PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D50

PROVIDER -
Methodist Hospitals of Memphis
Memphis, Tennessee

Provider No.: 44-0049

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
TriSpan Health Services

DATE OF HEARING -
May 3, 2007

Cost Reporting Periods Ended -
December 31, 1995; December 31, 1996;
December 31, 1997; December 31, 1998;
and December 31, 1999

CASE NOs.: 00-1757, 00-1859, 01-0958,
03-0180 and 04-0110

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ISSUE:

Whether the Intermediary's adjustment to the Provider's per resident amount (PRA) 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. §1395h, 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 portion 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.

Section 1886(h) of the Medicare Act prescribes the Medicare payment method for direct graduate medical education (DGME) costs. 42 U.S.C. §1395ww(h). In brief, the DGME payment is the product of a hospital's average per resident amount, derived and updated from a 1984 base period, times the hospital's number of interns and residents in approved programs during the payment year, times the hospital's Medicare patient load.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Methodist Hospitals of Memphis (Provider or Methodist) is a Medicare certified teaching hospital located in Memphis, Tennessee. In October of 1995, the Provider merged with LeBonheur Children's Medical Center (LeBonheur). After the merger, the provider number for LeBonheur was terminated, and the merged facilities were certified as a single provider and operated under the Medicare provider number of Methodist. Both hospitals operated distinct GME programs prior to the merger.

During the audit of the Provider's fiscal year 1995 cost report, TriSpan Health Services, (Intermediary) calculated the Provider's Medicare GME payment by using two different GME per resident amounts. Specifically, for residents who were located at the Provider's pre-merger facilities, it used the GME per resident amount previously established for the Provider, while for residents who were at the LeBonheur facility, it used the GME per resident amount that had been established for LeBonheur prior to the merger.[1] For fiscal year 1995, this resulted in an aggregate weighted average per resident amount of $53,480.98 for primary care/OB-GYN residents and $51,346.10 for all other residents.[2] For the years subsequent to FYE 1995, the Intermediary applied the annual update factor to the 1995 weighted base year per resident amount to obtain the updated PRA. These adjustments resulted in a cumulative reduction of Medicare reimbursement of approximately $1,089,840 for the five years under appeal.[3]

The Provider appealed the Intermediary's adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Provider was represented by Mary Susan Philp, Esquire, of Powers, Pyles, Sutter & Verville PC. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that the Intermediary's averaging of the Provider's per resident amount with that of LeBonheur is contrary to the text of the Social Security Act and Medicare regulations. Section 1886(h)(2)(A) of the Act states that "[t]he Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." The statute refers to a single average per resident amount for each hospital based on the costs incurred during the hospital's base year.

In accordance with the statutory requirement, a GME per resident amount was determined for Methodist based on its base year costs. After the merger with LeBonheur, Medicare certified Methodist and LeBonheur as a single provider, and the Provider was the surviving entity. The Medicare regulation governing reimbursement for GME costs reads, "except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital . . ." 42 C.F.R. §413.86(e)(1)(i). Since Methodist was the "hospital" remaining, the Provider asserts that its established PRA should have been used in FYE 1995 and forward rather than an average of the two PRAs.

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[1] Per the Intermediary workpaper at Exhibit I-4 (of CN: 00-1757), the Intermediary did not utilize "actual" resident FTE's in determining the number of residents at Methodist and LeBonheur. A percent to total of FTE's claimed on the original cost report was used to allocate the total audited FTE's to each facility.

[2] The per resident amounts established for Methodist Hospitals of Memphis were $56,491.88 for primary care/OB-GYN residents and $53,492.83 for all other residents. Provider Exhibit 2.

[3] Per the Intermediary's position papers, the Medicare reimbursement effect for each year is: 1995 - $121,000, 1996 - $200,000, 1997 - $252,290, 1998 - $292,054, 1999 - $224,496.

The Intermediary supports its handling of the PRA by referencing language in the preamble to the Medicare hospital inpatient prospective payment system (PPS) regulations for fiscal year 1998. In this preamble, CMS states, ". . . in implementing the COBRA 1985 provision establishing a hospital-specific per resident amount in the situation of a merger, we have calculated the revised per resident amount for the merged hospital using an FTE weighted average of each of the respective hospital's per resident amount which is part of the merger." 63 Fed. Reg. 26,318, 26,329 (May12, 1998).

The Provider responds that CMS' rationale as stated in preamble to the Medicare hospital inpatient prospective payment system regulations for FY 98[4] is contrary to other CMS policies in similar situations. For example, pursuant to the Tax Equity and Fiscal Responsibility Act (TEFRA), Pub. L. 97-248, CMS limits the rate of increase in a hospital's operating costs based upon the hospital's average cost per discharge during a base year. In response to proposed changes to the hospital inpatient PPS for 1999, CMS states, "one commenter recommended that the [Medicare] regulations be revised to state that where two hospitals are subject to different caps on TEFRA limits merge, the TEFRA cap that applies is the cap of the surviving hospital." CMS' response was that "[i]f two hospitals merge, the cap that applies depends on the status of the surviving hospital." CMS goes on to state that ". . . we do not believe that the regulations as described above can be interpreted any other way" and found that a change to the regulation was not necessary. 63 Fed.Reg. 40,954 and 41,001(July 31, 1998). The Provider contends that CMS' interpretation for a post-merger TEFRA limit is contrary to its interpretation in this instance and that CMS'dissimilar treatment is arbitrary and capricious.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The situation identified in this case, i.e. the handling of a PRA for two teaching hospitals that merge, is not explicitly addressed in the statute or the regulations. However, the controlling regulation is 42 C.F.R. §413.86, which reads in pertinent part:

> (e) Determining per resident amounts for the base period –
> (1) For the base period. (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:
> (A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, graduate medical education costs allocated to the nursery cost center, research and other non-reimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and graduate

[4] 63 Fed. Reg. 26,329 (May12, 1998).

> medical education costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.
>
> (B) Divide the costs calculated in paragraph (e)(1)(i)(A) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (e)(1)(i)(A) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

42 C.F.R. §413.86(e)(4) identifies exceptions to the above provision which establishes a hospitals base year PRA. The exceptions include: if a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period; and, if a hospital's base-period cost reporting period reflects GME costs for a period that is shorter than 50 weeks or longer than 54 work weeks. The Board notes that while it is foreseeable that there may be many changes at a provider once a PRA is established, the regulation does not allow for any other modification to the PRA. For example, if an approved GME program located at a provider closes and another provider agrees to train the displaced residents, there is no change in the absorbing hospital's PRA.

The Board finds that after the merger of Methodist and LeBonheur, LeBonheur ceased to exist; consequently, the only "hospital" that remains is Methodist. The exception provisions of 42 C.F.R. §413.86(e)(4) do not address the factual situation in this case; therefore, we conclude that 42 C.F.R. §413.86(e)(1)(i)(B) controls and that it prescribes how the Provider's PRA is to be computed: ". . . divide the costs . . . by the average number of FTE residents . . . of **the** hospital . . ." (emphasis added) and the only surviving hospital is Methodist. We find further that the Intermediary's reliance on the May 12, 1998 Federal Register is not permissible, as it was subsequent to the transaction at issue and cannot be retroactively applied.[5]

In addition, even if the Board found the averaging of the two PRA amounts to be appropriate, the methodology utilized by the Intermediary does not accurately and separately accumulate FTEs by facility location, thereby voiding the rationale for creating a weighted average PRA.

DECISION AND ORDER:

The Intermediary's adjustment to the PRA for Methodist Hospital was improper. The Intermediary's adjustment to average the PRA for Methodist and LeBonheur is reversed.

[5] The Provider identifies that prior to the May 12, 1998 Federal Register (Exhibit P-6), the Provider had no notice of CMS' interpretation of the GME regulations regarding the merger of two hospitals. The Provider identified a similar situation, however, regarding the TEFRA provisions, which were also silent as to when two hospitals that were subject to different TEFRA limits merged. In that case, CMS responded to a comment in the July 31, 1998 Federal Register. (Exhibit P-11)

BOARD MEMBERS PARTICIPATING:

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

DATE: July 19, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson