken; specifically, the execution of a more definitive agreement on November 29, 2001, two months after the close of the cost reporting period.

The Board majority finds that the MOU did not meet the written agreement criterion of 42 C.F.R. §413.86(f)(4)(ii) because it did not create an obligation during the cost reporting period. The regulation reads, "the written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salaries. . ." (emphasis added). As the regulation states "will incur" rather than "has incurred," neither the MOU nor the GME Agreement would suffice to retroactively apply the agreement. Even if the MOU could be considered to have become effective upon the execution of the more definitive agreement, the Board majority concludes that it still could not be considered to have been effective during that portion of the cost reporting period which preceded the "meeting of the minds."

The Board also reviewed the evidence relating to the argument that the Provider has not met the criterion set forth in 42 C.F.R. §413.86(f)(4)(i), which requires that the residents spend their time in patient care activities. The record shows that the Intermediary requested rotation schedules from the Provider on at least two occasions; once during the audit and again during discovery. [22] As the rotation schedules were not submitted during the audit, the Intermediary made its decision to disallow the dental residents FTEs based

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[20] See, Provider's Consolidated Post-Hearing Brief Exhibit P-66.

[21] It is noted that the Intermediary argues in its Post-Hearing brief, page 13, that an estimate of teaching salaries is not sufficient to meet the criteria.

[22] Rotation schedules are typically used to determine where the residents are located and the activity(s) in which they are participating.

on a listing of claimed residents that was submitted by the Provider in lieu of the rotation schedules.[23] The Provider then objected to the Intermediary's request to provide those documents through discovery.[24] There was no evidence furnished, even up through the date of hearing, that documented that the residents for which the Provider claimed FTE's actually participated in patient care activities. The Provider acknowledged that it had no control over the schedules, as they were the responsibility of the dental schools to maintain and provide the FTE count in the record for reimbursement purposes.[25] The Provider also acknowledged that the listing of claimed residents, as submitted prior to the hearing, was incomplete.[26]

It was not until the Provider was questioned at length during the hearing by the Board that schedules were furnished post-hearing.[27] Moreover, the Provider submitted with these assignment schedules un-sworn and unsigned statements explaining the entries on those schedules when it had wholly failed to prove its case at the hearing. It appears that those statements attempt to link each claimed resident to a submitted assignment schedule and to identify the portion of the year each resident was training at Harvard or Tufts. With few exceptions, the Provider claims that all of the time a resident was at Tufts or Harvard was for patient care related purposes, even time spent in the classroom. However, even if the Board were to accept these un-sworn statements as true, the Board majority finds that they are inadequate to confirm that the assignments on the schedules actually reflect patient care activities. For example, the following statement is included at Exhibit P-72, page 1, last paragraph,: "Literature review is essential to providing quality care and residents are training in how to support their treatment decisions through a review of literature and journals. Residents make case presentations regarding how literature supports their treatment decision-making." From that statement, it appears to assert that even "study time" should count as a patient care activity.

The Provider also submitted post-hearing a summary of dental resident FTEs, which attempts to summarize or extract information from the various schedules in Exhibits P-72 & Exhibit P-73.[28] We note that the totals do not correspond to the FTE's claimed by the Provider on its as-filed costs, and that the Provider is attempting to request reimbursement for more FTE's in its post-hearing brief.

In response to the Board's extensive questioning about the lack of evidence to support its claims, the Provider submitted post-hearing affidavits from the dental schools that state that the FTEs claimed were only for patient care activities. The Board majority finds that the submission of these documents post-hearing in response to the Board's extensive criticism & questioning of the Provider's evidence is inappropriate in that it contravenes

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[23] See, Exhibit P-25, pages 12-18 for copies of Intermediary's workpapers and resident listing.
[24] See, Exhibit I-28, Hallmark Health System, Inc.'s response to Intermediary's first request for production of documents, page 2 Number 5. The Provider responds with "general objections," which includes "Hallmark Health objects to the Request to the extent it purports to demand production of documents not in Hallmark Health's ownership, control or custody . . ."
[25] See, Transcript, pages 158 and 159.
[26] See, Transcript, page 162.
[27] See Post-Hearing submitted exhibits, P-72 and P-73. Transcript at 144.
[28] Exhibit P-74.

fundamental means of due process for the opposing party, allows a provider to use the hearing process merely to test the Board's views of an issue, and it undermines the finality of the hearing process. However, even if these documents were to be accepted, the Board finds them insufficient to meet the Provider's burden of proof to verify that the FTEs claimed represent time spent in patient care activities.

The Intermediary also argued that the Provider did not meet the criterion set forth in 42 C.F.R. §413.86(f)(4)(iii) which requires that "the hospital incur all or substantially all of the costs for the training program in the nonhospital site. . ." The Intermediary based its argument on the Provider's use of estimates. Schedule A of the MOU reflects that approximately 96% of the estimated costs claimed were for faculty salaries. The Board majority finds it impossible, based on the information in the record, to link those faculty salaries with any supervision of the residents claimed when they were engaged in patient care activities. The Board majority also finds the disparity between the amounts paid as supervisory teaching costs for the residents and the amount of money paid as stipends to the residents to raise many questions. The typical "substantial costs" claimed by providers are stipends and related items paid to the residents. Here, those expenses are only 4% of the total. If the supervisory teaching costs related to these FTEs are accurate, then we would expect to see a commensurate ratio with regard to those FTEs that rotated through other hospitals. For example, residents training in the Tufts General Practice Residency Program and Oral Surgery Program rotate to other facilities such as the New England Medical Center (NEMC), Boston University, Jewish Rehabilitation Center and Lemuel Shattuck Hospital.[29] Those facilities claimed a portion of the FTEs related to the residents being claimed by the Provider. However, there is no evidence in the record that those facilities paid the dental schools a commensurate payment for supervising teaching salaries as the Provider did.

Finally, the Intermediary has argued that the nature of the arrangement at issue violates the principle of cost redistribution and that the arrangement was set up solely to increase Medicare reimbursement. The record reflects that the dental residents provide absolutely no benefit to the Provider's patients. If the Provider's position were permitted, it would allow for a provider located on the east coast to incur costs of a training program located on the west coast that would have no association with the provider or its patients.

The Board majority finds that it is implicit in the IME/GME legislation and regulations that the hospital claiming the costs must be an active participant in the training. The following are examples of legislation that imply that the hospital that is being reimbursed for IME/DGME should be actively participating in the training and not merely providing financial support:

- 1886(h)(4)(H)(iii) identifies the data collection requirements for hospitals counting interns and residents for FY 1998 and subsequent years:

  > The Secretary may require any entity that operates a medical residency training program and to which

[29] Exhibit P-73. pages 51,56 and 62.

> subparagraphs (F) and (G) apply to submit to the Secretary such additional information as the Secretary considers necessary to carry out such subparagraphs. (emphasis added)

- 42 C.F.R. §413.86(b)(1) & (2) provides definitions for the term "affiliated group" as used in the context of DGME reimbursement. The definitions identified an affiliated group to be:

> (1) Two or more hospitals located in the same urban or rural area (as those terms are defined in 412.62(f) of this subchapter) or in contiguous areas if individual residents work at each of the hospitals during the course of the program; or
> (2) If the hospitals are not located in the same or a contiguous urban or rural area, the hospitals are jointly listed- (i) As the sponsor, primary clinical site or major participating institution for one or more of the programs as these terms are used in *Graduate Medical Education Directory, 1997-1998*; or (ii) As the sponsor or under "affiliation and outside rotations" for one or more programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs*. (emphasis added)

Prior to the addition of the non-provider setting provisions, DGME reimbursement was only permitted for hospital-based training in hospitals and certain other named medical providers/facilities. As of July 1, 1987 for DGME and October 1, 1997 for IME, the legislation changed to permit non-provider settings to also be counted, provided the hospital incurred the costs. The question is then whether the legislative change that permitted the non-provider settings to be counted worked as an exception to the prior requirement that the hospital had to be actively participating or whether the allowability of non-provider settings is merely an extension of the hospital's active participation. There is no indication that the overarching principle that the hospital be an active participate in teaching the residents it claims as FTEs has been removed. Although there was nothing explicit in the statute or regulation effective for the year in question to address this situation, the Board majority finds support in the various provisions quoted above that the intent was for the hospital to be actively involved in the resident training program.

The novel circumstances that we find presented here were not specifically addressed by CMS until the May 19, 2003 proposed rule.[30] The final rule, issued August 1, 2003,[31] created 42 C.F.R. 413.86(i), which specifically addressed situations such as this, where inappropriate application of Medicare direct DGME and IME payment policies relating

[30] 68 Fed. Reg 27211-27218 (May 19, 2003)
[31] 68 Fed. Reg 45434-45454 (August 1, 2003)

to the counting of FTE residents in nonhospital settings had taken place. That regulation states:

> (i) Application of community support and redistribution of costs in determining FTE resident counts.
> (1) For purposes of determining direct graduate medical education payments, the following principles apply:
> (i) Community support. If the community has undertaken to bear the costs of medical education through community support, the costs are not considered graduate medical education costs to the hospital for purposes of Medicare payment.
> (ii) Redistribution of costs. The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered graduate medical education costs to the hospital for purposes of Medicare payment.
> (2) Application. A hospital must continuously incur costs of direct graduate medical education of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents in accordance with the provisions of paragraphs (f) and (g)(4) through (g)(6) and (g)(12) of this section. This rule also applies to providers that are paid for direct GME in accordance with §405.2468 of this chapter, §422.270 of this subchapter, and §413.70.
> (3)(i) Effective date. Subject to the provisions of paragraph (i)(3)(ii) of this section, payments made in accordance with determinations made under the provisions of paragraphs (i)(1) and (i)(2) of this section will be effective for portions of cost reporting periods occurring on or after October 1, 2003.
> (ii) Applicability for certain hospitals. With respect to an FTE resident who begins training in a residency program on or before October 1, 2003, and with respect to whom there has been a redistribution of costs or community support determined under the provisions of paragraphs (i)(1) and (i)(2) of this section, the hospital may continue to count the FTE resident until the resident has completed training in that program, or until 3 years after the date the resident began training in that program, whichever comes first.

Although the Board majority finds support for disallowing the redistribution of costs in the statute and regulations in place during the time period in question, CMS nevertheless decided to allow grandfathering for residents who trained in a resident program that was

deemed to fall under the redistribution regulation 42 C.F.R. §413.86(i) but began their training prior to October 1, 2003. Therefore, the Board finds that the redistribution principle should not be utilized as a basis for disallowing the dental resident FTE's for this cost reporting period.

DECISION AND ORDER:

The Intermediary's adjustments to remove IME and DGME dental resident FTE's from the cost report were proper. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Yvette C. Hayes (Dissenting)

DATE: October 16, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson

Dissenting Opinion – Yvette C. Hayes (Dissenting in part, concurring in part)

I respectfully dissent with the Board majority's opinion that the MOU does not address each of the criteria established by the regulations. The written agreement regulatory requirements of 42 C.F.R. §412.86(f)(4)(ii) states that:

> The written agreement between the hospital and the 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 site and the hospital is providing reasonable compensation to the non-hospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the non-hospital site for supervisory teaching activities.

These same requirements were also incorporated by reference in the IME regulations at 42 C.F.R. §412.105(f)(ii)(C).

Although, the Intermediary's sole basis for disallowing all of the Provider's dental residents' FTEs used for calculating its direct graduate medical education and indirect medical education reimbursement was because the written agreement(s) did not meet the above stated requirements, the Board's decision addressed all statutory and regulatory requirements.

It is undisputed by the parties that the MOU was signed on September 28, 2001, two days prior to the end of the Provider's fiscal year end and that the definitive GME Agreement, which superseded the MOU was executed on November 29, 2001, after the close of the relevant fiscal year.

Regarding the Board majority's decision that the MOU does not address each of the criteria required by the regulation, the following analysis is offered:

Criteria for Written Agreements:

1 – Is the agreement in writing?

2 – Is the written agreement between the hospital and the non-hospital site?

3 – Does the written agreement indicate who (the hospital) will incur the cost of the residents' salaries and fringe benefits while they are training at the non-hospital site?

4 – Does the written agreement indicate who (the hospital) is providing compensation to the non-hospital site for supervisory teaching activities?

5 - Does the written agreement indicate how much compensation (the hospital) is being providing to the non-hospital site for supervisory teaching activities, if any?

Criteria 1 – Is the agreement in writing?

I disagree with the Intermediary's contention concerning what type of agreement is contemplated by the regulation. The regulation states that the parties must enter into a "written agreement". It does not specify that the written agreement be in the form of a "contract"[32] but simply that the agreement be in writing. There is no implied or explicit requirement in the regulations that the written agreement must be a contract.

Criteria 2 – Is the written agreement between the hospital and non-hospital site?

The MOU[33] was entered into by and between the Provider and the Schools on September 28, 2001. Therefore, I find the MOU satisfies the requirement that the agreement is between the hospital and the non-hospital site.

Criteria 3 – Does the written agreement indicate who (the hospital) will incur the cost of the residents' salaries and fringe benefits while they are training at the non-hospital site?

The Provider incurred the costs of the residents' salaries and fringe benefits as outlined on Schedule A of the MOU on 9/28/01 as evidenced by checks issued on the same date. See Exhibit P-24.

Criteria 4 – Does the written agreement indicate who (the hospital) is providing compensation to the non-hospital site for supervisory teaching activities?

The MOU indicates that the Provider compensated the Schools for the cost of the supervisory teaching time of the dental school faculty for the dental residents claimed on its cost report. See Section 1.1 and Schedule A.

Criteria 5 – Does the written agreement indicate how much compensation (the hospital) is providing to the non-hospital site for supervisory teaching activities, if any?

