PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D29

PROVIDER–
Doctors Hospital of Stark County

Provider No.: 36-0151

vs.

MEDICARE CONTRACTOR –
CGS Administrators

HEARING DATE –
November 19, 2015

Cost Reporting Periods Ended –
June 30, 2001; June 30, 2002;
June 30, 2003

CASE NOs.: 04-1447; 05-2052;
06-1034

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ISSUE STATEMENT:

Whether the Medicare Contractor's adjustments to the Provider's available beds and bed days and prior-year resident-to-bed ratio for cost reporting periods ending 6/30/2001, 6/30/2002 and 6/30/2003 were proper.

DECISION:

The Provider Reimbursement Review Board ("Board" or "PRRB") finds that the Medicare Contractor improperly adjusted the Provider's available beds and bed days for cost reporting periods ending 6/30/2001, 6/30/2002 and 6/30/2003. The Board also finds the Medicare Contractor properly used the fiscal year ("FY") 2000 (prior-year) resident-to-bed ratio in the Provider's 6/30/2001 cost report. The Board remands the cases to the Medicare Contractor to make the necessary adjustments to the Provider's Indirect Medical Education ("IME") payment.

INTRODUCTION:

Doctor's Hospital of Stark County ("Provider" or "Doctor's"), an acute care hospital located in Massillon, Ohio, operated an approved graduate medical education program and qualified to receive an IME adjustment from Medicare.[1] For fiscal years ending ("FYEs") in 2001, 2002 and 2003, the Medicare Contractor, CGS Administrators,[2] made a series of adjustments to the Provider's available beds, prior-year full-time equivalent ("FTE") resident counts and/or resident-to-bed ratios, which reduced the Provider's IME reimbursement.

The Provider timely appealed these audit adjustments to the PRRB and met the jurisdictional requirements for a hearing.[3] The Board held a hearing on November 19, 2015. Daniel J. Hettich, Esq. and Elizabeth N. Swayne, Esq. of King & Spalding, LLP represented Doctor's and Edward Y. Lau, Esq. and Joseph J. Bauers of Federal Specialized Services represented the Medicare Contractor.

STATEMENT OF THE FACTS:

The Medicare program reimburses teaching hospitals for the higher than average operating costs associated with the presence and intensity of residents' training in a hospital.[4] One of these additional payments, known as the IME adjustment,[5] is calculated in part on the hospital's ratio of FTE residents to the number of available beds (the "resident-to-bed ratio").[6] The

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[1] *See* Provider's Post-Hearing Brief, Tab for Proposed Decision at 2, Transcript ("TR") at 44-45.
[2] AdminaStar Federal, Inc. was the Medicare Contractor that made the adjustment. CGS Administrators succeeded AdminaStar Federal, Inc. as the Medicare Contractor and was responsible for these cases during appeal.
[3] Provider's Final Position Paper (2001) Exhibit P-14, (2002) Exhibit P-11 and (2003) Exhibit P-10.
[4] 42 U.S.C. § 1395ww(d)(5)(B). *See also OhioHealth 2004 Clark Bed Days Group v. CGS Adm'rs/Blue Cross Blue Shield Ass'n*, PRRB Hearing Dec. No. 2015-D1.
[5] 42 C.F.R. § 412.105 (2001).
[6] *Id.*

hospital's current year resident-to-bed ratio is compared to the hospital's prior-year resident-to-bed ratio.[7] The lesser of these two ratios is used in calculating the hospital's IME payment.[8]

A hospital's bed count is determined for IME "by counting the number of available bed days during the cost reporting period . . . and dividing that number by the number of days in the cost reporting period."[9] During the years at issue (2001-2003), the bed count excluded beds or bassinets in a healthy newborn nursery, custodial care beds and beds in excluded distinct part hospital units.[10] Generally speaking, the fewer number of beds and/or bed days that are counted for the IME ratio, the higher the IME payment to the provider.[11] It is the Medicare Contractor's determination regarding the number of available beds for Doctor's that is at issue in this case.

FYE 6/30/2001

On April 27, 2001, Triad Hospitals, Inc. purchased Doctor's.[12] Prior to the purchase, Doctor's had mistakenly submitted its FY 2000 cost report claiming 126 adult and pediatric ("A&P") beds, reflecting the number of beds licensed by the Ohio Department of Health.[13] Triad repeated this mistake on Doctor's FY 2001 cost report, realized its error and on May 7, 2003, Doctor's filed an amended cost report to reflect that only 90 A&P beds were actually available.[14]

During the settlement of the FY 2001 cost report in September 2003, the Medicare Contractor requested documentation to reflect the decrease in beds. Doctor's submitted some information and requested that the MAC perform an on-site verification.[15] The Medicare Contractor issued a Notice of Program Reimbursement ("NPR") on September 23, 2003 without performing an on-site verification. This NPR revised the FY 2001 available A&P beds from 90 beds, as submitted on Doctor's amended cost report, by adding 34 A&P beds and 12,412 available bed days. Additionally, this NPR adjusted the prior-year (FY 2000) resident counts and resident-to-bed ratio to reflect the higher number of beds.[16]

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[7] 42 C.F.R. § 412.105(a)(1).
[8] *Id.*
[9] 42 C.F.R. § 412.105(b).
[10] Section 4621(b)(1) of the Balanced Budget Act of 1997, Pub. L. No. 105-33, added subsection (vi) to 42 U.S.C. § 1395ww (d)(5)(B) in which the IME resident to bed ratio may not exceed the ratio calculated during the prior cost reporting period beginning on or after October 1, 1997.
[11] *Grant Med. Ctr. v. Hargan*, 875 F 3d 701, 703 (D.C. Cir. 2017); *Clark Reg'l Med. Ctr. v. DHHS*, 314 F.3d 214, 249 (6th Cir. 2002); *Little Co. of Mary Hosp. & Health Care Ctrs. v. Shalala*, 165 F.3d 1162, 1163 (7th Cir. 1999); *see also* H.R. Rep. No. 99-241, part 1, at 14 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 592 (noting the increase in a hospital's **IME** payment "var[ies] directly" with its "ratio of interns and residents to its number of beds").
[12] *See* Medicare Contractor's Final Position Paper (2002) Exhibit I-4 at 2.
[13] *See* Provider's Post-Hearing Brief at 24 and Provider's Final Position Paper (2001) Exhibit P-11.
[14] Provider's Final Position Paper (2001) Exhibit P-6.
[15] *See* Medicare Contractor's Final Position Paper (2001) Exhibit I-6 at 2 and Provider's Final Position Paper (2001) at 2.
[16] *See* Provider's Post-Hearing Brief at 5-6 and Provider's Final Position Paper (2001) Exhibit P-8.

Doctor's appealed both the final determination of the FY 2001 bed count as well as the prior year (FY 2000) bed count but later withdrew the FY 2000 appeal because of "jurisdictional impediments."[17]

FYE 6/30/2002

The Provider filed its amended cost report for FYE 6/30/2002 with a total of 88 A&P beds.[18] The Medicare Contractor issued an NPR on February 24, 2005[19] adding 34 A&P beds, increasing the available bed day count by 12,410, and adjusting the prior-year FTE resident counts and resident-to-bed ratio.[20] Doctor's appealed this final determination on August 23, 2004.[21]

FYE 6/30/2003

The Provider filed its cost report for FYE 6/30/2003 with a total of 86 A&P beds.[22] The Medicare Contractor issued an NPR on September 13, 2005,[23] again adding 34 A&P beds, increasing the available bed day count by 12,772 and adjusting the prior-year FTE resident counts and resident-to-bed ratio.[24] Doctor's appealed this final determination on March 9, 2006.[25]

On December 17, 2003, the Medicare Contractor performed the requested walk-through and verified an available bed count of eighty-six (86) A&P beds. The Medicare Contractor began using this bed count for Doctor's FY 2004 cost report. The Medicare Contractor did not reopen or otherwise adjust the bed count for Doctor's FY 2000 through FY 2003 cost reports, as the Provider did not document when the reduction in beds occurred[26] or that the beds did not exist prior to the walk-through.[27]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

For all fiscal years at issue, the Medicare Contractor argues that the Provider failed to sufficiently document the decrease in the number of available beds from 6/30/1998 through 6/30/2003.[28] According to the Medicare Contractor, the Provider has "consistently failed to supply any documentation to show that the beds that supposedly went out of service could not be

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[17] *Id.* at 26 and Exhibit P-14. *See also:* Provider's Post Hearing at Brief at 25.
[18] Medicare Contractor Final Position Paper (2002) Exhibit I-5.
[19] Provider's Final Position Paper (2002) Exhibit P-4.
[20] *Id.* at Exhibit P-5.
[21] *Id.* at Exhibit P-11.
[22] Medicare Contractor's Final Position Paper (2003) Exhibit I-4.
[23] Provider's Final Position Paper (2003) Exhibit. P-4.
[24] Medicare Contractor's Final Position Paper (2003) Exhibit I-1.
[25] Provider's Final Position Paper (2003) Exhibit P-10.
[26] Medicare Contractor's Post Hearing Brief at 13-15.
[27] Medicare Contractor's Final Position Paper (2001) at 10.
[28] The Medicare Contractor asserts that CMS' System for Tracking Audit and Reimbursement shows that the Provider filed its cost reports using the number of licensed inpatient beds (159 total beds) for this period. Medicare Contractor's Final Position Paper (2003) at 8-9.

put back into use within 24 hours for 30 consecutive days"[29] as required by 42 C.F.R. § 412.105(b) (2005). However, this standard was not written into regulations at 42 C.F.R. § 412.105(b) until 2005, outside of the cost report years at issue in this case. The Medicare Contractor acknowledges that attestations by three of the Provider's employees accurately reflect the number of beds found in the December 2003 walk-through, and admits that this revised count was used for FY 2004 and beyond.[30] However, the Medicare Contractor rejects using these attestations for the years at issue in these appeals because the statements are "contradictory" and unreliable due to the length of time between the bed count and submission.[31] The Medicare Contractor points out that the Provider has not met its burden of providing auditable documentation for the years under appeal as required by 42 C.F.R. § 413.20.[32]

Lastly, the Medicare Contractor argues that the Provider's FY 2001 appeal of its prior-year resident-to-bed ratio is limited because the Provider withdrew the FY 2000 resident-to-bed ratio issue from its FY 2000 appeal, and cannot not now litigate this issue. The Medicare Contractor also argues that the FY 2000 resident-to-bed ratio is a "predicate fact" that cannot be reopened and revised under the 2014 "predicate fact" regulation.[33] The Medicare Contractor concludes that because the FY 2000 appeal was withdrawn, the available bed count for FY 2000 remains at 126 A&P beds. This count resulted in a lower resident-to-bed ratio in FY 2000, which the Medicare Contractor believes it properly used for the FY 2001 IME calculation.

The Provider argues that the count of 86 beds for FY 2003 was exactly the same as the walk-though and roughly equivalent to the FY 2001 and FY 2002 bed counts claimed by the Provider.[34] The Provider believes the preponderance of evidence demonstrates a major change in its bed size occurred in 1997 when many of the Unit 1 South rooms became a geriatric-psych unit and this explains why, historically, a higher bed count existed.[35]

Additionally, Doctor's believes the Medicare Contractor erred in "mechanically" applying the FY 2000 (prior-year) resident-to-bed ratio for the Provider's 2001 cost report rather than allowing an exception to the general rule.[36] Further, the Provider argues that the predicate fact rule does not apply because the prior-year resident-to-bed ratio is an annual determination to which CMS has said the predicate fact rule does not apply,[37] rather than the establishment of a "base-year" determination to which CMS has stated the predicate fact rule does apply. Finally, the Provider contends that while the Board may be bound by the 2014 regulation itself, it is not

