PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D6

PROVIDER -St. Mary's Hospital
Huntington, West Virginia

Provider No. 51-0007

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Trigon Blue Cross and Blue Shield

DATE OF HEARING-
March 26, 1996

Cost Reporting Period Ended -
September 30, 1990

CASE NO. 93-1518+/C

INDEX

ISSUES:

1. Was the Intermediary's treatment of equity income as investment income proper?[1]

2. Does 42 C.F.R. § 412.106, as promulgated, violate the Medicare Act, the Administrative Procedure Act and/or the Constitution?[2]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Mary's Hospital ("Provider") is a not-for-profit, acute care hospital located in Huntington, West Virginia. For its fiscal year period ended ("FYE") September 30, 1990, the Provider timely filed its Medicare cost report, and was issued a Notice of Program Reimbursement ("NPR") on July 20, 1993 by Blue Cross and Blue Shield Association/Trigon Blue Cross and Blue Shield ("Intermediary"). In the NPR, the Intermediary treated the interest on the funds, borrowed by the Provider to contribute to Tri-State Magnetic Resonance Imaging ("TSMRI"), as non-allowable interest. In addition, the Intermediary treated as investment, the amount of TSMRI operating revenue received by the Provider which was proportional to the amount of operating funds the Provider contributed to TSMRI as capital. The Intermediary then offset the TSMRI operating revenue, which was deemed to be investment income, against the Provider's otherwise allowable interest expense. Since FYE 1990 was the Provider's base year for its Prospective Payment System ("PPS") Capital, this adjustment lowering its capital costs had the effect of reducing the Provider's PPS Capital Hospital Specific Rate. Also in FYE 1990, the Intermediary did not credit 981 days of inpatient care in the Provider's Disproportionate Share ("DSH") adjustment, because they were for Medicaid patients who had exhausted their per patient limits under either the West Virginia or Kentucky Medicaid plans. Pursuant to the provisions of 42 C.F.R. §§ 405.1835-.1841, the Provider appealed the Intermediary's determinations to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of these regulations. The estimated amount of Medicare reimbursement in controversy for issue 1 is approximately $41,000[3] in non-

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[1] The facts related to this issue form the basis of the Provider's appeal from its FYE 1990 NPR in Case No. 93-1518+ and its appeal from its Notice of Hospital Specific Rate for Capital-Related Costs in Case No. 93-1518C. The Board's decision on this issue will be applicable to both appeals.

[2] This issue is only applicable to Case No. 93-1518+. See Tr. at 5.

[3] See Provider Exhibit 44 for Case No. 93-1518+.

allowable interest and $283,000 in capital reimbursement.[4] The estimated amount of Medicare reimbursement in controversy for issue 2 is $133,950.[5]

The Provider was represented by David W. Thomas, Esquire, of Nash & Company. The Intermediary's representative was Michael F. Berkey, Esquire, of Blue Cross and Blue Shield Association.

Issue 1 - Treatment of Equity Capital as Investment Income:

Background

In 1985, the Provider decided to provide magnetic resonance imaging MRI services in its patient service area which required prior State Certificate of Need ("CON") approval. In West Virginia, responsibility for health planning and CON reviews lies with the West Virginia Health Care Cost Review Authority ("WVHCCRA") which functions as the State Health Planning and Development Agency. Although a moratorium was initially declared on CONs for MRI services, WVHCCRA subsequently adopted a formula for evaluating the potential need of such services which required a minimum projection of 2,500 procedures annually for both inpatient and outpatient combined.

Acting upon the advice of WVHCCRA, the Provider and another area provider, Cabell Huntington Hospital ("CHH"), applied jointly to obtain a CON for an MRI unit since neither facility could project a sufficient number of annual procedures to qualify separately for a CON. Upon obtaining CON approval for a joint venture MRI facility from WVHCCRA, a general partnership known as TSMRI was subsequently formed by the Provider and CHH with each owning an equal fifty percent ownership share. The operations of TSMRI were overseen by a governing board composed of the Chief Financial Officers and Chief Executive Officers of the Provider and CHH and was staffed by employees from each partner's facility. TSMRI operated as a separate entity with each partner being reimbursed separately for costs it incurred and all excess revenues, that is, the difference between TSMRI's revenues and expenses, divided on 50/50 basis.

The Provider made its initial capital contribution to TSMRI in part from operating funds ($150,000) and in part from borrowed funds ($397,592). The Provider accounted for its share of TSMRI using the equity method of accounting. The Provider recorded TSMRI revenue as operating revenue.

The Intermediary determined that only 266 out of 5,193 treatments rendered by TSMRI were to the Provider's inpatients. The Intermediary treated the interest on the funds borrowed by

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4 See Provider Exhibit 30 for Case No. 93-1518C

5 See Provider Exhibit 47 for Case No. 93-1518+.

the Provider to contribute to TSMRI as non-allowable interest. In addition, the Intermediary treated, as investment income, the amount of TSMRI operating revenue received by the Provider. The Intermediary offset this amount against the Provider's otherwise allowable interest expense.[6] The Intermediary's adjustment also affected the Provider's PPS Capital Hospital Specific Rate by lowering its capital cost in fiscal year 1990 which was the Provider's PPS Capital base year.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary erred by treating income generated by TSMRI as investment income. HCFA Pub. 15-1 § 1218.2 expressly defines "invested funds" as funds diverted to income producing activities that are not related to patient care. The sole activity conducted by TSMRI is the provision of MRI services. MRI services are clearly patient care-related activities. Thus, the funds contributed as capital to TSMRI are not invested funds. Not being such, they cannot generate investment income.

The Intermediary's argument that TSMRI is not conducting the Provider's patient care-related activities ignores the particular type of relationship that exists between TSMRI and the Provider. A MRI unit was needed in the Huntington area. Having no other alternative available to them under state law, the Provider and CHH pooled their resources, both economic and their respective projected annual MRI procedures, and created TSMRI for the specific purpose of providing MRI services to the Provider's and CHH's patients. TSMRI is both a Shared Service Organization as defined in HCFA Pub. 15-1 § 1011.6 and a Special Purpose Organization as defined in HCFA Pub. 15-1 § 1011.7. It is clear that such Special Purpose Organizations carry on the patient care-related activities of the Provider and CHH which created them. Because TSMRI is conducting the Provider's patient care-related activities, the patients treated at TSMRI are the Provider's patients.

Prior administrative precedent demonstrates that only income generated by "invested funds," as defined in HCFA Pub. 15-1 § 1218.2, can be used to offset otherwise allowable interest expense. See Hillhaven Inc. Group Appeal v. Ætna Life Insurance Company, PRRB Dec. No. 85-D38, April 23, 1985, Medicare & Medicaid Guide (CCH) § 34,637, aff'd HCFA Administrator, June 19, 1985, Medicare and Medicaid Guide (CCH) ¶ 34,894, See also The Brooklyn Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Greater New York, PRRB Dec. No. 82-D65, March 5, 1982, Medicare & Medicaid Guide (CCH) ¶ 31,885, aff'd HCFA Administrator, May 4, 1982, Medicare and Medicaid Guide (CCH) ¶ 31,972. The funds used to contribute capital to TSMRI are not invested funds as that term is defined in HCFA Pub. 15-1 § 1218.2, because the funds are used for patient care activities. Thus, the excess revenue generated by TSMRI is not investment income and should not be used to offset otherwise allowable interest expense.

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6 See Provider Exhibit 40.

Moreover, the excess revenue generated by TSMRI is not within the definition of investment income in HCFA Pub. 15-1 § 202.2, because that excess revenue does not constitute "dividends, interest, rental income, interest earned on temporary investments of withholding taxes, as well as gains or losses." Id.

The Provider contends that the Intermediary's arguments regarding this issue are unfounded. The Intermediary's contention that the Provider's position results in double reimbursement is incorrect, and it is the Intermediary's position which results in an impermissible cost shift. The Intermediary's argument, that TSMRI does not conduct the Provider's patient care-related activities, ignores HCFA Pub. 15-1 § 1011.7, which mandates the conclusion that TSMRI's activities are the Provider's activities.

The Intermediary's arguments, regarding how the Provider accounts for TSMRI, ignores HCFA Pub. 15-1 § 1218.2, which defines invested funds as funds divested to non-patient care activities. The Intermediary's contention that TSMRI's costs are not reported on the Provider's books or cost report ignores the reality of the Provider's accounting treatment of TSMRI. There is simply no effect on reimbursement caused by reporting net operating revenue as opposed to reporting gross revenue less costs. In either instance, the bottom line is that the Provider reports the net operating revenue of TSMRI.

The Intermediary's contention that the Provider has no medical records for TSMRI outpatients is wrong. TSMRI, a West Virginia partnership, has no separate legal existence apart from the partners, the Provider and CHH. The Intermediary's contention that the Provider accounted for TSMRI as an investment is also wrong. The Provider records its capital contribution to TSMRI as equity, and the Provider records the revenue generated by TSMRI as other operating revenue. The Intermediary's arguments, based upon the tax status of TSMRI, also ignore HCFA Pub. 15-1 § 1218.2, and are based upon hypothetical facts rather than the true facts of this case. In addition, the Intermediary's argument, regarding a mobile MRI unit, has no basis in fact.

The Intermediary's argument, that the Provider's 50 percent ownership interest in TSMRI is a negotiable instrument, is also in error. The partnership interest in TSMRI is not freely transferable, is not an unconditional promise to pay a fixed amount of money and is not payable upon demand or at a definite time. Therefore, under controlling West Virginia law, W. Va. Code § 46-3-104(a), the partnership interest is not a negotiable interest.

Finally, the Intermediary contends that, because TSMRI has its own provider number and is not located on the Provider's campus, it is an investment. The Intermediary's contentions ignore the HCFA Pub. 15-1. HCFA Pub. 15-1 § 1011.7 allows the creation of a related organization to conduct a provider's patient care activities, and HCFA Pub. 15-1 § 1011.6 allows providers to pool resources to create a related organization. These provisions describe TSMRI: a related organization, created by the pooling of resources of the Provider and CHH, to conduct the patient care activities of the Provider and CHH. However, such a related

organization need not adopt the Provider number of either parent. Home health agencies are often owned by, and reimbursed as part of, a hospital, yet have their own distinct provider numbers. The Provider has a number of sub-providers which have their own provider numbers but are reimbursed as part of the Provider. For example, the Provider's psychiatric unit, the Provider's home health agency, and the Provider's skilled nursing facility all have their own provider number, but all these sub-providers are reimbursed as part of the Provider. Moreover, a centralized facility apart from the campuses of the Providers that created a HCFA Pub. 15-1 § 1011.6 pooling organization is one of the principle advantages of such an organization. By eliminating duplicate space and staff, HCFA Pub. 15-1 § 1011.6 pooling organizations reduce the costs of services.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that HCFA Pub. 15-1 § 202.2 provides that investment income earned on operating funds, not borrowed, "consists of the aggregate net amount realized from dividends, interest, rental income interest earned on temporary investment or withholding taxes, as well as all gains and losses." Thus, the investment made by the Provider qualifies as equity in the earnings of another entity as the investment represents:

a. Non-borrowed funds which were invested into the equity of TSMRI. This is evidenced by the intermediary's audit of interest expense during the FYE 1987, 1988, 1989, and 1990.

b. TSMRI does not provide services exclusively to the Provider and thus not all costs are related to patient care at the Provider. Only 5.12 percent of the treatments performed at TSMRI are the Provider's. Thus, the entity does not provide services to the Provider only; in fact, services for the Provider represent only a very small fraction of TSMRI's total services.

c. Per the Provider's financial statements,[7] the partnership investment in TSMRI is handled using the equity method. This method recognizes the Provider's investment at cost on the balance sheet and recognizes income as investment income.

Thus, the Provider invested funds in a joint venture that is not an extension of the Provider's patient care activities in accordance with HCFA Pub. 15-1 § 2102.2. For example, the entity TSMRI has a separate billing number for Medicare reimbursement that requires billing to the Part B carrier, Nationwide Insurance Company, and subsequent treatments as a freestanding radiology center. This results in the entity being paid for outpatient MRI services in a totally different environment based on a percentage of charges. Thus, TSMRI is reimbursed completely outside of the hospital prospective payment system separately from the Provider. Had the Provider's operating funds not been invested into the equity of TSMRI, HCFA Pub.

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[7] See Intermediary Exhibit 10.

15-1 § 202.2 would require the offset of all income earned regardless of what type of instrument into which it had been invested.

