CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Henry Ford Hospital	
Provider	**Determination for Cost Reporting Periods Ending: December 31, 1991 through December 31, 1996; and December 31, 1998 and 1999**
vs.	
Blue Cross BlueShield Association National Government Services, LLC-WI	**Review of: PRRB Dec. No. 2008-D34 Dated: September 12, 2008**
Intermediary	

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 in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The Intermediary submitted comments requesting that the Administrator reverse the Board's decision to remand the case in Issue No.1 and to fully reverse the Board's decision in the remaining three issues. The parties were then notified of the Administrator's intention to review the Board's decision. Subsequently, the Provider submitted comments requesting that the Administrator reverse Issue No. 1, in part, and affirm the Board's decision in the three remaining issues of the case. CMS' Center for Medicare Management (CMM) also submitted comments requesting that the Administrator review the Board's decision. CMM agreed with the Board's decision in Issue No.1 and requested reversal of the three remaining issues. Accordingly, the case is now before the Administrator for final administrative decision.

BACKGROUND

The Provider is a 903-bed, nonprofit, acute care teaching hospital located in Detroit, Michigan. The Provider included Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) full time equivalents (FTEs) on its cost reports for fiscal years ending (FYEs) December 31, 1991 through 1996 and December 31, 1998 through 1999. The Intermediary audited the cost reports and adjusted the as-filed IME and DGME FTEs to its audit findings.

ISSUE NO. 1 AND BOARD'S DECISION

Issue No. 1 is whether the Intermediary properly excluded FTEs attributable to rotations by residents in certain unaccredited training programs. The Board found that the Intermediary's adjustments excluding FTEs attributable to rotations by residents in certain unaccredited training programs, were proper. The Board also remanded the issue to the Intermediary to determine the accuracy of claimed costs under the regulations.

ISSUE NO. 2 AND BOARD'S DECISION

Issue No. 2 is whether the Intermediary properly excluded FTEs attributable to time spent by residents in research that was required by the residents' approved medical residency programs. The Board found that the Intermediary's adjustments, reducing the Provider's IME FTE resident count for the time spent by residents in research that was required by the residents' approved medical residency program, were improper. The Board remanded the issue to the Intermediary to recalculate the IME adjustment to incorporate the time spent by residents in research activities that were part of their approved medical residency training program.

ISSUE NO. 3 AND BOARD'S DECISION

Issue No. 3 is whether the Intermediary properly excluded FTEs attributable to resident leave time when it is taken during rotations in which the resident is conducting research. The Board found that the Intermediary's adjustments reducing the Provider's IME FTE resident count for resident leave time taken by residents when in a research rotation was

improper. The Board remanded the issue to the Intermediary to recalculate the IME adjustment to incorporate the leave taken by residents when in a research rotation.

ISSUE NO. 4 AND BOARD'S DECISION

Issue No. 4 is whether the Intermediary properly excluded from the FTE cap, FTEs attributable to time spent by residents in new programs. The Board found that the Intermediary improperly excluded FTEs attributable to time spent in new programs from the FTE cap. The Board remanded the issue to the Intermediary to include all FTEs attributable to time spent in new programs in the 1996 FTE cap.

SUMMARY OF COMMENTS

The Intermediary submitted comments disagreeing with the Board's conclusion that a remand is proper in Issue No. 1 and requested reversal of the Board's decision to remand. The Intermediary asserted that the Provider could have claimed certain costs related to services of Fellows in non-approved training programs as Part B costs, however, the Provider did not make any effort to claim the costs on its as-filed cost report, and never supplied any documentation supporting such costs or claims. The Intermediary argued that the Provider did not want to go through the trouble of establishing its Part B costs unless and until the Board ruled against the Provider on its claim that the Fellowship programs qualified as approved programs. Accordingly, the Intermediary argued that it is not reasonable that the Provider should be able to make a wholly new claim at this late date.

Regarding Issue Nos. 2 and 3, concerning time spent in research activities, the Intermediary maintained that time spent by residents performing research activities, not directly related to patient care, must be excluded from the resident count. Similarly, leave time taken during a research rotation should be excluded from the resident count. Therefore, the Board was incorrect to include IME FTEs related to research rotations.

Regarding Issue No. 4, the Intermediary asserted that the regulation permits the addition of FTEs to the cap for new medical residency programs that receive initial accreditation between January 1, 1995 and August 5, 1997. The Intermediary argued that the programs were accredited before January 1, 1995, and, therefore, were not new programs as they had begun training residents before January 1, 1995.

CMM submitted comments requesting affirmation of the Board's decision in Issue No. 1 and reversal of the Board's decision in the remaining three issues. Regarding Issue No. 1, CMM stated that the Board properly disallowed the FTE residents in the programs in question from the direct GME and IME counts.

Regarding Issue No.2, CMM disagreed with the Board's conclusions concerning counting research time for purposes of IME payment and asserted that the Intermediary's adjustments were correct. CMM asserted that it has been a longstanding policy that research time cannot be counted for IME payment purposes. CMM argued, that essentially, the regulations and statutes indicate that Medicare never intended to provide reimbursement for research since it is not related to patient care.

Regarding Issue No. 3, CMM disagreed with the Board's finding that the vacation time associated with a research rotation should be allowed for the same reason that the research rotation itself should be allowed. CMM argued that, although it is expected that residents will use vacation and other approved leave during the course of an academic year, vacation time is not intrinsically part of the approved GME program.

Finally, regarding Issue No. 4, CMM disagreed with the Board's findings that the Vascular and Interventional Radiology program and the Clinical Neurophysiology program are "new." According to CMM, the Provider's programs were existing and, therefore, any residents in those programs in the base year were already included in the hospital's caps and do not warrant additional FTE cap adjustment.

The Provider commented, requesting reversal of the Board's decision in Issue No.1. The Provider disagreed with the Board's decision, which ruled that the Provider had not adequately demonstrated that the programs at issue would count toward certification in a residency program listed in the American Medical Association's Directory of Graduate Medical Education Programs (the "Green Book"). The Provider requested reversal of this aspect of the Board's decision since the plain language in the Green Book demonstrates that time spent in the programs at issue may count toward certification, and the programs were, therefore, "approved programs" for purposes of DGME and IME reimbursement.

Regarding Issue No. 2, the Provider claimed that the Board properly determined that the Intermediary incorrectly removed the time spent in research as part of an approved medical residency program from the IME FTE count. The Provider asserted that prior court decisions support the Board's decision and have rejected CMS' position that research time should be excluded from the IME FTE count.

Regarding Issue No. 3, the Provider argued that the Board's decision should be affirmed. The Provider asserted that the Intermediary's exclusion of vacation time that occurred

during a research rotation was improper since the basis of the Board's decision is the same as in Issue No. 2. The Provider also argued that if the Administrator determines that research time may not be included in the IME FTE count, the Administrator should modify the Board's decision and find that the disputed vacation time must be included in the IME FTE count.

Finally regarding Issue No. 4, the Provider asserted that the Board properly determined that the regulations require an addition to the Provider's FTE cap for programs that receive initial accreditation between January 1, 1995 and August 5, 1997.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments were received timely and are included in the record and have been considered.

Prior to 1983, Medicare reimbursed providers on a reasonable cost basis. Section 1861(v)(1)(a) of the Act defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included…." Section 1861(v)(1)(a) of the Act does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters.

The Secretary promulgated regulations which explained the principle that reimbursement to providers must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.[1] Reasonable cost includes all necessary and proper cost incurred in furnishing the services. Necessary and proper costs are costs, which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Accordingly, if a provider's costs include amounts not related to patient care, or costs that are specifically not reimbursable under the program, those costs will not be paid by the Medicare program.

Under reasonable cost, the allowable costs of educational activities included trainee stipends, compensation of teachers and other direct and indirect costs of the activities as

[1] See e.g. 42 C.F.R. §413.9.

determined under Medicare cost finding principles. The Secretary promulgated the regulation at 42 C.F.R. §413.85 which permits reimbursement for the costs of "approved educational activities"[2] This regulation 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.

The regulations governing research cost, under the "reasonable cost" system of reimbursement were found at 42 C.F.R. §405.422, et seq., and stated that the "[c]osts incurred for research purposes over and above usual patient care, are not includable as allowable costs."[3] The regulation at 42 C.F.R. §405.422(b)(2) further stated that:

> Where research is conducted in conjunction with and as a 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….[4]

Section 223 of the Social Security Act of 1972 amended section 1861(v)(1)(A) to authorize the Secretary to set prospective limits on the cost reimbursement by Medicare.[5] 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.

In 1982, in an effort to further curb hospital cost increases and encourage greater efficiency, Congress established broader cost limits than those authorized under section 1861(v)(1)(A), the existing routine cost limits. The Tax Equity and Fiscal Responsibility Act (TEFRA) added section 1886(a) to the Act, which expanded the existing cost limits to include ancillary services operating costs and special care unit operating costs in addition to routine operating costs. Pursuant to section 1886(1)(a)(ii) of the Act, these expanded cost limits, referred to as the "inpatient operating cost limits," applied to cost reporting periods beginning after October 1, 1982. The costs related to approved medical education program were not subject to the routine cost limits.

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[2] 42 C.F.R. §413.85(b)(1998). 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).

[3] See 31 Fed. Reg. 14814 (Nov. 22, 1966). See 42 C.F.R. §405.422, re-designated 42 C.F.R. §413.5(c)(2), and now at 42 C.F.R. §412.90.

[4] Id.

[5] Pub. Law 92-603.

Under the routine cost limits, under §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.[6] Thus, 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.[7]

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.[8] 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 "pass-through," i.e., paid on a reasonable cost basis.[9] Later, for the cost years at issue, the direct costs of the approved graduate medical education program

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[6] 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 educational costs …."

[7] 45 Fed. Reg. 21584 (April 1, 1980)(indirect teaching adjustment under pre-TEFRA cost limits); 46 Fed. Reg. 33637 (June 30, 1981)("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 to the new limits. …. The increase in the percentage amount of the adjustment … results from the fact that total *inpatient operating costs*, which include special care unit and inpatient ancillary costs, are more heavily influenced than routine costs by changes in the level of teaching activity. 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." (Emphasis added.)

[8] Pub. Law 98-21 (1983).

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

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).

However, Congress recognized that teaching hospitals might be adversely affected by implementation of inpatient PPS because of the indirect 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 the IPPS rates.[10] Thus, under §1886(d)(5)(B) of the Act, hospitals subject to IPPS, with approved teaching programs, receive an additional payment to reflect these IME costs.[11] The statue states 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 section (a)(2)* [i.e. under the reasonable cost routine cost limits] .... (Emphasis added.)

The regulation at 42 C.F.R. §412.105 governs IME payments to Medicare providers. 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.[12] The resident must be enrolled in an approved teaching program. In addition, the regulation at 42 C.F.R. § 412.105(f)(ii) explains that in order to be included in the FTE count, the resident must be assigned to one of the following areas:

> (A) The portion of the hospital subject to the prospective payment system portion of the hospital;
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> (B) The outpatient portion of the hospital;
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> (C) Effective for discharges occurring on or after October 1, 1997, the time spent by residents in a nonhospital setting in patient care activities under an

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[10] See 50 Fed. Reg. 35646, 35681 (1985).

[11] This IME payment is distinguished from the direct medical education costs.

[12] 42 C.F.R. §412.105(a)(1)(1997). See 49 Fed. Reg. 234 (1983) which noted that this additional payment is computed in the same manner as the indirect teaching adjustment under the notice of hospital cost limits published September 30, 1982 (47 Fed. Reg 43310).

> approved medical residency training program is counted towards the determination of full-time equivalency.[13]

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

> Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals receive an additional payment for 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 or the need of hospitals with teaching programs to maintain more detailed medical records. [Emphasis added.][14]

Moreover, in a final 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 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 graduated medical education programs.[15] [Emphasis added.]

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

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[13] 42 C.F.R. §412.105(f)(1)(1997).
[14] See 51 Fed. Reg. 16772 (May 6, 1986).
[15] See 54 Fed. Reg. 40282 (Sep. 29, 1989).

education programs.[16] Consistent with the Act and the regulations, the above principles were set forth the Provider Reimbursement Manual (PRM) at §2405.3F2 and state that a resident must not be counted for the IME adjustment if the resident is engaged exclusively in research. (Rev. 345, Aug. 1988)

Issue No. 1 - Accreditation of Training Programs

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

> (1) Is approved by one of the national organizations listed in §415.200(a) of this chapter.
>
> (2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:
>
> (i) The Director of Graduate Medical Education Programs published by the American Medical Association …; or
> (ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.

[16] The Administrator notes that the Secretary's longstanding policy of requiring hospitals to identify and excluded time spent by residents involved exclusively in research for purposes of the IME count adjustment was clarified at 42 C.F.R. §412.105(f)(1)(iii)(B)(2001). See 66 Fed. Reg 39896 (Aug. 1, 2001).

> (3) Is approved by the Accreditations Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

Likewise, the IME regulation at 42 C.F.R. §412.105(f)(1)(i) defines an approved program as one that meets one of the following requirements:

> (A) Is approved by one of the national organizations listed in §415.200(a) of this chapter.
>
> (B) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:
>
> (1) The Director of Graduate Medical Education Programs published by the American Medical Association:
> (2) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.

Applying the foregoing laws and regulations above to the facts of this case, the Administrator finds that the Board correctly found that the Intermediary's exclusion of FTEs attributable to rotations by residents in unaccredited training programs was proper. The Provider has not met the burden of proof to show that its training programs in dispute would or could be counted toward certification. The record is void of any such proof or documentation to demonstrate that its programs would count toward a certification as required under the regulations above.

In addition, the Administrator finds that the Board's decision to remand this issue to the Intermediary, to determine costs incurred (for salary, and salary-related fringe benefits) as reasonable costs under Part B is not appropriate. Even though the Provider's fellowship programs met the requirements of a non-approved educational program under the regulations, the Administrator finds that the Provider has failed to timely document and support its claims. The existing statutes, regulations, and case law indicate that the burden of proof is on the Provider to provide timely evidence to establish its claims.[17] In this case,

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[17] <u>See</u>, *e.g.*, *Rush University Medical Center v. Blue Cross Blue Shield Association*, Adm. Dec. No. 2007-D3, where the Administrator held that the Provider in *Rush* never claimed costs for transplant surgery residents and as such, could not at this late date be remanded to the Intermediary for further cost finding. a*ffirmed*, *Rush University Medical Center v. Leavitt*, No. 07-3648 (7th Cir. 8/1/2008) (pps. 12-13), *citing Little Co. of Mary Hosp. v.*

much like the case in *Rush*, *supra*, the Provider may not attempt to belatedly raise the alternative claim before the Board and expect reconsideration for reimbursement of costs since the Intermediary never had the opportunity to review such costs within the required timelines established under the statutes and regulations. Accordingly, the Administrator modifies the Board's decision to and vacates the remand in Issue No. 1 in this case.

Issue No. 2 - Research Rotations and Issue No. 3 - Resident Leave Time

Since the inception of the Medicare program, as discussed above, Congress has allowed the cost of training physicians based on the premise that these activities enhance the quality of care in an institution. The IME payment amount is based, in part, on the number of intern and resident full-time equivalents participating in a provider's GME program. Fiscal years 1991 through 1996, 1998, and 1999, at issue in this case, fall under the regulation originally codified at 42 C.F.R. §412.105(g) which states:

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

Effective October 1, 2001, the regulations governing the IME payment was clarified. The revised regulation at 42 C.F.R. §412.105(f)(1)(iii)(B) specifically excluded all time spent by residents in research not involving the care of a particular patient by stating:

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

Shalala, (165 F.3d 1162, 1165 (7th Cir. 1999), *St. Mary of Nazareth Hospital Center v. Shalala*, 96 F.Supp. 2d 773, 779 (N.D. Ill. 2000), and *Mercy Home Health v. Leavitt*, 436 F.3d 370,380 (7th Cir. 2006), 42 U.S.C. §1395*g*(a) and 42 C.F.R. §413.24(a)).

Applying the foregoing laws and regulations above to the facts of this case, the Administrator finds that the Board's decision on this issue was improper. The Intermediary's exclusion of research time for purposes of the IME payment was proper in this case. The Intermediary's adjustments were correct since time spent by residents performing research activities, not directly related to patient care, must be excluded from the resident count.

As indicated above, the August 1, 2001 *Federal Register* notice represents a clarification of the Secretary's longstanding policy on the treatment of research activities when calculating IME payment. Contrary to the Board's conclusion that this notice represents a "change in policy," the Administrator finds that this notice was a clarification and reinforcement of existing and longstanding policy that sets forth the prohibition of including research and non-patient care activities in the calculation of IME payments. Such activities are not related to the provision of patient care medical services for Medicare patients and, accordingly, should not be considered for the basis of calculating Medicare reimbursement.

The historical regulations set forth above at 42 C.F.R. §405.422, §413.5(c), and presently at §412.90 represent the progressive and consistent position of policy on this issue as it relates to indirect medical education costs. Congress specifically instructed the Secretary to implement the IME adjustment under IPPS, consistent with the indirect teaching methodology in place under reasonable cost routine cost limits. Historically, the indirect teaching adjustment has been related to higher inpatient costs related to patient care activities. In addition, the PRM at §2405.3F2 which prohibits the counting of residents engaged exclusively in research has been in place since 1988. When the historical rules on research are reviewed, it is clear that the regulations and manual instructions on research that are present today reflect and support the Intermediary's decision to exclude resident activities from the IME payment calculation since those activities are non-patient care research activities unrelated to Medicare.

Contrary to the Board's opinion, time spent by residents conducting research as part of an approved residency program in the fiscal periods at issue should not be included in the IME calculation when such activities are not related to patient care. The existing and historical policy and regulations has linked IME payments to the provision of patient care. The payment of such costs were based on the premise that for such costs to be allowable, i.e., such costs had to be reasonable, necessary and related to patient care as reflected in the regulations at 42 C.F.R. §413.9. As such, hospitals were required to separate operating

costs, i.e., patient care costs, from costs for other activities such as research and advertising to consumers.

In addition, the purpose of the IME adjustment, as reflected above, is limited to the unique characteristics and conditions of teaching hospitals that relate to the delivery of patient care. The IME adjustment is an add-on to the per case payment, which is based upon the standardized amount and the relative weight of the DRG, and which recognizes that teaching hospitals have higher allowable costs than non-teaching hospitals. This premise reinforces the notion that there is an intended connection between the count of the FTE residents used to calculate the IME adjustment and reasonable cost principles. FTE resident time counted for purposes of the IME payment must be limited to only encompass time spent by residents in the diagnosis and treatment of particular patients. Otherwise, Medicare would effectively be reimbursing a provider for non-patient care activities which were never intended to be paid by the Secretary since such costs were not costs incurred in the delivery of health care services attributable to Medicare beneficiaries.

Finally, the "are" within the hospital where the residents were "assigned" is a criteria under the regulations. The regulation at 42 C.F.R. §412.105(f)(1)(ii) states that in order to be counted, the residents must be "assigned" to either the "portion of the hospital subject to the prospective payment system" or "the outpatient department of the hospital."[18] Generally, as Medicare is a financing mechanism it is using such terms, not as geographical terms, but as terms that identify the scope of activies or functions or operations. The Administrator also notes that the regulations must be read and applied within the context of the reasonable cost regulations that likewise uses such terms as they relate to the inpatient hospital scope of patient care related activities for purposes of identifying costs. The Intermediary and Provider stipulated that "these FTEs represent the time that was spent while the residents were assigned either to areas of the Provider subject to the prospective payment or to the

[18] The Board referred to its previous decisions in University of Chicago Hospitals and Clinics v. Blue Cross Blue Shield Association / National Government Services, (PRRB Dec. No. 2007-D57, Aug. 8, 2007) and University Medical Center (Tucson, Ariz.) v. BCBS/Blue Cross and Blue Shield of Arizona, (PRRB Dec. No. 2005-D36, April 11, 2005). The Administrator disagrees with this interpretation of the regulation and they are not binding here. Similarly, the Board refers to the case in Riverside Methodist Hospital v. Thompson, [2003-2 Transfer Binder] Medicare Medicaid Guide (CCH) ¶ 301,431 (S.D. Ohio July 31, 2003), where the court recognized that time spent by residents in journal clubs and seminars is allowed in the IME count. The Administrator finds that the court's decision in Riverside is not binding and is also distinguishable from the facts of this case since the Riverside court did not address or deal with the issue of research.

