PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

On the Record
2022-D25

PROVIDER –
St. John Medical Center

RECORD HEARING DATE –
March 22, 2021

Provider No. –
36-0123

Cost Reporting Period Ended –
December 31, 2011

vs.

MEDICARE CONTRACTOR –
CGS Administrators, LLC (J-15)

CASE NO. –
15-2439

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor erred in disallowing Medicare managed care payments associated with the Provider's operation of its pastoral care allied health education program.[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor's adjustment to disallow the Provider's Nursing and Allied Health Managed Care add-on payment for the fiscal year ending December 31, 2011 ("FY 2011") was proper.

INTRODUCTION

St. John Medical Center ("St. John" or "Provider") is an acute care hospital located in Westlake, Ohio.[2] St. John's assigned Medicare contractor[3] is CGS Administrators, LLC ("Medicare Contractor").

St. John disputes the Medicare Contractor's Audit Adjustment No. 19 in the final settled cost report for FY 2011. This adjustment disallowed St. John's claimed $78,739 Nursing and Allied Health Managed Care ("NAHMC") add-on payment.[4]

St. John timely appealed the issue to the Board, and met the jurisdictional requirements for a hearing. The Board approved a hearing on the record on March 22, 2021. St. John was represented by David Johnston, Esq. of Bricker & Eckler LLP. CGS Administrators was represented by Joseph Bauers, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

St. John operated an approved pastoral education nursing and allied health program in its FY 2011 and received Medicare reasonable cost reimbursement for that program.[5] St. John also operated the same program in its cost reporting periods ending September 20, 2008 and December 31, 2009 and received Medicare reasonable cost reimbursement.[6]

Significantly, St. John experienced an internal change of ownership ("CHOW") effective December 31, 2009. As a result of the CHOW, St. John filed a cost report for the period October

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[1] Stipulation of Parties (hereinafter "Stip.") at ¶ 1.
[2] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 5.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Medicare Contractor's FPP at 12. St. John also appealed the Medicare Contractor's adjustments to its claim for reimbursable bad debts, but subsequently withdrew the bad debts issue from its appeal.
[5] Stip. at ¶ 5.
[6] *Id.* at ¶ 6.

1, 2007 to September 30, 2008 followed by a long cost report for the period October 1, 2008 to December 31, 2009, a fifteen-month period.[7]

Congress established and refined the entitlement of hospitals that operate approved nursing and allied health education programs and receive reasonable cost reimbursement for those programs, to additional payments based on each hospital's Medicare + Choice utilization. First, § 541 of the Balanced Budget Refinement Act ("BBRA") of 1999 provides for additional payments to hospitals for the costs of nursing and allied health education associated with services to Medicare + Choice enrollees. Hospitals that operate approved nursing and allied health education programs and receive Medicare reasonable cost reimbursement for these programs receive additional payments. Section 541 limits total spending under the provision to no more than $60 million in any calendar year ("CY").[8]

Congress further refined that the add-on payment in § 512 of the Benefits Improvement and Protection Act ("BIPA") by changing the formula for determining the additional amounts to be paid to hospitals for Medicare + Choice nursing and allied health costs.[9] Under § 541 of the BBRA, the additional payment was determined based on the proportion of each individual hospital's nursing and allied health education payment to total nursing and allied health education payments made to all hospitals. However, this formula did not account for a hospital's specific Medicare + Choice utilization. BIPA § 512 revised this payment formula to specifically account for each hospital's Medicare + Choice utilization.

As a result of BBRA § 541 and BIPA § 512, 42 U.S.C. of the Benefits Improvement and Protection Act ("BIPA"), 42 U.S.C.A. § 1395ww(l) provides additional payments to hospital based on each hospital's Medicare + Choice utilization as follows:

> *(l) Payment for nursing and allied health education for managed care enrollees*
>
> (1) *In general*
>
> For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for **an additional payment amount** for any hospital that receives payments for the costs of approved educational activities for nurse and allied health professional training under section 1395x(v)(1) of this title.
>
> (2) *Payment amount*
>
> The additional payment amount under this subsection for each hospital for portions of cost reporting periods occurring in a year

[7] Medicare Contractor's FPP at 14.
[8] Pub. Law 106-113, Appendix F § 541, 113 Stat. 1501, 1501A–391 (1999).
[9] Pub. Law 106-554, Appendix F § 512, 114 Stat. 2763, 2763A–533 (2000).

shall be an amount specified by the Secretary in a manner consistent with the following:

(A) *Determination of managed care enrollee payment ratio for graduate medical education payments*

The Secretary shall estimate the ratio of payments for all hospitals for portions of cost reporting periods occurring in the year under subsection (h)(3)(D) to total direct graduate medical education payments estimated for such portions of periods under subsection (h)(3).

(B) *Application to fee-for-service nursing and allied health education payments*

Such ratio shall be applied to the Secretary's estimate of total payments for nursing and allied health education determined under section 1395x(v) of this title for portions of cost reporting periods occurring in the year to determine a total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year; except that in no case shall such total amount exceed $60,0000,000 in any year.

(C) *Application to the hospital*

The amount of payment under this subsection to a hospital for portions of cost reporting periods occurring in a year is equal to the total amount of payments determined under subparagraph (B) for the year multiplied by the ratio of—

(i) the product of (I) the Secretary's estimate of the ratio of the amount of payments made under section 1395x(v) of this title to the hospital for nursing and allied health education activities **for the hospital's cost reporting period ending in the second preceding fiscal year, to the hospital's total inpatient days for such period**, and (II) the total number of inpatient days (as established by the Secretary) for such period which are attributable to services furnished to individuals who are enrolled under a risk sharing contract with an eligible organization under section 1395mm of this title and who are entitled to benefits under part A or who are enrolled with a Medicare + Choice organization under part C; to

(ii) the sum of the products determined under clause (i) for such cost reporting periods.

The regulation at 42 C.F.R. § 413.87 implements 42 U.S.C.A. § 1395ww(l), stating, in relevant part:

> (a) *Statutory basis*. This section implements section 1886(1) of the Act, which provides for additional payments to hospitals that operate and receive Medicare reasonable cost reimbursement for approved nursing and allied health education programs and the methodology for determining the additional payments.
>
> (b) *Scope*. This section sets forth the rules for determining an additional payment to hospitals that receive payments for the costs of operating approved nursing or allied health education programs under § 413.85.
>
> (c) *Qualifying conditions for payment*. (1) For portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001, a hospital that receives payment for a nursing or allied health education program under § 413.85 may receive an additional payment amount associated with Medicare + Choice utilization. The hospital may receive the **additional** payment amount, which is calculated in accordance with paragraph (d) of this section, **if** both of the conditions specified in (c)(1)(i) and (c)(1)(ii) of this section are met.
>
> (i) **The hospital must have received Medicare reasonable cost payment for an approved nursing and allied health education program under § 413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year**. (For example, if the current year is calendar year 2000, the fiscal year that is 2 years prior to calendar year 2000 is fiscal year 1998.) For a hospital that first establishes a nursing or allied health education program after FY 1998 and receives reasonable cost payment for the program as specified under § 413.85 after FY 1998, the hospital is eligible to receive an additional payment amount in a calendar year that is two years after the respective fiscal year so long as the hospital also meets the condition under paragraph (c)(1)(ii) of this section.
>
> (ii) The hospital must be receiving reasonable cost payment for an approved nursing or allied health education program under § 413.85 in the current calendar year.
>
> (2) For portions of cost reporting periods occurring on or after January 1, 2001, in addition to meeting the conditions specified in paragraphs (c)(1)(i) and (c)(1)(ii) of this section, the hospital must have had a Medicare + Choice utilization greater than zero in its

cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year. . . .

***

(e) *Calculating the additional payment for portions of cost reporting periods occurring on or after January 1, 2001.* For portions of cost reporting periods occurring on or after January 1, 2001, subject to the provisions of § 413.76(d) relating to calculating a proportional reduction in Medicare + Choice direct GME payments, the additional payment amount specified in paragraph (c) of this section is calculated according to the following steps:

(1) *Step one*. Each calendar year, determine for each eligible hospital the total –

(i) Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year; and

(ii) Inpatient days for that same cost reporting period.

(iii) Medicare + Choice inpatient days for that same cost reporting period.

(2) *Step two*. Using the data from step one, determine the ratio of the individual hospital's total nursing or allied health payments, to its total inpatient days. Multiply this ratio by the hospital's total Medicare + Choice inpatient days.

(3) *Step three*. CMS will determine, using the best available data, for all eligible hospitals the total of all-

(i) Nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year;

(ii) Inpatient days from those same cost reporting periods; and

(iii) Medicare + Choice inpatient days for those same cost reporting periods.

(4) *Step four.* Using the data from step three, CMS will determine the ratio of the total of all nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar

> year, to the total of all inpatient days from those same cost reporting periods. CMS will multiply this ratio by the total of all Medicare + Choice inpatient days for those same cost reporting periods.
>
> (5) *Step 5*. Calculate the ratio of the product determined in step two to the ratio of the product determined in step four.
>
> (6) *Step 6*. Multiply the ratio calculated in step five by the amount determined in accordance with paragraph (f) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.
>
> (f) *Calculation of the payment "pool."* (1) Subject to paragraph (f)(3) of this section, each calendar year, CMS will calculate a Medicare + Choice nursing and allied health payment "pool" according to the following steps:
>
> (i) Determine the ratio of projected total Medicare + Choice direct GME payments made in accordance with the provisions of § 413.76(c) across all hospitals in the current calendar year to projected total direct GME payments made across all hospitals in the current calendar year.
>
> (ii) Multiply the ratio calculated in paragraph (f)(1)(i) of this section by projected total Medicare nursing and allied health education reasonable cost reimbursement payments to all hospitals in the current calendar year.
>
> (2) The resulting product of the steps under paragraphs (f)(1)(i) and (f)(1)(ii) of this section is the Medicare + Choice nursing and allied health payment "pool" for the current calendar year.
>
> (3) The payment pool may not exceed $60 million in any calendar year.[10]

The *sole* issue in this appeal is the interpretation, and implementation, of the following regulatory phrase in § 413.87(c)(1)(i):

> The hospital must have received Medicare reasonable cost payment for an approved nursing and allied health education program under § 413.85 *in its cost reporting period(s)* ***ending in the fiscal year*** *that is 2 years prior to the current calendar year*.[11]

[10] (Bold and underline emphasis added.)
[11] 42 C.F.R. § 413.87(c)(1)(i) (emphasis added).

Thus, St. John's entitlement to a managed care add-on payment ***in its FY 2011*** for its nursing and allied health educational costs is *dependent upon* whether it received reasonable cost reimbursement for an approved nursing and allied health education program "in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year" where "the current calendar year" for purposes of FY 2011 was the calendar year 2011.[12] Thus, if the term "fiscal year" refers to federal fiscal year ("FFY"), then "2 years prior to the current calendar year"[13] would be FFY 2009 which covered the period October 1, 2008 to September 30, 2009. As a result of a change of ownership ("CHOW"), St. John filed a fifteen-month cost report for the period of October 1, 2008 to December 31, 2009. Therefore, because of the CHOW, St. John did ***not*** have a cost reporting period that actually ended in FFY 2009 and, thus, did ***not*** receive "Medicare reasonable cost payment for an approved nursing and allied health education program . . . in its cost reporting period(s) ending in the [FFY 2009]."[14]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor contends that it made the adjustment at issue in accordance with following excerpt from the Program Memoranda, Transmittal No. A-03-043 ("PM A-00-043")[15]:

> [t]he Provider must have received reasonable cost Medicare payment for a nursing or allied health education program in its cost reporting period ending in the ***federal fiscal year*** that is two years prior to the current calendar year. The current calendar year ended December 31, 2011. The federal fiscal year that is two years prior is October 1, 2008 – September 30, 2009. As a result of a CHOW, the Provider did *not* have a cost report that ended during the ***federal fiscal year*** ending September 30, 2009. Its September 30, 2008 cost report ended prior to FFY 2009 and its December 31, 2009 cost report ended after FFY *2*009. Therefore, since the Provider does not have a cost report that ends during FFY 2009, the Provider does not qualify for the NAHMC add-on payment in calendar year 2011.[16]

St. John argues that "[b]esides being inconsistent with allowing the cost reimbursement under 42 C.F.R. § 413.85, the [Medicare Contractor's] disallowance is in error because [St. John] satisfied all of the requirements for receiving the managed care payments under 42 C.F.R. § 413.87."[17] St. John states that the Medicare Contractor is incorrectly reading the regulation, arguing that the

> [F]ederal fiscal year that is two years prior to the calendar year ending December 31, 2011 actually refers to two federal fiscal years: FFY 2009 (10/1/2008 – 9/30/2009) and FFY 2010 (10/1/2009 – 9/30/2010). Accordingly, St. John contends FFY 2009 contains the

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[12] *Id*.
[13] *Id*.
[14] *Id.*
[15] Exhibit C-6 (copy of CMS Program Memoranda, Nursing and Allied Health Education, Transmittal No. A-03-043 (May 23, 2003)).
[16] Medicare Contractor's FPP at 14 (emphasis added).
[17] Provider's Final Position Paper (hereinafter "Provider's FPP") at 10.

> date that is two years prior to the beginning of calendar year 2011 (*i.e.*, two years prior to January 1, 2011 is January 1, 2009) and FFY 2010 contains the date that is two years prior to the ending of calendar year 2011 (i.e., two years prior to 12/31/2011 is 12/31/2009). Measured based on either date, the Provider did receive reimbursement for an allied health program during the federal fiscal year ending two years prior to calendar year 2011.[18]

The Board notes that, in the relevant Federal Register issuances, "federal fiscal year" and "fiscal year" are synonymous, and that the phrase, "the fiscal year that is 2 years prior to the current calendar year" is clarified in those issuances. The Interim Final Rule, published on August 1, 2000 discussed the implementation of the Allied Health education payments under BBRA § 541 and stated, "[o]ther provisions do not become effective **until Federal fiscal year (FY) 2001** or later."[19] Similarly, the Board notes that the PM A-00-043 states:

> The hospital must have received reasonable cost Medicare payment for a nursing or allied health education program(s) in its cost reporting period(s) ending in the Federal FY that is two years prior to the current calendar year. For example, if the current calendar year is CY 2001, the FY is two years prior to CY 2001 is FY 1999.[20]

PM A-00-043, like the Federal Register, uses the term "Federal fiscal year" and "fiscal year" interchangeably. Indeed, the regulation uses the same language as that used in 42 U.S.C. § 1395ww(l)(2)(C)(i) and a review of § 1395ww confirms the term "fiscal year" refers to federal fiscal year.[21] Thus, the phrase "two years prior to the current calendar year" means, for St. John, the 2009 federal fiscal year that is two years prior to calendar year ending December 31, 2011. The memorandum clearly indicates that the cost report period end date is the driver for this purpose. This requirement allows for the calculation of a hospital's NAHMC add-on payment for the current cost report year. The Hospital Cost Report Information System ("HCRIS") gathers the data for hospitals claiming entitlement to a NAHMC add-on payment. The ***data*** from hospital cost reporting periods ending in FFY 2009 would both establish entitlement to, and factor into the calculation of, any NAHMC add-on payment for those associated with calendar year 2011.[22] However, St. John's September 30, 2008 cost report period ended prior to FFY 2009 and its December 31, 2009 long cost report period ended after the close of FFY *2*009 on September 30,

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[18] *Id.* at 10-11.

[19] 65 Fed. Reg. 47026, 47027 (Aug. 1, 2001) (emphasis added) (interim final rue entitled "Medicare Program; Provisions of the [BBRA]; Hospital Inpatient Payments and Rates and Costs of Graduate Medical Education").

[20] *See also id.* at 47027.

[21] For example, the inpatient prospective payment system is based on federal fiscal year and the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for federal fiscal years 1986 forward as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and then cross referenced in § 1395ww(d)(3(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) defines the term "applicable percentage increase" starts with "fiscal year 1986" and referenced the percentage increase for each subsequent "fiscal year."

