PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D68

PROVIDERS
St. Joseph's Hospital
St. Paul, Minnesota
Provider No. 24-0063

St. John's Northeast Hospital
Maplewood, Minnesota
Provider No. 24-0210

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Noridian Government Services

DATE OF HEARING -
August 27, 2004

Cost Reporting Periods Ended -
St. Joseph's: August 31, 1996, 1997, 1998, 1999, 2000

St. John's: August 31, 1998

CASE NOs.: St. Joseph's: 99-2630, 00-3142, 01-1808, 02-1095, 03-1383

St. John's: 01-2158

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ISSUES:

1. Whether the Intermediary's exclusion of certain non-Medicaid general assistance and other state-only funded patient days (General Assistance Days or GADs) from the Provider's Medicaid Proxy was proper based on the instructions contained in Program Memorandum A-99-62. (St. Joseph's for FYE 1997 through 2000)

2. Whether Medicare + Choice days were properly treated in the Provider's disproportionate share hospital (DSH) calculation. (St. Joseph's for FYE 1998, 1999 and 2000)

3. Whether the Intermediary properly excluded, for indirect medical education (IME) and direct graduate medical education (DGME) reimbursement purposes, certain resident rotations at related non-hospital locations. (St. Joseph's for FYE 1997, 1998 and St. John's for FYE 1998)

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due providers 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Joseph's Hospital is a not-for-profit acute care hospital located in St. Paul, Minnesota, and St. John's Northeast Hospital is a not-for-profit acute care hospital located in

Maplewood, Minnesota (hereinafter referred to as St. Joseph's, St. John's, or the Providers). HealthEast Care System of Minnesota is the parent company of both Providers.[1]

On its FYE 1996 through 2000 cost reports, St. Joseph's claimed reimbursement for DSH. Noridian Government Services (Intermediary) disallowed these costs due to the Providers inclusion of GADs and/or Medicare + Choice days in the calculation. On the FYE 1997 and 1998 cost reports for St. Joseph's, and on the FYE 1998 cost report for St. John's, the Providers claimed reimbursement for IME and DGME. The Intermediary denied a portion of the Providers' claims for residents in non-provider settings where there were no written agreements. The Providers filed timely appeals to the Provider Reimbursement Review Board (Board) and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841.

The Provider was represented by Gregory Etzel, Esquire, and Jason Pinkall, Esquire, of Vinson & Elkins L.L.P. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

Issue 1 – General Assistance Days (GADs)

Relevant Medicare Statutory, Regulatory, and Programmatic Background:

Under section 1886(a)(2)(B) of the Social Security Act (the Act or SSA), codified at 42 U.S.C. §1395ww, the Secretary is directed to provide for appropriate adjustments to the limitation on payments that may be made under the Prospective Payment System (PPS) for the reasonable operating costs of inpatient hospital services, including:

> (B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter . . .

42 U.S.C. §1395ww(a)(2)(B).

42 U.S.C. §1395ww(d)(5)(F)(i) specifies that the Secretary shall provide for an additional payment to hospitals that serve a significantly disproportionate number of low-income or Medicare Part A patients. The formula used to calculate a provider's DSH adjustment is the sum of two fractions, expressed as percentages. 42 U.S.C. §1395ww(d)(5)(F)(vi). The first fraction's numerator is the number of hospital patient days for patients entitled to both Medicare Part A benefits and Supplemental Security Income, excluding patients receiving state supplementation only, and the denominator is the number of patient days for patients entitled to Medicare Part A. Id. The second fraction's numerator is the number of hospital patient days for patients who were eligible for medical assistance under a State plan approved under Title XIX for such period but not entitled to benefits

[1] This case involves multiple years for two providers, St. Joseph's and St. John's. Where possible, for ease of reference, the cited exhibits are from St. Joseph's FYE 1996 appeal, PRRB case number 99-2630.

under Medicare Part A, and the denominator is the total number of the hospital's patient days for such period. Id.; see also, 42 C.F.R. §412.106(b)(4). The second fraction is frequently referred to as the Medicaid Proxy. Providers whose DSH percentages meet certain thresholds receive an adjustment which results in increased PPS payments for inpatient hospital services. 42 U.S.C. §1395ww(d)(5)(F)(ii).

In the mid-1990s, a controversy arose over CMS' interpretation of the DSH formula as set forth under the statute. Pursuant to the statute, the Medicaid component of the DSH formula:

> . . . is the number of the hospital's patient days for such period which consists of patients who (for such days) were *eligible* for medical assistance under a State plan approved under subchapter XIX. . .

42 U.S.C. §1395ww(d)(5)(F)(vi)(II) (emphasis added).

CMS' regulation governing a provider's DSH percentage in effect at the time of the controversy referred to the "number of patient days furnished to patients *entitiled* to Medicaid." 42 C.F.R. §412.106(b)(4) (1993) (emphasis added). In applying the statute and the regulation, CMS' interpretation substituted the concept of payment and coverage by Medicaid for each day of care for the statutory standard of "eligibility" for Medicaid coverage. However, in HCFA Ruling No. 97-2 (February 27, 1997), HCFA (now CMS) changed its prior policy of including in the DSH calculation only inpatient days of service which were actually *paid* by a Medicaid state plan. HCFA's change in interpretation was in recognition of the holdings on this issue of the United States Courts of Appeals in the Fourth, Sixth, Eighth, and Ninth Circuits, which rejected HCFA's prior interpretation of including only patient days *paid* by Medicaid.

Thus, in HCFA Ruling 97-2, HCFA conceded that it should include in the Medicaid fraction all days attributable to inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan, whether or not the hospital received payment for those inpatient hospital services.

The language in HCFA Ruling 97-2 and the implementing instructions regarding which individuals qualify as "eligible for medical assistance under a State plan approved under Title XIX" created a new controversy. HCFA Ruling 97-2 and the implementing instructions stated HCFA's policy that days attributed to individuals eligible for general assistance and other state-only funded programs (collectively, State-only program days) should be excluded from the DSH calculation. Intermediaries in certain states historically had allowed providers to include State-only program days applicable to health programs not contained in the relevant Medicaid State plans in their DSH calculations even though Section 1886(d)(5)(F)(vi)(II) of the Act states that only days attributable to individuals "eligible for medical assistance *under a State plan approved under Title XIX"* are to be included in the DSH calculation. (emphasis added). Based on the Ruling and the implementing instructions, several intermediaries that previously had

allowed inclusion of State-only program days in their providers' DSH calculations began amending their policies on this issue.

Providers in certain states raised concerns with the need to repay the portion of the DSH payments attributable to the State-only program days. In response to these concerns, CMS decided to hold harmless hospitals that had received certain additional Medicare DSH payments because guidance regarding the days that should be included in the computation of the DSH adjustment was not sufficiently clear.

CMS issued its guidance to fiscal intermediaries in Program Memorandum A-99-62, dated December 1999 (the Program Memo). The Program Memo addressed treatment of the State-only program days issue on both a prospective and retrospective basis. The first portion of the Program Memo addressed CMS' clarification of the issue for cost reporting periods beginning on or after January 1, 2000. It is this provision that is at issue in this case. For such future periods, CMS clarified that "the term 'Medicaid days' refers to days on which a patient is eligible for medical assistance benefits under an approved Title XIX State plan." Program Memo at 2. The Program Memo provides an example of which days were not included in the term "Medicaid days." As an example, the Program Memo provided that the term "Medicaid days" does not refer to days such as those utilized by beneficiaries in state programs that were not Medicaid programs but that provided medical assistance to beneficiaries of state-funded income support programs.[2] Those beneficiaries were generally not eligible for health benefits under a State plan approved under Title XIX; therefore, according to the Program Memo, days utilized by those beneficiaries did not count in the Medicare DSH calculation. Furthermore, the Program Memo declared that no State-only program days would be counted as Medicaid days for purposes of the DSH calculation for cost reporting periods beginning on or after January 1, 2000 for any provider.

The second portion of the Program Memo communicated CMS' policy regarding the treatment of State-only program days applicable to cost reporting periods beginning prior to January 1, 2000. CMS split the hospitals that could retain or receive payments into two groups. The first group of hospitals included those "Hospitals That Received Payments Reflecting the Erroneous Inclusion. . ." of general assistance or other State-only program days. For cost reporting periods beginning prior to January 1, 2000, CMS directed intermediaries not to disallow the portion of Medicare DSH payments previously made to hospitals attributable to the inclusion of the general assistance or other State-only program days in the Medicaid Proxy component of the Medicare DSH formula. In addition, the Program Memo explained that for open cost reports, intermediaries were to allow only those State-only program days that the hospital *received* payment for in previous cost reporting periods settled before October 15, 1999.

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[2] The Program Memo contained an exhibit that outlines other types of days that also did not qualify as Medicaid days for purposes of the DSH calculation.

The second group of hospitals addressed by the Program Memo focused on those hospitals that did *not* receive a Medicare DSH payment based on the inclusion of the general assistance or other State-only program days. The Program Memo provided that, if for cost reports that were settled before October 15, 1999, a hospital never received any DSH payment based on the erroneous inclusion of general assistance or other State-only program days and the hospital did not file a jurisdictionally proper appeal to the Board on this issue prior to October 15, 1999, then intermediaries were not to pay the hospital DSH funds based on the inclusion of these types of days for any open cost reports for periods beginning prior to January 1, 2000. The Program Memo further explained that on or after October 15, 1999, intermediaries were not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of general assistance or other State-only program days in the Medicare DSH formula. However, if for cost reporting periods beginning prior to January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the Board on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, the intermediary was to reopen the cost report at issue and revise the Medicare DSH formula to reflect the inclusion of these types of days as Medicaid days. In addition, intermediaries were directed to settle all other open cost reports for periods prior to January 1, 2000 based on the inclusion of such days for such hospitals.

