PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D1

PROVIDER -
Kaiser Foundation Hospitals-Southern California Region 1999 through 2003 GME FTE CAP Groups

Provider Nos.: Various (See attached Appendix A)

vs.

INTERMEDIARY –
Palmetto GBA/First Coast Service Options

DATE OF HEARING -
September 25, 2009

Cost Reporting Periods Ended -
12/31/1999, 12/31/2000; 12/31/2001, 12/31/2002 and 12/31/2003

CASE NOs.: 06-0419G; 06-1433G; 06-1482G; 06-1451G; 07-0020G

INDEX

ISSUE:

Whether the Intermediary has improperly adjusted the Providers' direct graduate medical education (GME) intern and resident full-time equivalent (FTE) counts for their respective fiscal years ended (FYE) 12/31/1999 through 12/31/2003 by disallowing various FTEs associated with rotations to the Providers' outpatient medical office clinics in FYE 12/31/1996, the GME FTE cap base year.

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 to organizations known as fiscal intermediaries or Medicare Administrative Contractors. 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 and 413.24.

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 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.§§405.1835-1837.

The Medicare program provides that a determination of an intermediary may be reopened with respect to findings on matters at issue in such determination. 42 C.F.R. § 405.1885(a). A request to reopen must be made within three years of the date of the notice of the intermediary determination. No reopening of an intermediary's determination is permitted after three years unless it is determined to have been procured by fraud or similar fault. 42 C.F.R. §405.1885(d).

The Medicare Program reimburses teaching hospitals for their share of costs associated with direct graduate medical education (GME). The calculation and reimbursement requires a determination of several factors, including (1) the total number of full-time equivalent residents in the teaching program; (2) the FTE limit or "cap" applicable to each provider. See, 42 U.S.C. § 1395ww(h)(4)(F); and (3) the "average per resident amount" (APRA), a hospital-specific rate determined from a base period. See 42 U.S.C. § 1395ww(h)(2)(A). In general, a hospital's direct GME costs are determined by multiplying its APRA times the number of FTEs that worked at the facility pursuant to 42 U.S.C. § 1395ww(h)(3). These costs are then apportioned to Medicare based upon a hospital's ratio of Medicare inpatient days to total inpatient days.

Implementing regulations at 42 C.F.R. § 413.86 (1999)[1] provide specific rules for counting FTE residents for GME.

The regulation places a limit on the number of FTEs a hospital can include it its count of residents for GME payment purposes. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count for residents in allopathic and osteopathic medicine may not exceed the hospital's unweighted count for its most recent cost reporting period ending on or before December 31, 1996, herein referred to as the "GME FTE cap." 42. C.F.R. §413.86(g)(4). During the fiscal periods at issue, a hospital's GME-weighted FTE count must equal the average of the actual weighted FTE count for its current cost reporting period and the preceding two cost reporting periods – the prior and penultimate years. 42 C.F.R. §413.86(g)(5). All of the years that are figured into this three-year rolling average FTE count affect the calculation of the GME FTE cap. Thus under the GME payment methodology, the accuracy of the hospital's GME FTE cap is critical to a hospital's GME reimbursement in all subsequent years.

The issue in this case concerns the amount of GME reimbursement to which the Providers are entitled for the fiscal years at issue, and in particular, whether the Intermediary has properly applied the regulatory time limit for reopening a cost report as grounds for declining to adjust the Providers' GME FTE caps.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Kaiser Foundation Hospitals ("Providers") own and operate several hospitals in Southern California, all of which have outpatient service clinics.[2] In 1996, the HCFA Administrator determined that the Providers' outpatient service clinics were hospital-based and that, for purposes of indirect medical education ("IME") reimbursement, the residents rotating through the clinics could be included in the IME FTE counts.[3] Consequently, Wisconsin Physicians Service Insurance Corporation ("Intermediary") recalculated the Providers IME FTE counts for fiscal years 12/31/1999 through 12/31/2003 by including those interns and residents rotating through the Providers outpatient hospital based clinics. However, the Intermediary declined to increase the Providers'1996 GME FTE cap to include the interns and residents rotating through the Providers' outpatient clinics.

The Providers appealed the Intermediary's disallowance to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 -1840 (2008). The Providers were represented by Jordan B. Keville, Esq., Jon P. Neustadter, Esq., and Nina N. Adatia, Esq. from the law firm of Hooper,

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[1] The GME regulation at 42 C.F.R. § 413.86 has been reorganized and moved to 42 C.F.R. §§413.75 through 413.83 (69 Fed. Reg. 49254 August 11, 2004). This decision will refer to 42 C.F.R.§413.86 the regulation in effect during the fiscal years at issue.

[2] See Appendix A for list of the hospitals participating in this appeal.

[3] *Kaiser Foundation Group-IME Costs v. Aetna Life Insurance Co.*, PRRB Dec. No. 1996-D50 (August 14, 1996), *reprinted in* [1996-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶44,559 (Provider's Exhibit P-5), *aff'd, Kaiser Foundation Group-IME Costs v. Aetna Life Insurance Co.*, HCFA Administrator Decision (October 21, 1996) , *reprinted in,* [1996-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶44,980 (Provider's Exhibit P-4).

Lundy & Bookman, P.C. The Intermediary was represented by Marshall Treat, Specialist Cost Report Appeals, Wisconsin Physicians Service Insurance Corp.[4]

PARTIES' STIPULATIONS:

The Providers and Intermediary stipulated to the following: [5]

1. The sole issue in these cases is whether the Intermediary has improperly adjusted the Providers' direct graduate medical education ("GME") intern and resident full time equivalent ("FTE") counts for their respective fiscal years ended (FYE) 12/31/99 through 12/31/2003 cost reports by disallowing various FTEs associated with rotations to the Providers' outpatient medical office clinics in FYE 12/31/1996, the GME FTE cap base year.

2. The parties agree that the GME FTE cap for the Providers should have been increased to reflect additional FTEs associated with outpatient rotations. However, the Intermediary's position is that the FYE 12/31/1998 cost reports are the first ones to set forth the 1996 GME FTE cap amount, and since the FYE 12/31/1998 cost reports are no longer reopenable, the GME FTE cap is closed and cannot be reopened or corrected to add in the outpatient rotations for these Providers. The Providers' position is that a correction of the 1996 GME FTE cap amount does not require a reopening, and a corrected GME FTE cap can be properly set forth and used on the cost reports for the Providers and years at issue in these group appeals, i.e. the Providers' FYEs 12/31/1999 through 12/31/2003.

3. After review and consideration by the Intermediary, and should the Providers prevail on the legal issue, the parties have agreed to use the following revised GME FTE cap amounts that would include the outpatient rotations for each hospital in these groups:
    a. Kaiser Foundation Hospitals – Anaheim (05-0609): 22.45 FTEs
    b. Kaiser Foundation Hospitals – Bellflower (05-0139): 4.94. FTEs
    c. Kaiser Foundation Hospitals – Harbor City (05-0411): 3.00 FTEs
    d. Kaiser Foundation Hospitals – Fontana (05-0140): 40.55 FTEs
    e. Kaiser Foundation Hospitals – Panorama City (05-0137): 1.99 FTEs
    f. Kaiser Foundation Hospitals – Riverside (05-0686): 18.40 FTEs
    g. Kaiser Foundation Hospitals – San Diego (05-0515): 11.73 FTEs
    h. Kaiser Foundation Hospitals – West Los Angeles (05-0561): 1.62 FTEs
    i. Kaiser Foundation Hospitals – Woodland Hills (05-0677): 16.85 FTEs
    j. Kaiser Foundation Hospitals – Sunset (05-0138): 157.60 FTEs

4. The parties agree that should the Providers prevail at the PRRB or in court, there is no need to remand for a determination or audit of the number of FTEs for the GME FTE cap amounts at issue for the Providers. Instead, the parties agree that, should the Providers prevail, the Intermediary will use the GME FTE cap amounts set forth in the preceding paragraph to recalculate the Providers' allowable GME reimbursement. Specifically, the

[4] Subsequent to the hearing, the appeal was transferred to J-1 Medicare Administrative Contractor (MAC), Palmetto/First Coast Service Options.
[5] Joint Stipulation dated February 19, 2009.

Intermediary will use the above GME FTE cap amounts to re-compute the allowable current year, prior year, and penultimate year GME FTE counts, and the related three year GME rolling average, as set forth on the cost reports for each fiscal year and each Provider at issue in the above-captioned five group appeals.

PARTIES' CONTENTIONS:

The Providers contend that their 1996 GME FTE caps are inaccurate as acknowledged by the Intermediary, and that the cap amounts should be increased to reflect the additional FTEs associated with outpatient rotations. [6] The Providers maintain they are not seeking any adjustments to reimbursement made in their respective 1996 or 1998 closed cost reports, and instead are merely seeking to have the correct 1996 GME FTE cap applied to their properly appealed cost reports for FYEs 12/31/99 through 12/31/2003.[7] The Providers assert since they are not requesting any additional reimbursement for any closed cost report years, the reopening rule set forth at 42 C.F.R. § 405.1885 is not applicable and does not preclude the Intermediary from correcting the Providers' erroneous 1996 GME FTE caps.

The Providers assert that the case law and Board decisions support their position that an adjustment to the 1996 GME FTE cap in a properly appealed cost report does not constitute a re-opening of that cost report.[8] The Provider argues that these decisions consistently held that the correction of a predicate factual issue does not otherwise impact the total reimbursement in a closed year and therefore does not constitute a reopening under 42 C.F.R. § 405.1885.

Finally, the Providers address the Kaiser Foundation Hospital - Anaheim ("Anaheim") Provider, whose cost report appeal for FYE 12/31/2001 was dismissed by the Board for failure to submit a preliminary position paper.[9] The Providers contend that even if Anaheim is unsuccessful in having its FYE 12/31/2001 appeal reinstated, and the Providers otherwise prevail on the primary legal issue in the group appeals, the Intermediary may nevertheless adjust Anaheim's FYE 12/31/2001 GME FTE count for the purposes of calculating Anaheim's three-year rolling average and the related GME reimbursement for FYEs 12/31/2002 and 12/31/2003. The Providers assert that, consistent with the other providers in the group, adjustment of Anaheim's GME FTE count for FYE 12/31/2001 does not constitute a reopening of the entire cost report because Anaheim's overall reimbursement for FYE 12/31/2001 would not be impacted.[10] Instead, the adjustment of Anaheim's GME FTE count for FYE 12/31/2001 is necessary to ensure the accuracy of Anaheim's GME FTE counts in FYE 12/31/2002 and FYE 12/31/2003, which are properly under appeal.

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[6] Joint Stipulation No. 2.
[7] Provider's Final Position Paper at 15; Transcript (Tr.) at 11.
[8] Provider's Final Position Paper at 8-12; Tr. at 23 – 24; *Regions Hospital v. Shalala*, 522 U.S. 448, 452 (1998) (*"Regions")* (Provider's Exhibit P-9), *Healtheast Bethesda Lutheran Hospital & Rehabilitation Center v. Shalala*, 164 F.3d 415 (8th Cir. 1998) *("Healtheast")* (Provider's Exhibit P-8); *Edgemont Hospital v. Mutual of Omaha Insurance Co.*, PRRB Dec. No. 95-D34, [1995-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶43,264 (April 6, 1995) (*"Edgemont"*) (Provider's Exhibit P-10).
[9] The Provider acknowledges it has appealed the Board's dismissal decision and the case is currently pending in federal court. *See*, Provider's Supplemental Final Position Paper Regarding GME-FTE Cap at 1.
[10] *Id*. at 3.

The Intermediary contends that it is unable to make any corrections to the Providers GME FTE caps because they are beyond the three year reopening periods.[11] The Intermediary asserts that, as stated in the preamble to the implementing regulations at 62 Fed. Reg. 46004 (August 29, 1997), the Secretary intended the 1998 cost report to be the basis for establishing the unweighted GME FTE cap amount.[12] The Intermediary asserts that absent a reopening of the 1998 cost reports, it is unable to make the corrections and add the outpatient clinic rotations to the Providers' GME FTE caps.

The Intermediary further contends that the case law and the Board decision cited by the Providers are not applicable to the Providers' appeals. For example, *Regions* involves re-audit of GME costs and *Healtheast* pertains to interest expense, while the Board decision in *Edgemont* involves the TEFRA target rate.[13] The Intermediary argues that because the decisions do not specifically address the GME FTE cap issue, they have no relevance to the Providers' appeals.

Finally, in the event the Provider prevails on the issue, the Intermediary asserts that the Board's lack of jurisdiction over the Anaheim FYE 2001 appeal precludes its 2001 GME FTE cap from being corrected for the purposes of determining Anaheim's GME reimbursement for FYEs 2002 and 2003.

In response to the Intermediary's contentions, the Providers argue that neither the statute at 42 U.S.C. §1395ww(h)(4)(F) nor the regulations at 42 C.F.R. § 413.86(g)(4) require that the GME FTE cap be based solely on the number set forth in the 1996 or 1998 audited cost reports.[14] Instead, the legal authority states that a provider's FTE count for later periods cannot be any higher than what it was in the last year ending before 12/31/1996. The Providers contend that since there is no authority tying a provider's GME FTE cap to any particular cost report, it would not constitute a reopening of any closed cost reports if the Intermediary applied the correct GME FTE caps for the purpose of determining the Providers correct GME reimbursement in the open cost report years under appeal.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION

After consideration of Medicare law and guidelines, the parties' contentions and the evidence, including stipulations contained in the record, the Board finds and concludes as follows:

It is undisputed that the Providers' 1996 GME FTE caps as reflected on their 1998 cost reports were understated.[15] Despite acknowledging the error, the Intermediary declined to correct the 1996 GME FTE cap because of the reopening regulations, as more than three years had passed since the Providers' 1998 cost reports became final. The legal issue before the Board is whether correction of the Providers' GME FTE caps constitutes a reopening of their 1998 cost reports which is subject to the three year limitation period set forth in 42 C.F.R. S 405.1885(a).

[11] Stipulation No. 2.
[12] Intermediary's Post-hearing brief at 11; Intermediary's Post-hearing Brief Exhibit 1.
[13] Intermediary's Post-hearing brief at 9-10.
[14] Provider's Final Position Paper at 13, Tr. at 20-21.
[15] Stipulation No. 2.

This legal issue has been previously addressed in case law and Board decisions. For example, in *Regions*, the Supreme Court considered whether the Secretary was precluded from promulgating a regulation that called for intermediaries to re-audit providers' 1984 base-year costs and average GME FTEs, and exclude non-allowable or misclassified costs. The Supreme Court held:

> Furthermore, the Secretary's re-audits leave undisturbed the actual 1984 reimbursements and reimbursements for any later cost-reporting year on which the three-year reopening window had closed. The adjusted reasonable cost figures resulting from the re-audits are to be used solely to calculate reimbursements for still open and future years.

Regions at 456 (1998).

In *Healtheast*, the Eighth Circuit Court of Appeals considered whether an intermediary was barred from determining that certain loans obtained by a provider in 1980 and 1982 were unnecessary. The intermediary excluded from reimbursement to the provider any payments for interest in 1988 the intermediary deemed unnecessary. The intermediary did not adjust the provider's reimbursement for interest on those loans for the 1980 and 1982 cost years, which were already closed under the reopening regulations. In analyzing the reopening regulations, the court reasoned:

> The three-year limitation on reopening applies solely to the amount of total reimbursement. The reconsideration of predicate factual issues (such as the necessity of a loan), with no intention of changing the total reimbursement amount applicable to a year, thus does not fall within the definition of an "intermediary determination" and, accordingly, is not subject to the three-year limitation.

Healtheast at 417 (8th Cir. 1998).

The Board finds the reasoning and results in *Regions* and *Healtheast* instructive. In the current cases, the aim of adjustments to the Providers' respective 1996 GME FTE caps is to accurately determine historical data such that each subsequent year's cost report likewise reflects accurate data. Since such an adjustment would have no effect on Providers' reimbursement for FYE 12/31/1996 or FYE 12/31/1998 (or any closed year), it would not constitute a reopening of their 1996 or 1998 cost reports.

In *Edgemont*, the Board addressed the TEFRA target rate and rejected the provider's argument that the intermediary's adjustment of the provider's base year TEFRA rate constituted an impermissible cost report reopening beyond the three-year limitations period. The Board found:

> [B]ecause the base-year rate serves as a foundation for future years it must be as correct as possible. Therefore, there must be a mechanism with which to correct erroneous base-year costs and to apply the corrected cost information to future years… The record is clear that the referenced cost reporting periods have not been reopened. Moreover, the Intermediary has not sought to recover additional

> reimbursement relating to those years. There is no statutory or regulatory support for the concept that adjusting the TEFRA rate in subsequent years, to conform with a correct base-year determination, amounts to a reopening. As such, the policy in favor of administrative finality is not compromised.

Edgemont at ¶43,264.

Like TEFRA target rate addressed in *Edgemont*, the GME FTE cap established by 42 C.F.R. §413.86(g)(4) serves as a foundation for all future years and therefore also must be as correct as possible. Adjusting the Providers' FTE counts in later years to reflect a corrected base year FTE cap year determination does not amount to a reopening. Thus, the Board finds there is no basis for the Intermediary's refusal to use the correct GME FTE caps for the purposes of determining the Providers' GME reimbursement for the cost report years under appeal, all of which are open with the exception of Anaheim's FYE 12/31/2001 cost report.

The Board finds the Intermediary's attempt to distinguish the aforementioned court and Board decisions based on a different substantive issue unpersuasive. The Intermediary has failed to recognize that *Regions*, *Healtheast* and *Edgemont* are significant for the way the cases analyze the scope of the regulatory limitation on reopening, the legal question before the Board. Each of the cases confirms that for the purposes of 42 C.F.R. §405.1185(a), a cost report is only reopened when the total amount of reimbursement in the fiscal period covered by the cost report is altered. The cases make clear and wholly support the Providers' position that the correction of predicate factual issues in a closed year does not constitute a reopening when the corrections are made for the purposes of determining a provider's reimbursement in a later open year.

The Intermediary referenced some preamble language in the Federal Register at 62 Fed. Reg. 46004 (August 29, 1997) to support its position that the Providers' GME FTE caps can only be corrected by reopening the respective 1998 cost reports. However, the Federal Register cited by the Intermediary does not state expressly, nor even suggest, that a provider's GME FTE cap is forever limited to the number of FTEs that were included in that provider's audited 1998 cost report.

Moreover, neither the governing GME statute nor regulations mandate the use of the 1998 FTE count as it appeared on the audited 1998 cost report for the purposes of establishing the GME FTE cap. Rather the controlling statute states only:

> [T]he total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training programs in the fields of allopathic medicine and osteopathic medicine may not exceed the number of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

42 U.S.C. §1395ww(h)(4)(F).

The regulation is fully consistent with the statutory language. 42 C.F.R. §413.86(g)(4). Accordingly, since the GME FTE cap is not necessarily tied to any particular cost report, it does not follow that the only way an erroneous FTE cap can be corrected is through the reopening process. The Board finds that the correction of the understated GME FTE caps does not require a reopening of any closed cost reports and therefore is not subject to the three year limitation on reopening.

As to the Anaheim 2001 appeal, consistent with the Board's decision on the primary legal issue, the Board finds there is nothing precluding the Intermediary from applying what the parties agree is the most accurate FTE figures to two of Anaheim's open cost reports. Consequently, although the Anaheim appeal for FYE 12/31/2001 has been dismissed, the Intermediary may nevertheless correct Anaheim's FTE count for 2001 only to the extent it impacts Anaheim's GME reimbursement calculation for FYE 12/31/2002 and 12/31/2003.

DECISION AND ORDER:

The Intermediary is not precluded by the three year limitation on reopening from adjusting the Providers' respective GME FTE caps for the purpose of determining the Providers' GME reimbursement for the cost report years under appeal. The Intermediary shall recalculate the Providers' GME reimbursement for the fiscal years at issue using the GME FTE caps agreed upon by the parties by stipulation. The Intermediary's determination is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Keith E. Braganza, C.P.A
John G. Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: OCTOBER 1, 2010

APPENDIX A
SCHEDULE OF PROVIDERS

PROVIDER NAME CITY COUNTY, STATE	PROVIDER NUMBER	FYE(S)
Kaiser Foundation Hospital- Anaheim Anaheim, Orange CA	05-0609	12/31/1999, 12/31/2002, 12/31/2003
Kaiser Foundation Hospital-Bellflower Los Angeles, CA	05-0139	12/31/1999, 12/31/2000, 12/31/2002, 12/31/2003
Kaiser Foundation Hospital-Harbor City Harbor City, Los Angeles, CA	05-0411	12/31/1999, 12/31/2000, 12/31/2001, 12/31/2002
Kaiser Foundation Hospital-Fontana Fontana, San Bernardino, CA	05-0140	12/31/1999, 12/31/2000, 12/31/2001, 12/31/2002, 12/31/2003
Kaiser Foundation Hospital- Panorama City Panorama City, Los Angeles, CA	05-0137	12/31/1999
Kaiser Foundation Hospital- Riverside Riverside, CA	05-0686	12/31/1999, 12/31/2000, 12/31/2001, 12/31/2002, 12/31/2003
Kaiser Foundation Hospital- San Diego San Diego, CA	05-0515	12/31/1999, 12/31/2000, 12/31/2001, 12/31/2002, 12/31/2003
Kaiser Foundation Hospital- West Los Angeles Los Angeles, CA	05-0561	12/31/1999, 12/31/2000 12/31/2001, 12/31/2002, 12/31/2003
Kaiser Foundation Hospital- Woodland Hills Woodland Hills Los Angeles, CA	05-0677	12/31/1999, 12/31/2001, 12/31/2002, 12/31/2003
Kaiser Foundation Hospital- Sunset Los Angeles, CA	05-0138	12/31/2000, 12/31/2001, 12/31/2002, 12/31/2003