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[29] Medicare Contractor's Final Position Paper (2001) at 9.
[30] *Id.* at 10.
[31] *Id.* at 11. Medicare Contractor's Post Hearing Brief at 13, 15; Tr. at 28.
[32] Medicare Contractor's Post Hearing Brief at 16.
[33] 42 C.F.R. § 405.1885.
[34] *See* Provider's Post-Hearing Brief at 9. The FY 2002 count of 88 would include 2 beds in room 217 that were later closed and converted to a nursing station (*id.* at 7) and the FY 2001 count would include beds in rooms 188 and 189 that were converted to an obstetrical exam room and a private breastfeeding and education room (*id.*).
[35] *See* Provider's Post-Hearing Brief at 20.
[36] *Id.* at 26.
[37] *Id.*

bound by CMS' contention that the amendment was a mere "clarification" that can be applied retroactively.[38]

After considering the Medicare law and regulations, the parties' contentions and evidence submitted, the Board finds that the Provider's bed count should be adjusted, consistent with the December 2003 walk-through, with certain adjustments for minor changes as follows: 86 A&P beds for FYE 6/30/2003, 88 A&P beds for FYE 6/30/2002 and 90 A&P beds for FYE 6/30/2001. The Medicare Contractor conducted a physical walk-through on December 17, 2003, confirming a count of 86 available A&P beds. The Medicare Contractor did not use this bed count for the years under appeal because Doctor's had not sufficiently documented when the reduction to its beds occurred. However, on the day of the hearing Doctor's submitted documentation,[39] as well as testimony, showing the reduction in beds occurred in 1997. Specifically, Doctor's documented a renovation to Unit 1 South that closed beds and converted the space to the geriatric-psych unit, an obstetrical waiting room, etc. The Board finds this documentation supports the testimony of Doctor's witnesses that the bed count was reduced back in 1997.

Additionally, the Medicare Contractor's walk-through confirmed that there were only 86 "gas hookups" available[40] and it raised no question regarding whether any of the beds taken out of service could be put back into use within 24 hours for 30 consecutive days as the Medicare Contractor later argues in its position papers. The Board finds the affidavits[41] and the testimony of the witnesses credible because although the affidavits were signed, and the witnesses testified many years after the cost reporting periods at issue, the affiants/witnesses were all employed by the hospital during the periods in which the beds were taken out of service and had specific knowledge regarding the bed count during this period. The Board finds no reason to question this testimony. Additionally, the Board finds the documents submitted by the Provider on the day of the hearing contain 1997 construction estimates, invoices and building permits for the geriatric-psych unit and show the reduction in the Provider's bed count occurred well before the years under appeal.

Further, CMS itself has explained that it does *not rely* on the hospital license as the definitive bed count for purposes of determining the applicable bed count because the states have no consistent method or standards for defining a licensed bed.[42] The Board concurs with CMS' position on this issue and finds that it is incorrect to simply use the number of state-licensed beds as the number of available beds for the purposes of the IME calculation when evidence to the contrary exists.

In the preamble to a 2005 final rule, CMS declared that it sought to "reflect a hospital's available bed count as accurately as possible" and avoid including beds that are "essentially hypothetical in nature"[43] and at least one court has stated the general rule that CMS must use the "best

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[38] *Id.* at 27.
[39] *See* Provider's Post-Hearing Brief (2001) Exhibit P-18, (2002) Exhibit P-16 and (2003) Exhibit P-14.
[40] Provider's Post-Hearing Brief at9, (2001) Exhibit P-16 at 4, (2002) Exhibit P-14 at 4 and (2003) Exhibit P-12 at 4.
[41] *See* Provider's Final Position Paper (2001) Exhibits P-1, P-2 and P-3.
[42] 69 Fed. Reg. 48916, 49096 (Aug. 11, 2004).
[43] 69 Fed. Reg. at 49094.

available data" in calculating reimbursement.[44] The Board is persuaded that the Medicare Contractor itself established an accurate number of available beds during its December 2003 walk-through, and Doctor's provided sufficient evidence of which beds were removed from service from 1997 to 2001 to accurately reflect the number of available beds for all of the fiscal years at issue in these cases.

FY 2001 Cost Report and the 2013 Predicate Fact Rule

The Board finds that the Medicare Contractor correctly used the prior-year resident-to-bed ratio for the Provider's FY 2001 IME calculation. Federal regulation, 42 C.F.R. § 412.105(b), requires that the Medicare Contractor use the "lower of" the prior, or current year resident-to-bed ratio. Since the FY 2000 resident-to-bed ratio was admittedly[45] lower than the FY 2001 resident-to-bed ratio, the Board finds that the Medicare Contractor correctly used the FY 2000 resident-to-bed ratio. While the Provider appealed the FY 2000 resident-to-bed ratio, it withdrew its appeal on procedural grounds.

The question before the Board is whether this FY 2000 resident-to-bed ratio can be challenged in a later year (FY 2001) because it was applied in the earlier year's (FY 2000) IME calculation, what, in Medicare parlance, has come to be known as a "predicate fact." CMS defines "predicate facts" as "factual underpinnings" of a specific reimbursement determination that first rose in or were first used to determine a provider's reimbursement in a cost reporting period different from the current period under review. In 2013, CMS amended its reopening regulation, 42 C.F.R. § 405.1885, to prohibit the reopening of a final determination, i.e., the predicate fact, more than three years after the determination which is expected to have a continuing effect on subsequent payments.[46] The Provider, not surprisingly, argues that the bed count is not a predicate fact because the bed count can change on an annual basis.[47] Conversely, the Medicare Contractor argues that once the resident-to-bed ratio is established for the prior-year and the three-year reopening period has run, this resident-to-bed ratio cannot be reopened and relitigated, i.e., it has become a predicate fact, in subsequent applications.

In the 2013 regulation, CMS did, indeed, qualify its definition of a predicate fact to exclude those factors that are determined annually.[48] In each fiscal year, the number of residents and the number of beds can vary, and indeed, may be reestablished on an annual basis. However, the use of these annual numbers to calculate the resident-to-bed ratio is a fact that may become predicate unless challenged in the year in which it was first established or first applied. In the present case, the Provider did not challenge the resident-to-bed ratio in FY 2000, so it became a predicate fact to be applied in a subsequent year (FY 2001).

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[44] *See, e.g., Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[45] Provider's Post-Hearing Brief at 26.
[46] 78 Fed. Reg. 74826, 75162 (Dec. 10, 2013). *See* Medicare Contractor's Post Hearing Brief Exhibit I-15.
[47] Provider's Post-Hearing Brief at 26.
[48] 78 Fed. Reg. at 75167. In the preamble to the final regulation, CMS applied this new rule to all appeals pending on the date of the final rule. *See id.* at 75168. The cases before the Board were filed in 2004-2006 and were pending before the Board in December 2013, so the Board believes that it is bound by the amended regulation.

From the Board's perspective, the focus of this appeal is the number of beds that existed in the fiscal years from 2001 to 2003. As the FY 2001 resident-to-bed ratio was established in Doctor's FY 2000 cost report and the appeal of this issue was dropped by the Provider, the Board finds that in accordance with 42 C.F.R. § 412.105(a)(1), the Medicare Contractor was correct in applying the FY 2000 prior-year resident-to-bed ratio in the FY 2001 IME calculation.

DECISION:

The Board finds that the Medicare Contractor improperly adjusted the Provider's available beds and bed days for cost reporting periods ending 6/30/2001, 6/30/2002 and 6/30/2003. The Board also finds the Medicare Contractor properly used the FY 2000 (prior-year) resident-to-bed ratio in the Provider's 6/30/2001 cost report. The Board remands the cases to the Medicare Contractor to make the necessary adjustments to the Provider's IME payment.

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.
Charlotte Benson, CPA
Gregory Ziegler, CPA, CPC-A

FOR THE BOARD:

/s/
L. Sue Andersen
Chairperson

DATE: March 22, 2018