PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D12

PROVIDER –
Immanuel - St. Joseph's Hospital
Mankato, Minnesota

Provider No.: 24-0093

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Noridian Administrative Services

DATE OF HEARING –
August 12, 2004

Cost Reporting Period Ended -
September 30, 1996

CASE NO.: 99-3024

INDEX

ISSUE:

Whether the Intermediary's adjustment to reduce the unweighted FTE resident count and related adjustment cap for time spent by residents providing services at the Mankato Clinic was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Medicare reimburses teaching hospitals for their share of costs associated with direct graduate medical education (GME) and indirect medical education (IME). The calculation for reimbursement requires a determination of the total number of full-time equivalent residents (FTEs) in the teaching program. The Statutory and Regulatory Background for this case is as follows:

The Medicare Act provides, in relevant part:

> 42 U.S.C. §1395ww(d)(5)(B)(iv) -- Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a non-hospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

> 42 U.S.C. §1395ww(h)(4)(E) -- Counting Time Spent In Outpatient Settings. Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

The Secretary's implementing regulation, 42 C.F.R. §413.86(f), entitled *Determining the total number of FTE residents*, provides in pertinent part:

> (iii) On or after July 1, 1987, the time residents spend in non-provider 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.

This case arises from a dispute over the FTE count.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Immanuel - St. Joseph's Hospital (Provider) is a rural acute care hospital with 212 licensed beds located in Mankato, Minnesota. The Provider entered into an agreement with the University of Minnesota School of Medicine Family Practice Program to begin training residents on July 1, 1995. As part of the family practice residency program, the residents spent time at the Mankato Clinic, an unrelated, non-hospital setting.

During the audit of the Provider's September 30, 1996 cost report, Blue Cross and Blue Shield of Minnesota[1] (Intermediary), adjusted the hospital's FTE count of residents to exclude the time spent at the Mankato Clinic. The adjustment was made because the Provider did not have a written agreement with the Mankato Clinic stating that the residents' compensation for training time spent at the clinic would be paid by the hospital. The estimated amount of Medicare reimbursement withheld as a result of this adjustment is $41,000.

[1]Noridian Administrative Services subsequently replaced Blue Cross and Blue Shield of Minnesota as the Intermediary.

The Provider appealed the Intermediary's adjustment to the Board and met the jurisdictional requirements of 42 C.F.R §§405.1835- 405.1841. The Provider was represented by Mr. David Glaser, Esquire, Fredrikson & Byron, P.A. The Intermediary was represented by Mr. Bernard Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that it entered into a written agreement with the University of Minnesota Medical School to train residents in the family practice residency program.[2] This agreement became effective July 1, 1995 and was in effect during the cost reporting year in question. The Provider contends that it paid the University of Minnesota Medical School $50,000[3] each year for each resident at the Provider, and that this payment was supported with invoices and cancelled checks. The Provider asserts that this payment represents all the cost associated with the residents in training, including the cost of the residents' time at the Mankato Clinic.

Medicare regulations at 42 C.F.R. 413.86 (f)(1)(iii) set forth the conditions that must be met in order for time residents spend in non-provider settings to be included in a hospital's FTE resident count.

The Provider contends that it met the written agreement requirement of the regulation, because a written contract was in place during the cost reporting year between the hospital and an outside entity, the University of Minnesota Medical School. The Provider claims that it was not until 1999 that the language of the regulation was revised to specify that the contract must be between the hospital and the "non-hospital site." The Provider also argues that the invoices from the medical school and the subsequent payment of those invoices by the Provider constitute a written agreement between the Provider and the University. The Provider contends that since the regulation for this time period was not specific as to whom the written contract was to be between, the Provider's written contract with the sponsoring university fulfilled the requirement of the regulation.

The Provider additionally argues that the regulation's requirement of having a written agreement between the parties is invalid because it contradicts the plain language of the Medicare statute, Section 1886(h)(4)(E) of the Social Security Act. The Provider maintains that the statute contains only one requirement that must be met in order for a provider to include the time residents spend in non-hospital settings in its FTE count: that the Provider is paying all, or substantially all, of the cost of operating the training program. Therefore, the Intermediary is required to count the residents' time spent at the Mankato Clinic. The Provider further argues that the written contract requirement of the regulation is outside the scope of the statute and that case law supports the fact

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[2] Provider's Supplemental Position Paper, Exhibit 5 - Agreement of Affiliation between the University of Minnesota Medical School Department of Family Practice and Community Health on behalf of the Board of Regents and Waseca Area Memorial Hospital and Immanuel-St. Joseph's Hospital

[3] Intermediary's Position Paper, Exhibit 2, Stipulation 6

that when the text of the statute is plain and unambiguous, a regulation cannot vary from the text.

The Intermediary contends that the written agreement between the Provider and the University of Minnesota does not meet the requirements of the regulation; therefore, the FTEs relating to the residents rotating to the Mankato Clinic should not be included in the calculation of the hospital's resident count. The Intermediary argues that based on the context of the cited regulation and the preceding paragraphs, the only logical reading of 42 C.F.R. 413.86(f)(iii)(B) requires the contract to be with the "non-provider setting." The Intermediary asserts that, to be in compliance with the regulations, the Provider's contract would have to be with the Mankato Clinic, and having a contract with just "an outside entity" is not enough to satisfy the requirement. The Intermediary also asserts that the implied contract attributed to the invoices and payments between the University and the Provider would also not satisfy the regulation's requirement, as the contract relationship would be with the University and not the Mankato Clinic.

The Intermediary asserts that the Provider's argument that the regulation is invalid because it goes beyond the plain language of the statute is unsubstantiated. It is within the Secretary's discretion to promulgate regulations implementing the statute, and in this case, the regulation closes the documentation gap between what the law requires and what the Provider is asserting is its proper FTE count. The Intermediary also argues that the Board is bound by the regulation and has to take it at face value, and therefore cannot make the determination if the regulation is inconsistent with the statute.[4]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and program instructions, evidence and the parties' contentions, finds and concludes as follows:

It is undisputed that there was a contract between the Provider and the University establishing collaboration between the two entities for the family practice residency program. It is also undisputed that as part of the residents' training, they spent a portion of their time providing patient care at the Mankato Clinic, an unrelated entity, and that no contract existed between the Provider and the Clinic relating to residents prior to January 1, 1998.[5]

The Provider has claimed that the written agreement between the Provider and the University of Minnesota fulfilled the written agreement requirement of 42 C.F.R. 413.86 (f)(iii)(B). At the hearing, the Provider contended that two separate statements in the written agreement between the Provider and the University require the Provider to incur the costs of the residents training at the clinic.[6] However, the Board has reviewed that written agreement and found that it does not explicitly address who will

[4] Transcript Pages 30-32.
[5] Intermediary Position Paper, Exhibit 2 – Stipulation of Undisputed Facts
[6] Transcript pages 43-45

bear the cost of the program, nor does it identify the outside entity where the training will take place.

With regard to the Provider's argument that the implied contract attributed to the invoices and payments between the University and the Provider constitutes a written agreement for the Provider to incur the costs of the residency program and fulfills the requirements of the regulation, the Board finds that this "implied contract" does neither. The contractual relationship would be with the University rather than the Mankato Clinic, and it does not address whether the resident training costs at the Mankato Clinic would be paid by the Provider.

The Board recognizes the Provider's argument that CMS removed the language in the regulation requiring providers to have a written agreement between the provider and the off-site entity in order to include the time residents spent in an off-site entity as part of the hospital's resident count. The Board also recognizes that CMS admitted that the written agreement requirement was not necessarily the most efficient tool in verifying which party incurred all or substantially all of the cost in the off-site training program.[7] However, the Board does not have the authority to apply a later regulation to an earlier year and therefore can not provide the relief that the later regulation allows to the Provider in this case.

Lastly, the Board has reviewed the Provider's argument relating to the discrepancy between the statute and the regulation but does not have the authority to deem the two inconsistent.

DECISION AND ORDER:

The Intermediary's adjustment to reduce the unweighted FTE resident count and related adjustment cap for time spent by residents providing services at the Mankato Clinic was proper. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

Date: December 23, 2005

Suzanne Cochran
Chairperson

[7] 69 Federal Register 49179