Factual Background Related to GADs:

FYE 1996 GADs

For FYE 1994 through 1996, St. Joseph's used an internally generated report to determine the number of days it would include in its Medicaid Proxy for DSH. In FYE 1995, the Intermediary rejected the internal report utilized by St. Joseph because its sample review indicated an unacceptably high error rate due to the inclusion of GADs.[3] Because the 1996 DSH calculation was based on the same internal report as the Provider's FYE 1995 calculation, the Intermediary rejected St. Joseph's FYE 1996 DSH calculation that included GADs. The disallowance was based on the audit work done in FYE 1995, and the Intermediary did not sample the 1996 data before rejecting it.[4] On March 17, 1999 St. Joseph's appealed the NPR for FYE 1996 and disputed the Intermediary's disallowance of GADs, among other issues.[5] St. Joseph's transferred the Medicare eligible days issue to a group appeal and requested that the Intermediary apply the DSH policy from the Program Memo to its FYE 1996 cost report.

Unlike other fiscal intermediaries in New York, Pennsylvania and several other states, the Minnesota Intermediary had adopted a policy to exclude GADs from the DSH calculation during the relevant time period.[6] This was despite the fact that the state Medicaid agency

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[3] See, Provider Exhibit P-12 in case number 99-2630 for the Transcript from St. Joseph's FYE 1995 appeal; Provider Exhibit – 20 for PRRB Dec. No. 2004-D32 for St. Joseph's 1995 case at 6.
[4] Tr. at 77.
[5] See, Provider Exhibit 1997-12; Tr. at 79.
[6] See, Provider Exhibit P-12 at 145-146.

was never able to give the Intermediary definitive information as to whether or not the GADs were actually federally funded.[7]

After the Program Memo was issued, the Provider submitted a written inquiry to the Intermediary for a determination as to whether it was eligible for relief. After a year and a Congressional letter of inquiry, CMS replied on June 7, 2001 and indicated the Provider was not eligible. Provider Exhibit 1996-14. Shortly thereafter, the Intermediary replied, as well, incorporating CMS' reply. Id. Although acknowledging a timely appeal, CMS stated that "[e]ven though these appeals were filed before October 15, 1999, the wording in the appeals for both years does not specifically mention the types of days described in [the Program Memo]." Id.

FYEs 1997-2000 GADs

Because of the Intermediary's previous determinations in FYE 1995 and 1996, St. Joseph's changed the method of supporting its DSH calculation for FYE 1997 through 2000; however, it continued to appeal the DSH adjustment each year because the Intermediary did not apply the DSH policy from the Program Memo to its FYE 1997 through 2000 cost reports. Tr. at 73-74; 92-93.

PARTIES' CONTENTIONS:

St. Joseph's contends that the facts related to its FYE 1996 DSH appeal are indistinguishable from its FYE 1995 DSH appeal. See, St. Joseph's Hospital v. Blue Cross Blue Shield Association/Noridian Administrative Services, PRRB Dec. No. 2004-D32, August 12, 2004, Medicare & Medicaid Guide (CCH) ¶ 81,183, rev'd, CMS Administrator, October 13, 2004, Medicare & Medicaid Guide (CCH) ¶ 81,265, rev'd, sub. nom. St. Joseph Hospital v. Leavitt, 425 F. Supp. 2nd 94 (March 31, 2006)(St. Joseph's). St. Joseph's indicates that it used the same internal report that included GADs, and that it properly appealed the DSH adjustment prior to the October 15, 1999 deadline in the Program Memo. St. Joseph's contends that the Board's decision in FYE 1996 should follow its decision in FYE 1995, that is, that St. Joseph's qualifies for relief under the Program Memo because it had a jurisdictionally proper appeal on the issue of GADs in the DSH calculation prior to October 15, 1999.

St. Joseph's also argues that a separate method of qualifying for relief under the Program Memo applies to its FYE 1996 through 2000 DSH appeals and references specific language in the Program Memo:

> Where, for cost reporting periods beginning before January 1, 2000, a hospital filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula on or after October 15, 1999, reopen the settled cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, but

[7] Id. at 140-142.

> only if the hospital appealed, before October 15, 1999, the denial of payment for the days in question in previous cost reporting periods.

Provider Exhibit 1996-10, at 4 (emphasis in original).

In addition, CMS directed that:

> You [the Intermediary] are to continue paying the Medicare DSH adjustment reflecting the inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for all open cost reports for cost reporting periods beginning before January 1, 2000, to any hospital that, before October 15, 1999, filed a jurisdictionally proper appeal to the PRRB specifically for this issue on previously settled cost reports.

Id.

St. Joseph's states that prior to October 15, 1999, it filed a jurisdictionally proper appeal on GADs related to DSH for FYE 1995. The Board found for St. Joseph's on this issue; therefore, it qualifies to include GADs in the DSH calculation for all subsequent fiscal years prior to Januray 1, 2000.

