CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Kaleida Health	**Cost Reporting Period Ending: December 31, 1998**
Provider	
vs.	
BlueCross BlueShield Association/ National Government Services	**Review of: PRRB Dec. No. 2011-D27**
Intermediary	**Dated: April 26, 2011**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period mandated in §1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. § 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The Provider submitted comments requesting that the Administrator modify the Board's decision as to Issue No. 1 and uphold the Board's decision as to Issue No. 2. CMS' Center for Medicare (CM) commented, requesting that the Administrator reverse the Board's decision on Issue Nos. 1 and 2. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

Kaleida Health (Provider) is a Medicare certified teaching hospital located in Buffalo, New York. On March 31, 1998, three teaching hospitals (Buffalo General Health System, also known as Buffalo General Hospital (Buffalo General); The Children's Hospital of Buffalo (Children's); and Millard Fillmore Hospital (Millard)) and one non-teaching hospital (DeGraff Memorial Hospital (DeGraff)) merged into Chilmilgen Corporation (renamed CFG Health System). CFG Health System was later renamed Kaleida Health. On April 1, 1998, CMS issued a tie-in notice to the Provider assigning Kaleida Health the provider number

previously assigned to Buffalo General,[1] the largest merging hospital,[2] and retired the provider numbers of Children's, Millard, and DeGraff. The Intermediary issued notices to the Provider to use the Buffalo General 1984 base year per-resident amount (PRA),[3] updated for inflation, when filing its cost reports.[4]

On September 18, 2007, the Intermediary issued a notice of program reimbursement (NPR) for the cost reporting period ending December 31, 1998, which adjusted,[5] among other things, the Provider's direct GME PRA using a weighted average of the base period 1984 PRAs for Buffalo General, Children's, and Millard.[6] The Intermediary also made adjustments to the weighted Full Time Equivalent (FTE) resident counts. The Provider appealed.

ISSUES AND BOARD DECISION

Issue No. 1 was whether the Intermediary's adjustment of the Provider's direct Graduate Medical Education (GME) per resident amount was proper.

The Board found that the Intermediary's adjustment to the Provider's PRA was improper. The Board stated that, following the merger and at CMS direction, the Provider was

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[1] *See* Provider's Final Position Paper, Exhibit P-5.

[2] *See* Provider's Final Position Paper, Exhibits P-6 and P-7.

[3] The Buffalo General 1984 base year GME PRA was established through settlement of a PRRB case (Case No. 91-2852M). *See* Provider's Final Position Paper, Exhibit P-11.

[4] *See* Provider's Final Position Paper, p.6. *See also* Provider's Final Position Paper, Exhibit P-8.

[5] *See* Provider's Final Position Paper, Exhibit P-2, Adjustment #288.

[6] The Buffalo General base year GME PRA is $51,604.73, and was established through settlement of a PRRB case (Case No. 91-2852M). *See* Provider's Final Position Paper, Exhibit P-11. This was due in part to the fact that New York State's reimbursement system was operating under a waiver from the Medicare program during 1984. *See* Provider's Final Position Paper, Exhibit P-16. Under the terms of this Medicare waiver, GME costs reported on the 1984 Medicare cost report had no impact on a New York hospital's Medicare reimbursement for 1984, since New York hospitals were, instead, reimbursed for all payors under the New York Prospective Hospital Reimbursement Methodology. *See Id.* The Millard base year GME PRA is $39,070, and was also established through settlement of a PRRB case (Case No. 91-2849M). *See* Provider's Final Position Paper, Exhibit P-13. The Children's base year GME PRA is $26,702.79. *See* Provider's Final Position Paper, Exhibit P-22. Children's had also filed a timely PRRB appeal (Case No. 91-2851M) contesting the base year GME PRA assigned to it by the Intermediary. Children's withdrew this appeal. The weighted average base year GME PRA calculated by the Intermediary for Kaleida Health is $40,503.92. *See* Provider's Final Position Paper, Exhibit P-10.

assigned Buffalo Hospital's provider number. However, the Board noted that assignment and retiring of provider numbers in the event of a merger does not mean that the PRAs of the merging hospitals are also re-assigned or retired. According to CMS policy, the provider number is not changed merely because there was a merger of facilities or change in ownership. Instead, the Board stated, when merged facilities operate as a single institution, CMS will assign a single provider number to be used in order to avoid misunderstanding on the part of the beneficiaries, and that CMS uses the provider number previously assigned to the larger of the merging facilities and retires the other provider numbers.[7] The Board noted there is nothing in this policy to suggest that the PRA associated with the surviving provider number is also re-assigned to the new entity.

The Board claimed that at the time of the transaction in this case, neither the statute nor the regulations explicitly addressed how to calculate the PRA in the event of a merger. The only agency authority or purported authority was contained in the "Questions and Answers" (Q&As) issued on November 8, 1990. The Board did not find this to be determinative. The Board noted that the Provider was not contesting the assigned PRA, but instead is contesting a revision to that PRA eight years following the merger and the accuracy of the data used to determine the revised PRA. The Board disagreed with the Provider's assertion that the assigned PRA was final and not subject to redetermination. The parties stipulated, and the witness for the Provider acknowledged, that the direct GME payments based on Buffalo General's PRA were for periodic interim payments. In accordance with CMS policy, interim payments are subject to retrospective adjustment based on a submitted cost report.

The Board found that, as to the calculation of the PRA, it was appropriate for the Intermediary to use a weighted average methodology in this case. However, the Board noted that the Provider's PRA data was inaccurate, and held that in calculating an accurate PRA, *Mercy Catholic Center v. Thompson*[8] was instructive. Thus, the Board reversed the Intermediary's adjustment, and remanded the case to the Intermediary to recalculate the PRA using a weighted average methodology, and instructed the Intermediary to use the date

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[7] The Administrator notes that contrary to the Board's characterization, the State Operations Provider Certification Manual (CMS-Pub. 100-07) states at §2779F that when a single provider number (now known as a CMS Certification number (CCN)) is assigned by the regional office (RO), "the notices of utilization mailed to beneficiaries will not identify which component rendered the service but will show the name of the organization to which the CCN is assigned (which may be entirely different from the name of the component). To avoid misunderstanding on the part of beneficiaries, CMS must approve, in advance, some method devised by the provider for informing its Medicare patients as to the designation on the notices of utilization. The RO uses the CCN previously assigned to the larger of the merging facilities or, in the case of the merger of 2 provider corporations, uses the CCN of the surviving corporation and retires the other number or numbers."

