PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D27

PROVIDER:
Henry Ford Allegiance Health

PROVIDER NO.:
23-0092

vs.

MEDICARE CONTRACTOR:
WPS Government Health Administrators

RECORD HEARING HELD:
November 30, 2018

FISCAL YEAR END: 06/30/2014

CASE NO.: 17-1392

INDEX

ISSUE STATEMENT:

Did the Medicare Contractor properly calculate the per-resident amount ("PRA") for Medicare payment of direct graduate medical education ("DGME")?[1]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds the Medicare Contractor properly calculated the base year PRA by applying 42 C.F.R. § 413.77(e)(1)(iii)[2] and the data from the hospital's 1998 census region.

INTRODUCTION:

Henry Ford Allegiance Health (the "Provider") is an acute care hospital located in Jackson, Michigan. Wisconsin Physician Services serves as the Provider's Medicare administrative contractor ("Medicare Contractor").[3] `The Provider and the Medicare Contractor cannot agree on the correct methodology to calculate the Provider's base year PRA in its cost report for fiscal year ending ("FYE") June 30, 2014. The Medicare Contractor believes it must use the 1998 census region hospital data from the May 14, 1999 bulletin (the "99 Bulletin") issued by the Centers for Medicare and Medicaid Services ("CMS")[4] for the base year PRA calculation.[5] However, the Provider believes the PRA must be calculated using data from the most recently settled cost reports, as outlined in the inpatient prospective payment system ("IPPS") final rule published on August 1, 2002.[6]

The Provider timely appealed its cost report for the fiscal year ending June 30, 2014 ("FY 2014") and met the jurisdictional requirements for a hearing. The Provider requested a record hearing[7] in this matter due to its similarities to the Board's decision in *Our Lady of the Lake Reg'l Med. Ctr. v. Novitas Solutions, Inc.*[8] The Board granted this request on November 30, 2018. In submitting their respective final position papers, the Provider was represented by Andrew Ruskin, Esq., of Morgan, Lewis and Bockius, LLP, and the Medicare Contractor was represented by Wilson Leong, Esq., CPA of Federal Specialized Services.

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[1] Provider's Final Position Paper at 2. Medicare's direct graduate medical education payment is referred to interchangeably as DGME or GME.
[2] In 2004, 42 C.F.R. § 413.86(e)(5) was redesignated to 42 C.F.R. § 413.77(e), pursuant to 69 Fed. Reg. 48916, 49235, 49257-58 (Aug. 11, 2004).
[3] Formerly known as fiscal intermediaries, CMS' payment and audit functions under the Medicare program are now contracted to organizations known as Medicare administrative contractors. However, the term "intermediary" is still used in various statutes and regulations, and is interchangeable with the terms "Medicare administrative contractor" or "Medicare contractor."
[4] Copy included at Provider's Final Position Paper, Exhibit P-5.
[5] *See* MAC Final Position Paper at 9.
[6] Provider's Final Position Paper at 5-6, 20 (*citing* 67 Fed. Reg. 49982, 50068 (Aug. 1, 2002)).
[7] *See* Letter to the Board (Oct. 18, 2018).
[8] PRRB Dec. No. 2018-D46 (July 31, 2018).

STATEMENT OF FACTS:

The Medicare program reimburses teaching hospitals for costs associated with approved graduate medical education programs. In general, the DGME payment is calculated by multiplying the hospital's base year PRA (updated for inflation) by the weighted number of full-time equivalent ("FTE") residents working at the hospital, and multiplying that amount by Medicare's share of the hospital's inpatient days.[9]

In general, a hospital's PRA[10] is determined by dividing the hospital's base year DGME program costs by the average number of FTE residents working at the hospital in the base year.[11] For most hospitals, the base year PRA is the hospital's fiscal year beginning during the federal fiscal year ("FFY") 1984. However, if a hospital did not have residents or did not participate in the Medicare program during the 1984 base period, 42 U.S.C. § 1395ww(h)(2)(F) specifies that the Secretary of Health and Human Services shall determine the PRA based on approved FTE resident amounts for comparable programs.

In 1989, the PRA base year implementing regulations at 42 C.F.R. § 413.86(e)(4) explained that Medicare contractors shall establish a PRA for new teaching hospitals, established after the 1984 base year, using data from the first cost reporting period during which the hospital participated in Medicare and the residents were on duty during the first month of that period. The PRA was required to be based upon the lower of the hospital's actual medical education program costs incurred during the base year, or the mean value of per resident amounts of hospitals located in the same geographic area. However, if there were fewer than three amounts that could be used to calculate the mean value, the Medicare contractor was required to contact CMS for a determination of the appropriate amount to use.

CMS modified these regulations, effective October 1, 1997, requiring Medicare contractors to establish the PRA for all new teaching hospitals.[12] In this regard, 42 C.F.R. § 413.86(e)(4)(i) (1997) required contractors to make the PRA calculation based on the lower of the following:

> A. The hospital's actual costs, incurred in connection with the graduate medical education program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.
>
> B. The mean value of per resident amounts of hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter, for cost reporting periods beginning in the same fiscal years. If there are fewer than three amounts that can be used to calculate the mean value, the calculation of the per resident amounts includes all

[9] 42 U.S.C. § 1395ww(h)(3)(A).
[10] The PRA is also referred to as the "approved FTE resident amount." *See* 42 U.S.C. § 1395ww(h)(2).
[11] 42 C.F.R. § 413.77(a) (2004).
[12] *See* 62 Fed. Reg. 45966, 46003-46004, 46034 (Aug. 29, 1997).

> hospitals in the hospital's region as that term is used in § 412.62(f)(1)(i).

The Balanced Budget Refinement Act of 1999 ("BBRA")[13] and the Medicare, Medicaid, and State Children's Health Insurance Program ("SCHIP") Benefits Improvement and Protection Act of 2000 ("BIPA")[14] temporarily made changes to how DGME payments were calculated by establishing a "floor" and a "ceiling" based on a locality-adjusted, updated, weighted average PRA, calculated using fiscal year 1997 data.[15] This methodology compared a hospital's PRA to the floor and ceiling to determine whether its PRA should be revised. This change was implemented via regulation at 42 C.F.R. § 413.86(e)(4).

CMS made further revisions to the DGME regulations in 2002. In the May 9, 2002 proposed rule, CMS explained that it had become administratively burdensome to recreate base year information, and proposed to simplify and revise the weighted average PRA methodology under 42 C.F.R. § 413.86(e)(5)(i)(B)[16] to reflect the average of all PRAs in a metropolitan statistical area ("MSA")[17] using data from the most recently settled cost reports. CMS adopted this change as part of the August 1, 2002 final rule.[18] Specifically, the new regulation at 42 C.F.R. § 413.86(e)(5) (2002), was amended to read:

> *Exceptions* – (i) *Base period for certain hospitals*. If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period . . . . The per resident amount is based on the lower of [the following:]
>
> (A) The hospital's actual costs, incurred in connection with the graduate medical education program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.
>
> (B) Except as specified in paragraph (e)(5)(i)(C) of this section–. . . .
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> (2) For base periods beginning on or after October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated

[13] Consolidated Appropriations Act, 2000, Pub. L. No. 106-113, 113 Stat. 1501, 1501A-362 (1999).
[14] Consolidated Appropriations Act, 2001, Pub. L. No. 106-554, § 511, 114 Stat. 2763, 2763A-533 (2000).
[15] 42 C.F.R. § 413.86(e)(4) (2000). *See also* 65 Fed. Reg. 47054, 47091-93 (Aug. 1, 2000).
[16] In 2004, 42 C.F.R. § 413.86(e)(5) was redesignated to 42 C.F.R. § 413.77(e), pursuant to 69 Fed. Reg. at 49235, 49257-58.
[17] 67 Fed. Reg. 31404, 31467 (May 9, 2002). The terms "geographic wage area" and "MSA" are interchangeable.
[18] 67 Fed. Reg. at 50119-50120.

> using all per resident amounts . . . and FTE resident counts from the most recently settled cost reports of those teaching hospitals.
>
> (C) If, under paragraph (e)(5)(i)(B)(*1*) or (e)(5)(i)(B)(*2*) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region as that term is used in § 412.62(f)(1)(i) of this chapter.

The parties agree that the base year for the Provider's PRA was FY 2014,[19] and that there were fewer than three teaching hospitals in the Provider's geographic wage area.[20]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Provider argues that using the 99 Bulletin updated for inflation to derive the census area weighted average PRA for FY 2014 does not reflect the changes in the mix of teaching hospitals in the census region over time and does not reflect any updates resulting from the BBRA and BIPA floors.[21] Further, the Provider points out the Medicare Contractor's methodology does not include the most current PRAs as reflected in the most recently settled cost reports, which the Provider asserts is required by CMS regulations.[22] The Provider is requesting that its base year PRA be assigned based upon the census region PRA cap calculated using cost report data for the most recently settled cost reports prior to the Provider's FY 2014.[23]

As stated by the Provider, the overarching goal of 42 U.S.C. § 1395ww(h)(2)(F) is to ensure that new teaching hospitals are paid a reasonable amount based on the PRAs that peer hospitals currently receive.[24] The BBRA and BIPA floors established for 2001 and 2002 benefited comparable programs. The Provider asserts that the most recent settled cost reports should be used in determining its PRA so it can also benefit from the floors established by BBRA and BIPA.[25]

The Provider contends that the 99 Bulletin was not distributed to the hospitals, but only to the Medicare contractors and cannot be used in the computation of the Provider's PRA because the 99 Bulletin does not constitute a duly promulgated regulation and cannot be reconciled with the governing statutes, regulations, and published regulatory guidance.[26] The Provider also asserts that updating the PRA based upon a weighted average per resident amount established in 1997

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[19] Provider's Final Position Paper at 3; MAC Final Position Paper, Exhibit C-1.
[20] Provider's Final Position Paper at 5; MAC Final Position Paper at 10.
[21] Provider's Final Position Paper at 15-16.
[22] *Id.* at 20-21.
[23] *Id.* at 26.
[24] *See* i*d.* at 16-17, 23-24.
[25] *Id.* at 15, 19-21.
[26] *Id.* at 5-6, 12-13.

does not reflect the PRAs of newly established hospitals, nor does it include the PRAs that were adjusted in 2001 and 2002 to equal a base floor.[27] Finally, the Provider believes that the use of essentially stale data in the 99 Bulletin is not a reasonable reading of the statutory term "comparable programs."[28]

The Board is sympathetic towards the Provider's arguments and understands the logic behind wanting to use the PRAs in the most recent settled cost reporting periods. However, based upon a review of the regulations, the Board is convinced that CMS knowingly decided to compute the PRAs for new teaching hospitals with *at least* three teaching hospitals in the MSA differently from teaching hospitals with less than three hospitals with PRAs in the MSA.

Effective October 1, 1997, when the Medicare Contractor began calculating the PRAs for all new teaching hospitals, CMS modified its regulations such that a new teaching hospital's PRA was calculated "based on the lower of the new teaching hospital's actual cost per resident in its base period or a weighted average of all the PRAs of existing teaching hospitals in the same MSA." However, effective for cost reporting period beginning October 1, 1997, if there were *less than* three existing teaching hospitals with PRAs within the new teaching hospital's MSA, the Medicare Contractor was to use the updated regional weighted average PRA determined for the census region to calculate the new teaching hospital's PRA.[29]

Subsequently, in the August 1, 2002 final rule, CMS established a revised methodology to be used to determine the PRA for new teaching hospitals.[30] In proposing this new regulation, the agency explained the change was being made because the "[current] methodology is particularly problematic in instances where there are large numbers of teaching hospitals in an MSA."[31] As a result, the agency proposed to simplify and revise the weighted average PRA methodology under 42 C.F.R. § 413.86(e)(5)(i)(B) to reflect the average of all PRAs within an MSA. This new methodology continued to calculate a weighted average PRA, but rather than use 1984 base year data, it used PRA and FTE data from the most recently settled cost reports of teaching hospitals in an MSA.[32]

The Board finds that the change CMS made in 2002 (*i.e.*, to use data from the most recently settled cost reports) only applies if the new hospital has at least three existing hospitals with PRAs in its MSA. Although the Provider would like this change to apply when the new teaching hospital has less than three existing hospitals with PRAs in the MSA, the Board can find no basis for this interpretation.