St. Joseph's also points to the Question and Answers Related to Program Memorandum A-99-62 released by CMS on June 21, 2000 (Program Memo Q&As) as further support for its position. The answer to Question 11 states in relevant part:

> A jurisdictionally proper appeal on the issue of general assistance or other State-only, charity care, Medicaid DSH, and/or ineligible waiver or demonstration days for a cost reporting period beginning before January 1, 2000, must have been filed before October 15, 1999 in order for the hospital to be held harmless for that specific cost report. However, if the hospital filed a jurisdictionally proper appeal on this issue before October 15, 1999 for a prior cost reporting period, the Intermediary should also reopen that hospital's cost report for any cost reporting period beginning before January 1, 2000 for which an appeal was filed after October 15, 1999.

Provider Exhibit 1996-15, at 3-4 (emphasis in original).

Also, in response to Question 12, it states:

> October 15, 1999 is the date that HCFA first communicated the hold harmless position. Therefore, in order to have an appeal

> resolved by the intermediary under the hold harmless rules described in PM A-99-62, a hospital must have filed an appeal on this issue for at least one of its cost reports for a cost reporting beginning before January 1, 2000 before the October 15, 1999 date that HCFA first announced the hold harmless position.

Id. (emphasis added).

Finally, St. Joseph's contends that the Intermediary's position that the Program Memo applied only to "providers who presented a loud, in-your-face kind of challenge to its intermediary saying – pounding on the table and saying these [GADs] belong in [the DSH calculation]" Tr. at 61, is absurd. St. Joseph's asserts that this post hoc standard is not supported in the Program Memo, statute, regulation or case law, and that it took every necessary step provided by law to appeal GADs prior to the October 15, 1999 deadline.

The Intermediary asserts that there were two categories of hospitals entitled to the hold harmless benefit. The first category are those that were paid prior to October 15, 1999, had final settled cost reports before that date, and acted like they expected to be paid in the future. Tr. at 60. The second category are those providers that presented a loud, in-your-face kind of challenge to their intermediaries pounding on the table and saying these days belong in there. Id. This was the Intermediary's argument in the FYE 1995 case, and the Intermediary maintains that its position was correct even though the Board found for St. Joseph's in the FYE 1995 case. The Intermediary claims that the evidence in the FYE 1995 case was tangled and involved a couple of false claims and some passing reference to GADs. There was not enough evidence to clearly indicate that the Provider intended to pursue a specific claim for GADs. With respect to FYE 1996, the Intermediary acknowledges that the appeal was filed prior to the October 15, 1999 date, but it did not clearly assert a claim for GADs. With respect to St. Joseph's FYE 1997 through 2000, the Intermediary argues that the language in the Program Memo Q&As numbered 11 and 16, may permit a provider to claim additional years of GADs in certain situations. However, the Intermediary continues to maintain that the earlier appeals were not valid, and even if they were, a provider was still required to show in any subsequent year appeals that it was entitled to GADs in its DSH and that it had claimed them on its cost report. The Intermediary claims that St. Joseph's did not use the appeal phraseology that entitles providers to the hold harmless benefit in the subsequent FYEs, 1997 through 2000.

Issue 2 – Medicare + Choice Days

Factual Background

In 1990, CMS published a statement in the Federal Register indicating that Medicare HMO days had been counted in the SSI Fraction. See, Intermediary Supplemental Exhibit. 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).

It states in relevant part:

> *Comment:* One commenter believes that the disproportionate share adjustment calculation should be expanded to include days that Medicare patients utilize health maintenance organizations (HMOs) since these beneficiaries are entitled to Part A benefits.
>
> *Response:* Based on the language of section 1886(d)(5)(F)(vi) of the Act, which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A", we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs and, therefore, were unable to fold this number into the calculation. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time, we have been including HMO days in SSI/Medicare percentage.

Congress enacted the Medicare + Choice (M + C) program in the Balance Budget Act of 1997. Under this legislation, Medicare beneficiaries entitled to benefits under Part A and enrolled in Part B could elect to receive care under Medicare Part C from an assortment of public or private health plan options including health maintenance organizations, preferred provider organizations, etc. CMS did not publish any further guidance on the treatment of M + C patient days in the DSH calculation until 2003 and 2004.

In proposed regulations, 68 Fed. Reg. 27154, 27208 (May 19, 2003), CMS indicated that M + C days should not be counted in the SSI fraction. CMS also proposed to permit hospitals to count these days in the numerator of the Medicaid fraction when a M + C enrollee is also eligible for Medicaid. It stated in relevant part:

> **8. Medicare + Choice (M + C) Days**
>
> Under §422.1, an M + C plan "means health benefits coverage offered under a policy or contract by an M + C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M + C plan." Generally, each M + C plan must provide coverage of all services that are covered by Medicare Part A and Part B (or just Part B if the M + C plan enrollee is only entitled to Part B).
>
> We have received questions whether patients enrolled in an M + C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation. The question

> stems from whether M + C plan enrollees are entitled to benefits under Medicare Part A since M + C plans are administered through Medicare Part C.
>
> We note that, under §422.50, an individual is eligible to elect an M + C plan if he or she is entitled to Medicare Part A and enrolled in Part B. However, once a beneficiary has elected to join an M + C plan, that beneficiary's benefits are no longer administered under Part A.
>
> Therefore, we are proposing to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M + C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.