The MOU indicates that the Provider provided compensation to the Schools in the amount of $904,000 (Tufts) and $489,132[34] (Harvard) for FY 2001.

Based on the above analysis, I find the MOU satisfies all criteria established by the regulations for an acceptable written agreement.

The Board majority agreed with the Intermediary's contentions that because the MOU is contingent, then by its very nature, it is incomplete and does not create an obligation during the cost reporting period but rather a retroactive application of the agreement upon execution of the definitive GME agreement. The Board majority concluded that the MOU

[32] A "contract" is defined as: an agreement between two or more parties, especially one that is written and enforceable by law; a legally, enforceable agreement.

[33] A "MOU" or memorandum of understanding is defined as: a legal document describing a bilateral agreement between parties that expresses a convergence of will between the parties, indicating an intended common line of action, rather than a legal commitment; a legal document outlining the terms and details of an agreement between parties including each parties requirements and responsibilities.

[34] Per Schedule A of the MOU, the GME disbursement to Harvard for Faculty Salaries was projected/estimated at $435,300.

on its own was not adequate but even if considered to have become effective upon the execution of the GME agreement, it still could not be considered to have been effective during the portion of the cost reporting period which preceded the "meeting of the minds."

Although, the MOU states that it is "only a summary of the agreements that have been reached among [the parties] as of the date of this MOU" and the parties cooperatively agreed "to develop a mutually agreed upon definitive [GME] agreement among them[selves] within 60 days of signing this MOU" and that "upon execution by the parties, the definitive [GME] agreement shall replace this MOU," I do not find this language negates the fact that the MOU is a written document that outlines the terms and details of an agreement reached by and between the parties and therefore, both the MOU and the definitive GME agreement independently meet the written agreement requirement of the Medicare regulations. I also find that both agreements were effective for the entire cost reporting period in question, one executed prior to and the other after the end of the cost reporting period.

Further, I find the plain language of the regulation at 42 C.F.R. §413.86(f)(4)(ii) which states: "the written agreement …must indicate that the hospital will incur the cost…" does not infer that the agreement must be entered into prior to the Provider incurring the costs of the residency program. Rather, it speaks to the hospital's commitment to incur these costs and I find that the MOU is evidence of the Provider's commitment to incur specific costs for the cost reporting period at issue buttressed by the fact that the Provider fulfilled its responsibility by making the agreed upon payments.

Again, I do not agree with the Intermediary's contention that the written agreement must be in entered into before resident rotations begin or the Board majority's opinion that the written agreement must be executed during the cost reporting period. In this instance, this standard would have been met if not for the fact the Board majority found the MOU unacceptable as a written agreement. Rather, if the written agreement is effective for the cost reporting period in question and is made available upon request to the Intermediary, I find that sufficient to support the costs incurred by the provider.

The Board also reviewed the evidence relating to the argument that the Provider has not met the requirement set forth in 42 C.F.R. §413.86(f)(4)(i) that states:

> The resident spends his or her time in patient care activities.

I find it unfavorable to the Provider the fact that it did not provide rotation schedules (although the Intermediary requested them on more than one occasion) until post-hearing at the request of the Board. The Board's examination of these schedules and the summaries provided generated more questions than it answered. Therefore, it is my opinion that further audit work would have been required to ascertain whether or not the resident's time was spent in allowable patient care activities. That said, I concur with the Board majority that the information provided is inadequate to meet the Provider's burden of proof that the FTEs claimed were only for time spent in patient care activities. It is for

this reason that I find the Provider does not meet all the regulatory requirements for claiming the dental residents' FTEs for IME and DGME reimbursement purposes.

A critical question posed by the Board concerned whether the legislative change that permitted the non-provider settings to be counted worked as an exception to the prior requirement that the hospital had to be actively participating [in the resident's training] or whether the allowability of non-provider settings is merely an extension of the hospital's active participation.

The Board majority found "…nothing explicit in the statute or regulation effective for the current year in question to address this situation", however, it did find an implied "overarching principle" in the IME/DGME regulations (although not plain on its face) that the hospital must be an active participate in the training of the residents it claims. I do not find this an unreasonable interpretation prior to the (BIPA) legislative change but after, I find that Congress intended to reimburse not only hospitals but non-hospital entities engaged in providing graduate medical education training to residents in approved programs involved in patient care activities.

Residents assigned to or working at non-provider sites may not necessarily be concurrently assigned to or working at the hospital/provider during their rotation to the non-hospital site and to my knowledge there has never been any such requirement that they be (or prove that the resident was otherwise assigned or working at a given provider during a given fiscal year period).

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Yvette C. Hayes