PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D34

PROVIDER -
Henry Ford Hospital
Detroit, Michigan

Provider No.: 23-0053

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services, LLC -WI

DATE OF HEARING –
September 19, 2007

Cost Reporting Periods Ended -
December 31, 1991 through
December 31, 1996 and December 31, 1998; December 31, 1999

CASE NOs.: 02-1010, 02-0892, 02-1663, 02-2148, 03-0597, 03-1011, 04-0021, 04-0022 (respectively)

INDEX

ISSUES:[1]

1. Whether the Intermediary properly excluded FTEs attributable to rotations by residents in certain unaccredited training programs.

2. Whether the Intermediary properly excluded IME FTEs attributable to time spent by residents in research that was required by the residents' approved medical residency programs. (On the Record)

3. Whether the Intermediary properly excluded FTEs attributable to resident leave time when it is taken during rotations in which the resident is conducting research.[2]

4. Whether the Intermediary properly excluded from the FTE cap, FTEs attributable to time spent by residents in new programs.

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.

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[1] Cases 03-0597, 03-1011, 04-0021 and 04-0022 were heard before the Board on September 19, 2007. Subsequently, the parties stipulated that the identical issues were at stake in 02-1010, 02-0892, 02-2148 and 02-1663 and requested that the those cases be included in the Board's decision for the four cases heard. The Board has agreed to include cases 02-1010, 02-2148 and 02-1663 in its decision. Also, an additional issue, off-site rotations, was argued the day of hearing. Whether the Intermediary properly excluded FTEs attributable to time spent in a non-provider setting. However, the Provider withdrew the issue in a letter dated November 16, 2007.

[2] Two other aspects of resident leave time were argued during the hearing, maternity leave and other extended leaves of absence but subsequently resolved by the parties after the hearing and withdrawn by the Provider in a letter dated November 16, 2007.

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 residents (FTEs) in the teaching program. This case arises from a dispute over the FTE count.

Unaccredited training programs

In determining the total number of FTE residents, 42 C.F.R §413.86(f)(1) instructs that subject to weighting factors, the count of FTE residents includes "[r]esidents in an approved program working in all areas of the hospital complex … " Historically, the statutory definition of an "approved program" for purposes of the cost reimbursement system for inpatient hospital services expressly included only those programs that were accredited by one of several enumerated national organizations, including the predecessor to the Accreditation Council for Graduate Medical Education (ACGME). As defined by the statute, an "approved medical residency training program" means "a residency or other postgraduate medical training program participation in which may be counted toward the certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary." 42 U.S.C. §1395 ww(h)(5)(A). The DGME and IME regulations defined the phrase "approved medical residency program" similarly. The DGME regulation defines an approved program as follows:

> *Approved medical residency program* means a program that meets one of the following criteria:
>
> (1) Is approved by one of the national organizations listed in §415.200(a) of this chapter.
>
> (2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:
>
> > (i) The Director of Graduate Medical Education Programs published by the American Medical Association . . . ; or
> >
> > (ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties . . .
>
> (3) Is approved by the Accreditations Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

42 C.F.R. §413.86(b).[3]

[3] The section cross-referenced in the regulation did not contain a list of national organizations. This provision was corrected on July 30, 1999 to refer to 42 C.F.R. §415.152, which does contain such a list. However the 1999 version was only in effect for the final six months of the last cost reporting period at issue in this appeal.

Likewise, the IME regulation defines an approved program as follows:

> An approved teaching program is one that meets one of the following requirements:
>
> (A) Is approved by one of the national organizations listed in §415.200(a) of this chapter.
>
> (B) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:
>
> (1) the Directory of Graduate Medical Education Programs published by the American Medical Association:
>
> (2) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.
>
> (C) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

42 C.F.R §412.105(f)(1)(i).

Research rotations and resident leave time when taken during research rotations

Since the inception of the Medicare program, Congress has allowed the cost of training physicians based on the premise that ". . . these activities enhance the quality of care in an institution."[4] 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 methodology and 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 the 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 interns and residents to beds. Id. Thus, the IME payment amount is based, in part, on the number of intern and resident full-time equivalents participating in a provider's GME Program.