Id.

In 2004, however, CMS amended the DSH regulation to begin counting M + C (now the Medicare Advantage program) days in the Medicare/SSI fraction with respect to discharges on or after October 1, 2004. 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004). It stated in relevant part:

> 4. Medicare + Choice (M+C) Days
>
> Under existing §422.1, an M + C plan means "health benefits coverage offered under a policy or contract by an M + C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of costsharing to all Medicare beneficiaries residing in the service area of the M + C plan." Generally, each M + C plan must provide coverage of all services that are covered by Medicare Part A and Part B (or just Part B if the M + C plan enrollee is only entitled to Part B).
>
> We have received questions whether the patient days associated with patients enrolled in an M + C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation. The question stems from whether M + C plan enrollees are entitled to benefits under Medicare Part A since M + C plans are administered through Medicare Part C.
>
> We note that, under existing regulations at §422.50, an individual is eligible to elect an M + C plan if he or she is entitled to

> Medicare Part A and enrolled in Part B. However, once a beneficiary has elected to join an M + C plan, that beneficiary's benefits are no longer administered under Part A. In the proposed rule of May 19, 2003 (68 FR 27208), we proposed that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary would not be included in the Medicare fraction of the DSH patient percentage. Under our proposal, these patient days would be included in the Medicaid fraction. The patient days of dual-eligible M + C beneficiaries (that is, those also eligible for Medicaid) would be included in the count of total patient days in both the numerator and denominator of the Medicaid fraction.
>
> *Comment:* Several commenters indicated that they appreciated CMS's attention to this issue in the proposed rule. The commenters also indicated that there has been insufficient guidance on how to handle these days in the DSH calculation. However, several commenters disagreed with excluding these days from the Medicare fraction and pointed out that these patients are just as much Medicare beneficiaries as those beneficiaries in the traditional fee-for-service program.
>
> *Response:* Although there are differences between the status of these beneficiaries and those in the traditional fee-for-service program, we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M + C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M + C beneficiaries in the Medicare fraction. As noted previously, if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at §412.106(b)(2)(i) to include the days associated with M + C beneficiaries in the Medicare fraction of the DSH calculation.

Id.

The parties dispute where the M + C choice days belong in the DSH calculation and whether those days have in fact been counted.

Parties' Contentions:

St. Joseph's contends that days for dual eligible Medicare + Choice enrollees must be included in the Medicaid Proxy of the DSH patient percentage calculation based on the clear language of the DSH statute wherein the Medicaid Proxy is defined as:

> Patient days related to patients eligible for medical assistance under a State plan approved under Title XIX of the Act (Medicaid), but who are not entitled to Medicare Part A benefits
>
> ———————————————————————
>
> Total patient days

42 U.S.C. §1395ww(d)(5)(F)(vi)(II).

The Intermediary's policy since 1990, see Tr. at 65 and Intermediary Supplemental Exhibit at 3, Final Rule, 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990), was to include such days in the Medicare Proxy as Medicare Part A HMO days. St. Joseph's contends that it is legally incorrect to do so, and that dually eligible M + C enrollees belong in the Medicaid Proxy because such patients are not entitled to benefits under Medicare Part A. The Provider cites Jewish Hospital, Inc. v. Secretary of Health and Human Services, 19 F.3d 270 (6th Cir. 1994) in which a distinction was made between the patient's eligibility as a qualification for benefits and the patient's being "entitled" to benefits for which the provider would receive payment. That difference applies to this case. In order to enroll in M + C, an individual must be entitled to benefits under Medicare Part A and enrolled in Part B. 42 U.S.C. §1395w-21(a)(3)(A). However, once an individual has elected coverage under M + C, the payment of the individual's benefits shifts from Medicare Part A to Medicare Part C. 42 U.S.C. §1395w-21(a)(1). Accordingly, M + C enrollees are not "entitled" to Medicare Part A. The Provider also notes the creation of a graduate medical education (GME) special payment for M + C enrollees because such individuals were not included in the GME payment for patients whose payment was made under Part A. See, Provider's Post Hearing Brief at 22-23.

The Provider notes that CMS recognized this fact, and in proposed regulations (68 Fed. Reg. 27154, 27208 (May 19, 2003)) stated:

> to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M + C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.

It should be noted, however, that in the final regulation, 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004), CMS determined that M + C days would be incorporated into the Medicare Proxy and stated that " . . . once Medicare beneficiaries elect Medicare Part C coverage,

they are still, in some sense, entitled to benefits under part A." CMS also amended its regulation to include the days associated with M + C beneficiaries in the Medicare fraction of the DSH calculation. Id.

The Provider claims that this would be the status quo. Tr. at 72. However, the Provider asserts that the Intermediary did not include these days in its Medicare Proxy. The Provider states that if the days were included, the number of Medicare days in the SSI data should exceed the Medicare paid days by approximately the number of M + C days, but there is no difference in the data presented. This fact supports the Provider's argument that M + C days were, in fact, not included. See, Provider Exhibit 1998-18. St. Joseph's indicates that this is evidence that CMS' position regarding where M + C days belong, squares with its position that these days were included in the Medicaid proxy prior to the Final Rule.

The Intermediary believes that the rules have been consistent throughout, despite the proposal in 2003 to change the rule, which was not adopted. The Intermediary does not know why these days may not have been counted for the Provider, but contends that does not change where the days should be counted.

Issue – 3 IME and DGME

Factual Background

The Providers have a graduate medical education program that rotates certain of their residents through non-hospital locations as part of their specialty or sub-specialty training. It is not disputed by the Intermediary that the residents' time at issue in such rotations was spent in patient care activities in furtherance of the residents' training in an approved GME program, or that the Providers incurred all or substantially all of the cost associated with the resident training in the non-hospital locations at issue. The sole question is whether the Providers needed a written agreement with their related party non-hospital locations in order to include time spent at these sites in the FTE count for IME and DGME purposes. The Intermediary does not dispute that the other HealthEast-owned clinics are related parties and has treated other organizations within HealthEast as related for Medicare reimbursement purposes.

The regulations at issue are 42 C.F.R. §413.86(f) for DGME and 42 C.F.R. §412.105(f) for IME. The applicable regulations require that the following conditions be met in order to include the residents' time in such settings in the DGME or IME FTE count:

(i) the resident spends his or her time in patient care activities.

(ii) 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.

42 C.F.R. §413.86(f)(3)(i) & (ii) (1998).

The Parties' Contentions:

The Providers contend that the written agreement requirement of the regulation does not apply to the related clinics because they are not "outside entities."

The Board has previously ruled on this issue in Good Samaritan Regional Medical Center v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Arizona, PRRB Decision No. 2000-D4, October 19, 1999, Medicare & Medicaid Guide (CCH) ¶80,343, rev'd, CMS Administrator, December 21, 1999, not reported (Good Samartian). In that case, the Board decided that a provider is not required by the regulation to have a written agreement with its related facilities in order to have the subject resident rotations included in its GME count.

The Intermediary, however, counters that the CMS administrator, in reversing the Board decision in Good Samaritan, found that the regulation requires a written agreement with the non-provider settings even when the parties are related.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Issue 1 – General Assistance Days (GADs)

The Board finds that the Provider qualifies under the provisions of the Program Memo to have its GADs included in its DSH adjustment for FYE 1996 through 2000. Both the Program Memo and CMS' questions and answers regarding the counting of GADs address this issue. If a provider was either paid for GADs or had a jurisdictionally proper appeal pending before the Board regarding the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, it is entitled to have GAD's included in its DSH adjustment. St. Joseph's clearly met the requirements of the Program Memo.

The Board has previously found that St. Joseph's had a jurisdictionally proper appeal on the issue of GADs from its FYE 1995 cost report. St. Joseph's, supra. The Board found that the issue of GADs was specifically mentioned in the Intermediary's audit adjustment denying reimbursement for DSH, and the Provider properly appealed that specific audit adjustment. The Board found that "[t]he need for any specific language in the appeal was unknown at the time the Provider filed its appeal and should not be used to deny its otherwise valid appeal of GADs." Id. at 8.

The CMS Administrator reversed the Board's decision, finding that although the Provider had filed an appeal before October 15, 1999, the appeal did not raise the precise issue of

the exclusion of GADs. The CMS Administrator stated that the Provider's appeal merely stated the following:

> We believe the DSH reimbursement is significantly understated. The Intermediary did not properly recognize all appropriate DSH related days of service. Effect is $10,000.

The CMS Administrator found that the Provider's preliminary position paper did not mention GADs in its DSH argument, and the Provider only did so after the issuance of the Program Memo. The CMS Administrator cited the following language from the Program Memo, which instructed intermediaries:

> not to reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before the Board on other Medicare DSH issues or other unrelated issues.

Id. (emphasis in original.)

In reversing the Board's decision, the CMS Administrator referred to the decision in United Hospital v. Thompson, 383 F.3d 728 (8th Cir. 2004), which upheld the Program Memo's limitation on adding the GADs issue to appeals after the October 15, 1999 deadline. The Court stated:

> The Program Memo does not extend to all hospitals that had filed a jurisdictionally proper appeal before October 15, 1999, and that raised the issue of the exclusion of general assistance days. Rather, on its face, the Program Memo extends only to hospitals that had filed a jurisdictionally proper appeal on the issue of the exclusion of general assistance days before October 15, 1999. In other words, on it face, the Program Memo requires that, in order to be eligible for relief, a hospital must have raised the precise issue of exclusion of general assistance days before October 15, 1999.

The CMS Administrator found that, "while the Provider filed an appeal before October 15, 1999, the appeal did not raise the precise issue of the exclusion of GA (General Assistance) days." Id.

The Provider's FYE 1995 cost report appeal has since been decided by the Federal District Court for the District of Columbia. In finding for the Provider, the court made the following in-depth analysis of the facts in the case.