[8] 380 F.3d 142 (3d Cir., Aug. 18, 2004).

from the most recently settled cost reports[9] of the merged hospitals, in order to assure maximum accuracy of the PRA.

Issue No. 2 was whether the Intermediary properly excluded research time the Provider alleges was related to patient care from the FTE resident count for direct Graduate Medical Education (GME) and Indirect Medical Education (IME).

The Board found that the Intermediary's adjustments to the direct GME and IME FTE counts related to a research rotation were improper. With regard to the direct GME FTE counts, the Board found that, while the Intermediary contended that it excluded the resident research time because the record did not demonstrate whether the research actually occurred in the hospital instead of in some adjacent research facility, the regulations make no distinction in the areas of the hospital used to determine FTE counts. The Board noted that during the cost reporting period at issue, the regulation indicated that "Residents in an approved program working in all areas of the hospital complex may be counted." The Board found that the documents presented showed that the research was conducted on the hospital complex, and therefore should be included in the Provider's direct GME FTE count.

As to the IME FTE counts, the Board noted that the Intermediary excluded the research time because the record does not show that such time was directly related to patient care. The Board found that the regulations in effect during the cost reporting period at issue did not exclude research time from the IME FTE resident count, nor did it require resident time to be related to patient care. The Board noted that its findings were consistent with other court decisions.[10] That Board stated that the record showed that the residents at issue were enrolled in an approved GME program and that they worked in either the portion of the Provider's facility subject to the inpatient prospective payment system (PPS) or an outpatient area. Thus, the Board found that the Intermediary's adjustment removing the FTEs from the count was improper, and the Board reversed the adjustments made by the Intermediary. The Board instructed the Intermediary to evaluate the documentation contained in the record in verifying the resident's research time used to determine the FTE counts for direct GME and IME purposes.

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[9] It is unclear from the Board's ruling whether it intended that the Intermediary should use data from the most recently settled cost report as of the date of the merger, or as of the date of the Board's decision.

[10] *Henry Ford Hospital System v. Sebelius*, 680 F.Supp. 2d 799 (E.D. Michigan 2009), *Riverside Methodist Hospital v. Thompson*, 2003 WL 22658129 (S.D. Ohio 2003), *University Medical Center Corp. v. Leavitt*, 2007 WL 891195 (D. Ariz. 2007).

SUMMARY OF COMMENTS

The Provider commented, disagreeing with the Board's finding on Issue No. 1, and agreeing with the Board's finding on Issue No. 2. CMS' Center for Medicare (CM), Division of Acute Care commented, disagreeing with the Board's rulings on both Issue Nos. 1 and 2, and recommending that the Administrator overturn them.

Issue No. 1:

The Provider noted that it had made several arguments to the Board on this issue. First, the Provider stated that the Intermediary was required to use the PRA that flowed with the provider agreement and provider number assigned to the merged hospital system. In the alternative, if the Board determined that the statute and regulations were silent on the methodology to be used to determine PRAs in the case of mergers occurring at the time of the Provider's merger, that the Intermediary could not legally make the adjustment that it made, and its actions must be reversed. The Provider disagreed with the Board's rejection of its first argument, and cited to the argument set forth in its Post-Hearing Brief, where the Provider argued that the Intermediary's use of a weighted average GME PRA is contrary to the Medicare statute and regulations.

The Provider claimed that the contention that CMS policy at the time of the merger required the Intermediary to calculate the PRA using a weighted average methodology using direct GME costs and resident data from the 1984 base year cost report was incorrect, as the merger was consummated on April 1, 1998. The Provider noted that CMS cited to preamble language in an inapplicable May 12, 1998 Inpatient Prospective Payment System (IPPS) rulemaking and an August 18, 2006 Federal Register, but has no evidence that this policy existed prior to the April 1, 1998 merger date.

The Provider stated that if the Administrator determined that the Board erred in directing that data from the most recently settled cost report be used, then the proper remedy would be to overturn the Board's decision and reinstate the Intermediary's adjustments. However, the Provider did not believe that the individual negotiated PRAs determined for each teaching hospital involved in the merger should be used. CMS only entered into a settlement agreement with the two adult acute hospitals, Buffalo General and Millard Fillmore. The Provider argued that part of the issue in this case was that the errors in the base year GME allowable cost data for Children's were never corrected. Children's had appeal rights that would have allowed it to correct its misclassified supervising physician costs, which it exercised in timely appealing its base year PRA. However, it should not have been expected that a freestanding children's hospital with less than one percent Medicare utilization would have pursued such an appeal to conclusion, when to do so would have had no economic impact on its reimbursement. Thus, the Provider did not agree that the erroneous Children's PRA should be used to calculate a weighted average PRA for merged entity Kaleida Health.

The CM commented that, under §1886(h) of the Social Security Act, Medicare makes payments to teaching hospitals for the direct costs of graduate medical education using a hospital specific, prospectively determined per resident amount, determined by dividing a hospital's allowable costs of direct GME in the base period by its number of interns and residents in that year (FY 1984 for most hospitals). Beyond the base period, the PRA is updated for inflation each year, however, payment for GME is not based on the actual GME costs that are incurred in subsequent years. In the August 18, 2006 *Federal Register*, CMS noted,

> our policy has always been that when two or more teaching hospitals merge, we determine the weighted average PRA for the surviving merged hospital using direct GME costs and resident data from the base year cost report for each teaching hospital involved in the merger.[11]

The CM noted that this policy was in effect at the time of the merger in this case, and was initially stated by CMS in the "Questions and Answers" (Q&As) on Medicare GME Payments, issued on November 8, 1990. In the May 12, 1998 Inpatient PPS final rule, CMS also stated

> [I]n implementing the COBRA 1985 provision establishing a hospital-specific PRA in the situation of a merger, we have calculated the revised PRA for the merged hospital using an FTE weighted average of each of the respective hospital's PRA which is part of the merger.[12]

The CM stated that it disagreed with the Board's decision to remand the case to the Intermediary to recalculate the PRA using a weighted average methodology using the Provider's most recently settled cost reports.[13] The CM noted that it agreed with the Board that it is appropriate to calculate the PRA using a weighted average methodology. However, the data used in the calculation should not be from the most recently settled cost reports. Instead, generally the PRA should be calculated using a weighted average methodology using direct GME costs and resident data from the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984[14] for each teaching hospital involved in the merger. However, the CM acknowledged that certain New York teaching hospitals, including some of those involved in this appeal, were granted separately negotiated base

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[11] 71 Fed. Reg. 47,870, 48,073.

[12] 63 Fed. Reg. 26,318, 26,329.

[13] The CM noted that it understood the Board decision to mean the Intermediary should use data from the most recently settled cost report as of the date of the merger, not as of the date of the Board's decision.

[14] Commonly referred to as the "1984 base year".

year PRAs by CMS due to inaccuracies in the available 1984 cost report data that resulted from the hospital's participation in the New York Medicare Waiver. Thus, in this case, the CM noted, the weighted average would be based on the PRAs that CMS had originally established for each of the hospitals that were subsequently involved in the merger. Accordingly, the Intermediary's original weighted average PRA calculation using the individual negotiated PRAs is appropriate. The CM noted that, the current policy for calculating the PRA, where there has been a merger, established in the August 18, 2006 Final Rule,[15] is to calculate the PRA using a weighted average methodology based on FTE [and PRA] data from the most recently settled cost reports of the merging hospitals prior to the merger. However, that policy was not in effect prior to October 2006 and, therefore, is not applicable to the 1998 Kaleida merger.

Thus, the CM recommended[16] that the Administrator overturn the Board's decision on Issue No. 1 and reinstate the Intermediary's adjustment. The CM stated that the Intermediary properly calculated the PRA using a weighted average methodology using the individual negotiated PRAs determined for each teaching hospital involved in the merger, and the number of residents in each hospital's base year cost report, as this was CMS's policy at the time of this merger. The CM also noted that it is not appropriate to revise the base year determination of the PRAs to include costs that were inadvertently omitted from the base year costs. The initial PRA determinations were subject to a provider appeal at the time they were issued, and those determinations can no longer be appealed or revisited.

Issue No. 2:

The Provider contended that the Administrator should uphold the Board's decision on this issue, and cited to the reasons stated in its Post-Hearing Brief. The Provider argued that the GME regulations in effect for FYE 12/31/98 did not require disallowing the time residents spend doing research, so long as they worked in an area of the "hospital complex." Based on the uncontested testimony offered at the hearing, along with exhibits, the Provider was able to prove that all additional FTE residents that it sought to include for GME worked in areas of the "hospital complex."[17] Regarding IME, the Provider's argument, made in the Post-Hearing Brief, was that the statute and regulations governing IME in effect during the cost reporting period at issue did not require proving that research was related to patient care in order to count residents who conduct research in a "portion" of the hospital that was

[15] 71 Fed. Reg. 47,870, 48,073.

[16] The CM originally submitted comments recommending that the Administrator overturn the Board's decision and require the Intermediary to calculate the PRA using a weighted average methodology using direct GME costs and resident data from the 1984 base year cost report for teaching hospitals involved in the merger. Corrected comments giving the above recommendation were later timely submitted.

[17] *See* Provider's Post-Hearing Brief, p. 35.

subject to the inpatient PPS system or in the outpatient department of the hospital, and that the phrase "portion of the hospital" describes a geographic area, rather than a function.[18]

The CM commented that for direct GME payment purposes, the regulations at 42 C.F.R. §413.78(a) states that "residents in an approved program working in all areas of the hospital complex may be counted." As explained in the September 29, 1989 *Federal Register*, the hospital complex consists of the hospital and the hospital-based providers and subproviders. For IME, the regulation at 42 C.F.R. §412.105(f)(1)(iii)(B) states that "the time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable." The CM noted that it disagreed with the Board that the research rotation should be included in the Provider's direct GME FTE count, and that it agreed with the Intermediary that the documentation provided was not sufficient to indicate whether the residents were training in the hospital complex. The CM agreed with the Intermediary that the hospital has the burden of proof to demonstrate where the training took place, and if the training sites were indeed part of the hospital complex. Thus, the CM agreed with the Intermediary's disallowance of the research FTEs from the direct GME and the IME FTE count, unless the hospital can document the fact that the research was on the hospital complex, and not, for example, at a related university site.

The CM also stated that it disagreed with the Board's decision to instruct the Intermediary to include the research rotation time in the Provider's IME FTE count, and that it disagreed with the Board's claim that the regulations in effect during the cost reporting period at issue did not exclude research time from the IME FTE resident count. The CM noted that §5505(B) of the Affordable Care Act amended §1886(d)(5)(B)(x)(III) to specify that research activities that are not associated with the treatment or diagnosis of a particular patient are excluded from the allowable IME count of FTE residents. This section also stated that it should not give rise to any inference as to how the law in effect prior to October 1, 2001 should be interpreted. The CM noted that as CMS explained in the November 24, 2010 Final Rule,[19] while Congress specified that date of cost reporting periods beginning on or after October 1, 2001 as an effective date for the statutory exclusion of research time for IME, "…Congress did not state that research activities prior to October 1, 2001, are allowed. Rather, Congress deferred to the Secretary to interpret and implement policy regarding research time for IME payment purposes prior to October 1, 2001."[20]

The CM stated that the language at §5505(c) means that in the instances where providers disagree with the Secretary's interpretation of research policy in cost reports prior to October 1, 2001, and the providers appeal research time that was disallowed from their IME FTE counts in those reports, the matter would be reserved for adjudication in the courts.

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[18] *Id.* at 36-37.
[19] 75 Fed. Reg. 71,800, 72,145.
[20] *Id.*

Accordingly, the CM noted, the longstanding policy, even prior to October 1, 2001, has been to exclude research that is not associated with the treatment or diagnosis of a particular patient from the IME FTE count. Thus, the CM recommended that the Administrator reverse the Board's findings with respect to the direct GME and IME FTE counts for residents spending time in research activities.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. Comments timely submitted have been included in the record and have been considered.

Issue No. 1:

Until 1983, Medicare paid for covered hospital inpatient services on the basis of "reasonable cost." Section 1861(v)(1)(A) of the Act defines "reasonable cost" as "the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." While §1861(v)(1)(A) does not prescribe specific procedures for calculating reasonable cost, it authorizes the Secretary to promulgate regulations setting forth the methods to determine reasonable cost and the items to be included in reimbursable services.

In addition, Medicare historically has paid a share of the net costs of "approved medical education activities" under the reasonable cost provisions.[21] The Secretary's regulations define approved educational activities as formally organized or planned programs of study, usually engaged in by providers to enhance the quality of care in an institution.[22] The activities include approved training programs for physicians, nurses and certain paramedical health professionals. Under the reasonable cost system, the allowable costs of the activities included: the direct costs of salaries and fringe benefits of interns and residents, the salaries attributable to teaching physicians' supervisory time, other teachers' salaries; and indirect or institutional overhead costs, including employee health and welfare benefits, that were appropriately allocated to the proper cost center on a provider's Medicare cost report.[23]

In 1982, Congress modified the Medicare program to provide hospitals with better incentives to render services more efficiently. Pursuant to the Tax Equity and Fiscal Responsibility Act (TEFRA),[24] Congress amended the Act by imposing a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. Payments made pursuant to the TEFRA ceiling on the rate-of-increase are determined based upon the target

[21] 20 CFR §405.421 (1966); 42 CFR §405.421 (1977); 42 CFR §413.85 (1986).
[22] 42 CFR §413.85(b).
[23] 54 Fed. Reg. 40,286 (Sept. 27, 1989).
[24] Pub. L. 97-248.

amount which is derived from the hospital's allowable net Medicare operating costs[25] in the hospital's base year. However, under §1886(a)(4), GME costs were excluded from the definition of inpatient operating costs for purposes of the TEFRA base year and, thus, were not included in the hospital's TEFRA base year costs for purposes of determining the hospital's target amount.

In 1983, §1886(d) was added to the statute to establish an inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital services furnished to Medicare beneficiaries.[26] Under IPPS, providers are reimbursed their inpatient operating costs based on prospectively determined national and regional rates for each patient discharge, rather than on the basis of reasonableness. GME costs continued to be paid on a reasonable cost "pass-through."

However, applicable for all periods beginning on, or after, July 1, 1985, pursuant to §1886(h) of the Act,[27] Congress established a new payment policy for direct GME costs. Section 1886(h)(2)(A) of the Act provides that:

> The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this title for direct graduate medical education costs of the hospital for each full-time equivalent resident.

As a result of the legislative change, the Secretary established a new payment policy for direct GME costs for all periods beginning on, or after, July 1, 1985.[28] To implement the new payment policy, the Secretary promulgated regulations at 42 C.F.R. §413.86, *et seq*.

The regulation at 42 C.F.R. §413.86(e)(1)(i) (1997) specifically states that to determine a base-period average PRA for each hospital, an intermediary must:

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[25] "Operating costs" are defined in §1886(a)(4) of the Act as including: "all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services."

[26] Section 601(e) of the Social Security Amendments of 1983. Pub. L. No. 98-21 (1983).

[27] Section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

[28] 54 Fed. Reg. at 40,297. (Revised payment method applies to all hospitals regardless of status under PPS.) *See* 50 Fed. Reg. 27,722 (July 1985)(Final rule that hospitals would be reimbursed lesser of allowable costs for current year or hospitals' approved GME costs incurred during 1984 FY; nullified by Section 1861(v)(1)(Q) pursuant to Section 9202 of COBRA 1985). Section 9314 of Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509) added Section 1886(h)(4)(E).

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, graduate medical education costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and graduate medical education costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.
(B) Divide the costs calculated in paragraph (e)(1)(i)(A) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (e)(1)(i)(A) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

Pursuant to 42 C.F.R. §413.86(e)(1)(ii) (1997)[29] in determining the base-period per resident amount under (e)(1)(i) of this section, the intermediary:

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;
(B) Excludes from the base-period graduate medical education costs any nonallowable or misclassified costs, including those previously allowed under §412.113(b)(3); and
(C) Upon the hospital's request, includes graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under §412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(2) of this section.

To ensure that the average per resident amount (APRA) would accurately reflect legitimate GME costs incurred during the base period, 42 C.F.R. §413.86(e)(1) authorized intermediaries to re-audit and verify providers' base year cost reports; exclude non-allowable costs; and, to include GME costs that were misclassified as operating costs in the GME base period. The regulation further instructed intermediaries to issue a notice of average per resident amount (NAPRA) to each provider after completing the re-audit of the base year. Hospitals could appeal this amount within 180 days of the date of that notice.[30]

[29] The determination of the per resident amounts was recodified to 42 C.F.R. §413.77. *See* 69 Fed. Reg. 48,916, 49,254 (Aug. 11, 2004).
[30] 42 C.F.R. §413.86(e)(1)(v) (1997).

The Administrator finds that the policy of using the weighted average of the GME PRAs for merged hospitals, as applied by the Intermediary in this case, was detailed in Questions and Answers (Q&As) on Medicare GME payments issued on November 8, 1990, which stated that:

> [When] two hospitals merge and file one cost report … the merged hospital's per resident amount would be based on the weighted average of the per resident amount of both hospitals. Weights are applied based upon the numbers of FTE residents in each hospital…

As reflected in this agency issuance, this policy was implemented prior to the merger in this case, and as indicated below, was consistently applied for all the years following. The policy was further discussed in the preamble of the final rule published May 12, 1998 in the *Federal Register*.[31] The preamble specifically stated that:

> In implementing the COBRA 1985 provision establishing a hospital-specific per resident amount in the situation of a merger, we have calculated the revised per resident amount for the merged hospital using an FTE weighted average of each of the respective hospital's per resident amount which is part of the merger.[32]

Furthermore, the rationale for the historical policy was reiterated, as recently as the inpatient prospective payment system final rule published August 18, 2006, in the *Federal Register*.[33] The Secretary noted that it is not appropriate to provide a merged hospital the option of adopting the surviving hospital's PRA, instead of the average weighted PRA. Adopting the surviving hospital's PRA would ignore the fact that the merger is a result of multiple hospitals with pre-existing and statutorily established PRAs joining together and could inappropriately provide an incentive to choose the surviving hospital based on which surviving hospital's PRA would yield the highest reimbursement.[34]

The Provider argued that the use of Buffalo Genera's provider number meant that the PRA of Buffalo General should be used as the PRA of the merged entity. In its Post-Hearing Brief, the Provider noted that the plain language of the GME statute and regulations bar adjustment of the GME PRA since the Medicare program determined that Kaleida Health is

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[31] 63 Fed. Reg. 26,318, 26,239 (May 12, 1998).
[32] 63 Fed. Reg. 26,318. The preamble noted that this method of handling the per resident amount for merged facilities set the precedent for determining the FTE cap for merged hospitals.
[33] 71 Fed. Reg. 47,870 (August 18, 2006).
[34] *Id.* at 48,076.

the successor to Buffalo General Hospital.[35] The Provider stated that the GME statute and regulations in effect at the time of the Kaleida Health merger required that there were to be no redeterminations of a hospital's base year GME PRA due to changes occurring after the base period (except for new hospitals or for hospitals whose base period was shorter than 50 weeks or longer than 54 weeks) and did not authorize any averaging of the base year GME PRAs of hospitals that merge after the establishment of the base period PRA. The Provider also cited *Methodist Hospitals of Memphis vs. BlueCross BlueShield Association*,[36] and argued that the Board's decision in that case was correct and should be followed, and that the Administrator's decision reversing the Board in that case was incorrect.

The Administrator finds that calculating a weighted average PRA for the surviving merged entity is not an attempt to re-determine a new PRA, as alleged by the Provider, but rather, this policy is an accurate adjustment to account for the fact that the Provider is comprised of three merged teaching hospitals with three statutorily determined PRAs as established in accordance with the law. The weighted average PRA is calculated by adding the product of each hospital's base year PRA and its base year FTE resident count divided by the total number of the base year FTE residents for those hospitals. The PRAs are then updated using the CPI-U inflation factor to coincide with the fiscal year end of the surviving teaching hospital. The Administrator finds that it is appropriate that the FTEs of each of the hospitals should be counted and used to weigh the combined average PRA. After the merger, the FTE residents on all campuses are counted and paid under the weighted average PRA on the same cost report filed by the surviving entity.

The Administrator points out that while CMS issued a tie-in notice to the Provider assigning Kaleida Health the provider number previously assigned to Buffalo General (the largest merging hospital), and retired the provider numbers of Children's, Millard, and DeGraff, no provider agreement is retired, even if operations at one facility are scaled back or ceased. Rather, in the case of a merger such as this, the Medicare provider agreement of one hospital is subsumed into the provider agreement of the surviving provider.[37]

The Administrator finds that the weighing of the PRA to reflect the merger of the hospitals is consistent with §1886(d) of the Act and the regulation at 42 C.F.R 413.86(e). The weighing of the established PRAs of the hospitals involved in the merger which were developed from the respective GME base years is a reasonable application of the regulation and statute to the circumstances at hand. In addition, this policy is reasonable as it ensures that, where there is a merger, neither the hospital, nor the Medicare program, will receive a windfall or be penalized, depending upon the assignment of the provider number and, thus,

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[35] *See* Provider's Post-Hearing Brief, p. 17-21.
[36] PRRB Dec. No. 2007-D50 (July 19, 2007).
[37] *See* 75 Fed. Reg. 71,800, 72,213 (Nov. 24, 2010).

makes the assignment of the provider agreement and choice of the surviving entity payment neutral with respect to the PRA.

While the Board found it was appropriate to use a weighted average methodology in this case, the Board found that the Intermediary's method was incorrect, noting that the Provider's PRA data was inaccurate. Thus, the Board reversed the Intermediary's adjustment and remanded the case to the Intermediary to recalculate the PRA using data from the most recently settled cost reports of the merged hospitals. The Administrator disagrees with the Board's conclusion that the Provider's PRA data was inaccurate.[38] Each of the PRAs used were the result of the procedures in place allowing provider's to appeal their regional NAPRA. The base year GME PRA of Buffalo General and Millard were

[38] In addition, the Administrator finds reliance on Mercy Catholic Medical Center misplaced. In *Mercy Catholic Medical Center*, *supra* n. 8, the Provider sought reversal of the Board's decision (PRRB Dec. No. 2001-D55, Administrator declined to review) denying reclassification of certain GME costs. Recognizing that some hospitals would no longer have the records required to support a reclassification of misclassified GME costs, the Secretary had allowed auditors to accept time records from subsequent time periods as proxy, and where subsequent year records were also unavailable, hospitals were allowed to perform three-week times studies of current physician workloads to provide a rough estimate of the time allocation of teaching physicians in the base year for auditing the regional base year costs. *See* Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1991 Rates, 55 Fed. Reg. 36,064. The use of this substitute documentation was limited to verifying costs originally claimed as GME costs in the GME base year, but could not be used to increase the GME costs originally claimed by reclassifying costs. The Provider conducted a three-week time study that tracked the portion of each teaching physician's time devoted to services that qualify as GME costs. During the reaudit, the Provider realized it had misclassified all of the time spent by physicians in three departments as operating costs in the GME base year. The intermediary refused to recognize these misclassified costs. The Board affirmed the intermediary's determination. The Third Circuit Court of Appeals reversed this decision, finding that the plain language of the GME rule does not support limiting corrections upon reaudit to misclassified operating costs, but rather anticipates corrections of misclassified GME costs and operating costs. 380 F.3d at 153. The Court of Appeals further stated that the regulation's plain language also requires the intermediary to correct all misclassified costs, not just misclassified GME costs. *Id.* The Court of Appeals found that to make the APRA accurate and avoid perpetrating errors, the reaudit requires correcting all relevant classification errors, not just those that resulted in a reduction of GME costs. The Administrator notes that this case involved the timely appeal of the original issued PRA. In contrast, in the instant case under review, the Provider is seeking to have either the PRA for the largest hospital used for all merged hospitals or to have reopened an already audited APRA for Children's Hospital, for which an appeal was not originally pursued.

established through settlement of PRRB cases.[39] The former provider, Children's, had an opportunity to establish its base year GME PRA through the same process, but chose to withdraw its appeal. The time for appeal has passed, and the calculation can no longer be appealed or reopened. Thus, the Administrator reverses the Board's decision and upholds the Intermediary's calculation of the Provider's PRA for purposes of the GME payment.

Issue No. 2:

Prior to 1983, under Title XVII of the Social Security Act, Medicare reimbursed providers on a reasonable cost basis for Part A—Hospital Insurance Benefits. Section 1861(v)(1)(A) of the Social Security Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. This section of the Act also defines reasonable cost as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Since its inception Medicare has recognized the increased operating costs related to a provider's approved graduate medical education programs through an indirect teaching adjustment.

Congress has allowed hospitals' costs for operating programs for residents' training based on the premise that "…these activities enhance the quality of care in an institution."[40] Congress explained, in enacting the Medicare program, that:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.[41]

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[39] *See* Provider's Final Position Paper, Exhibits P-11 and P-13.

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

[41] S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965); H.R. No. 213, 89th Cong., 1st Sess. 32 (1965).

Congress specifically provided for direct "educational" costs incurred by hospital to be reimbursable. The establishment of payment for medical education costs was an exception under Medicare and only possible due to congressional direction. It was also limited to direct educational costs and, *inter alia*, by the anti-redistribution and the community support principles. Thus, to the extent the Medicare program has always historically paid the costs related to patient care, Congressional directive allowed a narrow exception for direct medical education costs to come under that "umbrella" as limited by the forgoing language. Similarly, the regulations governing research cost, under the "reasonable cost" system of reimbursement were found in 42 C.F.R. §405.422 (1977) *et. seq.*, and stated that the "costs incurred for research purposes over and above usual patient care, are not includable as allowable costs. The regulation at 42 C.F.R. §405.422(b)(2) further stated that "where research is conducted in conjunction with and as part of the care of patients, the costs of usual patient care are allowable to the extent that such costs are not met by funds provided for the research…" Consistent with the regulation, § 500 of the Provider Reimbursement Manual explains that "costs incurred for research purposes, over and above usual patient care, are not includable as allowable costs."[42] Where research costs include usual patient care costs in conjunction with research, a provider is required to offset costs incurred for usual patient care with applicable research funds.

The Secretary promulgated the regulation at 42 C.F.R. §413.85 which permits reimbursement for the costs of approved educational activities.[43] The regulation at 42 C.F.R §413.85 also defines approved educational activities as "formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution"[44] As the Supreme Court in *Thomas Jefferson v. Shalala*, noted:

> Graduate medical education (GME) programs are one category of approved educational activities. GME programs give interns and residents clinical training in various medical specialties. Because participants learn both by treating patients and by observing other physicians do so, GME programs take place in a patient care unit (most often in a teaching hospital), rather than in a classroom. Hospitals are entitled to recover the "net cost" of GME and other approved educational activities, a figure "determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition." §413.85(g). A hospital may include as a reimbursable GME

[42] *See* § 505.1 of the PRM. Section 502 of the PRM defines Research.

[43] 42 C.F.R. §413.85(b) (1997) further re-designated at 42 C.F.R. §413.90(2007). This language has been in effect since the beginning of the Medicare program although it was formerly designated 42 C.F.R. §405.421(1977) and 20 C.F.R. §405.421 (1967).

[44] *See*, 31 Fed. Reg. 1481 (Nov. 22, 1966). *See* 42 C.F.R. §405.422, re-designated at 42 C.F.R. §413.5(c)(2) and now at 42 C.F.R. §412.90.

> cost not only the costs of services it furnishes, but also the costs of services furnished by the hospital's affiliated medical school. §413.17(a). [45]

Section 223 of the Social Security Act of 1972 amended §1861(v)(1)(A) to authorize the Secretary to set prospective limits on the cost reimbursement by Medicare.[46] These limits are referred to as the "223 limits" or "routine cost limits" (RCL), and were based on the costs necessary in the efficient delivery of services. Beginning in 1974, the Secretary published routine cost limits in the Federal Register. These "routine cost limits" initially covered only inpatient general routine operating costs. Under this cost methodology, Medicare recognized the increased indirect costs associated with a teaching program. In particular, the Secretary stated:

> We included this adjustment to account for increased routine operating costs that are generated by approved internship and residency programs, but are not allocated to the interns and residents (in approved programs) or nursing school cost centers on the hospital's Medicare cost report. Such costs might include, for example, increased medical records costs that result from the keeping, for teaching purposes, of more detailed medical records than would otherwise be required. Because our analysis of the data we used to develop the new limits shows that hospital inpatient operating costs per discharge tend to increase in proportion to increases in hospital levels of teaching activity, we have adopted a similar adjustment… In our opinion, this adjustment accounts for the additional inpatient operating cost which a hospital incurs through its operation of an approved intern and resident program."[47]

Consequently, in contrast to direct medical education costs which are only allowed due to the specific Congressional directive to include direct educational costs, the indirect teaching adjustment methodology arises out of the more limited authority granted the Secretary for administering the Medicare program and for paying costs related to patient care activities. In 1982, in an effort to further curb hospital cost increases and encourage greater efficiency, Congress established broader cost limits than those authorized under §1861(v)(1)(A), the existing routine cost limits. The Tax Equity and Fiscal Responsibility Act (TEFRA) added §1886(a) to the Act, which expanded the existing routine cost limits[48] to include ancillary services, operating costs and special care unit operating costs in addition to routine operating costs. Pursuant to §1886(1)(a)(ii) of the Act, these expanded cost limits, referred to as the

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[45] 512 U.S. 540 (1994).
[46] Pub. L. 92-603.
[47] 46 Fed. Reg. 33,637 (June 30, 1981).
[48] While implemented under TEFRA, this provision relates to the routine cost limits under §1886(a) of the Act and not the often referred "TEFRA" limits under §1886(b) of the Act.

"inpatient operating cost limits" applied to cost reporting periods beginning after October 1, 1982. Notably, the direct costs related to approved medical education were not subject to the routine cost limits. Under the routine cost limits, and pursuant to §1886(a)(2) of the Act, Medicare also paid for the increased indirect costs associated with a hospital's approved graduate medical education program through an indirect teaching adjustment.[49] Thus, since its inception, Medicare has recognized the increased (patient care) operating costs related to a provider's approved graduate medical education programs through an indirect teaching adjustment.[50] However, under the routine cost limits and prior to IPPS, the relevance of residents' FTEs and hence the tracking of resident activities was far from sophisticated and exact. While one could distinguish between allowable and non-allowance costs (such as research), there was not a method to consistently and accurately isolate all the time spent by residents in nonpatient care activities. Therefore, at that time, no consideration was given to where residents were training in the hospital or the activities of the residents with respect to patient care, or other activities.[51]

In 1983, §1886(d) of the Act was added to establish the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital services furnished to Medicare beneficiaries.[52] Under IPPS, providers are reimbursed their inpatient operating costs based on prospectively determined national and regional rates for each patient discharge, rather than on the basis of reasonable operating costs. Under §§1886(a)(4) and (d)(1)(A) of the Act, the costs of approved medical education activities were specifically excluded from the definition of "inpatient operating costs" and, thus, were not included in the PPS hospital-specific, regional, or national payment rates or in the target amount for hospitals not subject to PPS. Instead, payment for approved medical education activities costs were separately identified and paid as a "pass-through," i.e., paid on a reasonable cost basis.[53] Later, for the cost years at issue, the direct costs of the approved graduate medical education program were paid under the methodology set forth at Section 1886(h) of the Social Security Act. These provisions were promulgated at 42 C.F.R. §413.86 (1997). The regulation notes that the count of FTE residents is determined as follows:

> (i) Residents in an approved program working in all areas of the hospital complex may be counted.

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[49] Section 1886(a)(2) states that the Secretary shall provide "for such … adjustments to, the limitation…as he deems necessary to take into account—(A)…Medical and paramedical education costs…"

[50] 45 Fed. Reg. 21,584 (Apr. 1, 1980) (indirect teaching adjustment under pre-TEFRA cost limits).

[51] 71 Fed Reg. 47,870, 48,089 (Aug 18, 2008).

[52] Pub. L. 98-21 (1983).

[53] Section 1814(b) of the Act.

> (ii) No individual may be counted as more than one FTE. If a resident spends time in more than one hospital, or, except as provided in paragraph (f)(1)(iii) of this section, in a nonprovider setting, the resident counts as a partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proporotion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.
>
> (iii) On or after July 1, 1987, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:
>
> (A) The resident spends his or her time in patient care activities.
>
> (B) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.[54]

A "hospital complex" is defined as "complexes that include, in addition to a hospital, subproviders such as psychiatric units and other hospital-based providers such as skilled nursing facilities or home health agencies."[55] The cost report instructions in the Provider Reimbursement Manual (PRM), Part II, §304 had a similar definition since 1980.[56] It states in part:

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[54] 42 C.F.R. §413.86(f) (1997).

[55] 54 Fed. Reg. 40,286 (Sept. 29, 1989). *See also* 71 Fed. Reg. 47,870, 48,093 (Aug. 18, 2006) ("As explained in the September 29, 1989 Federal Register document…the hospital complex consists of the hospital and the hospital-based providers and subproviders.") See also Id. ("We understand that it is quite common for hospitals, especially large academic medical centers, to be located on the same campus as a medical school, where the buildings are very closely situated or even connected, and the facilities are often shared. However, as the commenter indicated, hospitals, nonhospital sites, and medical schools are structured separately for legal and financial purposes, and are recognized independently for state licensing and Medicare cost reporting purposes.").

[56] *See also* §4090 of the Provider Reimbursement Manual (Part 2), Form CMS-2552-10 (Rev. 12-10).

HOSPITAL, HOSPITAL-SKILLED NURSING FACILITY COMPLEX AND SKILLED NURSING FACILITY STATISTICAL DATA

Part I – General. –

NAMES AND ADDRESSES, PROVIDER NUMBERS AND DATES CERTIFIED.
Enter on the appropriate lines the names and addresses, provider of identification numbers and certification dates of the facility and its various components, if any. The following definitions apply when completing these cost reporting forms.

HOSPITAL—An institution meeting the requirements of section 1861(e) of the "Health Insurance for the Aged and Disabled Act" and participating in the Medicare program, or a Federally controlled institution approved by the Secretary.

SUBPROVIDER—A general hospital which has been issued subprovider identification numbers because it offers clearly different types of service, e.g., short-term acute and long-term tuberculosis. See PRM, Part I, chapter 23, for a complete explanation of separate cost entities in multiple facility hospitals.

SKILLED NURSING FACILITY—An institution meeting the requirements of section 1861(j) of "Health Insurance for the Aged and Disabled Act" and participating in the Medicare program, or a Federally controlled institution approved by the Secretary.

HOSPITAL-BASED SKILLED NURSING FACILITY—A distinct part and separately certified component of a hospital where skilled nursing and related services are provided.

HOME HEALTH AGENCY—An institution meeting the requirements of section 1861(o) of the "Health Insurance for the Aged and Disabled Act" and participating in the Medicare program, or a Federally controlled institution approved by the Secretary. The remainder of the statistical data for a provider-based home health agency should be entered on form HCFA-1728A.

SPECIAL PROVIDER-CONTROLLED FACILITY—A separate cost entity controlled and/or owned by one provider or jointly by more than one provider. This entity usually has its own administration, staff, building, location and financial autonomy. Examples include a provider-controlled comprehensive health center and a patient service facility financed and operated by two or

> more providers on a shared-cost basis. The services rendered are under the control of the provider (s) and are services usually covered for Medicare reimbursement by title XVIII statutory or regulatory provisions. A special provider-controlled facility could not participate in the Medicare program in the absence of the provider or providers to which it is related.

Consequently, the Secretary has consistently explained that the "hospital complex" is made up of the provider and subproviders and may not include all buildings or functions set forth in a medical center campus.

Congress recognized that teaching hospitals might be adversely affected by implementation of IPPS because of the indirect patient care costs of the approved graduate medical education programs. These may include the increased department overhead as well as a higher volume of laboratory test and similar services as a result of these programs which would not be reflected in the IPPS payments or because they are patient care related in the GME payment. Thus, hospitals with approved teaching programs, receive an additional payment to reflect these IME costs.[57] Before Congress passed the 1983 law that included the IME adjustment and the IPPS, the Secretary submitted a report to Congress in 1982 that explained why an IME adjustment was important. The report stated that, "the indirect costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs," and that "there is no question that hospitals with teaching programs have higher patient care costs than hospitals without."[58] Consequently, the statute states at §1886(d)(5)(B) of the Act that:

> The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under the regulations (in effect as of January 1, 1983) *under subsection (a)(2)* ….(Emphasis added.)

The IME payment compensates teaching hospitals for higher-than-average operating costs that are associated with the presence and intensity of residents' training in an institution but which cannot be specifically attributed to, and does not include, the costs of residents'

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[57] This IME payment is distinguished from the direct medical education costs. While GME time spent in research is includable if it occurred on the hospital complex, notably, the original research costs were not allowed in the establishment of the GME base year per resident amount. Thus, the rationale is that a provider will be penalized twice if the time is not allowed in counting the FTE as the research costs have already been removed from the calculation.

[58] *See Report to Congress Required by the Tax Equity and Fiscal Responsibility Act of 1982*, December 1982, pp. 48-49.

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."[59] The regulation at 42 C.F.R. §412.105 governs IME payments to Medicare providers. For fiscal year 1998, at issue in this case, the regulations governing IME reimbursement were codified at 42 C.F.R. §412.105(f)(1997).[60] The regulations state in part:

> (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purposes 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.

The regulation states that CMS "makes an additional payment to hospitals for indirect medical education costs" in part by determining the ratio of the number of FTE residents to the number of beds. The IME adjustment is an add-on to the per-case payment which is based upon the standardized amount originally derived from the reasonable routine operating costs for providing patient care.[61]

Notably, when §1886(d) of the Act was amended and the regulation was promulgated to address the additional costs that teaching hospitals incur in treating patients, the Secretary discussed this IPPS formula for IME payments and explained that:

> Section 1886(d) of the Act provides that prospective payment hospitals receive an additional payment for the indirect costs of medical education computed in the same manner as the adjustments for those costs under regulations in effect as of January 1, 1983. Under [the] regulations [then set forth at 42 C.F.R. §412.118], we provided that the indirect costs of medical education incurred by teaching hospitals are the increase operating costs (that is, *patient care costs*) that are associated with approved intern and resident programs. These increased costs may reflect a number of factors; for example, an increase in the number of tests and procedures ordered by interns and residents relative to the number ordered by more experienced physicians

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[59] 71 Fed. Reg. 47,870, 48,087 (Aug. 18, 2006).
[60] This regulation was re-designated from 42 C.F.R. §412.105(g) to §412.105(f). *See* 62 Fed. Reg. 45,966, 46,029 (Aug. 29, 1997).
[61] 42 C.F.R. §412.105(f)(1) (1997)

> or the need of hospitals with teaching programs to maintain more detailed medical records. (Emphasis added.)[62]

Moreover, in a final 1989 rule implementing changes to direct GME reimbursement, the Secretary further explained:

> We also note that section 1886(d)(5)(B) of the Act and section 412.115(b) of our regulations specify that hospitals with "indirect cost of medical education" will receive an additional payment amount under the prospective payment system. As used in section 1886(d)(5)(B) of the Act, "indirect costs of medical education" means those additional operating (that is, *patient care*) costs incurred by hospitals with graduate medical education programs.[63] (Emphasis added.)

Finally, the Administrator notes that the Secretary's longstanding policy of requiring hospitals to identify and exclude time spent by residents involved exclusively in pure research was codified at 42 C.F.R. §412.105(f)(1)(iii)(B)(2001). Specifically, that section states that "the time spent by a resident that is not associated with the treatment or diagnosis of a particular patient is not countable."[64] In 2001, the Secretary adopted clarifying language that expressly excluded time that was spent by residents in research unrelated to the care of a specific patient from the count of residents for IME.[65]

The Administrator finds that the August 1, 2001 *Federal Register* Notice did not represent a change in policy. There have been longstanding regulations concerning research, which historically were at §405.422, then were moved to §413.5(c)(2), and now are at §412.90. In addition, the PRM prohibiting the counting of residents engaged exclusively in research has been in place since 1988. Consistent with the foregoing regulation, §2405.3.F of the PRM[66] explains that:

> The term "interns and residents in approved programs" means individuals participating in graduate medical education programs approved as set forth in §404.1.A…It is recognized that situations arise in which it may be unclear whether an individual is counted as an intern or resident in an approved program for the purpose of the indirect medical education adjustment…Intermediaries must not count an individual in the indirect

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[62] *See* 51 Fed. Reg. 16,772 (May 6, 1986).
[63] *See* 54 Fed. Reg. 40,282 (Sep. 29, 1989).
[64] *See* 66 Fed. Reg. 39,896 (Aug. 1, 2001) for full recitation of historical overview of policy. For further discussions, *see also* 71 Fed. Reg. 47,870, 48,081-48,093 (Aug. 18, 2006).
[65] 42 C.F.R. §412.105(f)(1)(iii)(B) (2001).
[66] Transmittal Rev. 345 (Aug. 1988).

> medical education adjustment if any of the following conditions exist: **** The individual is engaged exclusively in research…

Because of these longstanding regulations and PRM, it is evident that the regulation text at 42 C.F.R. §405.105(f)(1)(iii)(B) (2001), which specified the patient care requirement, was simply the codification of existing policy in the IME regulations text.

Thus, from the beginning of its implementation of the Congressional directives regarding medical education costs, Medicare has only paid for research costs related to patient care even within the context of the increased direct and indirect costs associated with approved medical education programs.

In this case, the Provider argued that the documentation presented showed that the time spent by residents performing research activities as part of an approved residency program should be included in the GME and IME FTE calculations. Regarding GME, the Administrator finds that the documentation provided[67] was insufficient to show that the residents were conducting research in the hospital complex,[68] and thus, should not be included in the Provider's direct GME FTE count. Regarding IME, the Provider argued that to count the FTE for IME purposes, it must simply show that residents were serving rotations in geographic areas of the hospital subject to IPPS, and that it did not have to show that the research was related to patient care. The Provider admitted that the documentation it provided did not indicate the kind of research being done, or whether the research was directly related to patient care.[69] The Administrator finds that historically under the reasonable cost system of reimbursement, costs associated with research activities that were not related to patient care were not reimbursed and allowed. This exclusion extended to the indirect education (or teaching) adjustment paid under reasonable cost limits for the higher operating costs incurred by hospitals with medical education programs. The Administrator further finds that the indirect teaching adjustment methodology used under the reasonable cost limits was adopted under §1886(d)(5)(B) of the Act. Under both the reasonable cost and IPPS methodology, only the indirect costs of teaching programs relating to patient care (operating costs) is intended to be reimbursed by Medicare. This functional reading of the

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[67] *See, e.g.* Provider's Final Position Paper, Exhibits P-41, P-42, P-43, and P-44.

[68] While the documentation lists the general location of the research, it is not sufficient to conclude that the research was conducted on the hospital complex, as defined above. For example, the Intermediary pointed out, "The documentation doesn't establish for the direct GME research that resident research actually occurred in the hospital [complex] itself. Adjacent to these facility are related research facilities." *See* Transcript of Oral Hearing, p. 206. Moreover, the Provider acknowledged that the designated locations for the research were not self-evident. Id. at 218-19.

[69] *See* Transcript of Oral Hearing, p. 222-223.

word "area" was upheld by the Court of Appeals for the First Circuit in *Rhode Island Hospital v. Leavitt*,[70] which noted that:

> [T]he IME adjustment's legislative and administrative history adequately support the Secretary's conclusion that this provision was intended to compensate teaching hospitals for added costs of patient care unremunerated by the prospective payment system.[71]

Thus, to the extent that the residents' time at issue in this case is spent exclusively in research activities (not related to patient care), the time must be excluded from the IME FTE count pursuant to the above principles. Based on the Provider's inability to show whether the research time was directly related to patient care, the Administrator finds that the Intermediary's exclusion of research time for the IME FTE count was proper.[72]

[70] 548 F.3d 29 (2008).
[71] Id. at 44.
[72] Moreover problematic is whether the interns and residents, although assigned to an IPPS or outpatient area on "paper", were in fact working in the IPPS or outpatient area of the hospital when conducting their research.

DECISION

Issue No. 1:
The decision of the Board is reversed consistent with the foregoing opinion.

Issue No. 2:
The decision of the Board is reversed consistent with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 6/17/11

/s/
Marilynn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services