Fiscal years 1991 through 1996, 1998, and 1999, are at issue here. 42 C.F.R. §412.105(g). It was redesignated from 42 C.F.R. §412.105(g) to §412.105(f) in 1997.[5] The regulation governing IME reimbursement, originally codified at 42 C.F.R. §412.105(g) states in pertinent part:

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[4] H.R. Rep. No. 213, 89th Cong., 1st Sess., 32 (1965); see also Medicare Payment Advisory Commission (MEDPAC) Report to the Congress, Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals, at 5 (Aug. 1999). (Provider Exhibit P-36)

[5] See 62 Fed. Reg. 45,966, 46,029. (Exhibit P-31).

> (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:
>
> (i) The resident must be enrolled in an approved teaching program...
>
> (ii) ... the resident must be assigned to one of the following areas:
>
> > (A) The portion of the hospital subject to the prospective payment system.
> >
> > (B) The outpatient department of the hospital.

In 1997, the regulation was recodified as 42 C.F.R. §412.105(f) and amended to include time spent by residents providing direct patient care in non-hospital settings in the count. This amendment was therefore applicable for the 1998 and 1999 cost reporting years. The amendment stated:

> (C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth at §413.86(f)(i)(iii) are met.

Id.

Effective October 1, 2001, CMS amended the Medicare regulations governing the IME payment. The revised regulation specifically excluded all time spent by residents in research not involving the care of a particular patient:

> The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable.

42 C.F.R. §412.105(f)(1)(iii)(B).

FTE cap

For cost reporting periods beginning on or after October 1, 1997, the Medicare program established a cap on the number of residents a hospital can count for purposes of graduate medical education payments, based on each hospital's number of resident FTEs during the most recent fiscal year that ended on or before December 31, 1996.[6] The regulations also allow for adjustments to the cap based on the addition of residents in "medical residency training programs established on or after January 1, 1995." Specifically, CMS regulations state in pertinent part:

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[6] See 62 Fed. Reg. 45,966, 46,004 (Aug. 29, 1997); see also 42 C.F.R. §413.86(g)(4) and 42 C.F.R. §412.105(f)(1)(iv).

> (6) If a hospital established a new medical residency training program as defined in this paragraph (g) after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted as follows:
>
> * * * * *
>
> (ii) If a hospital had residents in its most recent cost reporting period ending before January 1, 1995, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997. . . .
>
> (7) For purposes of paragraph (g) of this section, a new medical residency training program means a medical residency that received initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.

42 C.F.R. §413.86(g) (1998).

The IME regulation incorporated the DGME requirements for adjustments to the cap for new medical residency training programs. 42 C.F.R. §412.105(f)(1)(vii).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Henry Ford Hospital (Provider) is a 903-bed, not-for-profit, acute care teaching hospital located in Detroit, Michigan. The Provider included IME and DGME FTEs on its cost reports for FYEs December 31, 1991 through December 31, 1996 and December 31, 1998 and 1999. National Government Services, LLC (Intermediary) audited the cost reports and adjusted the as-filed IME and DGME FTEs to its audit findings.

The Provider appealed the Intermediary's adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Provider was represented by Ronald S. Connelly, Esquire, of Powers, Pyles, Sutter & Verville, P.C. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

Issue #1 - FTEs attributable to rotations by residents in certain unaccredited training programs

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly denied FTEs for residents training in one or more of the following subspecialty training programs: Headache, Breast/MRI, Cross Sectional, Musculoskeletal Radiology, Cerebrovascular Disease/Stroke, and Neurology-Oncology. The Provider argues that although these programs were not accredited by a national organization, they were all "approved programs" because they met the definition of an approved program in 42 C.F.R. §413.86(b) and 42 C.F.R §412.105(f)(1)(i)(B). The Provider asserts that

each of the programs met the criteria that allow a Provider to count the time residents spent in an unaccredited program if the program may "count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications . . ."

The Provider asserts that the Breast/MRI, Cross Sectional and Musculoskeletal Radiology programs could count toward certification in the subspecialty of Vascular/Interventional Radiology. The Headache and Neurology-Oncology programs could count toward certification in the subspecialty of Clinical Neurophysiology. The Cerebrovascular Disease/Stroke program could count toward subspecialty certification in Vascular Neurology. The Provider contends that Vascular/Interventional Radiology, Clinical Neurophysiology and Vascular Neurology are all approved programs listed in the Green Book, and therefore any training which may count toward certifications in those programs would also be considered part of an approved program.

The Provider contends that the Intermediary is narrowly interpreting the regulation and improperly requiring that the Provider document for each resident that the time spent in its unaccredited programs was used to obtain certification. The Provider asserts that as certification of each resident in a subspecialty is not required, actual verification that the time spent in an unaccredited program was used to obtain certification cannot be required. The Provider further argues that the Intermediary's interpretation that the regulation be applied to each resident is irrational as the intent of the regulation was not for the Provider to perform an in-depth examination into certification applications for each resident in question.

Finally the Provider argues that if the Board determines the above fellowship training programs are not approved, then the Provider should be reimbursed on a reasonable cost basis (1999)(Formerly 42 C.F.R. §405.523(1995)).

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that the Provider is asking the Board to interpret 42 C.F.R. §413.86(b) and 42 C.F.R. §412.105(f)(1)(i) so broadly that they would be impossible to implement. The Intermediary asserts that the Provider's reading of the regulations would allow any training to be counted if it could be used for certification purposes.

The Intermediary contends that the regulation cannot be interpreted broadly, but instead must be applied to each particular resident. Therefore, the Intermediary asserts that if the Provider cannot document for each resident that the training in an unaccredited program counted toward certification, the FTEs related to the time spent training in the unaccredited program cannot be counted. The Intermediary argues that the Provider was unable to point to any documentation in the record that any of the time spent by residents in unaccredited programs actually counted toward a resident's certification. The Intermediary argues that it is not enough for the training to "maybe" count toward certification, it must be documented that it was counted toward certification.

The Intermediary also argues that the Provider has not documented, but only presumed, that its unaccredited programs would count toward specific subspecialty certifications. The Intermediary contends that the Provider reached the presumption by reading certification applications and attempted to tie its specific programs to those certification applications

requirements. In addition, the Intermediary argues that the Provider cannot document that the training would count toward certification until the actual training is included on a certification application, and the appropriate body has made that determination.

The Intermediary asserts that the Provider made no attempt to contact certifying bodies to ensure that its presumptions were correct. The Intermediary testified that it did, in fact, contact one certifying body, the American Board of Radiology, and was notified that other criteria would have had to have been met prior to the resident's rotation to count the time spent in the specific unaccredited program toward certification.[7] The Intermediary contends that the Provider neither established that the residents had the proper prerequisites prior to taking the training to allow the training to be counted toward certification, nor that the residents would have qualified to sit for the certification examination. Without knowing the specific situation for each resident, the Intermediary asserts that there would be no definitive way to know if the unaccredited training program would count toward a certification.

Finally, the Intermediary argues that the FTEs specifically related to the Provider's Cerebrovascular Disease/Stroke program should not be counted in the IME/DGME count as there was no certification in existence during the time of the training in which the program could have counted. The subspecialty of Vascular Neurology was not approved by the American Board of Medical Specialties until 2003, several years after the years at issue in this appeal. Therefore, at the time the residents in question participated in the unaccredited program, there was no certification in existence in which the training could have been used to fulfill the requirements. The Intermediary argues that the Provider's interpretation of the regulation is so vague that a certification does not even have to be in existence when the training in an unaccredited program takes place.

The Intermediary conditionally agreed with the Provider's alternative argument that if the fellowship programs are not approved, then the Provider should be reimbursed on a reasonable cost basis under Medicare Part B for the services furnished by the fellows in unapproved programs under 42 C.F.R. §415.202.[8] The conditions included the hospital was not billing for the residents services and the Provider supply the documentation needed to complete Worksheet D-2.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds and concludes that the Intermediary's exclusion of FTEs attributable to rotations by residents in unaccredited training programs was proper.

42 C.F.R. §413.86(b) and 42 C.F.R. §412.105(f)(1)(i) both contain the broad term "may count towards certification" in describing an approved teaching program. The Board finds inherent in the broadly worded regulations the requirement of proof that the training program would count toward certification. The Board agrees that the regulation does not require a resident to obtain certification as a prerequisite to count the unaccredited training, but that does not exempt the

[7] Tr. 185-187.
[8] Tr. page 194, line 16.

Provider from having to document that the training would indeed count toward certification. Absent evidence of acceptance from the certifying body, the Provider would have to furnish alternative documentation to support its assertion that the training could be counted toward certification.

The Board finds that the Provider has not met the burden of proof to show that its training programs in dispute would or could be counted toward certification. Without evidence to demonstrate even one case in which the unaccredited training was used toward obtaining certification by a certifying body, the Provider has failed to persuade the Board that these programs would in fact count toward a certification.

The Board also notes that the Provider's fellowship programs do meet the requirements of a non-approved educational program under 42 C.F.R. §415.202. As such, the costs incurred (salary and salary-related fringe benefits) are allowable. The Provider is to submit the necessary documentation to the Intermediary to support those costs including a completed Worksheet D-2. The Board remands this issue to the Intermediary to review the Provider's claimed cost under this regulatory provision.

Issue#2 - IME FTEs attributable to time spent by residents in research that was required by the residents' approved medical residency programs

PROVIDER'S CONTENTIONS:

The Provider contends that the time residents spend performing research activities as part of an approved residency program should be included in the IME FTE calculation based upon the pertinent statute and controlling regulation. While 42 U.S.C. §1395ww(d)(5)(B) provides specific instructions for calculating the IME adjustment, it does not exclude time spent by residents performing research activities. The regulation at 42 C.F.R. §412.105(f) provides more specific rules for counting FTE residents for IME. These rules require that residents who worked in non-hospital settings be engaged in patient care activities in order to be included in the IME FTE resident count. The Provider further argues that in analogous cases, both the Board[9] and the courts[10] have concluded that IME research time is properly included in the IME FTE calculation.

The Provider also contends that the August 1, 2001 amendment to the IME regulation cannot be viewed as a clarification of existing policy since it establishes new recordkeeping requirements; i.e., time spent by residents performing patient and non-patient care activities while assigned to a research rotation. This amendment cannot be applied to the eight cost reporting periods included in this appeal because retroactive rule making is prohibited.

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[9] University Medical Center (Tucson, Ariz.) vs. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Arizona, PRRB Dec. No. 2005-D36, April 11, 2005.

[10] Riverside Methodist Hospital v. Thompson, No. C2-02-94 (S.D. Ohio, July 31, 2003) (Exhibit P-9); University Medical Center Corp. v. Leavitt, 2007 WL 891195 (D.Ariz. March 21, 2007) (Exhibit P-52); see also H. Rep. No. 98-25, reprinted in 1983 U.S.C.C.A.N. 219 (Exhibit P-44).

INTERMEDIARY'S CONTENTIONS:
The Intermediary contends that time spent by residents performing research activities that are not directly related to the care of patients is excluded from the resident count. In the instant case, only resident rotations specifically titled "research" were excluded from the Provider's IME FTE count, and the Provider submitted no documentation to show that the time was, in fact, patient-care related. The Intermediary cites section 2405.3.F.2 of the Provider Reimbursement Manual, which states that a resident must not be included in the IME count if "[t]he individual is engaged exclusively in research", and 66 Federal Register 39823, 39896, August 1, 2001, where CMS explains that resident time spent "exclusively" in research means that the research is not associated with the treatment or diagnosis of a particular patient of the hospital. The Intermediary also cites 42 C.F.R. §412.105(f)(1)(iii)(B), amended through the August 1, 2001, Federal Register, which CMS notes as a clarification of long-standing policy. The section states that, "[t]he time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable."

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:
After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Boards finds and concludes that the Intermediary's removal of IME FTEs related to a research rotation was improper.

The Board addressed this issue in University of Chicago Hospitals and Clinics v. Blue Cross Blue Shield Association/ United Government Services, PRRB Dec. No. 2007-D57, Aug. 8, 2007 and University Medical Center (Tucson, Ariz.) vs. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Arizona, PRRB Dec. No. 2005-D36, April 11, 2005. In those cases the Board found that the regulation in effect during the subject cost reporting periods did not exclude research time from the IME FTE resident count, nor did it require resident time to be related to patient care. In pertinent part, the regulation states:

> (1) . . . the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:
>
> (i) The resident must be enrolled in an approved teaching program. . . .
>
> (ii) In order to be counted, the resident must be assigned to one of the following areas:
>
> (A) The portion of the hospital subject to the prospective payment system.
>
> (B) The outpatient department of the hospital.
>
> (C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting. . . .

It is undisputed that the residents at issue in this case were enrolled in an approved GME program and that they worked in either the portion of the Provider's facility subject to PPS or an outpatient area. Consequently, the Intermediary's adjustment removing them from the count was improper.

The Board notes that its finding is consistent with the court's decision in *Riverside Methodist Hospital v. Thompson*. In part, the court concluded that "the [IME] regulation as it was written at the time in question, does not by its plain language contain any requirement that the time spent by residents had to be spent in direct patient care in order to be counted." The Board also notes that both its findings and those of the court in Riverside were affirmed by the court in University Medical Center Corp. v. Leavitt.[11] There, the court concluded:

> The [pre-2001] regulation is not ambiguous, and when considered in context with the historical intent of both the regulation and its governing statute, it is evident that all time spent by residents in research and other scholarly activities while they are "assigned to" the Hospital must be included when determining the Hospital's resident count for purposes of calculating the IME payment.

Additionally, the Board finds that the 2001 amendment to the IME rule excluding non-patient care research time from the resident count represents a change in policy that cannot be applied retroactively to the cost reporting periods in issue. As the court in *Riverside* explained, the IME regulation is clear, in that the time spent by residents performing non-patient care related activities is not excluded from the resident count, and "if the Secretary desires to include a new requirement regarding excludable time, it must be done by amendment, and in compliance with the necessary administrative procedures for amending regulations."[12]

Issue #3 - FTEs attributable to resident leave time when it is taken during rotations in which the resident is conducting research

PROVIDER'S CONTENTIONS:

The Provider included leave time in its calculation of resident FTEs for purposes of both DGME and IME. The Intermediary disallowed paid leave that residents used while in research rotations. This leave was not made up by the residents and it did not extend the residents' training programs. The Provider argues that CMS' general approach to leave time is that leave time (for such items as vacation) should be reflected in the FTE counts for purposes of DGME and IME payments, as long as the leave time is a part of the general overhead associated with an employee's compensation, and the resident is not required to make up the approved leave. In this case, the Intermediary has not followed its general approach, and has removed the leave time from the IME FTE count, because the leave time was taken during a research rotation which the Intermediary has also deemed should not be included in the IME FTE count.

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[11] See, University Medical Corp, pg. 9.
[12] See, Riverside, pg. 9.

The Provider argues that the Intermediary's disallowance of leave time used by residents is contrary to Medicare rules governing DGME and IME payment adjustments and leads to inequitable reimbursement for medical education. As longstanding CMS policy is to include paid leave time, the Intermediary should include all leave time in the Provider's DGME and IME counts regardless of the rotation the resident was involved in when they used their leave. Even assuming however, that FTEs in research rotations should not be included in the IME FTE count, the Provider argues that any leave time that the resident took during the rotation should be counted based on the premise that when the resident is on leave, he or she is not conducting research.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that time spent by residents performing research activities that are not directly related to the care of patients is excluded from the resident count; therefore any paid leave taken during the research rotation should be treated the same and excluded from the count.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds and concludes that the Intermediary's removal of the vacation time associated with a research rotation was improper. The Board finds that for the same reasons that resident FTEs in research rotations should be included in the IME FTE count, so also should the residents' leave time taken during a research rotation be included.

Issue #4 – Exclusion of FTEs attributable to time spent in new programs from the FTE cap

PROVIDER'S CONTENTIONS:

CMS regulations at 42 C.F.R. §413.86(g) and 42 C.F.R. §412.105(f)(1)(vii) unambiguously permit a provider to add FTEs to its cap for new medical residency training programs that receive initial accreditation between January 1, 1995 and August 5, 1997. On March 9, 1995, the Provider received accreditation for its Vascular and Interventional Radiology training program. On July 1, 1996, the Provider's program in Clinical Neurophysiology received accreditation. The Provider asserts that although it is undisputed that the initial accreditation date of these programs falls within the allowable time period, the Intermediary incorrectly interprets language in the Federal Register preamble to continue to deny the adjustment to the cap. The Provider argues that the Intermediary's interpretation provides a distinction between being a "new" program and an "established" program which is not in the regulation and has denied the adjustment to the cap because the program was "established" prior to the January 1, 1995 date.

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that although the Provider's Vascular and Interventional Radiology training program and its Clinical Neurophysiology training program did not receive accreditation until after January 1, 1995, the programs were established prior to January 1, 1995, and therefore, are not eligible for an adjustment to the cap. The Intermediary testified at hearing that

the process to obtain an adjustment to the cap is two-fold. First, the program must be determined to meet the criteria of a "new" program, and once that is determined, the criteria listed under 42 C.F.R. §§413.86(g)(6)(i) and 413.86(g)(6)(ii) are applied to determine if the new program qualifies for an adjustment to the FTE cap.[13] Therefore, although the programs were certified on or after January 1, 1995, and meet the criteria for a "new" program, since they were established or in existence before that date, they do not qualify for an adjustment to the cap. The Intermediary also argues in its post-hearing brief that the FTEs in question were included in the 1996 FTE cap; therefore, no additional adjustment to include the FTEs in the cap is necessary.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds and concludes that the Intermediary improperly excluded FTEs attributable to time spent in new programs from the FTE cap.

The Provider has clearly demonstrated that the programs at issue were accredited between January 1, 1995 and August 5, 1997. The regulatory language at 42 C.F.R. 413.86(g) clearly defines what constitutes a "new" program, as a program that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995. The Intermediary's interpretation of the regulation requiring a "two-fold" determination is without merit as the plain language of the regulation is clear.

The Board also finds that although the Intermediary did allow some FTEs from these programs in the 1996 FTE cap, other allowable FTEs were not included in the count. Therefore, the portion of the FTEs not already included in the 1996 FTE count should be added.

DECISION AND ORDER:

Issue #1 - FTEs attributable to rotations by residents in certain unaccredited training programs

The Intermediary's adjustments excluding FTEs attributable to rotations by residents in certain unaccredited training programs were proper. Further, this issue is remanded to the Intermediary to determine the accuracy of claimed costs under 42 C.F.R. §415.202. The Intermediary's adjustments are modified.

Issue #2 - IME FTEs attributable to time spent by residents in research that was required by the residents' approved medical residency programs

The Intermediary's adjustments reducing the Provider's IME FTE resident count for the time spent by residents in research that was required by the residents' approved medical residency program were improper. The issue is remanded to the Intermediary to recalculate the IME adjustment to incorporate the time spent by residents in research activities that were part of their approved medical residency training program.

[13] Tr. 201-204.

Issue #3 - FTEs attributable to resident leave time when it is taken during rotations in which the resident is conducting research

The Intermediary's adjustments reducing the Provider's IME FTE resident count for resident leave time taken by residents when in a research rotation was improper. The issue is remanded to the Intermediary to recalculate the IME adjustment to incorporate the leave taken by residents when in a research rotation.

Issue #4 – Exclusion of FTEs attributable to time spent in new programs from the FTE cap

The Intermediary improperly excluded FTEs attributable to time spent in new programs from the FTE cap. The issue is remanded to the Intermediary to include all FTEs attributable to time spent in new programs in the 1996 FTE cap.

BOARD MEMBERS PARTICIPATING

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 12, 2008