PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D36

PROVIDERS –
University of Wisconsin Hospitals and Clinics Authority

Provider No.: 52-0098

vs.

MEDICARE CONTRACTOR –
National Government Services

HEARING DATE –
May 10, 2017

Cost Reporting Periods Ended –
June 30, 2005, June 30, 2006, June 30, 2007, June 30, 2008 and June 30, 2010

CASE Nos. –
13-0929, 13-3153, 13-3155, 13-3156 and 15-1780

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ISSUE STATEMENTS[1]:

Issue 1:
Whether the Medicare Contractor's adjustments, decreasing the Provider's direct Graduate Medical Education ("GME")[2] and Indirect Medical Education ("IME") Full Time Equivalent ("FTE") Caps to a level below the Provider's audited and adjusted fiscal year ending June 30, 1996 ("FY 1996") GME and IME Medicare resident counts, should be reversed. This issue applies to the fiscal years ending June 30, 2005 ("FY 2005"), June 30, 2006 ("FY 2006") and June 30, 2010 ("FY 2010").[3]

Issue 2:
Whether the Medicare Contractor's adjustments disallowing certain bad debt claims with respect to indigent patients whose indigency was determined through the Save Our Seniors ("SOS") Program should be reversed. This issue applies to the fiscal years ending June 30, 2007 ("FY 2007"), June 30, 2008 ("FY 2008") and FY 2010.[4]

DECISION:

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds:

> Issue 1 – The Medicare Contractor used the incorrect 1996 GME and IME FTE caps when calculating University of Wisconsin Hospitals and Clinics Authority's ("UWH" or "Provider") GME and IME payments for FYs 2005, 2006 and 2010. Accordingly, the Board remands these cost reports to the Medicare Contractor to adjust UWH's GME cap to 324.18 and UWH's IME cap to 287.66 and to modify UWH's GME and IME reimbursement for the appealed years based on these adjustments.

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[1] At the hearing, there were four issues read into the record. However, the third and fourth issues no longer reside in the relevant cases underlying this consolidated decision and, accordingly, this decision does not address them. Specifically, the third issue entered into the record questioned "[W]hether the Medicare Contractor's disallowance of tax payments the Provider made to the state of Wisconsin was proper for fiscal year 2010 in case number 15-7180." However, on January 23, 2019, Provider's counsel advised the Board that it was withdrawing the state tax issue from its appeal in Case No. 15-1780, as a result of the decision of the Court of Appeals for the District of Columbia, in *Dana-Farber Cancer Institute v. Hargan*, 878 F.3d 336 (D.C. Cir. 2017). Transcript ("Tr.") at 8-9. Similarly, the fourth issue read into the record was "[W]hether the Provider's Medicare Disproportionate Share Hospital ("DSH") reimbursement calculation was understated due to the Centers for Medicare and Medicaid Services' ("CMS" or "Agency") and the Medicare Contractor not including all patient days for patients who were eligible for and enrolled in the SSI program, but not have received any SSI payment for the month in which they received services from the Provider ("SSI Eligible days") in the numerator of the Medicare Fraction of the DSH percentage for fiscal year 2007 in case number . . . 13-3155, for fiscal year 2008 in case number 13-3156 and for fiscal year 2010 in Case Number 15-1780." *Id.* at 9-10. However, for FYs 2007 and 2008, this issue was subsequently transferred to Case No. 18-0336G and, for FY 2010, this issue was transferred to Case No. 17-1408G.
[2] Direct graduate medical education is referred to as DGME or simply "GME."
[3] Tr. at 7.
[4] *Id.* at 8.

Issue 2 – The Medicare Contractor incorrectly denied all the bad debts UWH claimed based on indigent determinations made by the SOS Program. Accordingly, the Board remands UWH's FYs 2007, 2008 and 2010 cost reports back to the Medicare Contractor to review the SOS documentations to determine if the patients were properly determined to be indigent, and to adjust UWH's bad debt reimbursement based on the results of this review.