outpatient department of the Provider." The record is not in dispute that the Providers were involved in research while notated as "assigned to" these departments in the hospital. However, even if the research activities conducted by the residents while they were notated as assigned to IPPS/OP departments in the hospital, such activities would not be reimbursable since the activity itself is not related to patient care and has no affect on the cost of such care. In fact, the "area" or scope of the residents' activities was "research" within that department. The Provider did not demonstrate that the research involved inpatient or outpatient patient care related activities in the department. Instead, the record indicates that the residents were doing research in the respective departments. As CMM noted, simply because resident are assigned to portions of the hospital subject to the IPPS, it does not mean such activities performed by the resident should be counted. It would be unreasonable to count a resident that is listed as "assigned to" an approved department, such as the outpatient department, but in fact, was involved in performing research activities at the medical library, since this resident's activities, in that scenario, will not affect the patient care costs of the hospital. While notated as assigned to that department, the residents here were performing "pure" "research" activities that may come under the broader educational umbrella of that department, but the activities are not related to the patient care scope of that department. The intent of listing where the resident is assigned is to identify the scope of her activities, which for these residents, is acknowledged to be "research" and, hence, involves a research rotation. Otherwise, to ignore the residents' activities would allow a provider to craft a rotation list which best maximizes Medicare reimbursement, without regard to the residents' activities. Accordingly, the Board's decision in Issue No. 2 is reversed. The Board was incorrect to approve research activities conducted by rotating residents to be included in the IME calculation.

Regarding Issue No. 3, the vacation and leave time in this case, the Board found that vacation time associated with a research rotation should be allowed for the same reason that the research rotation itself should be allowed. The Administrator finds that, although it is expected that residents will use vacation and other approved leave during the course of an academic year, vacation time is not intrinsically part of the approved GME program.

Such time, as explained in the August 22, 2007 IPPS final rule at 72 *Fed. Reg.* 47374, is neither patient care time, nor non-patient care time. It has always been CMS' policy to attribute each vacation period with the educational time that occurs immediately prior to, or after, the vacation. As such, if the rotation schedule indicates that the vacation occurs during an IPPS rotation, or in between two IPPS rotations, then the vacation time is associated with the allowable IPPS rotations, and is countable for IME and direct GME.

As discussed in Issue No. 2 above, the research activity is a non-allowable rotation for IME purposes and, as such, the vacation taken by the residents during the period in a non-allowable rotation, cannot be recognized for IME purposes. Accordingly, the Administrator reverses the Board's decision to allow leave time associated with research rotations.

Issue No. 4 - FTE Caps

For cost reporting periods beginning on or after October 1, 1997, the Medicare program established a cap on the number of residents a hospital can count for purposes of graduate medical education payments, based on each hospital's number of resident FTEs during the most recent fiscal year that ended on or before December 31, 1996.[19] The regulations also allow for adjustments to the cap based on the addition of residents in "medical residency training programs established on or after January 1, 1995." Specifically, the regulations at 42 C.F.R. §413.86(g) state:

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

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

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

The regulations state that in order to be an approved program, the program must either be accredited by a national accrediting organization, or the program counts toward board certification in a particular specialty or subspecialty. As recognized under the definition of an approved program at 42 C.F.R. 413.86(b) and 412.105(F)(1), it is not uncommon for certain specialties to be recognized by the American Board of Medical Specialties (ABMS) for purposes of board certification, prior to the time that the national accrediting agency (the ACGME in this instance) has had an opportunity to establish accreditation standards and begin to accredit these programs accordingly.

Both the Vascular and Interventional Radiology program and the Clinical Neurophysiology programs were approved by the ABMS prior to 1995. These programs were already established, and the Provider had already begun training residents in these programs before January 1995. Therefore, the Provider's programs in these specialties were existing and do not warrant additional FTE cap adjustments. Accordingly, the Administrator reverses the Board's findings on this issue. The Administrator finds that the time spent in the Vascular and Interventional Radiology and the Clinical Neurology programs were properly excluded by the Intermediary.

DECISION

Issue No. 1

In accordance with the foregoing opinion, the decision of the Board is modified.

Issue No. 2

In accordance with the foregoing opinion, the decision of the Board is reversed.

Issue No. 3

In accordance with the foregoing opinion, the decision of the Board is reversed.

Issue No. 4

In accordance with the foregoing opinion, the decision of the Board is reversed.

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

Date: **11/13/08**

/s/
Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services