> At the time that St. Joseph's filed its appeal, the PRRB required only that an initial notice of appeal be filed "in writing" and that it

> include an identification of the issues in dispute, a *short* explanation of the basis for the dispute, the final audit report, the audit adjustment numbers, a copy of the final determination, and the audit adjustment pages relating to the issue in dispute. . . . Plaintiff's appeal said, in relevant part: "Adj. No. 46 — Disproportionate Share Adjustment[.] We believe the DSH reimbursement is significantly understated. The intermediary did not properly recognize all appropriate DSH related days of service. Effect is $10,000.". . . Plaintiff included with its appeal the final audit report, which stated, for audit adjustment No. 46, "Disallow DSH since the provider is including non-Medicaid days in their DSH calculation." (42 CFR 42.102, Subpart G) 16-8B-1." . . . The string 16-8B-1 referred to audit workpapers for the specific adjustment, which workpapers contained the more detailed analysis of the intermediary's basis for the adjustment. Those workpapers (1) state that "based on the sample above, this report includes general assistance patients. . . . Due to the number of errors found (22% error rate) DSH will be disallowed," and (2) demonstrate that the audit specifically listed and labeled patient-day claims "paid by General Assistance . . . program does not contain Federal funds." . . . The Secretary hints that the plaintiff should not be allowed to rely on the language in the intermediary audit worksheets, which, he concedes, were attached to the hospital's appeal. . . . The Secretary suggests that it is not permissible, under the Hold Harmless Rule, "to go beyond the notice of appeal itself." This argument is, I think, untenable. It is akin to asking an appellate court to look only at a motion a party filed below, without considering the exhibits that were attached to the motion. It is a nonsensical interpretation of the memorandum, especially given that PRRB instructions specifically made attachments part of a party's notice of appeal. . . .

The Federal District Court also found that the St Joseph's and United Hospital cases differed in a crucial respect. It stated in relevant part:

> In the *United Hospital* case, the plaintiff sought to use an existing regulation to do something the memorandum explicitly said it could not do — raise a DSH appeal that it had failed to raise prior to October 15, 1999. In this case, the plaintiff is using the PRRB's directions to explain why it would be unreasonable to expect that a jurisdictionally proper DSH appeal raised prior to October 15, 1999 would include highly specific or detailed descriptions of the exact nature of the appeal — and thus unreasonable to expect it to include the magic words "general assistance days."

The Board continues to believe that the Provider had a jurisdictionally valid appeal on the issue of GADs for its FYE 1995 cost report. The Board notes that the Program Memo instructions and questions and answers indicate that if the Provider had a jurisdictionally valid appeal for any year prior to the October 15, 1999 deadline, then the Intermediary is to allow GAD for all years. Therefore, the Board finds that the Provider is entitled to claim GADs for FYE 1996 through 2000 based upon its jurisdictionally valid appeal in FYE 1995.

The Board also notes that the Provider's claim for DSH in its FYE 1996 cost report is similar to the claim it made in the FYE 1995 cost report. The Provider stated that from 1994 to 1996 it utilized the same internally generated report to determine the number of days to include in the Medicaid Proxy of the DSH patient percentage calculation. See, Tr. at 74 and 92. As noted above, the Intermediary denied the Provider a DSH adjustment in FYE 1995 because, among other things, it contained GADs. Testimony indicated that the only difference between the FYE 1995 and 1996 DSH audits was that the Intermediary did not sample the internally generated report in FYE 1996 before rejecting the data. Tr. at 78. Testimony also indicated that the Intermediary's rejection of the FYE 1996 DSH calculation was based upon its reliance on its audit work in FYE 1995 and the Provider's acknowledgement that the FYE 1996 data was in the same form as the FYE 1995 data; that is, the data included GADs. Id. The Provider appealed the DSH disallowance in FYE 1996 based upon the rejected internal report that included GADs. The appeal was filed on March 17, 1999, prior to the October 15, 1999 deadline established in the Program Memo. The Board therefore finds that the Provider also had a jurisdictionally valid appeal on the issue of GADs for FYE 1996. Based upon the Program Memo instructions and questions and answers that indicate that if the Provider had a jurisdictionally valid appeal for any year prior to the October 15, 1999 deadline, the Intermediary is to allow GAD for all years, the Board finds that the Provider is entitled to claim GADs for FYE 1996 through 2000 based upon its jurisdictionally valid appeal for FYE 1996.

With respect to FYE 1997 through 2000, the Board notes that the Intermediary raised an additional objection with regard to the Provider's DSH claims for these years. The Intermediary argues that Program Memo Q&As 11 and 16 state that it is not enough to merely have a claim before October 15, 1999, rather, a provider must continue to claim GADs in all subsequent years by either including them in the calculation or by filing GADs as a protested item. Tr. at 62-63. The Provider states that after the FYE 1995 and 1996 audits, it self-disallowed GADs or filed protested DSH amounts and filed appeals directly to the Board. The Provider indicates that this method of preserving its appeal rights is specifically supported by the U.S. Supreme Court decision in Bethesda Hospital Association v. Bowen, 485 U.S. 399 (1988). The Board agrees with the Provider that the Bethesda case is applicable to this DSH issue. Based on its FYE 1995 and 1996 audits, the Provider received direction from the Intermediary to exclude GADs from its DSH calculation. Although the Provider complied with the Intermediary's direction, it continued to appeal the DSH calculation directly to the Board in FYE 1997 through 2000 and, therefore, did not abandon its claim as suggested by the Intermediary.

Issue 2 – Medicare + Choice

The Board finds that the M+C days should be included in the DSH calculation in the Medicare fraction. CMS' initial position with regard to HMO days was included in the 1990 Federal Register. It states, in relevant part, that "[b]ased on the language of section 1886(d)(5)(F)(vi) of the Act, which states that the disproportionate share adjustment computation should include 'patients who were entitled to benefits under Part A', we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO."

With the advent of the M + C program and Part C of the Medicare program, CMS initially indicated, in the 2003 proposed regulation, that these days should be included in the Medicaid fraction, because M + C enrollees were no longer entitled to benefits under Part A once they elected to participate in the M + C program. The Board notes, however, that CMS reconsidered its position and, in the final regulation in 2004, provided that these days continue to be included in the Medicare fraction portion of the DSH calculation. It reasoned that "[a]lthough there are differences between the status of these beneficiaries and those in the traditional fee-for-service program, we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A." The Board agrees that M + C eligibility for Part C is based on their eligibility for Part A and therefore these days should be counted in the Medicare fraction of the DSH calculation.

Having determined that these days should be included in the Medicare fraction of the DSH calculation, the Board is unable to determine whether these days were actually counted. The Intermediary indicates that these days should have been included in the Medicare Proxy, and thus reflected in the SSI data. Tr. at 67. The Provider points out that if this were correct, then the number of Medicare days in the SSI data should exceed Medicare paid days by approximately the number of M + C days. The Provider presented a comparison of Medicare paid days to the SSI days for each of the fiscal years at issue. See, Provider Exhibit 1998-18. The Provider asserts that the correlation between Medicare paid days and SSI days is so close that it demonstrates that the M + C days were, in fact, not included. The Board agrees with the Provider that there is no evidence that the M + C days have been properly included in the Medicare Proxy of the DSH calculation. The Board remands this matter to the Intermediary to review the Provider's data and determine whether they have properly been credited for M + C days in the Medicare portion of the DSH calculation for the years in issue.

Issue 3 – IME and DGME Resident FTEs

Prior to July 1, 1987 the Medicare regulations only permitted counting resident time spent in ambulatory settings if that setting was organizationally part of the hospital where the resident's training program was located. Section 9314 of the Omnibus Budget Reconciliation Act of 1986 changed the law to permit counting all time spent by residents in approved medical residency training programs without regard to the setting in which the activities were performed if the hospital incurred the costs for the training in that

setting. This provision was implemented in the regulations at 42 C.F.R. §413.86(f)(1) (1997) which stated in relevant part:

> (i) Residents in an approved program working in all areas of the hospital complex may be counted.
>
> (ii) No individual may be counted as more than one FTE. If a resident spends time in more than one hospital or, except as provided in paragraph (f)(1)(iii) of this section, in a non-provider setting, the resident counts as a partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.
>
> (iii) On or after July 1, 1987, the time residents spend in nonprovider 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.

The critical issue is whether the additional settings claimed by the Providers were part of the hospital complex or were non-provider settings as envisioned in the regulation quoted above. The Providers' position paper indicates that the time being claimed was for training programs through "non-hospital locations." See, Provider Position Paper at 16. Therefore, the requirements of the regulation at 42 C.F.R. §413.86(f)(1)(iii) are relevant. There is no dispute that the additional resident time being claimed as part of this appeal was for time spent in patient care activities and that the costs associated with the training were paid by the Providers. However, there is also no dispute that the Providers did not have written agreements as required by the regulation. Tr. at 136 and 137. The Board finds that any relatedness between the non-provider setting and the hospitals does not eliminate the need for a written agreement between the parties when notations are to non-provider settings. The Board finds that the Intermediary's adjustments were proper.

DECISIONS AND ORDERS:

Issue 1 – General Assistance Days

The Intermediary's determination that the Program Memo does not apply to the Provider was incorrect. The Intermediary's determination is reversed. The Board remands the matter to the Intermediary to recalculate the Provider's DSH payments for fiscal years 1996 through 2000.

Issue 2 – Medicare + Choice

The Board agrees that M + C days should be counted in the Medicare fraction of the DSH calculation. The Board remands this matter to the Intermediary to review St. Joseph's data and determine whether it has properly been credited for M + C days in the Medicare portion of the DSH calculations.

Issue 3 – IME and DGME Resident FTEs

The Board finds that a written agreement was needed to claim FTEs in a non-provider setting. The Intermediary's adjustments are affirmed.

Board Members Participating:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Elaine Crews Powell, CPA

DATE: September 14, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson