CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
St. Joseph's Hospital **St. John's Northeast Hospital** **Provider** **vs.** **Blue Cross /Blue Shield Association** **Noridian Administrative Services** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: Various** **Review of:** **PRRB Dec. No. 2007-D68** **Dated: September 14, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). CMS' Center for Medicare Management (CMM) submitted comments requesting that the Administrator review the Board's decision on Issue No. 2. The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from CMM on Issue No. 2. The Intermediary and the Provider submitted comments on Issue Nos. 1, 2 and 3. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

Issue No. 1 – General Assistance Days and PM A-99-62

Whether the Intermediary's exclusion of certain non-Medicaid general assistance and other State-only funded patient days general assistance (GA) days from the Provider's Medicaid Proxy was proper based on the instructions contained in Program Memorandum A-99-62 (St. Joseph's for fiscal years ending (FYE) 1996 through 2000).

Relying on an earlier decision involving the same parties, the same issue in the district court for the District of Columbia's decision in St. Joseph's Hospital,[1] the Board held that the Provider qualified under the provisions of PM A-99-62 to have its GA days included in its DSH adjustments for FYEs 1996 through 2000. The Board reversed the Intermediary's determination and remanded the matter back to the Intermediary to recalculate the Provider's DSH payments for the years in dispute.

Issue No. 2 – Medicare + Choice Days

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

The Board held that the M+C days should be included in the DSH calculation in the Medicare fraction. In reaching this determination, the Board reviewed the history of the M+C program and Part C of the Medicare program and determined that M+C eligibility for Part C was based on Part A eligibility. However, because the Board was unable to determine whether these days had been actually counted in the Medicare proxy, the Board remanded this matter to the Intermediary to review St. Joseph's data and determine whether it had been properly credited for M+C days in the Medicare portion of the Provider's DSH calculation.

Issue No. 3 – IME and GME

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

The Board held that the regulations required that the Providers have a written agreement with the non-provider even if the parties were related. The Board disagreed with the Providers' contention that the requirements for written agreements did not apply to related clinics because they were not "outside entities."

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[1] See, *St. Joseph's Hospital v. Blue Cross Blue Shield Association/Noridian Administrative Services*, PRRB Dec. No. 2004-D32, August 12, 2004, Medicare & Medicaid Guide (CCH) ¶81,183, rev'd, CMS Administrator, October 13, 2004, Medicare & Medicaid Guide (CCH) ¶81,265, rev'd, sub. nom. *St. Joseph Hospital v. Leavitt*, 425 F. Supp. 2nd 94 (March 31, 2006).

SUMMARY OF COMMENTS

Issue No. 1 —General Assistance Days and PM A-99-62

The Intermediary commented requesting that the Administrator reverse the Board's decision because it reflected an incorrect interpretation of the regulations and program instructions. Specifically, the Intermediary argued that the Provider did not meet the "hold-harmless" provision of PM A-99-62 because the Provider's appeal request was not specific enough to show that the appeal was on the issue of the exclusion of GA days from the Medicare DSH formula. The Intermediary points out that the Provider filed its preliminary position paper in December 1999 and made no specific reference to the GA days issue, therefore, the Provider made no focused complaint about rejection of GA days in its DSH claim. Only after the issuance of PM A-99-62, did the Provider acknowledge the GA days in its argument.

The Provider commented requesting that the Administrator affirm the Board's decision. Specifically, the Provider argued that it had a jurisdictionally proper appeal on the issue of the excluded GA days because they filed a request for a hearing on March 18, 1998, for FYE 1995, appealing DSH adjustment number 46, which included "non-Medicaid" GADs, before October 15, 1999. Therefore, they are entitled to claim GA days for FYEs 1996 through 2000. The Provider also relied on the District Court for the District of Columbia's decision in St. Joseph's Hospital, to support its position that it is entitled to claim GA days for FYEs 1996 through 2000.

Issue No. 2 —Medicare+Choice Days

The Intermediary commented requesting that the Administrator reverse the Board's decision. The Intermediary stated that the record does not support a need to audit the Medicare fraction. Furthermore the Intermediary stated that it correctly calculated the Provider's DSH calculation.

The Provider commented requesting that the Administrator affirm in part and reverse in part the Board's decision. The Provider concurred with the general finding of the Board that the M+C days should be included when calculating the Provider's DSH calculation but disagreed with the Board's determination that the M+C days should be included in the Medicare fraction.

The Provider argued that M+C days should be included in the Medicaid fraction. The Provider contended that once a beneficiary elects to receive benefits through the M+C program, the patient is no longer entitled to payment under Part A; therefore, such days should be included in the numerator of the Medicaid fraction. To further support the Provider's argument that M+C days belong in the Medicaid fraction, the

Provider relied on Congress's treatment of M+C enrollees in the graduate medical education (GME) context. Congress adopted a M+C specific GME reimbursement payment to be paid to hospitals in addition to the normal GME payment. Congress created this additional reimbursement mechanism because it recognized that M+C patients were not "patients with respect to whom payment may be made under part A," and would not be represented in the normal GME payment.

CMM agreed with the Board's interpretation that dual-eligible M+C days should be included in the Medicare DSH calculation. However, the Board erred in remanding the matter because the regulation clearly indicates that CMS' calculations of hospitals' Medicare fraction are fixed, when performed, and that no change to the Medicare fraction, either higher or lower is allowed based on updated or corrected data. The regulation at 42 C.F.R. §412.106(b) (3) only allows a hospital to have its DPP calculated based upon the hospital's cost reporting period rather than the Federal fiscal year. If a hospital request to have this done, the calculation is "performed once per hospital per cost reporting period" and the resulting DPP "becomes the hospital's official [DPP] for that period." Therefore, the Board's remand was not in accordance with the regulations at 42 C.F.R. §412.106(b) et. seq.

Issue No. 3 —IME and GME —Non-Provider Setting

The Intermediary submitted comments concurring with the Board's decision.

The Providers commented requesting that the Administrator reverse the Board's decision. The Providers contended that the Providers and the related non-hospital locations to which residents rotated were "related parties," as such, the non-hospital locations do not constitute "outside entities" under the relevant regulations. To support the Providers' position, the Providers cited *Good Samaritan Regional Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Arizona*, PRRB Dec. 2000-D4 (Oct. 19, 1999), Medicare & Medicaid Guide (CCH) ¶80,343, *rev'd*, Administrator, December 21, 1999. In that case, the Board decided that a provider was not required by the regulation to have a written agreement with its related facilities in order to have the subject resident rotations included in its GME count.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Issue No. 1 —General Assistance Days and PM A-99-62

Relevant to the issue involved in this case, CMS issued Program Memorandum (PM) A-99-62, dated December 1999. This program memorandum explained that State-only and waiver days were not to be counted in the Medicaid proxy. However, for those providers that were genuinely confused or held a genuine belief that, for example, certain "State-only" days and/or "waiver days were to be included in the DSH calculation, CMS announced a hold harmless policy for cost reporting periods beginning before January 1, 2000. Regarding hospitals that did not receive payments reflecting the erroneous inclusion of days at issue, CMS stated that:

> If, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days. The actual number of these types of days that you use in this revision must be properly supported by adequate documentation provided by the hospital. Do not reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before PRRB on other Medicare DSH issues or other unrelated issues. (Emphasis added.)

In an earlier decision involving the same parties, the same issue,[2] the Administrator reversed the Board's determination and held that the Provider was not entitled to the benefit of the "hold harmless" provision of PM A-99-62 because GA days were not specifically raised in the Provider's appeal before October 15, 1999. The District Court for the District of Columbia in *St Joseph Hospital*[3] reserved the Administrator's decision holding that the issue of the inclusion of GA days formed a part of the Provider's appeal based on the Intermediary's underlying audit adjustment involving GA days. The Court determined that was sufficient to qualify the Provider to be held harmless. As a result the Court ordered judgment for the Provider.

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[2] Supra n. 1.

[3] Id.

The Administrator finds that PM A-99-62, clearly instructed Intermediaries' "not to reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before the Board on other Medicare DSH issues or other under unrelated issues." The Administrator agrees with the District Court in *United Hospital n. Thompson*,[4] which stated:

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

However, the Administrator recognizes that the opinion of the District Court for the District of Columbia involved the same facts, the same issue, and the same parties. Therefore, Administrator finds that for FYEs 1996 through 2000, the Provider is entitled to claim GA days based upon the Court's finding that the Provider had a jurisdictionally valid appeal in FYE 1995.

Issue No. 2 —Medicare+Choice Days

The regulations at 42 C.F.R. § 412.106(b) provide that CMS will calculate a hospital's Medicare fraction based on its discharge data for a Federal fiscal year (FFY). The regulations at 42 C.F.R. §412.106(b) (3) permits a hospital to choose to have its disproportionate patient percentage (DPP) calculated based upon the hospital's cost reporting period rather than the FFY. If a hospital requests for this to be done, the calculation is "performed once per hospital per cost reporting period" and the resulting DPP "becomes the hospital's official [DPP] for that period." Read together with other regulatory provision at 42 C.F.R. §412.106, the regulation clearly indicates that CMS' calculations of hospitals' Medicare fractions are fixed when performed and that no change to the Medicare fraction, either higher or lower, is allowed based on updated or later data. There is no provision for doing re-computations based on updated or later data and thus, one should not be implied.

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[4] 2003 U.S. Dist. LEXIS 9942 (D. Minn. June 9, 2003), affirmed, 2004 U.S. App. 8th Cir. Lexis 1882.

Generally, CMS only performs a recalculation of an IPPS payment determination based on updated or later data where the regulations explicitly provide for such recalculation. In contrast, where the regulations have not provided explicitly for re-determinations, CMS or its designees do not perform them.

In this case, while the Provider agreed with the Board's determination that M+C days must be included in the Provider's DSH calculation, the Provider argued that M+C days belong in the numerator of the Medicaid fraction instead of the Medicare fraction. The Administrator agrees with the Board's finding that dual-eligible M+C days should be included in the Medicare DSH calculation. However, the Administrator finds that Board erred in remanding the matter to the Intermediary to review St. Joseph's data and determine whether it had properly been credited for M+C days in the Medicare portion of the Provider's DSH calculation.

The Administrator finds that, the regulation does not provide for a recalculation of the SSI calculation based upon updated or later data once it is completed by CMS. A review of the applicable law and regulations show that the Secretary did not intend for the DSH calculations to be recomputed or recalculated based upon later, or corrected, data. As the regulation shows, only a limited exception for recalculation of the Medicare fraction based upon a provider's cost reporting period is allowed. Notably, this limited exception was based on the explicit time period (a provider's cost reporting period) which was set forth in the statute. In contrast, no such explicit provision for recalculation of the Medicare fraction based on later, or corrected data, is set forth in the statute, nor in the regulation.

Thus, the Administrator finds that the regulation precludes the recalculation of the Medicare fraction based on updated or corrected data. Further, as the Board is bound by the regulations, it is not authorize to order any recalculation of the SSI ratio based on updated or corrected data.

Issue No. 3 —IME and GME

Since July 1, 1987, the Social Security Act has permitted hospitals to count the time residents spend training in sites that are not part of the hospital, non-hospital sites, for purposes of graduate medical education (GME).[5] Section 1886(h) (4) (E) of the Act states that the Secretary's rules concerning computation of FTE residents for purposes of GME payments shall:

> [P]rovide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an

[5] Omnibus Budget Reconciliation Act of 1986 (Pub. Law No. 99-509).

> approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs *all, or substantially all,* of the costs for the training program in that setting. (Emphasis added.)

The regulation governing payment for GME at 42 C.F.R. §413.86(b) (1999) states:

> For purposes of this section the following definitions apply:
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> ....
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> *All or substantially all of the costs for the training program in the nonhosptials setting* means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the costs of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education. (Emphasis added.)

Further, the regulation explains at 42 C.F.R. §413.86(f) (3) that:

> On or after July 1, 1987, and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in nonprovider settings, such as freestanding clinics, nursing homes and physician offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:
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> (i) The resident spends his or her time in patient care activities. (ii) There is a written agreement between the hospital and the outside entity that states the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.[6]

Moreover, in response to the payment of certain qualified nonhospital providers for GME, the regulation at 42 C.F.R. §413.86(f) (4) (1999) was amended to specify that:

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[6] See also 62 Fed. Reg. 45966, 46007 (Aug. 29, 1997) (Section 413.86(f) (1) allows hospitals to include resident time in nonhospital sites when the hospital incurred all or substantially all of the costs. Under section 42 C.F.R. §413.86(f) (1(iii) (B) we have defined "all or substantially all" to mean that the hospital has a written agreement with the nonhospital site that it will continue to pay the residents' salary for training in that setting .....)

> For portions of cost reporting periods occurring on or after January 1, 1999, [and before October 1, 2004,][7] the time residents spend in non-provider setting the time residents spend in non-provider settings, such as freestanding clinics, nursing homes and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:
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> (i) The resident spends his or her time in patient care activities.
>
> (ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the non-hospital site for supervisory teaching activities.
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> (iii) The hospital must incur all or substantially all of the costs for the training program in the non-hospital setting in accordance with the definition in paragraph (b) of this section.

Notably, the definition of "all or substantially all" of the costs was clarified pursuant to the FFY 1999 IPPS final rule (July 31, 1998). The Secretary explained in the FFY 1999 IPPS final rule that:

> We proposed that, in order for a hospital to include residents' training time in a nonhospital setting, the hospital and the nonhospital site must have a written contract which indicates the hospital is assuming financial responsibility for, at a minimum, the cost of residents' salaries and fringe benefits (including travel and lodging expenses where applicable) and the costs for that portion of teaching physicians' salaries and fringe benefits related to the time spent in teaching and supervision of residents.

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[7] For periods after October 1, 2004, the regulation was amended to allow providers to count the FTE residents in the calculation without a written agreement if certain criteria were including that "all or substantially all" of the costs are paid by the hospital met. The regulation at 42 C.F.R. §413.86(f) was redesignated to 42 C.F.R. § 413.78(d) (2007) and included at (d)(4) that the hospital is subject to the principles of community support and redistribution of costs as specified in 42 C.F.R. §413.81.

> The contract must indicate that the hospital is assuming financial responsibility for these costs directly or that the hospital agrees to reimburse the nonhospital site for such costs.

One commenter objected to the changes on the basis that some arrangements between hospitals and nonhospital settings for the training of residents predated the GME base year. However, the Secretary explained that:

> hospital and nonhospital sites will have 5 months following publication of this final rule to negotiate agreements that will allow hospitals to continue counting residents training in nonhospital sites for indirect and direct GME. These agreements are related solely to financial arrangements for training in nonhospital sites. We do not believe that the agreements regarding these financial transactions will necessitate changes in the placement and training of residents[8]

The Secretary also stated, in response to a commenter who suggested that CMS should encourage "affiliations," that the revised definition of "all or substantially all" of the costs provides incentives for hospitals and nonhospital sites to reach agreement with regard to financial arrangements for training in nonhospital sites to avoid the situation where neither entity receives payment for GME. The Secretary also addressed the effect of the related party rule on the written agreement requirement stating that:

> With regard to the costs of related parties under §413.17, our policy was not to include costs associated with training in non-hospital clinics in the per resident amount even though certain direct GME costs of related parties could have been allowable. We also do not believe that §413.17 has applicability to our proposed policy. We are requiring a written agreement between hospitals and non-hospital sites even where the hospital and the non-hospital site are related organizations under

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[8] 63 Fed Reg. 40986 40995(July 31, 1998) One commenter asked whether hospitals would be eligible to receive payments in situations where the teaching faculty volunteers their services and neither the hospital or nonhospital entity incurs costs for supervisory teaching physicians, but the hospital incurs the costs of resident salaries and fringe benefits (including travel and lodging expenses where applicable). 63 Fed Reg. 40996. The Secretary found that, for purposes of satisfying the requirement of a written agreement, the written agreement between a hospital and a nonhospital site may specify that there is no payment to the clinic for supervisory activities because the clinic does not have these costs.

> §413.17. In practice, since we are requiring an agreement between hospitals and nonhospitals sites that are under common ownership or control the agreements are a formality.[9]

Subsequent to the cost years in this case, in the FFY 2008 IPPS rule, the Secretary addressed the existing policy in discussing the further clarification to the definition of "all or substantially all" costs and stated that:

> Global agreements with lump sum payment amounts, either for teaching physician costs or for nonhospital training in general, have not been sufficient under existing policy and would not be sufficient under the finalized policy. Similarly, as under current policy, if two (or more) hospitals train residents in the same accredited program, and the residents rotate to the same nonhospital site(s), the hospitals cannot share the costs of that program at that nonhospital site (for example, by dividing the FTE residents they wish to count according to some predetermined methodology), as we do not believe this is consistent with the statutory requirement at section 1886(h)(4)(E) of the Act which states that the hospital incur "all, or substantially all, of the costs for the training program in that setting."[10] (Emphasis added.)

In addition, prior to October 1, 1997, for IME payment purposes, hospitals were not permitted to count the time residents spent training in non-hospital settings. Section 4621(b)(2) of the Balanced Budget Act of 1997 revised §1886(d)(5)(B) of the Act to

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[9] 63 Fed. Reg. 40986, 40996 (July 31, 1998). See also Medicare Policy Clarifications on Graduate Medical Education Payments for Residents Training in Non-Hospital Settings (April 2005), "Question 8) Must the hospital incur the teaching physician costs and have a written agreement with the nonhospital site if a) the nonhospital site is owned by the hospital, or b) the nonhospital site is owned by the same organization that owns the hospital? Answer 8) In either scenario, the hospital must incur the teaching physician costs, and there must be a written agreement in place before the time the residents begin training in the nonhospital site ... The hospital would need to demonstrate, under either ownership scenario, that it is paying all or substantially all of the costs of the training program by actually paying the nonhospital site through the hospital's accounts payable system. (If the hospital and nonhospital site share a single accounting system, the hospital could demonstrate payment of the nonhospital site training program costs using journal entries that expense these costs in the hospital's GME cost center and credit the nonhospital site.)"

[10] 72 Fed. Reg. 26870, 26968 (May 11, 2007).

allow providers to count time residents spend training in non-hospital sites for IME purposes, effective for discharges occurring on or after October 1, 1997. Section 1886(d) (5) (B) (iv) of the Act was amended to provide that:

> [A]ll the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs *all or substantially all*, of the costs for the training program in that setting.(Emphasis added.)

The regulation was amended to read at 42 C.F.R. §412.105(f) (1) (ii) (C) (1999) that:

> Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency program is counted towards the determination of full time equivalency *if the criteria set forth at 413.86(f)(4)*[11] are met. (Emphasis added.)

The Providers contended that the Providers and the related non-hospital locations to which residents rotated were "related parties", thus, the non-hospital locations do not constitute "outside entities" under the relevant regulations and therefore, no written agreements were required. The Board held that the regulations required that the Providers have a written agreement with the non-provider even if the parties were related. The Board disagreed with the Providers' contention that the requirements for written agreements did not apply to related clinics because they were not "outside entities."

The Administrator agrees with the Board's determination that for purposes of the IME and GME count of FTEs for residents performing work at nonhospital settings, there must be a written agreement, even if the hospital and the nonhospital setting are related. A rule of statutory construction equally applicable to regulatory interpretation is that the specific controls over the general. The specific regulation controlling the counting of FTEs in the nonhospital setting does not provide for an exception, pursuant to the related party regulation, to the written agreement requirement. Further, the Secretary specifically confirmed that a written agreement was required under these circumstances.

The Administrator finds that the related party rule, under reasonable costs, is to prevent inflated costs from being borne by the Medicare program. In the GME and IME context, a purpose of the written agreement is to show that the provider is

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[11] Redesignated at 413.78(c) and 413.78(d).

financially responsible for paying the costs of the residents and supervising physicians. The related party rule does not ensure that the provider is in fact financially responsible to pay "all or substantially all" of the costs and, therefore, that the provider meets the statutory requirement. Rather, the related party rule is to ensure the payment of only reasonable costs by Medicare. Consequently, where the nonhospital setting involves a related party, the hospital is still required to have in place a written agreement with the nonhospital setting that meets the criteria of 42 C.F.R. §412.86. Accordingly, as the Providers in this case did not have written agreements in conformity with the statutory and regulatory requirements, the Administrator affirms the decision of the Board.[12]

[12] The Board's decision found that there was no dispute costs associated with the training of these residents were paid by the Providers. However, the Administrator finds that it is more accurate to state that the Intermediary did not address that issue as it had disallowed the FTEs because of the lack of a written agreement.

DECISION

Issue No. 1

The decision of the Board with respect to Issue No. 1 is affirmed in accordance with the foregoing opinion.

Issue No. 2

The decision of the Board with respect to Issue No. 2 is modified in accordance with the foregoing opinion.

Issue No. 3

The decision of the Board with respect to Issue No. 3 is affirmed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: 11/13/07

/s/
Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services