HCFA Pub. 15-1 § 1218.2 indicates that investment income consists of funds diverted to activities which are not related to patient care. Whenever the Medicare program uses the phrase "related to patient care," it means related to the care of patients at the provider in question. Therefore, the Provider's investment in TSMRI, as far as the Provider is concerned and as far as 4,927 of the 5,193 TSMRI procedures are concerned, was not as investment in an activity "related to patient care." Thus 94.88 percent of the Provider's return on its investment in TSMRI qualifies as an investment, as defined in HCFA Pub. 15-1 § 1218.2.

The Intermediary believes that a patient may only be a patient of one facility at a time, and that whether the costs or charges for a service are reimbursed to a particular provider depend upon whether that service was rendered to that particular provider's patients. See Curators of the University of Missouri, d/b/a University of Missouri Medical Center v. Sullivan, No. 89-4415-CVC-9 (D.C.W. Dist. Mo., Central Div., June 24, 1991), Medicare and Medicaid Guide (CCH) ¶ 39,497, aff'd, No. 91-2939WM (8th Cir. May 4, 1992), Medicare and Medicaid Guide (CCH) ¶ CCH 40,224. If a patient is a patient of another provider, the Provider may not claim the costs of such patient, and if the provider invests in that other provider, the Provider is invested in a facility that is not rendering patient care for purposes of the Provider's cost report. Rather, the Provider has invested in an activity that is producing investment income, which may be used to offset the Provider's interest expense.

In this case, 4,927 of the 5,193 procedures or 94.88 percent of TSMRI's services were not rendered to the Provider's patients, but to TSMRI's patients. Some of the indications that TSMRI patients are, for the most part, not the Provider's patients are as follows:

1. TSMRI is a separately certified Medicare facility with its own provider number.

2. TSMRI is not located on the Provider's campus.

3. Costs for the 4,927 procedures in question were not reported on the Provider's books or on its cost report, but rather on TSMRI's books and financial statements.

4. No Provider medical record was established for the 4,927 procedures rendered to TSMRI's own patients.

5. TSMRI billed the Medicare program (Part B Carrier) separately on a fee for service basis for the services it rendered to its own patients.

6. The Provider accounted for its investment in TSMRI as an "investment".

Both parties agree that for the services rendered by TSMRI to the Provider's patients, the Provider is properly entitled to claim the cost incurred by TSMRI on the Provider's cost report, and that the income earned by the Provider related to such services is not investment income subject to offset.[8]

Although the Provider maintains that it is related to TSMRI, the focus of this appeal is not whether TSMRI is related to the provider, but the scope of TSMRI's activities on behalf of the Provider. TSMRI is barely furnishing any "services, facilities, and supplies" to the Provider. Instead, TSMRI is furnishing those services, facilities, and supplies to its own patients or patients of CHH. For the activities generating the income in dispute, TSMRI is certified and bills its own patients under its own provider number. Thus, while TSMRI and the Provider might be related parties because of the few services not in dispute (266 out of 5,193 procedures rendered by TSMRI to the Providers inpatients), for the activities in dispute (4,927 of the 5,193 procedures) there is no buyer-supplier relationship between the Provider and TSMRI. The related party rules set forth in Medicare regulation 42 C.F.R. § 413.17 simply do not apply to the charges, costs, or income related to the 4,927 procedures in dispute.

The Provider claims that through the offset of investment income and the reduction of cost of purchased MRI services it is being doubly penalized. The Intermediary takes exception to this as these are two separate issues. As the Intermediary's workpapers demonstrate,[9] the costs associated with the very few treatments, 5.12 percent, that are related to the care of Provider patients were allowed, and no investment income offset occurred in connection with those treatments. on the other hand, the Intermediary did offset the Provider's share of investment income related to the other 94.88 percent of the treatments and did not reduce the Provider's cost for any payments made to TSMRI for those treatments. Thus, the net result to the Provider was that it received its reasonable cost for treatments to its own patients, and incurred an investment income offset for its share of the income related to treatments to other patients. No double penalty was imposed.

The Intermediary asserts that it is the Provider's position which would require the Medicare program to make duplicate payments for the same services. TSMRI has already been paid for most of the services in dispute (4,927 of the 5,193) under Part B and the Provider has been paid for the rest of those disputed services through its own Medicare Part A cost report. If the Provider's assumption is correct, the Intermediary would have to allow the cost for all of those disputed activities on the Provider's cost report, as well as, the costs of a related party. See HCFA Pub. 15-1 § 1000. The Medicare program would be required to pay for the services twice, once under Part B and again on the Part A Medicare cost report.

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8 Intermediary Exhibit 6.

9 Intermediary Exhibits 3 and 4.

The funds used to acquire an interest in the equity of TSMRI represents an investment in an entity that has no direct relationship to patient care at the provider. The Provider's contention that its investment represents direct patient care is incorrect because TSMRI is a separate provider receiving outpatient referrals from the community at large.

The Provider's claim that the Intermediary is "double dipping" by offsetting investment income and adjusting purchased service expenses to related party costs is incorrect as these are mutually exclusive issues. The Provider's investment in the equity of TSMRI should be considered unsheltered income based on the above. The Intermediary respectfully requests that the Board uphold its adjustment.

Issue 2 - Disproportionate Share Adjustment:

Background

Medicare reimbursement for hospital inpatient services is paid pursuant to the statutorily mandated PPS. PPS reimbursement is adjusted to take into account the differences between hospitals due to a number of factors, including the number of low income patients served by a hospital. Providers serving a disproportionately high number of low income patients are entitled, by statute, to additional payment known as a DSH adjustment. See 42 U.S.C. § 1395ww(d)(5)(F).

In calculating the DSH adjustment, one must use the number of Medicaid patient hospital days. In the statute, the language specifies counting the number of hospital days for patients "eligible" for Medicaid. See 42 U.S.C. § 1395ww(d)(5)(F)(vi). In interpreting and implementing the DSH statute, HCFA regulation provides that one is to count the number of hospital days for patients "entitled" to Medicaid. See 42 C.F.R. § 412.106. Due to limitations on Medicaid payments under various state plans, the number of patients "entitled" can be lower than the number "eligible." Under the methodology for the DSH calculation, a reduction in the number of Medicaid hospital days counted results in a reduced DSH payment.

Facts

In fiscal year 1990, the Provider rendered 10,007 days of hospital care to patients eligible for Medicaid under the Ohio, West Virginia and Kentucky. Under the provisions of the West Virginia and Kentucky Medicaid plans, there were limits on the number of hospital days that are paid for per stay, 25 and 14 days, respectfully. The Provider rendered a total of 981 hospital days for Medicaid patients, for which patients were "eligible," but for which the Provider was not paid, because the patients were not "entitled" to payment under the Medicaid plans. In calculating the Provider's DSH adjustment for fiscal year 1990, the Intermediary did not include the 981 days.

PROVIDER'S CONTENTIONS:[10]

The Provider contends that the plain language of the DSH statute mandates that the numerator of the fraction described therein include "the number of the hospital's patient days for such period which consists of patients who (for such days) were eligible for medical assistance," not as the regulation states, the number of the hospital's patient days for such periods which consists of patients who (for such days) were "entitled" to Medicaid. Compare 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added) with 42 C.F.R. § 412.106(b)(4).

The Provider points out that the regulation, at 42 C.F.R. § 412.106(b)(4), and the statements accompanying its promulgation, at 51 Fed. Reg. 16772, 16777 (May 6, 1986) and 51 Fed. Reg. 31457, 31460-61 (September 3, 1986), are inconsistent with the plain language of the statute and the intent of Congress as set forth in the legislative history and thus the regulation is invalid. The regulation and attendant policy violate the Medicare Act and deny the Provider its full DSH adjustment due under the Medicare Act. The regulation and attendant policy deny the Provider equal protection of the law and due process, in violation of the Fifth Amendment to the United States Constitution. Finally, the Secretary's certification of the relevant Medicaid plans for Boren Amendment purposes indicates that there can be no "unpaid" Medicaid days, thus rendering the DSH regulation invalid.

The Provider asserts that the regulation and policy regarding the DSH adjustment are contrary to, and are an impermissible construction of, the DSH statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), are unconstitutional, and are further in violation of the Administrative Procedure Act, 5 U.S.C. § 706(2)(A), in that the regulation and attendant policy are arbitrary and capricious, an abuse of discretion, and not in accordance with law.

The Provider indicates that the Board has jurisdiction over the matter but is bound by the HCFA regulation. See 42 C.F.R. § 405.1867.

INTERMEDIARY'S CONTENTIONS:

The Intermediary indicated that it makes the same arguments that HCFA made in its appeal in Cabell Huntington Hospital v. Shalala. See Cabell Huntington Hospital v. Shalala, 101 F. 3d. 984 (4th Cir. 1996).

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law:

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[10] See Provider's Consolidated Post-Hearing Brief at 32-81, for detailed arguments and supporting citations.

5 U.S.C. § 553 et seq.	-	Administrative Procedure Act
42 U.S.C. § 1395x(v)(1)(A)	-	Reasonable Cost
42 U.S.C. § 1395ww(d) et seq.	-	PPS Transition Period; DRG Classification System; Exceptions and Adjustments to PPS

2. Regulations - 42 C.F.R.:

§ 405.1835 et seq.	-	Right to Board Hearing
§ 405.1867	-	Sources of Board's Authority
§ 412.106 et seq.	-	Special Treatment: Hospitals that Serve a Disproportionate Share of Low-Income Patients
§ 413.17	-	Cost to Related Organizations
§ 413.153 et seq.	-	Interest Expense

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 202.2	-	Necessary Interest
§ 1000	-	Cost to Related Organizations-Principle
§ 1011.6	-	Special Applications - Shared Service Organizations
§ 1011.7	-	Special Applications - Special Purpose Organization
§ 1218.2	-	Invested Funds
§ 2102.2	-	Costs Related to Patient Care

4. Case Law:

The Brooklyn Hospital v. Blue Cross Association/Blue Cross and Blue Shield of Greater New York, PRRB Dec. No. 82-D65, March 5, 1982, Medicare and Medicaid Guide (CCH) ¶ 31,885, aff'd HCFA Administrator Dec., May 4, 1982, Medicare and Medicaid Guide (CCH) ¶ 31,972.

Cabell Huntington Hospital v. Shalala, 101 F. 3d. 984 (4th Cir. 1996).

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Presbyterian Medical Center of Philadelphia v. Ætna Life Insurance Company, PRRB Dec. No. 96-D75, September 30, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,702, mod'd HCFA Administrator, November 29, 1996, Medicare and Medicaid Guide (CCH)
¶ 45,032.

5. Other:

Administrative Procedure Act, 5 U.S.C. § 553 et seq.

W. Va. Code § 46-3-104(a)

51 Fed. Reg. 16772 (May 6, 1986)

51 Fed. Reg. 314457 (September 3, 1986)

HCFA Ruling No. 97-2, Medicare and Medicaid: Determination of Disproportionate Patient Percentaage, February 27, 1997, Medicare and Medicaid Guide (CCH)
¶ 45,105

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration and analysis of the controlling law, regulations and manual instructions, the facts of the case, documentary evidence, parties' contentions, testimony elicited at the hearing, and post-hearing brief, finds and concludes that:

Issue 1 - Treatment of Equity Capital as Investment Income:

The Board finds that the Intermediary properly treated the equity income associated with TSMRI as investment income to be offset against the Provider's interest expense in accordance with the provisions of 42 C.F.R. § 413.153.

The Board finds that the Provider is entitled to claim only the costs associated with the 266 TSMRI services furnished to its inpatients in conformity with the related organizations principles established in 42 C.F.R. § 413.17. With respect to the remaining 94.88 percent of TSMRI procedures performed (4,927 out of 5,193), the Board finds that these services were not rendered to the Provider's patients and, thus, are not activities related to patient care for purposes of the Provider's investment in TSMRI. Accordingly, the Board finds that the Provider's return on its investment in TSMRI to the extent of 94.88 percent must be offset against the Provider's interest expense pursuant to 42 C.F.R. § 413.153 et seq. and HCFA Pub. 15-1 § 202.2.

The Board believes that the key determining factor as to whose patients are receiving services at TSMRI is governed by the entity that bills for the services provided. Although TSMRI is a jointly owned partnership of the Provider and CHH, it is a separate legal entity which maintained its own medical records and performed all of the billing functions for its patients. As a separately certified Medicare facility with its own provider number, TSMRI billed the Medicare program separately on a fee for service basis under Part B for the services it rendered to its own Medicare patients. The costs and charges associated with the service rendered were recorded on TSMRI's books and financial records and reported on its financial statements. With respect to the TSMRI services rendered to inpatients of the Provider or CHH, TSMRI billed the respective hospitals and received payment based on its established charge structure. The financial data relating to the 266 TSMRI services rendered to the Provider's inpatients are reflected on the Provider's books and records and the Provider is entitled to claim the costs incurred by TSMRI on its Medicare cost report pursuant to the cost to related organizations principles. However, the costs and charges relating to the 4,927 TSMRI services that were not rendered to the Provider's patients should not and were not reported on the Provider's books or on its Medicare cost report. Moreover, the Board majority notes that the Provider accounted for its investment in TSMRI under the equity method of accounting in its financial statements under generally accepted accounting principles.

The Board rejects the Provider's argument that TSMRI's patients should be deemed the Provider's patients by virtue of the fact that it has a 50 percent ownership in the partnership or because patients are referred to TSMRI by physicians who have privileges at its hospital facility. Neither of these factors have any bearing in identifying the facility providing the patient care services. Whereas the related organizations principles are applicable for the 266 TSMRI services furnished to the Provider's inpatients, they do not apply to the remaining 94.88 percent of TSMRI's patient care activities. The application of the cost to related

organizations principles is set forth in 42 C.F.R. § 413.17, and is only applicable where a provider obtains items of "services, facilities or supplies" from an entity that is owned or controlled by the provider. Where such a relationship exists, the provider is treated as if the items are obtained from itself and only the cost to the related organization is allowed to be claimed by the provider in determining Medicare reimbursement. Unless a buyer-supplier relationship exists, the cost to related organizations principles have no relevant application.

In the instant case, TSMRI is not furnishing any "services, facilities or supplies" to the Provider for 94.88 percent of the activities which are in dispute (4,927 of the 5,193 TSMRI procedures). Accordingly, the related party rules do not apply to the charges, costs or income related to the 4,927 procedures at issue. As to the Provider's argument that TSMRI functions as both a "shared service organization" and a "special purpose organization" as defined in HCFA Pub. 15-1
§§ 1011.6 and 1011.7, the Board majority finds that the Provider has not demonstrated that TSMRI qualifies for either of these special applications under the related organizations principles. Moreover, the application of these manual provisions are written as exceptions to the related organizations principles and, thus, are irrelevant where the related organizations principles do not apply.

Based on the substantial evidence presented, the majority of the Board finds that an investment income offset must be applied against the Provider's interest expense for 94.88 percent of the gain realized from the Provider's investment in TSMRI for the fiscal year in contention. The gain realized from the Provider's investment in TSMRI meets the definition of investment income under HCFA Pub. 15-1 § 202.2, and the Board majority finds that the Intermediary properly applied the offset in accordance with the interest expense regulations at 42 C.F.R. § 413.153.

Issue 2 - Disproportionate Share Adjustment:

The Board finds that its decision in Presbyterian Medical Center of Philadelphia v. Ætna Life Insurance Company, PRRB Dec. No. 96-D75, September 30, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,702, mod'd HCFA Administrator, November 29, 1996, Medicare and Medicaid Guide (CCH) ¶ 45,032, is applicable to the instant case.

In addition, the Board notes the issuance of HCFA Ruling No. 97-2, Medicare and Medicaid: Determination of Disproportionate Patient Percentage, February 27, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,105, which directly addresses the issue of Medicaid days to be included in the DSH adjustment. In the ruling, HCFA determined that it will count all inpatient days for patients eligible for Medicaid, without regard to whether the hospital received payment. The ruling was made applicable to properly pending appeals on this issue under 42 C.F.R. § 405.1835. Since the Provider has a properly pending appeal pursuant to 42 C.F.R. § 405.1835, the Board finds that the Provider's DSH calculation should be modified to include all Medicaid eligible days.

DECISION AND ORDER:

Issue 1 - Treatment of Equity Capital as Investment Income:

The Intermediary's treatment of equity income as investment income was proper and is affirmed.

Issue 2 - Disproportionate Share Adjustment:

The Intermediary's failure to include all Medicaid eligible days in the Provider's DSH Calculation was improper. The Intermediary is directed to recalculate the DSH adjustment using all eligible Medicaid days.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq.

Date of Decision: November 17, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman