CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Atlantic 97 FTE Cap for IME Calculation Group	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: December 31, 1997**
Provider	
vs.	
Blue Cross Blue Shield Association / Riverbend Government Benefits Administrators	**Review of: PRRB Dec. No. 2007-D31 Dated: May 9, 2007**
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 parties were notified of the Administrator's intention to review the Board's decision. CMS' Center for Medicare Management (CMM) submitted timely comments, requesting reversal of the Board's decision. The Provider submitted timely comments requesting affirmation of the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

This group appeal was formed by Morristown Memorial Hospital and Overlook Hospital (collectively the "Providers"), which are acute care hospitals located in the State of New Jersey. For the cost report period that ended on December 31, 1997, the Providers used their total actual full time equivalent (FTE) counts (109.41 at Morristown; 93.14 at Overlook) to calculate their IME payments from January 1, 1997 through September 30, 1997. The

Intermediary applied CMS Pub. 15-2 §3630 (the cost report form CMS-2552-96 instructions) to develop a weighted average for the same period. There is no dispute that the Intermediary properly applied the reporting instructions.

ISSUE AND BOARD'S DECISION

The issue is whether the cost report instructions improperly apply the indirect medical education (IME) FTE cap to discharges prior to October 1, 1997.

The Board held that the Intermediary's calculation of the Providers' IME reimbursement was consistent with the cost report instructions at CMS Pub. 15-2 §360. However, the cost report instructions that subject payments for discharges prior to the October 1, 1997 FTE cap are inconsistent with the provisions of the Balanced Budget Act of 1997 (BBA-97).

The Board stated that the plain language of the statute requires the use of the total uncapped FTE count in the calculation of the IME ratio for discharges prior to October 1, 1997 and that resulting factor should then be applied to the actual DRG payments for discharges for that period. The Board reversed the Intermediary's adjustments for fiscal year 1997, and remanded the case to the Intermediary for recalculation consistent with the Board's decision.

SUMMARY OF COMMENTS

CMM submitted comments requesting that the Administrator overturn the Board's decision. CMM described the methodology outlined in CMS Pub 15-2 §3630 to calculate the IME payments for providers where the October 1, 1997 effective date falls within the hospital's cost reporting period. CMM asserted that since the calculation of the weighted average FTE count takes into consideration percentages of discharges prior to, and on or after October 1, 1997 and applies the cap to only the period after October 1, 1997 the methodology appropriately implements the statutory provision in the BBA-97.

The Provider submitted comments stating that the Board correctly found that the cost report instructions issued by CMS to implement BBA-97 require providers to apply the IME FTE base year cap to discharges prior to October 1, 1997. The Provider asserted that CMM overlooked the fact that application of the instructions has the effect of imposing the IME cap on discharges prior to the operative date of the IME cap, i.e. October 1, 2007, to the disadvantage of hospitals. The Provider asserted that the Board followed settled law in ruling that the cost report instructions with respect to the IME reimbursement were

inconsistent with the plain language of the implementing legislation and, therefore, could not be enforced.

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. After a review of the record, applicable regulations and manual instructions, it is apparent that the Intermediary's calculation of the Providers' IME reimbursement was proper.

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 there from 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 the inception of the Medicare program, Congress has allowed hospitals' costs for operating programs for residents' training base don the premise that "…these activities enhance the quality of care in an institution."[1] In 1983, Congress recognized that teaching hospitals have indirect operating costs that would not be reimbursed under the prospective payment system or by the Direct Graduate Medical Education (DGME) payment methodologies, and it authorized an additional payment known as the IME payment to hospitals with GME programs.[2]

Specifically, 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' instruction. The IME adjustment attempts to measure teaching intensity base on "the ratio of the hospital's full-time equivalent interns and residents to beds."[3] Thus, the

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[1] 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).

[2] 42 U.S.C. §1395ww(d)(5)(B).

[3] Id.

IME payment amount is based, in part, upon the number of intern and resident FTEs participating in a provider's GME Program.

The BBA-97 placed a limitation on resident FTEs for purposes of determining the IME payment by amending section 1886(d)(5)(B)(v) of the Act as follows:

> In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or non-hospital setting may not exceed the number of such full time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 1, 1996.

The central issue in dispute is whether the cost report instructions which implement BBA-97 improperly apply the 1996 IME FTE base year cap to discharges prior to October 1, 1997. As specified in the cost report instructions at CMS Pub. 15-2 §3630, CMS instructed the Intermediary to apply a specific methodology for calculating the IME factor. First, providers are to enter the percentage of discharges to total discharges occurring prior to October 1, 1997 and the percentage occurring on or after October1, 1997 respectively, on specific lines of the cost report. Second, the cost report instructions direct providers to enter the full year's actual FTE count. Multiplication of the full year's FTE count by the percentage of discharges to total discharges in the two periods discussed above results in prorating the full year's FTE count based on discharges. Finally, the cost report instructions apply the IME cap only to the prorated FTE count for the period on or after October 1, 1997 and computes a weighted average FTE count for the full year that accounts for both the period prior to October 1, 1997 (in which the prorated FTE count based on discharges is not subject to the IME cap) and the period on or after October 1 (where the IME cap is applied). The resultant weighted average FTE count is then used in the calculation of the IME factor which is applied to the DRG payment for each discharge.

In light of the foregoing, the Administrator finds that the methodology outlined in CMS Pub 15-2 §3630 to calculate the IME payments for providers was appropriately applied by the Intermediary and does not conflict with BBA-97. The calculation of the weighted average FTE count takes into consideration percentages of discharges prior to, and on or after October 1, 1997, and applies the cap to only the period after October 1, 1997.

The Administrator finds that the existing cost report instructions at CMS Pub 15-2 §3630 do not disadvantage providers. The cost report instructions properly account for the application of the IME cap to the period on or after October 1, 1997. In fact, hospitals could benefit under the instructions if the hospital had trained disproportionately more residents in the portion of the cost reporting period occurring on or after October 1, 1997.

The Administrator also finds that, iven the already complex nature of calculating the IME factor, the methodology implemented under CMS Pub 15-2 §3630 is administratively expedient. Implementation of the alternative methodology asserted by the Board would unnecessarily increase the administrative burden on the Medicare program by adding excessive requirements for providers and intermediaries in administering an already complex reimbursement scheme.

Finally, there is no statutory requirement for CMS to develop a separate methodology to calculate a separate IME factor for periods prior to, and on or after October 1, 1997. This would unnecessarily require additional documentation by hospitals, a more complicated series of calculations and additional information to be reported in the cost report in order to apply two separate IME factors in the same cost reporting period.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

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

Date: 7/13/07

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