[22] 42 C.F.R. § 412.87(c)(i) states that "[t]he hospital must have received Medicare reasonable cost payment for an approved nursing or allied health education program under §413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year" and § 412.87(d) states that "[e]ach calendar year, determine the hospital's total nursing and allied health education program payments from its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year."

2009 and, thus, was not part of the relevant FFY 2009 data. Thus, the Board finds that St. John did ***not*** have a cost report period ending in FFY 2009 and, as a result, HCRIS did not pick up any data for St. John relative to FFY 2009 add-on payment pool. The absence of data for FFY 2009 disqualifies St. John from receiving an add-on payment for its FY 2011 and prevents the calculation of the NAHMC add-on payment for its FY 2011. Thus, St. John did not qualify for, and the Medicare Contractor correctly disallowed, the NAHMC add-on payment in its FY 2011 cost report.

The Board also notes that the *exact* scenario presented in this appeal was addressed in the preamble to the June 13, 2001 Interim Final Rule. In the preamble to the Interim Final Rule, CMS provided the following explanation of steps three and four (the denominator data) of the additional payment calculation in § 413.87(e)(3) and (4):

> To determine these totals, we will use the best available cost reporting data for the applicable hospitals from the Hospital Cost Report Information System ("HCRIS") for cost reporting periods in the fiscal year that is 2 years prior to the calendar year. . . . *If a hospital does* ***not*** *have a cost reporting period in the fiscal year that is 2 years prior to the current calendar year (such as a hospital with a long cost reporting period),* ***the hospital's data will be included in the calculations for the calendar year that is 2 years after the fiscal year in which the long cost reporting period ends***.[23]

As part of the August 1, 2001 FY 2002 IPPS Final Rule, the Secretary finalized the above interim final regulation.[24]

Here, St. John filed a 15-month cost report for the period of October 1, 2008 to December 31, 2009 which necessarily means it ended in FFY 2010. As a result, this long cost reporting period did not ***end*** in FFY 2009, which is the FFY 2 years prior to the FY at issue in this appeal and which ran from October 1, 2008 to September 30, 2009. Accordingly, the Board finds that St. John does ***not*** qualify for the NAHMC add-on payment for its ***FY 2011*** cost report.

The finding that St. John did not qualify for an add-on payment in ***FY 2011*** does not mean that St. John would not (or did not) qualify for an add-on payment at all *based on the data from the long cost reporting period ending December 31, 2009* (*i.e.*, the period from October 1, 2008 to December 31, 2009). Rather, it means that the add-on payment associated with the data from that long cost reporting period occurs *in a different fiscal year*. In this regard, the Board notes that, per the above excerpt from the preamble to the June 13, 2011 Interim Final Rule, St. John *would* qualify for the additional add-on payment based on that data in its FY 2012 cost report (*i.e.*, the cost report for the fiscal year ending December 31, 2012) because its FY 2009 cost report (*i.e.*, the cost report for the fiscal years ending December 31, 2009) ended in federal fiscal year 2010; the federal fiscal year that is two years prior to calendar year 2012 (October 1, 2009 – September 30, 2010). However, the FY 2012 cost report was *not* part of this hearing and it is unclear from the

[23] 66 Fed. Reg. at 32179 (emphasis added). The Board notes that *neither* party in this appeal addressed this preamble language in their position papers.
[24] 66 Fed. Reg. 39828, 39909-10 (Aug 1, 2001).

record in this appeal whether St. John filed a claim for the add-on payment as part of its FY 2012 cost report.[25]

DECISION AND ORDER

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor's adjustment to disallow St. John's NAHMC add-on payment for FY 2011 was proper.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD

9/12/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[25] Indeed, allowing St. John to receive an add-on payment for FY 2011 *based on data from the long period ended December 31, 2009* could result in a duplicate payment based on that same data since that data is what its add-on payment for FY 2012 would be based on. This duplicate payment would be contrary to the regulatory and statutory structure.