PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D25

PROVIDER –
Bergen Regional Medical Center
Paramus, NJ

Provider No.: 31-0058

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Novitas Solutions, Inc.

Cost Reporting Periods Ended -
December 31, 2005; December 31, 2006;
December 31, 2007; December 31, 2008;
December 31, 2009

CASE NOs.: 10-1237; 10-1236; 10-1235;
12-0034; 12-0033
(respectively)

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ISSUE:

Whether the Provider Reimbursement Review Board ("Board") has jurisdiction over the calculation of the Provider's 1996 Indirect Medical Education ("IME") Cap Reduction for the redistribution of unused residency slots.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due to a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended (Act), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. 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 to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulations, and interpretive guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs to be allocated to Medicare.[3] Each 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").[4]

A provider dissatisfied with the intermediary's final determination of total reimbursement (*i.e.*, the NPR) may file an appeal with the Board provided it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of receipt of the final determination.[5]

Since the inception of the Medicare program, Congress has authorized payment to hospitals for the direct cost of training physicians and that payment is referred to as Direct Graduate Medical Education ("DGME"). As part of the Social Security Amendments of 1983 ("SSA-1983"),[6] Congress established the prospective payment system for hospital inpatient operating costs ("IPPS") and recognized that teaching hospitals incur indirect operating costs that would not be reimbursed under the IPPS or the DGME payment methodology.[7] Specifically, § 601(e) of

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[3] *See* 42 C.F.R. § 413.20.
[4] *See* 42 C.F.R. § 405.1803.
[5] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1839.
[6] Pub. L. No. 98-21, 97 Stat. 65 (1983).
[7] *See* SSA-1983 § 601(e), 97 Stat. at 152- 162 (codified at 42 U.S.C. § 1395ww(d)).

SSA-1983 established, in pertinent part, 42 U.S.C. § 1395ww(d)(5)(B) to authorize an additional payment known as the Indirect Medical Education ("IME") payment to hospitals with GME programs. The IME payment compensates teaching hospitals for higher-than-average operating costs, which are associated with the presence and intensity of residents' training in an institution but which neither includes nor can be specifically attributed to the cost of residents' instruction.

Subsequently, as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Congress clarified that the IME adjustment attempts to measure teaching intensity based on "the ratio of the hospital's full-time equivalent interns and residents to beds."[8] Thus, the IME adjustment payment amount is based, in part, upon the number of intern and resident full-time equivalent ("FTE") interns participating in a provider's GME Program.

Further, as part of the Balanced Budget Act of 1997 ("BBA"),[9] Congress established a cap on the number of allopathic and osteopathic residents that a hospital could count for purposes of calculating the IME adjustment and DGME payments. Specifically, BBA §§ 4621(b)(1) and 4623 provided that, for purposes of IME and DGME respectively, a hospital's total number of FTE residents in the fields of allopathic and osteopathic medicine in a hospital or nonhospital setting could not exceed the number of FTE residents with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.[10] These sections also specified that, for the IME adjustment, the FTE resident cap applies to discharges occurring on or after October 1, 1997 and, for DGME payments, the FTE resident cap applies to cost reporting periods beginning on or after October 1, 1997.[11] Furthermore, these BBA provisions provided the Secretary with rulemaking authority to implement the 1996 DGME and IME FTE resident caps.

In addition to capping resident FTEs for IME and DGME, the Medicare program also removes unused resident slots from the IME and/or DGME FTE resident caps for certain providers and redistributes these FTEs to other providers seeking to expand their intern programs. Effective for cost reporting periods occurring on or after July 1, 2005, § 422 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)[12] directed CMS to remove 75% of the unused resident slots from the DGME/IME FTE caps of hospitals that were below their 1996 FTE resident caps in a specific period. Those unused resident slots were subsequently redistributed to qualifying hospitals that submitted timely applications for an increase to their 1996 FTE resident cap. Administrative or judicial review of this redistribution of unused resident positions is statutorily prohibited.[13]

MMA § 422 directs CMS to use a hospital's most recent cost reporting period ending on or before September 30, 2002, for which a cost report was settled, to determine whether a hospital's

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[8] COBRA § 9104(a), Pub. L. No. 99-272, 100 Stat. 82, 157 (codified at 42 U.S.C. § 1395ww(d)(5)(B)(ii)).
[9] Pub. L. No. 105-33, 111 Stat. 251 (1997)
[10] Codified at 42 U.S.C. § 1395ww(h)(4)(F)-(H).
[11] Codified at 42 U.S.C. §§ 1395ww(d)(5)(B)(v)-(viii).
[12] MMA § 422, Pub. L. No. 108-173, 117 Stat. 2066, 2284-2287 (2003).
[13] MMA § 422(a)(3) (as codified at 42 U.S.C. §1395ww(h)(7)(D) and later redesignated as 42 U.S.C. §1395ww(h)(7)(E) pursuant to Consolidated Appropriations Act, 2008 § 225(b)(1)(A), Pub. L. No. 110-161, 121 Stat. 1844, 2189 (2008)). √

1996 FTE resident cap should be reduced.[14] Hospitals were permitted to request the utilization of a cost report that included July 1, 2003, if its most recent settled cost report did not reflect the expansion of its existing medical residency training program.[15] To implement MMA § 422, CMS issued instructions in several Transmittals for One-Time Notification, CMS Pub. No. 100-20 ("OTN").[16] These OTN Transmittals specified that , if a hospital submitted a timely request to utilize a cost report which included July 1, 2003, the resident level for the hospital was counted as the unweighted allopathic and osteopathic FTE residents for that requested cost reporting period.[17] The FTE count used for the purpose of determining the MMA § 422 reduction of the 1996 FTE resident cap was subject to potential audit by the intermediary.[18]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Bergen Regional Medical Center ("Bergen" or "Provider") is a 100-bed acute care teaching hospital located in Paramus, New Jersey. Bergen operates a Psychiatric Residency program, wherein residents receive training in its Sub-Provider Psychiatric Unit and in its outpatient departments.

The Provider's fiscal year ends on December 31st. The Intermediary issued NPRs for the fiscal years (FYs) 2005 to 2009 and these NPRs implemented IME FTE resident cap reductions that were calculated subject to MMA § 422 utilizing the IME FTEs reported on the Provider's cost report for FY 2003. The Provider timely filed with the Board five individual appeal requests regarding its FYs 2005, 2006, 2007, 2008 and 2009 with each appeal containing the following issue: Whether the Intermediary's calculation of the Provider's allowable Intern and Resident Full Time Equivalents ("FTEs") for IME was proper. More specifically, the Provider is challenging the calculation of its 1996 IME FTE resident cap reduction for the redistribution of unused residency slots as applied to the five individual FYs at issue. The following table reflects the date of issuance and the case number for each of the NPRs at issue in this matter:

FY Covered by NPR	Date NPR Issued	PRRB Case No.
2005	April 22, 2010	10-1237
2006	May 10, 2010	10-1236
2007	June 8, 2010	10-1235
2008	October 13, 2011	12-0034
2009	June 16, 2011	12-0033

The Intermediary filed jurisdictional challenges in Case Nos. 10-1235, 10-1236, and 10-1237 on August 26, 2011, and in Case Nos. 12-0033 and 12-0034 on May 21, 2012. The Intermediary alleges the Board does not have jurisdiction to hear the Provider's challenge to the IME FTE cap reduction as rolled forward and applied to each FY at issue. The Provider filed consolidated

[14] *Id.* (as codified at 42 U.S.C. §1395ww(h)(7)(A)(i)).
[15] *Id.* (as codified at 42 U.S.C. §1395ww(h)(7)(A)(ii)).
[16] *See, e.g.*, OTN, Change Request 3247, Transmittals 77 (April 30, 2004) and 87 (May 26, 2004).
[17] *See id.*
[18] *Id.*

responses to the Intermediary's jurisdictional challenge in Case Nos. 10-1235, 10-1236, and 10-1237 on September 22, 2011, and in Case Nos. 12-0033 and 12-0034 on June 1, 2012.

INTERMEDIARY'S CONTENTIONS

The Intermediary contends that the Board does not have jurisdiction over the issue the Provider is appealing as Congress specifically barred appeals of the final cap redistribution determinations. The issue under appeal is the calculation of the Intern and Resident FTEs for IME that resulted from the implementation of MMA § 422 entitled "Redistribution of Unused Residency Positions." The Intermediary asserts that CMS issued several OTN Transmittals which outlined the procedures for submitting information for and reviewing cost report information pertaining to the redistribution of residents. OTN Transmittal 87 stated that a hospital's most recent cost reporting period ending on or before September 30, 2002 was to be used to determine whether the 1996 DGME or IME FTE resident cap, or both, should be reduced unless a provider submitted a request to utilize the cost report that included July 1, 2003. The Intermediary states that the Provider timely requested its FY 2003 as-filed cost report be used to compute the MMA § 422 redistribution of unused residency positions. On the 2003 cost report, the Intermediary states that the Provider reported 25.67 unweighted FTE's for DGME and zero FTEs for IME.[19]

The Intermediary refers to OTN Transmittal 92 dated July 2, 2004[20] which provided additional instructions to FI/MACs regarding the review and the redistribution of unused resident positions under to MMA § 422. Pursuant to this transmittal, FI/MACs were to complete FTE redistribution audits of cost reporting periods that included July 1, 2003 by April 15, 2005, allowing providers two weeks to supply information and five days to review and comment on proposed adjustments. This transmittal also required the FI/MACs to utilize a CMS-prescribed audit program to review and verify the FTE counts for the purposes of the redistribution. As part of this audit program, CMS included the following "General Instructions" to intermediaries:

> Request documentation from the provider to support the residents claimed on their cost report. However, the evidence necessary for the resident caps may be of a lesser degree than the evidence normally required for a payment audit.[21]

The Intermediary reviewed the Provider's reported unweighted GME and IME FTE counts pursuant to this audit program using the FTE residents as submitted on the Provider's FY 2003 cost report.[22] The Intermediary notified the Provider by letter dated May 2, 2005 of the reductions to the 1996 DGME and IME FTE resident caps, requesting the Provider contact them within ten business days if they believed there was an error in the computation and notifying the

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[19] Intermediary's Jurisdictional Challenge at 3

[20] Change Request 3353.

[21] *See* Direct Graduate medical Education (DGME and Indirect medical Education (IME) Resident Cap Audit Program for Cost Reports That Contain July 1, 2003 (copy available at MAC/BCBSA Preliminary Position Paper, Exhibit I-6, Page 1, GENERAL INSRUCTIONS, 2nd¶)

[22] Intermediary's Jurisdictional Challenge at 2-3.

Provider that 42 U.S.C. § 1395ww(h)(7) precluded administrative or judicial review with respect to the determination.[23] The Provider did not contact the Intermediary regarding any errors in the reported resident FTEs as required.[24]

The Intermediary asserts that MMA § 422 specifically precludes any administrative or judicial review of the redistribution of residents, and that this point was reiterated in OTN Transmittal 92. Therefore, the Provider's challenge to the reduced 1996 IME FTE resident cap from the NPRs is outside the Board's jurisdiction.[25]

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary incorrectly calculated the reduction in its 1996 IME FTE resident cap resulting in a new understated 12 month IME FTE resident cap on the five cost reports at issue. The Provider does not dispute that it requested its FY 2003 as-filed cost report be used to compute the MMA § 422 redistribution of unused residency positions. However, the Provider asserts the Intermediary failed to audit and verify the reported 2003 allowable IME FTE resident count on the Provider's FY 2003 as-filed cost report via a regular audit, prior to calculating the 1996 IME FTE resident cap reduction and the 2005/2006/2007/2008/2009 IME prorated FTE resident caps for the redistribution of unused residency slots. The Provider states that 42 C.F.R. § 412.105(f)(iv)(B)(3) and OTN Transmittal 92 required the Intermediary to audit and verify the reported 2003 allowable IME FTE resident count on the Provider's cost report and the Intermediary failed to do so. The Provider claims that they reported "zero" allowable IME FTE's on the FY 2003 cost report as a result of the Intermediary's improper exclusion of Psychiatric Resident FTEs from its cost reports for FYs 2001 and 2002.[26]

The Provider states that, subsequent to the MMA § 422 audits, the Intermediary audited the FY 2003 cost report and proposed an audit adjustment to increase allowable IME FTEs from zero to 13.98. The Provider argues that the Intermediary failed to make similar audit adjustments for allowable Psychiatric FTEs for the FY 1999 through FY 2002 cost reports, and that this led the Provider to believe that these Psychiatric FTEs were not allowable. The Provider asserts that the Intermediary is required to make both positive and negative adjustments to properly state the reimbursement to a provider, and that it relied on the expertise and instructions of the Intermediary. Even though the Provider reported "zero" FTEs regarding it 2003 allowable IME FTEs, the Provider claims the Intermediary should have audited the count for the FTE resident cap reduction through a special DGME/IME audit and made the increase to the FTEs at that time.[27] The Provider claims they are not challenging MMA § 422 per se, but the underlying procedural errors that the Intermediary made in performing the MMA § 422 audit. Therefore, the Provider argues that the Board does have jurisdiction to correct the Intermediary's procedural error.[28]

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[23] *Id* at Exhibit I-3.
[24] Intermediary's Jurisdictional Challenge at 3-4.
[25] *Id* at 4-5.
[26] Provider's Jurisdictional Challenge Response at 2-5.
[27] *Id.*
[28] *See id*, at 5-6.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

MMA § 422(a)(3) provides for a reduction in the 1996 DGME and IME FTE resident caps for certain hospitals, and a "redistribution" of the FTE slots resulting from the reduction to other hospitals that can demonstrate a need for the additional slots. This provision was effective for portions of cost reporting periods beginning on or after July 1, 2005. This section also specifies that "[t]here shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise, with respect to determinations made under this paragraph."[29] As 42 U.S.C. § 1395oo governs hearings before the Board, Board review of the redistribution of residency slots under the MMA is expressly prohibited.

In the preamble to the final rule published on August 11, 2004, CMS gave the following response to a comment urging CMS to establish an external appeal mechanism:

> [W]e believe the fact that Congress included the language at 1886(h)(7)(D) of the Act [*i.e.*, 42 U.S.C. § 1395ww(h)(7)(D)] stating that "There shall be no administrative or judicial review * * * with respect to determinations made under this paragraph," clearly means that the Congress did intend for the determination of the fiscal intermediary with regard to FTE resident cap reductions to be final, without any external appeal mechanism. Because of this statutory language, together with the requirement that all reductions and increases in FTE resident caps be made effective July 1, 2005, we do not believe it is appropriate to allow hospitals (or CMS) to appeal determinations concerning the FTE cap reductions (or the FTE cap increases, for that matter) under section 1886(h)(7) of the Act. . . . Furthermore, we note that, as with any audit and cost report settlement process, the fiscal intermediaries will provide the hospitals with an opportunity to review and respond to the audit adjustments before they are finalized.[30]

In this case, the Intermediary did offer the Provider an opportunity to review and respond to the audit adjustments prior to the finalization of the resident redistribution, and the Provider has admitted that it failed to respond.[31]

The Provider also failed to directly respond to the Intermediary's contentions that Congress specifically barred appeals of the redistribution of residents. The Provider's only argument for jurisdiction was an attempt to characterize their dissatisfaction as a material procedural error on the part of the Intermediary instead of as a challenge to the reduction of the Provider's 1996 FTE resident cap. Regardless of whether the result of the MMA § 422 audits may be understated, the

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[29] *See supra* note 17.
[30] 69 Fed. Reg. 48916, 49119 (Aug. 11, 2004).
[31] *See* Provider's Jurisdictional Challenge Response at 5.

Board cannot rule on the substantive accuracy of the Provider's 1996 IME FTE resident cap, if it does not have the jurisdiction to do so.

The Board finds that the issue in dispute is in fact the accuracy of the MMA § 422 reduction of the Providers' 1996 IME FTE resident cap, and the Board is expressly prohibited by statute from hearing appeals of determinations concerning the redistribution of 1996 FTE resident cap amounts. The only recourse the Provider had relating to the IME FTE resident cap reduction determination was to notify their Intermediary of their dissatisfaction within the ten day window as described in the FTE cap reduction notification sent to the Provider.[32] The Board finds that, pursuant to MMA § 422(a)(3), it does not have jurisdiction over the Intermediary's calculation of the 1996 IME FTE cap reduction on the Provider's cost reports for FYs 2005, 2006, 2007, 2008 and 2009.

DECISION AND ORDER:

The Board finds it does not have jurisdiction over the calculation of the 1996 IME FTE resident cap reduction for the redistribution of unused residency slots as applied in the Provider's five cost reports at issue. As this is the only issue in Case Nos. 10-1235, 10-1236, 10-1237, 12-0033 and 12-0034, the Board hereby dismisses these appeals.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: SEP 25 2012

[32] A copy of the FTE cap reduction notification is included in Exhibit 3 of the Intermediary's Jurisdictional Challenge.