PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2016-D14

PROVIDER –
Integris/Deaconess 2005 Non-Provider Setting IME/GME CIRP Group
Oklahoma City, Oklahoma

Provider Nos.: Various
(See Appendix A)

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

DATE OF RECORD HEARING -
July 9, 2015

Cost Reporting Periods Ended –
Various (See Appendix A)

CASE NO.: 07-1992GC

INDEX

ISSUE:

Was the Medicare Contractor's exclusion of all of the family practice interns and residents for each of the Hospitals from their respective full time equivalent ("FTE") counts and the Medicare Contractor's denial of the associated indirect medical education ("IME") and graduate medical education ("GME") reimbursement for residents that rotated through a joint venture non-hospital family practice clinic correct?[1]

DECISION:

After considering the Medicare law and program instructions, the evidence presented, and the Hospitals' contentions, the Board finds that the Medicare Contractor properly adjusted the Hospitals' FY 2005 IME and GME payments for family practice interns and residents rotating to the nonhospital family practice clinic.

INTRODUCTION:

Integris Baptist Medical Center ("Integris") and Deaconess Hospital ("Deaconess") are short-term acute care hospitals located in Oklahoma City, Oklahoma. The Medicare contractor[2] during the time at issue was Chisholm Administrative Services and the one currently assigned to Integris and Deaconess is Novitas Solutions Inc. (collectively referred to as the "Medicare Contractor").[3] Integris and Deaconess appealed the Medicare Contractor's refusal to reimburse them for the GME/IME costs of the family medicine training program at a non-hospital site.

STATEMENT OF FACTS:

Integris and Deaconess (collectively the "Hospitals" or "Providers") entered into an agreement with Great Plains Medical Foundation ("Great Plains") to establish a family practice graduate medical education program. As part of this program, interns and residents rotate through a non-hospital setting, Great Plains family practice clinic ("FPC"). The Hospitals each paid an equal amount for the training program to Great Plains[4] and each Hospital claimed GME and IME reimbursement for half of the Great Plains FPC residents on its FY 2005 cost report.[5]

The Medicare Contractor reduced the Hospitals' reimbursement for GME and IME for FY 2005 on the holding that neither Integris nor Deaconess paid "all or substantially all" of the costs of the Great Plains FPC training program.

The Hospitals timely appealed the Medicare Contractor's final determination to the Provider Reimbursement Review Board ("Board") and met the jurisdictional requirements for a hearing.

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[1] *See* Provider's Final Position Paper at 1.
[2] Fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs") will be referred to as Medicare contractors.
[3] In 2007, CMS designated TrailBlazer Health Enterprises ("TrailBlazer") as the Medicare Contractor for Oklahoma and was designated as the lead Medicare contractor for this appeal. TrailBlazer was later replaced by Novitas Solutions, Inc. *See* Provider's Final Position Paper at 2.
[4] *See* Provider Final Position Paper at 3.
[5] *See id.*

The Hospitals were represented by Joanne B. Erde, P.A. of Duane Morris, LLP. The Medicare Contractor was represented by Robin Sanders, Esq. of the Blue Cross and Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Hospitals essentially present three different arguments in support of their appeal. First, they assert that they complied with the regulatory requirements to be reimbursed for GME/IME costs and that the Medicare Contractor improperly reduced this reimbursement.[6] The Hospitals argue that the applicable statutory and regulatory provisions[7] allow Medicare reimbursement for resident and intern time spent in an approved nonhospital medical residency training program if the following conditions are met:

1) The resident/intern spends his or her time in patient care activities;
2) The hospital incurs all or substantially all of the costs for the training program in that setting; and
3) *Either* the hospital pays all or substantially all of the costs of the training program in a nonhospital setting within three months of the period during which the training occurred, *or* there is a written agreement between the hospital and nonhospital setting that states that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is in training at 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.

The Hospitals contend that all of the time claimed at Great Plains FPC was spent providing direct patient care activities and the hospitals paid "all or substantially all of the costs for the training program." The Medicare Contractor had allowed the FTEs for the Great Plains' residency programs in all years prior to FY 2005. Whether or not a written agreement was required pursuant to subsection (3) of 42 C.F.R. § 413.78(e) is not at issue in this case.

Second, the Hospitals assert that the Medicare Contractor failed to apply § 713(a) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA")[8] in which Congress imposed a moratorium on excluding family practice interns and residents from FTE counts at non-hospital settings for a 1-year period beginning January 1, 2004.[9] Specifically, § 713(a) states:

> (a) MORATORIUM ON CHANGES IN TREATMENT. - During the 1-year period beginning on January 1, 2004, for purposes of applying subsections (d)(5)(B) and (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), the Secretary shall allow all hospitals to count residents in osteopathic and allopathic family practice programs in existence as of January 1, 2002, who are training at non-

[6] *See id.* at 14.
[7] 42 U.S.C. §§ 1395ww(h)(4)(E), 1395ww(d)(5)(B)(iv); 42 C.F.R. § 413.78(e).
[8] P.L.108-173, 117 Stat 2066, 2340-41.
[9] *See* Provider's Final Position Paper at 15.

> hospital sites, *without regard to the financial arrangement* between the hospital and the teaching physician practicing in the non-hospital site to which the resident has been assigned.[10]

Finally, the Hospitals assert that Congress' later actions in in § 5504 of the Patient Protection and Affordable Care Act of 2010 ("ACA")[11] further supports their positions. This ACA section allows a hospital in certain situations to count a proportional share of the costs of training in a nonhospital setting as determined by a written agreement between the hospitals.[12] Based on the precise language in the statute, the Hospitals argue that the Medicare Contractor should reopen the FY 2005 cost reports and reverse the GME/IME adjustments because the Hospitals had a "jurisdictionally proper appeal pending as of the date of the enactment of this Act" as specified in ACA § 5504(c).[13] The Hospitals assert that CMS' interpretation that ACA § 5504 has a stated effective date of July 1, 2010 and, therefore, cannot apply to any prior periods[14] is contrary to the plain reading of ACA § 5504(c).

Set forth below is the Board's findings with respect to each of these arguments.

FINDINGS RELATING TO THE REQUIREMENT FOR PAYMENT OF ALL OR SUBSTANTIALLY ALL OF THE NON-HOSPITAL FAMILY MEDICINE PROGRAM COSTS

The Board disagrees with the Hospitals' position that they met all of the Medicare statutory and regulatory requirements for Medicare coverage of its GME/IME costs for interns and residents rotating to nonhospital clinics. For GME/IME reimbursement purposes, 42 U.S.C. §§ 1395ww(h)(4)(E) and 1395ww(d)(5)(B)(iv) entitle a hospital to count the time its residents spend in patient care activities in non-hospital settings, if "the hospital incurs all, or substantially all, of the costs *for the training program* in that [nonhospital] setting."[15] During FY 2005, federal regulations located at 42 C.F.R. § 413.75(b) defined the term "all or substantially all of the costs for the training program in the nonhospital setting" to mean "the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education (GME)."

In this case, there is insufficient evidence to demonstrate that either Integris or Deaconess paid "all or substantially all of the costs for the [entire] training program" in the Great Plains FPC (*i.e.*, the nonhospital setting). The Hospitals each claimed only half of the family practice FTEs

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[10] (Emphasis added.)
[11] Pub. L. 111-148, 124 Stat. 119, 559-660 (Mar. 23, 2010). The Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub L. 111-152, 124 Stat. 1029 (Mar. 30, 2010) amended certain ACA provisions; however, HCERA is not relevant to this case as it did not amend ACA §5504.
[12] *See* ACA § 5504 (amending 42 U.S.C. § 1395ww(h)(4)(E)(ii) for GME and 42 U.S.C. § 1395ww(d)(5)(B)(iv)(II) for IME).
[13] *See* Provider's Final Position Paper at 20 (discussing and quoting ACA § 5504(c)).
[14] 75 Fed. Reg. 71800, 72136 (Nov. 24, 2010). CMS further explained its interpretation in a clarification in 79 Fed. Reg. 49854, 50118 (Aug. 22, 2014).
[15] (Emphasis added.)

and, therefore, neither of the Hospitals met the requirement that it incur "all or substantially all of the costs *for the training program*."[16]

In support of its finding, the Board references the CMS GME/IME reimbursement policy that specifies that the impact of Medicare payment for these costs "does not redistribute costs and community support" for these programs. Specifically, CMS maintains that, by funding GME and IME costs, "Congress intended hospitals to facilitate training in nonhospital sites that would not have occurred *without the hospital's sponsorship*"[17] and that, unless the hospital incurs all or substantially all of the costs for the training program, it is possible that the nonhospital site could simply shift the costs of training residents in nonhospital sites that were previously funded from other community sources to the Medicare program.[18] To that end, 42 C.F.R. § 413.78(e)(2) (2005)[19] specifies that a hospital cannot count the time residents spend in nonhospital settings, such as clinics, in its GME/IME FTE count, unless "*the hospital* . . . incur[s] all or substantially all of the costs *for the training program* in the nonhospital setting."[20] In this case, the Hospitals admit that Great Plains Foundation incurs the full costs of the medical education program at the Great Plains FPC. The Hospitals make payments to Great Plains but neither has demonstrated that it pays "all or substantially all" of the cost of the entire training program. Payment of merely a proportional share of cost does not meet the full set of requirements mandated by 42 U.S.C. §§ 1395ww(h)(4)(E) and 1395ww(d)(5)(B)(iv) or 42 C.F.R. § 413.78(e)(2).

Recent case law supports the Board's finding that merely paying a pro-rata portion of a program cost is insufficient to meet the "all or substantially all" requirement in 42 C.F.R. § 413.78(e)(2). Specifically, in 2013, the District Court for the District of Columbia held in *Borgess v. Sebelius*[21] that, since Congress did not specifically speak to the issue of whether the "all or substantially all" language precluded the sharing of costs between two or more hospitals, it was a proper exercise of CMS' authority to interpret the statutory language in the restrictive manner it as prescribed. The Court further found that Secretary stated this interpretation as far back as 1998.[22]

Further, the Hospitals argue that the language of the statute regarding payment of all or substantially all of the costs of the training program is setting specific and relates only to the "medical residency training program that the hospital maintains and in which the residents participate. It does not refer to some separate and distinct program that may be in the non-hospital setting."[23] Even if the Board were to accept this argument, the Board still find that the Hospitals failed to meet the requirements of § 413.78(e)(2) because the Hospitals have failed to

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[16] (Emphasis added.)
[17] *See* 68 Fed. Reg. 45346, 45444 (Aug. 1, 2003) (emphasis added).
[18] *See id.*
[19] This regulation was originally codified at 42 C.F.R. § 413.86(f) and was redesignated as § 413.78(f) without substantive changes for cost reporting periods on or after October 1, 2004. *See* 69 Fed. Reg. 48916, 49111-49112, 49235-49236, 49254, 49258 (2004). 42 C.F.R. § 412.105(f)(1)(ii)(C) incorporates these GME requirements (as originally codified and later redesignated) into the IME requirements. *See id.* at 49244-49245.
[20] The Board further notes that 42 U.S.C. § 1395ww(d)(5)(B)(iv) similarly includes that condition that "*the hospital* incurs all, or substantially all, of the costs *for the training program* in that [nonhospital] setting." (Emphasis added.)
[21] 966 F. Supp. 2d 1 (D.D.C. 2013).
[22] *See Borgess* at 7 (citing language at 63 Fed.Reg. 40954, 40986 (July 31, 1998)).
[23] Provider's Final Position Paper at 6.

identify which of the residents participating in the Great Plains residency program are part of "the medical residency program that the hospital maintains" and, as a result, the payment of 50 percent of the Great Plains Foundation costs is not attributable to "their" residents. With respect to counting FTE's rotating to the Great Plains clinic, the evidence in the record does not attribute or identify individual residents as being specifically and entirely sponsored by either one or the other of the two joint venture hospitals forming the Great Plains Foundation, Integris or Deaconess, and who are the sole participants in this group appeal. Accordingly, the Board finds that this financial arrangement did not sufficiently comply with longstanding federal statute and regulation and that the Medicare Contractor's GME/IME adjustments for interns and residents rotating to nonhospital clinics were proper.

FINDINGS RELATING TO APPLICATION OF THE MMA MORATORIUM

The Board disagrees with the Providers' assertion that the MMA moratorium applies to the subject appeal. Section 713 of the MMA requires "all hospitals to count residents in osteopathic and allopathic family practice programs in existence as of January 1, 2002, who are training at non-hospital sites, without regard to the financial arrangement between *the hospital and the teaching physician* practicing in the non-hospital site to which the resident has been assigned."[24] The "financial arrangement" to which the MMA moratorium refers to defines the nature of the financial relationship between the hospital and the teaching physician at the nonhospital site, that is, whether the physician - hospital written agreement states that teaching physician is volunteering or being paid. The moratorium language does not directly address the entire cost of the residency program including overhead and payment of residents. Similarly, the moratorium does not modify the established requirements governing the nature of the financial relationship between the sponsoring hospital and the nonhospital clinic. The moratorium therefore, cannot be viewed as removing the "all or substantially all" requirement of 42 C.F.R. § 413.78(e)(2) which pertains to the universe of costs associated with the residency program and is at issue in the present case.

FINDINGS RELATING TO THE APPLICATION OF ACA § 5504

With respect to direct graduated medical education reimbursement (GME), ACA § 5504(a) amended 42 U.S.C. § 1395ww(h)(4)(E) to allow a hospital to count *all* the time that a resident trains at a nonhospital site so long as the hospital incurs both the costs of the residents' salaries and the associated fringe benefits for the time that the resident spends training at the nonhospital site. The ACA amendment removed both the language requiring hospitals to have a written agreement with the non-hospital setting and the requirement for the sponsoring hospital to incur the cost for supervisory teaching activities. ACA § 5504(b) made similar changes to 42 U.S.C. § 1395ww(d)(5)(iv) to apply these changes to indirect graduate medical (IME) reimbursement as well. Both §§ 5504(a) and (b) specify that they are effective prospectively for cost reporting periods or discharges on or after July 1, 2010.[25]

[24] (Emphasis added.)

[25] By its terms, ACA § 5504(a) pertaining to direct graduate medical reimbursement only was effective for cost reporting periods on or after July 1, 2010 and ACA § 5504(b) pertaining to indirect graduate medical reimbursement only was effective for discharges occurring on or after July 1, 2010.

With respect to the scope of implementation, ACA § 5504(c) addressed certain additional permissible and non-permissible applications of ACA §§ 5504(a) and (b) by stating the following:

> (c) The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).[26]

As part of the final rule published on November 24, 2010 (the "November 2010 Final Rule") CMS promulgated regulations at 42 C.F.R. §§ 413.78(g) and 412.105(f)(1)(ii)(E) to implement ACA § 5504.[27] In particular, 42 C.F.R. § 413.78(g)(6) echoes ACA § 5504(c) because it reads:

> The provisions of paragraph (g)(1)(ii), (g)(2), (g)(3), and (g)(5) of this section cannot be applied in a manner that would require the reopening of settled cost reports, *except* those cost reports on which there is a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.[28]

As part of the preamble to the final rule published on August 22, 2014 (the August 2014 Final Rule"), CMS included a section entitled "Clarification of Policies on Counting Resident Time in Nonprovider Settings Under Section 5504 of the Affordable Care Act."[29] In this section, CMS discussed at length the "longstanding substantive standard" which allowed hospitals to count FTE for residents training time if the one single hospital which sponsored the residency and then claimed GME and IME FTE's for the program also incurred all or substantially all of the costs for the training. CMS refers readers to final rules from 1998, 2003 and 2007.[30]

Regarding the retroactivity of newly granted latitude in claiming FTE's as per ACA §§ 5504(a) and (b), CMS stated: "The introductory regulatory language of 413.78(g) explicitly states that paragraph (g) governs only 'cost reporting periods beginning on or after July 1, 2010.' . . . [W]hereas earlier cost reporting periods are governed by other preceding paragraphs of 413.78."[31] Further, CMS explicitly clarified that retroactive application of the amendments was neither intended nor permitted to pending appeals before the Board:

> Accordingly, we believe that it is apparent that the provisions of sections 5504(a)(3) and (b)(2) of the Affordable Care Act are not

[26] ACA § 5504(c).
[27] 75 Fed. Reg. 71800, 72134 (Nov. 24, 2010).
[28] (Emphasis added).
[29] 79 Fed. Reg. 49854, 50117 (Aug. 22, 2014).
[30] *See id.* at 50117-50122.
[31] *Id.* at 50118.

> to be applied prior to July 1, 2010, irrespectively of whether a hospital may have had a jurisdictionally proper appeal pending as of March 23, 2010 on an IME or direct GME issue from a cost reporting period occurring prior to July 1, 2010.[32]

In summary, CMS explicitly and clearly maintains through its recent regulatory clarification at 42 C.F.R. § 413.78(g)[33] that the changes made in ACA §§ 5504(a) and (b) only apply prospectively beginning July 1, 2010 and do not apply to any appeals that were pending as of March 23, 2010 and had a GME or IME issue from a cost reporting period beginning prior to July 1, 2010.

The Board recognizes that its 2014 decision in *Eastern Maine Med. Ctr. v. Blue Cross Blue Shield Ass'n* ("*Eastern Maine*"),[34] conflicts with CMS' 2014 regulatory clarification of 42 C.F.R. § 413.78(g). However, the Board notes that CMS made the above regulatory clarification subsequent to the Board's decision in *Eastern Maine* and that, pursuant to 42 C.F.R. § 405.1867, the Board is bound by this regulatory clarification of 42 C.F.R. § 413.78(g)(6). Accordingly, consistent with this regulatory clarification, the Board concludes that ACA § 5504 is not applicable to the subject appeal because fiscal years at issue in this case began before July 1, 2010. This legal conclusion is consistent with the Board's more recent 2015 decision in *Lutheran Hospital of Fort Wayne Indiana v. WPS*[35] which relies on the 2015 decision of the U.S. Court of Appeals, Sixth Circuit in *Covenant Med. Ctr., Inc. v. Burwell* ("*Covenant*").[36] In *Covenant*, the Sixth Circuit upheld CMS' regulatory clarification precluding retroactive application of ACA § 5504 (a) and § 5504 (b) to fiscal years occurring prior to its issuance.[37]

DECISION AND ORDER:

After considering the Medicare law and program instructions, the evidence presented, and the Hospitals' contentions, the Board finds that the Medicare Contractor properly adjusted the Hospitals' FY 2005 IME and GME payments for family practice interns and residents rotating to the nonhospital family practice clinic.

BOARD MEMBERS PARTICIPATING:

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[32] *Id*. at 50119.
[33] 2015 IPPS rule, 79 FR 50,117-50,112 at 50,119 amending 42 C.F.R § § 413.78(g)(6).
[34] PRRB Dec. No. 2014-D10 (June 2, 2014), *rev'd*, CMS Adm'r Dec. (July 23, 2014).
[35] PRRB Dec. No. 2015-D13 (Aug. 28, 2015), *declined review*, CMS Adm'r (Sept. 22, 2015).
[36] 603 Fed. Appx. 360 (6th Cir. 2015) (involving FYs 1999 to 2006).
[37] *See id.*.

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: June 7, 2016

APPENDIX A
PARTICIPATING PROVIDERS

Provider Number	Provider Name	Fiscal Year End
37-0032	Deaconess Hospital	March 31, 2005
37-0028	Integris Baptist Medical Center	June 30, 2005