INTRODUCTION:

UWH is a Medicare-certified short-term acute care teaching hospital located in Madison, Wisconsin.[5] UWH's designated Medicare administrative contractor[6] is National Government Services, Inc. ("Medicare Contractor"). On its cost reports for FYs 2005, 2006 and 2010, UWH claimed GME and IME reimbursement using GME and IME caps that were based on the FTE counts from the Provider's reopened, re-audited and adjusted FY 1996 cost report.[7] However, the Medicare Contractor disallowed a portion of the GME and IME FTEs that the Provider claimed for these fiscal years because it determined that the adjusted 1996 cost report could not be used to determine the applicable caps.[8]

Additionally, on its cost reports for FYs 2007, 2008, and 2010, UWH included inpatient Part A and outpatient Part B bad debts.[9] However, the Medicare Contractor disallowed the bad debts for patients who were qualified as indigent under the SOS Program, as the Medicare Contractor determined that SOS had not satisfied the Medicare requirements for determining indigency.[10]

UWH timely appealed these issues to the Board and met the jurisdictional requirements for a hearing. The Board held a live consolidated hearing for the five (5) cases on May 10, 2017. UWH was represented by Daniel F. Miller, Esq. of Hall, Render, Killian, Heath & Lyman, P.C. The Medicare Contractor was represented by Scott Berends, Esq., of Federal Specialized Services.

ISSUE 1: GME and IME

STATEMENT OF FACTS AND RELEVANT LAW (ISSUE 1-GME/IME):

The Medicare program pays teaching hospitals for GME and IME costs based, in part, on the hospital's FTE resident count subject to a statutorily imposed cap.[11] CMS has promulgated regulations to address the application of these caps. For GME, 42 C.F.R. § 413.79(c)(2) states:

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[5] Provider's Combined Final Position Paper at 1 (Jan. 30, 2017).
[6] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[7] Provider's Combined Final Position Paper at 8-9.
[8] *Id. See also* MAC Final Position Paper at 5 (2005 and 2006).
[9] Provider's Combined Final Position Paper at 9-11.
[10] *Id.* at 10-11; MAC Final Position Paper at 26 (Feb. 28, 2017) (2008).
[11] 42 U.S.C. §§ 1395ww(h), 1395ww(d)(5)(B).

> (i) for cost reporting periods beginning on or after October 1, 1997, a hospital's resident level may not exceed the hospital's unweighted FTE count (or, effective for cost reporting periods beginning on or after April 1, 2000, 130 percent of the unweighted FTE count for a hospital located in a rural area) for these residents for the most recent cost reporting period ending on or before December 31, 1996.
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> (iii) If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section, the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

For IME, 42 C.F.R. § 412.105(f)(1)(iv)(A) states:

> Effective for discharges occurring on or after October 1, 1997 the total number of FTE residents in the fields of allopathic and osteopathic medicine in either a hospital or a nonhospital setting that meets the criteria listed in paragraph (f)(1)(ii) of this section may not exceed the number of such FTE residents in the hospital (or, in the case of a hospital located in a rural area, effective for discharges occurring on or after April 1, 2000, 130 percent of that number) with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

Based on the number of residents included in UWH's FY 1996 Notice of Program Reimbursement ("NPR"), the Provider's GME cap was established in its FY 1999 cost report as 309.43 and its IME cap was establish in its FY 1998 cost report as 285.75.[12] Subsequently, in 2001, the Medicare Contractor reopened UWH's FY 1996 cost report and issued a revised NPR changing the 1996 GME and IME counts.[13] Based on this 2001 reopening, UWH's GME count changed to 324.18 and its IME count changed to 287.66.[14] These revised counts were used as the Provider's GME and IME caps when settling UWH's cost reports from 2001 (the time of the 1996 reopening) until 2012 to 2013.[15]

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[12] Medicare Contractor Post Hearing Brief at 2 (Oct. 27, 2017). *See also* the MAC Final Position Paper at 30 (2010).
[13] MAC Final Position Paper at 32 (2010).
[14] Provider's Combined Final Position paper at 9; Exhibit P-32 at 278. *See also* Exhibit P-33 (identifying the 1996 GME cap of 324.18 and the 1996 IME cap of 287.66).
[15] Provider's Post Hearing Brief at 4-5 (July 7, 2017).

In June 2012, the Medicare Contractor notified UWH that it was reopening the Provider's FY 2005 and 2006 cost reports to adjust the GME and IME caps to reflect the caps that were established in the Provider's FY 1999 and 1998 cost reports respectively.[16] Likewise, when settling UWH's FY 2010 cost report the Medicare Contractor adjusted the GME cap to 309.43 and the IME cap to 285.75 based on the Provider's FY 1999 and 1998 cost reports respectively.[17]

The dispute in these appeals centers on which caps should be used in settling UWH's FY 2005, 2006 and 2010 cost reports.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW (ISSUE 1-GME/IME):

The Medicare Contractor contends that the GME cap of 309.43 was first determined on UWH's June 30, 1999 cost report and the IME cap of 285.75 was first determined on UWH's June 30, 1998 cost report and as predicate facts these caps must be used on UWH's cost reports for FYs 2005, 2006 and 2010.[18] The Medicare Contractor points out that these amounts were based on the FTE counts reflected in UWH's 1996 settled cost report.[19] Based on the principles of predicate facts, the Medicare Contractor maintains that UWH had to appeal or reopen the June 30, 1999 cost report to modify its GME Cap and the June 30, 1998 cost report to modify its IME cap.[20]

To support its position that UWH's GME and IME caps cannot be modified without an appeal or reopening of the 1999 and 1998 cost reports, the Medicare Contractor points to the December 10, 2013 Federal Register ("2013 Final Rule")[21] wherein CMS clarified its reopening regulations in response to the D.C. Circuit's decision in *Kaiser Foundation Hospital v. Sebelius* ("*Kaiser*").[22] Specifically, the Secretary disagreed with the *Kaiser* decision as it related to predicate facts and, in the 2013 Final Rule, stated:

> "[P]redicate facts" are determined once, either in the first fiscal period in which they arise or are first determined, or in the first fiscal period that they are used as part of a formula for reimbursement, and then applied as part of that formula for several fiscal period thereafter. These facts are not reevaluated annually . . .[23]
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> Under our longstanding interpretation and practice, once the 3-year reopening period has expired, neither the provider nor the

[16] MAC Final Position Paper at 7 & Exhibit I-1 (2005 and 2006).
[17] *Id.* at 28-29 & Exhibit I-22 (2010)
[18] *Id.* at 31-32 & Exhibit I-22; Exhibit I-1 (2005 and 2006).
[19] The Medicare Contractor points out that the NPRs for UWH's FY 1998 and 1999 cost reports were issued before the October 19, 2001 reopening of UWH's 1996 cost report and that UWH never requested that either its FY 1998 or 1999 cost reports be reopened to change the caps. *Id.* at 32 (2010).
[20] Medicare Contractor Post Hearing Brief at 2-3. *See also* Medicare Contractor's Final Position Paper at 30-33 (2010).
[21] *See* 78 Fed. Reg. 74826, 75163 (Dec. 10, 2013).
[22] 708 F.3d 226 (D.C. Cir. 2013).
[23] 78 Fed. Reg. at 75163.

> intermediary is allowed to revisit a predicate fact that was not changed through the appeal or reopening of the cost report for the fiscal period in which such predicate fact first arose or for the fiscal period for which such fact was first determined by the intermediary.[24]

The Medicare Contractor maintains that, since UWH did not appeal or ask for a reopening of the GME cap that was determined on the June 30, 1999 cost report or the IME cap that determined on the June 30, 1998 cost report, and the time for such an appeal or reopening has long passed, UWH's GME and IME caps were established in these cost reports and cannot be modified.

UWH disagrees with the Medicare Contractor and asserts that the GME FTE count of 324.18 and IME FTE count of 287.66 that were computed by the Medicare Contractor in the reopening of UWH's 1996 cost report, are the correct caps for its FYs 2005, 2006 and 2010 cost reports.[25] UWH believes that it is the actual FY 1996 GME and IME FTE counts that bind the provider not the Medicare Contractor's calculation of those FY 1996 counts as part of the settlement of the FY 1999 and FY 1998 cost reports.[26]

In analyzing the facts in the *Kaiser* case, UWH points out that the agency clearly stated that providers could challenge their FTE caps by directly challenging the counts in their FY 1996 cost reports.[27] As UWH's FY 1996 cost report was reopened *and* revised, and the FTE caps UWH is requesting for its FYs 2005, 2006 and 2010 cost reports are the GME and IME counts form the reopened and revised 1996 cost report, UWH believes the Medicare Contractor's adjustments should be reversed.[28]

The Board reviewed CMS' regulations and agrees with UWH that its revised FY 1996 cost report should be used to determine its GME and IME caps. Specifically, the GME and IME regulations both establish that the resident caps are based on "the hospital's most recent cost reporting period ending on or before December 31, 1996."[29] Additionally the cost report forms instruct the providers to report the "FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996."[30] The Board finds nothing in CMS' regulations that prevent the use of revised 1996 GME and IME counts when determining a provider's caps.

Rather, the Board finds that CMS addressed this issue in the 2013 Final Rule, when it discussed the facts in the *Kaiser* case. Specifically, CMS stated: "The providers could have challenged their FTE resident counts through timely appeals or reopenings of their 1996 fiscal period NPRs, and they could have challenged the calculation of their resident caps through timely appeals or

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[24] *Id*. at 75164.
[25] Provider's Combined Final Position Paper at 25-26; Exhibit P-22 (reflecting the as-filed caps for GME and IME).
[26] *Id.* at 24.
[27] *Id.* at 25. *See also* 78 Fed. Reg. at 75165.
[28] Provider's Combined Final Position Paper at 25-26.
[29] *See* 42 C.F.R. § 413.79(c)(2) (regulation governing GME); 42 C.F.R. § 412.105(f)(1)(iv)(A) (regulation governing IME).
[30] *See* Exhibit I-3 at 1, line 3.04 (giving IME instructions); Exhibit I-5 at 1, line 3.01 (giving GME instructions using language similar to the IME instructions) (2005 and 2006).

reopenings of their 1998 fiscal period NPRs, the first time the caps were applied."[31] The Board finds the 2013 Final Rule is clear that a provider has the opportunity to modify its GME/IME caps by a reopening or appeal of *either* the 1996 NPR *or* the NPR for fiscal period where the cap first applied. In this case, the Medicare Contractor reopened UWH's 1996 cost report and revised those both the GME and IME counts.[32] Therefore, the Board finds those revised FY 1996 counts must be used to determine UWH's GME and IME caps.

Finally, the Board points out that the 2013 Final Rule revised the reopening regulations at 42 C.F.R. § 405.1885 but did not change the regulations governing appeals to the Board at § 405.1835.[33] The D.C. Circuit court's decision in *Saint Francis Med. Ctr. v. Azar,* ("*Saint Francis"*)[34] held that 42 C.F.R. § 405.1885 which limits the time period to reopen a predicate fact does *not* apply to appeals of a fiscal intermediary determination to the Board. The Court stated that "[t]he reopening regulation applies *only* to reconsideration by the entity that made the decision at issue. It does ***not*** apply to administrative appeals."[35] Based on *Saint Francis*, the Board finds the Medicare Contractor is incorrect in asserting that UWH's GME and IME caps (as predicate facts) can only be modified through a reopening *or appeal* of UWH's FY 1999 and FY 1998 cost reports, as the "predicate fact" time limitation in the reopening regulations at § 405.1885 does not apply to appeals to the Board. The Board notes that the D.C. Circuit's decision in *St. Francis* is controlling precedent for the interpretation of § 405.1885.[36] Therefore, the Board finds a provider, dissatisfied with a predicate fact, can appeal that predicate fact to the Board even if that predicate fact was determined on a prior cost report.[37]

The Board concludes that UWH is not barred from appealing its GME and IME caps from its 2005, 2006, and 2010 cost reports to the Board. Additionally the Board finds that the GME and IME caps should be based on UWH's reopened and revised 1996 cost report. As the parties do not dispute the GME and IME counts resulting from UWH's reopened and revised 1996 cost report, the Board concludes that UWH's caps for FYs 2005, 2006, and 2010 should be adjusted to 324.18 for GME and 287.66 for IME.[38] The Board remands theses cost reports to the Medicare Contractor to effectuate these adjustments.

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[31] 78 Fed. Reg. at 75165.
[32] MAC Final Position Paper at 10 (2005), 9 (2006), 32 (2010); Provider's Combined Final Position Paper at 8. *See also* Exhibit P-32.
[33] 78 Fed. Reg. at 75169.
[34] 894 F.3d 290 (D.C. Cir 2018) (emphasis added).
[35] *Id.* at 294.
[36] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor Room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), *affirming*, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).
[37] *Saint Francis* at 295-297.
[38] Medicare Contractor Final Position Paper at 10 (2005), 9 (2006), 32 (2010). *See a*lso Provider's Combined Final Position Paper at 8; Exhibit P-32 at 278.

Issue 2: Bad Debts

STATEMENT OF FACTS AND RELEVANT LAW (ISSUE 2-BAD DEBTS):

Medicare regulations establish the general rule that bad debts are deductions from revenue and are not to be included in allowable costs.[39] However, in order to ensure that Medicare-covered costs are not shifted to individuals who are not covered by the Medicare program, these regulations expressly permit bad debts attributable to Medicare deductibles and coinsurance to be reimbursable as allowable costs. In order to qualify for this exception, bad debts must meet the following criteria to be considered allowable:

> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
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> (2) The provider must be able to establish that reasonable collection efforts were made.
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> (3) The debt was actually uncollectible when claimed as worthless.
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> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.[40]

CMS has provided extensive guidance on its bad debt policy in the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), §§ 308, 310, 312 and 322. PRM 15-1 § 308 requires that a provider make reasonable collection efforts and apply sound business judgment to determine that the debt is uncollectible. PRM 15-1 § 310 requires that a provider undertake a "reasonable collection effort" unless it determines that a patient is indigent. PRM 15-1 § 312 allows a provider to "deem" a Medicare beneficiary indigent if the individual has been determined eligible for Medicaid. However, if he/she cannot be deemed indigent, the provider should apply its customary methods for determining the indigence of Medicare patients using the following guidelines:

> A. The patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;
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> B. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

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[39] 42 C.F.R. § 413.89(a) (2004), redesignated from 42 C.F.R. § 413.80 pursuant to 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).
[40] 42 C.F.R. § 413.89(e).

> C. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian; and
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> D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.[41]

In addition, federal regulations, 42 C.F.R. §§ 413.20(d)(1) and 413.24(c), require that providers maintain auditable, verifiable documentation that assures proper payment by the program.

During the cost years at issue (*i.e.*, FYs 2007, 2008 and 2010), UWH had an agreement with the Dane County SOS Senior Council ("Agreement")[42] "to make available medically indicated and necessary services to Medicare eligible participants who are elderly and disabled citizens of Dane and surrounding counties."[43] Under the terms of the Agreement, the SOS Program was responsible for screening all applicants for eligibility, according to eligibility guidelines set out in the Agreement.[44] Eligibility for membership in the SOS Program was dependent upon an individual "[p]rovid[ing] the Council Screening Committee and UWHC with the necessary data to determine eligibility"[45] including demonstrating that he/she has "a gross annual income of 200% or less of poverty guidelines[.]"[46] Under the terms of the Agreement, UWH agreed not to balance bill patients who were SOS Program participants, for Medicare-covered services.[47] However, the Agreement permitted UWH to fully recover unpaid amounts related to non-covered services from the SOS Program members.[48]

Following an audit in each of the relevant cost years, the Medicare Contractor disallowed any bad debts related to UWH patients determined to be indigent if the SOS Program made that determination.[49] The Medicare Contractor's work papers indicate that it found numerous errors in its review of the sampled bad debts, including, but not limited to, a "lack of sufficient documentation of patient indigency."[50] The Medicare Contractor's work papers explained that:

> The provider was inconsistent in their documenting the indigency of the patients sampled. Some accounts the patient would have a detailed calculation with third-party documentation to support that the beneficiary was indigent. For others there was no calculation or documentation. When asked about this, the provider indicated

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[41] PRM 15-1 § 312.
[42] Exhibit P-45 (effective dates of April 1, 2008 through March 8, 2011); Exhibit P-123 (effective dates of April 3, 2003 through March 8, 2005). At the hearing, the Provider's witness represented that there were earlier versions of the UWH SOS Agreement admitted as Exhibit P-45, and later versions of this Agreement as well. Tr. at 146:3-13. Collectively the Board will the Board will refer to the various UWH-SOS agreements as the "Agreement."
[43] Exhibit P-45 at § II.B.
[44] *Id.* at § II.B.4.A.
[45] *Id.* at § II.B.2.A.c.
[46] *Id.* at § II.B.2.A.g.
[47] *Id.* at § II.B.3.A.1.
[48] *Id.*
[49] *See* MAC Final Position Paper at 27 (2008).
[50] Exhibit I-14 at 1 (2008); Exhibits P-39, P-41, P-43.

> that they placed reliance on a 3rd party entity to determine the indigency of the patient. The provider furnished a copy of a contract with the S.O.S. Senior Council @ WP E-30B-0K. This contract indicates criteria for an individual to be eligible for the program. Since there is no detail to verify the S.O.S. determination, the Intermediary has marked these accounts as errors with insufficient documentation proving the patient's indigency.[51]

The parties dispute whether the UWH's reliance on the SOS Program's determination of indigence, rather than the Provider itself making the indigence determination, satisfies Medicare's requirements for claiming bad debts.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW (ISSUE 2-BAD DEBTS):

The Medicare Contactor contends that it disallowed UWH's bad debts for patients determined to be indigent based on qualifying for the SOS Program because: (1) UWH itself did not make the determination of the patient's indigence; (2) the SOS Program did not apply asset/liability or income/expense tests when determining indigence; (3) UWH did not document the criteria the SOS Program used and the information it gathered to determine indigence; and (4) UWH's policy for determining indigence for non-Medicare patients was unclear so the Medicare Contractor could not tell whether UWH's Medicare and non-Medicare collection efforts were similar.[52]

UWH disagrees with the Medicare Contractor's determination and believes that it properly relied on its Agreement with SOS to determine the indigence of an SOS Program enrollee.[53] Additionally, UWH asserts that its charity care policies were similar for Medicare and non-Medicare patients[54] and that documentation of indigence is available for the patients in the SOS Program.[55] UWH believes that the Medicare Contractor's decision to reduce its bad debt reimbursement should be reversed.[56]

The Board reviewed the statute, regulations, and PRM and rejects the Medicare Contractor's contention that PRM 15-1 § 312.A requires that UWH, and not a third party acting on the UWH's behalf, determine a patient's indigence.[57] The Board recognizes that § 312.A states: "The patient's indigence must be determined *by the provider*, not by the patient"[58] but finds that this section is intended to prevent *patients* from determining their own indigence. The Board does not read this section in a way that prevents the provider from having a third party, acting on behalf of the provider, gather the information needed to determine if a patient qualifies as indigent by meeting the provider's charity care policy. In the instant case, it was the SOS

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[51] Exhibit I-14 at 1 (2008).
[52] MAC Final Position Paper at 23-27 (2010).
[53] Provider's Combined Final Position Paper at 29.
[54] Tr. at 146-147, 161-163.
[55] *Id.* at 151-153.
[56] Provider's Combined Final Position Paper at 29.
[57] Tr. at 211-13.
[58] (Emphasis added.)

Council that *screened* all applicants for the SOS Program, and obtained financial information from the applicant to determine if they qualified for the program. At the hearing the Medicare Contractor ultimately conceded that there is no statute, regulation or other guidance that explicitly prohibits a provider from satisfying the PRM bad debt requirements through use of an agent, a subcontractor or a third party working on the provider's behalf.[59]

Similarly, the Board finds no merit in the Medicare Contractor's argument that PRM § 312 (paragraphs B and D) *required* SOS to apply asset/liability or income/expense tests when making indigency determinations.[60] While the Board acknowledges that the CMS Administrator has interpreted PRM § 312 to "create a mandatory asset test,"[61] that interpretation was rejected by the District Court for the District of Columbia[62] in *Baptist Healthcare System v. Sebelius ("Baptist").* In the *Baptist* decision, the court found "[t]he Administrator's conclusions stand in stark contrast to the Agency's unequivocal statement that, a hospital may determine its own individual indigency criteria" and that PRM § 312 paragraphs B and D "are best construed as strong, but ***non****compulsory* recommendations."[63] The Board concurs with the District Court's holding in *Baptist* on this issue, and finds that it was improper for the Medicare Contractor to interpret PRM § 312 paragraphs B and D as mandatory requirements for UWH to evaluate a patient's assets as part of its determination of indigence.

The Board understands the Medicare Contractor's concerns that UWH must have similar collection and indigence policies for it Medicare and Non-Medicare patients. However, as set forth below, the Board finds that UWH did have similar collection policies for both Medicare and non-Medicare patients.[64] UWH included as part of the record its Policy & Procedure for Patient Eligibility for Charity Care ("indigence policy").[65] Based on this policy, patients were deemed indigent *if* they demonstrate, through submission of a financial statement, tax returns, and pay stubs, that their income level was at or below 200 percent of the federal poverty guidelines. Similarly, the record contains the Agreement with SOS that shows the criteria used to determine eligibility for the SOS Program. That documentation shows that, in order for a participant to be eligible for the SOS Program, the patient must demonstrate a gross annual income that is 200 percent or less than the national poverty guidelines for the year at issue.[66] "Gross income" was specifically defined in the Agreement as "that income that is stated on 1099, Homestead Credit, or other applicable reports."[67]

UWH provided a copy of the Homestead Credit form, which is a comprehensive accounting of numerous categories of sources of household income.[68] In addition, UWH provided PHI redacted copies of financial application materials related to a sample of SOS members, which

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[59] Tr. at 215-219.
[60] MAC Final Position Paper at 23 (2010).
[61] *Baptist Regional Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec., 7 (Feb. 8, 2008), *reversing*, PRRB Dec. No. 2008-D12 (Dec. 10, 2007).
[62] 646 F. Supp. 2d 28 (D.D.C. 2009).
[63] *Id*. at 34 (emphasis added).
[64] MAC Final Position Paper at 27 (2010).
[65] Exhibit P-116A.
[66] Exhibit P-45 at § II.B.2.A.g.
[67] *Id.* at § I.G.
[68] Exhibit P-124.

included the annual financial updates required to maintain SOS membership.[69] The Board notes that, on review of the financial application materials, it was clear that SOS did not simply rely on a patient's signed declaration of indigence. Rather, the documentation in the record demonstrates that the SOS Program required applicants to provide "proof of income" with their application,[70] and that the SOS Program maintained copies of that documentation.[71] Accordingly, the Board finds that UWH's general indigence guidelines are sufficiently similar, if not identical, to the indigence guidelines in the Agreement with the SOS Program and, therefore, UWH's charity care policy (including the Agreement) meets Medicare requirements.

The Board recognizes that Medicare regulations at 42 C.F.R. §§ 413.20(d)(1) and 413.24(c) require that providers maintain auditable, verifiable documentation that assures proper payment by the program. This would include documentation to support UWH's indigent bad debt claims, including the financial documentation to support that patients enrolled in the SOS program, qualified for that program. The Board understands that this documentation is available but was not supplied to the Medicare Contractor at the time of the FYs 2007, 2008 and 2010 audits because the Medicare Contractor did not believe UWH could rely on the SOS Program's determination of a patient's indigence.[72] Therefore, the Board remands the FYs 2007, 2008 and 2010 cost reports back to the Medicare Contractor to review the indigent bad debts that it denied in order to determine if the documentation obtained by SOS supports the finding that the patients qualified for the SOS Program and, as a result, meet UWH's charity care policy.

DECISION AND ORDER:

After considering Medicare law and regulations, arguments presented, and the evidence admitted the Board finds:

> Issue 1 – The Medicare Contractor used the incorrect 1996 GME and IME FTE caps when calculating UWH's GME and IME payments for FYs 2005, 2006 and 2010. Accordingly, the Board remands these cost reports to the Medicare Contractor to adjust UWH's GME cap to 324.18 and UWH's IME cap to 287.66 and to modify UWH's GME and IME reimbursement for the appealed years based on these adjustments.
>
> Issue 2 – The Medicare Contractor incorrectly denied all the bad debts UWH claimed based on indigent determinations made by the SOS Program. Accordingly, the Board remands UWH's FYs 2007, 2008 and 2010 cost reports back to the Medicare Contractor to review the SOS documentation to determine if the patients were properly determined to be indigent, and to adjust UWH's bad debt reimbursement based on the results of this review.

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[69] Exhibits P-117 to P-119.
[70] *See, e.g.*, Exhibit P-117 at 1.
[71] *See, e.g., id.* at 1445 (copy of bank statement), 1448 (copy of bank statement), 1452 (copy of annuity statement).
[72] Tr. 166 – 167.

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FOR THE BOARD:

8/29/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A