Specifically, the Board points out that the language in the regulations pertaining to hospitals that use census region data remained relatively unchanged. In this regard, 42 C.F.R. § 413.86(e)(5)(i)(C) (2002) states:

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[27] *Id.* at 15-16, 18-20.
[28] *Id.* at 15-16.
[29] 67 Fed. Reg. at 31467 (*citing* 62 Fed. Reg. 45966, 46004 (Aug. 29, 1997)).
[30] 67 Fed. Reg. at 50068-50069; 42 C.F.R. § 413.86(e)(5)(i)(B).
[31] 67 Fed. Reg. at 31467.
[32] *Id.*

> If, under paragraph (e)(5)(i)(B)(*1*) or (e)(5)(i)(B)(*2*) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region . . . .

This language is clearly different than the revised language in subsection (e)(5)(i)(B)(2) which specifically states that data from the most recently settled cost reports is used to calculate the updated weighted mean value PRA for base periods beginning October 1, 2002. The Board reviewed the May 9, 2002 proposed rule[33] and the August 1, 2002 final rule[34] implementing these revised regulations, and finds no support for the Provider's position that the most recent settled cost report data should be used to determine the weighted average PRA for the census region.

The Board further points out the new weighted average calculation was effective for cost reporting periods with DGME base years that started after October 1, 2002.[35] Although 42 C.F.R § 413.86(e)(5)(i)(B)(2) (2002) was revised stating "for base periods beginning on or after October 1, 2002," subsection (e)(5)(i)(C) still applies "for base periods beginning on or after October 1, 1997." The Board is convinced that CMS intended the new methodology to be used for calculations under subsection (e)(5)(i)(B)(2) only and not under subsection (e)(5)(i)(C).

Finally, as identified in the May 9, 2002 proposed rule, CMS made the change to use data from the most recently settled cost report, in part, because it had become "administratively burdensome" for CMS and the Medicare contractors to calculate the weighted average PRA of teaching hospitals within a particular MSA, particularly where there were numerous hospitals in the MSA.[36] The Board notes that a similar administrative burden would not have existed for a census region because CMS published the 99 Bulletin with the weighted average PRAs for each of the nine census regions.[37] CMS instructed the Medicare contractors to apply the applicable DGME update factor to these census region amounts. Had CMS changed its regulations to require data from the most recently settled cost reports to be used in calculating the weighted mean value of PRAs for all hospitals in a census region, this would have created an additional administrative burden each time a new teaching hospital, with less than three hospitals with PRAs in its MSA, needed a base year PRA calculated.

The Board concludes that the Medicare Contractor's decision to use the 99 Bulletin[38] conforms to Medicare regulations and CMS instructions. Additionally, the Board disagrees with the Provider's contention that use of the 99 Bulletin constitutes impermissible retroactive

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[33] 67 Fed. Reg. at 31467-68.
[34] 67 Fed. Reg. at 50067-69.
[35] *Id.*
[36] 67 Fed. Reg. at 31467.
[37] *See* Provider's Final Position Paper, Exhibit P-5.
[38] *See id.*

rulemaking, and finds that the 99 Bulletin was published by CMS in response to the FFY 1998 IPPS final rule published on August 29, 1997[39] providing the weighted average per resident amount for the nine census regions for cost reporting periods beginning on or after October 1, 1997 and ending before October 1, 1998. The Board understands that use of the 99 Bulletin may not produce the exact same results as data from the most recently settled cost reports and may not accurately reflect the PRAs of hospitals that were impacted by the floor and/or ceiling calculations required by BBRA and BIPA. However, this is the methodology adopted by CMS to eliminate much of the administrative burden on its contractors, and the Board is bound to follow the plain language of the regulation and reasonable interpretation of that regulation by CMS.

Since the parties have agreed that there are less than three existing hospitals with PRAs in the Provider's MSA, the Board finds the Medicare Contractor properly calculated the Provider's base year PRA for 2014 by applying 42 C.F.R. § 413.77(e)(1)(iii)[40] and CMS' instructions in the 99 Bulletin.

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds the Provider's base year PRA was properly calculated by applying 42 C.F.R. § 413.77(e)(1)(iii) and the 1998 census region hospital data.

BOARD MEMBERS PARTICIPATING:

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Gregory H. Ziegler, C.P.A., CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

5/30/2019

X Charlotte F. Benson

Charlotte F. Benson, C.P.A.
Board Member
Signed by: PIV

[39] 62 Fed. Reg. 4.
[40] In 2004, 42 C.F.R. § 413.86(e)(5) was redesignated to 42 C.F.R. § 413.77(e), pursuant to 69 Fed. Reg. at 49235, 49257-58.