PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D12

PROVIDER –
City of Hope National Medical Center
Duarte, CA

Provider No.: 05-0146

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/
Palmetto Government Benefit
Administrators/Cahaba Safeguard
Administrators/

DATE OF HEARING -
May 31, 2012

Cost Reporting Periods Ended -
September 30, 2004; September 30, 2005
and September 30, 2006

CASE NOs.: 10-1135, 10-1136; 10-1138

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ISSUE:

Whether the Intermediary properly offset investment income against operating and capital-related interest expense for the fiscal years ending September 30, 2004, September 30, 2005, and September 30, 2006?[1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due to a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended ('Act"), to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare and Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the U.S. Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[2] determine payment amounts due the providers under Medicare law, regulations, and interpretive guidelines published by CMS.[3]

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant period and the portion of those costs to be allocated to Medicare.[4] The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement ("NPR").[5] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of the NPR.[6]

Initially, Medicare providers were reimbursed on the basis of reasonable costs, or those costs "actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services..."[7]

In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act ("TEFRA"),[8] which imposed a ceiling on the rate-of-increase in inpatient *operating* costs recoverable by a hospital.[9]

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[1] Transcript, ("Tr.") at 6-7.
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[4] *See* 42 C.F.R. § 413.20.
[5] 42 C.F.R. § 405.1803.
[6] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.
[7] 42 U.S.C. § 1395x(v).
[8] Pub.L. 97-248, 96 Stat.324, (1982).
[9] *See* TEFRA § 101, 96 Stat. 339 (codified at 42 U.S.C. § 1395ww(b)).

Generally, the TEFRA ceiling amount, or target amount per discharge, is calculated based upon the allowable Medicare operating costs in a hospital's base year divided by the number of Medicare discharges in that year. The TEFRA target amount is updated annually. If a provider's actual cost per discharge is below the applicable TEFRA target amount in a given cost reporting year, it is entitled to reimbursement for its reasonable costs plus an additional incentive payment. However, if a provider's actual cost per discharge exceeds the TEFRA target amount, the provider is not reimbursed for the excess. Under TEFRA, capital costs are also paid based on reasonable cost. The regulation implementing TEFRA, 42 C.F.R. §413.40, permits providers to make requests to CMS for exemptions from, and exceptions and adjustments to, the TEFRA ceiling.

As part of the Social Security Amendments of 1983, Congress adopted a payment system known as the prospective payment system ("IPPS") for inpatient hospital services which made payment based on prospectively set rates per discharge.[10] At that time, capital-related costs continued to be paid on a reasonable cost basis. Capital-related costs allowable under the Medicare program include costs such as depreciation, interest, taxes, insurance, and similar expenses for movable plant, and fixed equipment.[11]

The implementing regulations, at 42 C.F.R. § 405.414 (later moved to 42 C.F.R. § 413.130),[12] defined "capital-related costs" as including interest expense and state in pertinent part:

> (f) *Interest expense.* (1) A provider must include in its capital-related costs interest expense, as described in § 413.153, if such expense is incurred in ---
> (i) Acquiring land or depreciable assets (either through purchase or lease) used for patient care; or
> (ii) Refinancing existing debt, if the original purpose of the refinanced debt was to acquire land or depreciable assets used for patient care.
> (2) If investment income offset is required under § 413.153(b)(2)(iii), only that portion of investment income that bears the same relationship to total investment income, as the portion of capital-related interest expense bears to total interest expense is offset against capital-related costs. [13]

Hospitals designated as cancer hospitals are exempt from IPPS if they meet the requirements for exemption at 42 C.F.R. § 412.23(f). Based on this exemption, these hospitals continued to be

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[10] Social Security Amendments of 1983 § 601, Pub. L. No. 98-21, 97 Stat. 65, 149-163 (1983) (codified at 42 U.S.C. §1395ww(d)).
[11] *See* 56 Fed. Reg. 43358-01 (Aug. 30, 1991).
[12] 51 Fed. Reg. 34790 (Sept. 30, 1986).
[13] 42 C.F.R. § 413.130(f) (1986); now located at 42 C.F.R. § 430.130(g).

reimbursed on a reasonable cost basis for operating and capital-related costs except that operating cost remained subject to TEFRA.

In 1991, Medicare instituted a prospective payment system for certain inpatient hospital capital-related costs ("capital IPPS") which replaced the prior reasonable cost basis of reimbursement.[14] CMS issued a final rule on August 30, 1991 ("1991 Final Rule") to implement capital IPPS.[15] The 1991 Final Rule specifically addressed capital-related costs paid to non-IPPS providers, stating:

> Previously, hospital inpatient operating costs were the only costs covered under the prospective payment system (part 412). Payment for capital-related costs has been made on a reasonable cost basis under part 413, subpart G because, under sections 1886(a)(4) and (d)(1)(A) of the Social Security Act (the Act), those costs have been specifically excluded from the definition of inpatient operating costs. However, section 1886(g)(1) of the Act now requires that capital-related costs be paid under a prospective payment system. In this final rule, we are adding a new subpart M to part 412 to provide for a prospective payment system for hospital inpatient capital-related costs. In addition, certain conforming changes and technical changes to other subparts in part 412 are being made in this final rule. *Hospitals and hospital distinct-part units that are excluded from the prospective payment system pursuant to part 412, subpart B will continue to be paid for capital-related costs on a reasonable cost basis under part 413, subpart G.*[16]

Thus, TEFRA providers are exempt from both IPPS and capital IPPS.

Additional program guidance can be found in the Provider Reimbursement Manual, CMS Pub. 15-1("PRM 15-1"). PRM 15-1 Chapter 2 entitled "Interest Expense" contains two sections relevant to this case. The first is § 202.2(C) entitled "Offset By Investment Income" which states the following in pertinent part:

> Patient care funds should be available for the provider's patient care purposes, enabling it to avoid interest expense attributable to unnecessary borrowing. If funds generated from patient care activities are invested in nonpatient care related activities, the provider's allowable interest expense is reduced (offset) by the provider's investment income in order to determine the amount of

[14] *See* 42 U.S.C. § 1395ww(g).
[15] *See supra* note 11.
[16] *Id.*, at 43358 (emphasis added).

> interest expense that is necessary and therefore allowable. The investment income is only offset against allowable interest expense. See §2806.1.G.
>
> Investment income for offset is the aggregate net amount realized from all investments of patient care funds in nonpatient care related activities and may include interest, dividends, operating profits and losses, and gains and losses on sale or disposition of investments. The methodology for determining the amount of the investment income is determined in part by whether the investment is in a related or unrelated organization. While investments in another organization may be accounted for under either the cost method or the equity method for financial accounting purposes, it is the relatedness of the organizations that determines the methodology for determining investment income offset for Medicare payment purposes. If the organizations are related, investment income offset is determined under subsection 2. If they are not related, then subsection 1 applies.
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> ...
>
> See § 202.6 for special rules regarding the treatment of investment income resulting from a pooling of funds for investment purposes.
>
> See §2806.1G for the requirements regarding investment income offset for hospitals reimbursed under the prospective payment system....

The second is § 202.6 entitled "Pooling of funds for Investment Purposes" which states the following:

> A provider may combine or "pool" various funds in order to maximize the return on investment by investing one large amount, rather than separate, smaller amounts. Part or all of various funds are placed in common investments, such as certificates of deposit, common stock, bonds or "NOW" accounts. Where funds are pooled, proper records must be maintained to preserve the identity of each fund in the pool in order to permit the earned income and the realized or unrealized gains and losses from investments to be related with the source. In order to accomplish this, the accounting for a pooling for investment purposes must utilize an appropriate fund valuation method, such as the market value method referred to in Chapter 4 of the AICPA Hospital Audit Guide. Fund

> valuation is essential where pooled investments are made so that identity of the funds and their value in relation to the total pool can be determined. This is necessary so that each fund comprising the pool can be properly identified, particularly where the pool includes funds that are subject to the investment income offset. Where the composition of the pool is undergoing change, valuation is also essential to record the relative value of new additions and to determine the true equity of withdrawn funds. The method elected by a provider must be followed consistently from one cost reporting period to another. Any change in method must be elected prospectively and shall be subject to intermediary approval.

Finally, PRM 15-1 Chapter 28 entitled "Prospective Payments" also contains guidance relevant to this case. In particular, § 2806.1 entitled "Costs Included in Capital-Related costs" states the following in subsection (G) with respect to interest expense for capital-related costs:

> G. Net interest expense as determined under Chapter 2 is includable in capital-related costs, if such expense is incurred in acquiring land and/or depreciable assets (either through purchase or lease) used for patient care or refinancing existing debt, if the original purpose of the refinanced debt was to acquire land and/or depreciable assets used for patient care. Since only the capital-related part of interest expense will be recognized as a capital-related cost, only a proportionate share of investment income should be offset (if investment income offset is required under §202.2 and/or §226.4B). This proportionate share is obtained by applying a ratio of capital-related interest expense to total interest expense to the total investment income. However, investment income generated from an advance refunding, as described in §233.3D, is not subject to apportionment between capital-related interest expense and operating interest expense.
>
> EXAMPLE 1: During the fiscal year ending September 30, 1984, Provider B incurs interest expense of $40,000 on a loan to purchase patient-care-related equipment and $10,000 on a loan to generate additional working capital. During the same fiscal year, the provider held investments purchased with income from prior operations which generated interest income of $4,500. Based on §202.2, the investment income must be used to reduce the interest expense. However, because only part of the interest expense is capital-related ($40,000), a proration must be made to ascertain that portion of the investment income to be used to reduce capital-related interest expense as follows:

Capital-related interest expense	$40,000 = 4/5 x $4,500 = $3,600
Total interest expense	$50,000

Total capital-related interest expense of $40,000 is reduced by a proportionate share of investment income of $3,600 to determine the net interest expense to be included in capital-related costs ($36,400).

EXAMPLE 2: During the fiscal year, the hospital had interest expense as follows:

Allowable capital-related interest expense	$150,000
Allowable noncapital-related interest expense	50,000
Non-allowable interest expense (related to a borrowing for non-patient care activities)	100,000
	$300,000

The hospital also had investment income as follows:

Interest income on funded depreciation account	$1,000,000
Interest income on hospital operating funds	250,000
	$1,250,000

To determine the offset:

Investment income from the funded depreciation account is not offset against interest expense (See §202.1.) The total investment income available for offset is $250,000.

The interest expense subject to offset by the investment income is $200,000 ($150,000 in allowable capital related interest and $50,000 in non-capital related interest).

The total capital-related interest expense of $150,000 is reduced by a proportionate share of the investment income determined as follows:

Capital-related interest	$150,000 = 3/4 X $250,000 = $187,500
Total allowable interest	$200,000

The balance of the investment income ($62,500) is offset against the non-capital interest expense of $50,000.

The investment income in excess of the interest expense ($37,500 in capital related and $12,500 in non-capital related) is not used to offset other expenses.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

City of Hope National Medical Center ("Provider") is a hospital located in Duarte, California. The Provider is governed by a nonprofit organization ("Home Office") which functions as a parent company and member of two facilities - the Provider and an associated research institution known as the City of Hope Research Institute. The Provider's fiscal year ("FY") ends September 30th.

The Provider specializes in the treatment of high acuity level cancer patients, and the majority of its patients are assigned a cancer diagnosis.[17] As a result, the Medicare program exempts the Provider from IPPS and capital IPPS, and the Provider has been reimbursed for its operating and capital-related costs under the TEFRA payment system since its FY 1982.[18]

At issue in this appeal are the Provider's cost reports for FYs 2004, 2005, and 2006 for which the Home Office filed cost statements to allocate many costs of services performed by the Home Office. The Provider identified investment income and interest expenses for several past years on these three cost reports. The Provider's methodology allocating these costs was to directly allocate, based on the source, between capital-related costs and operating costs. Once this offset had occurred, the remaining amount of interest was pooled and apportioned between capital-related costs and operating costs.[19]

The Intermediary adjusted the investment income by applying a pooled methodology using a ratio of capital-related interest expense to total interest expense, and then applied that ratio to total investment income to determine the amount offset.[20] The adjustments increased the offset against capital-related interest and decreased the offset against operating interest.[21] The parties agree on the amount of interest income and expense, but disagree on the methodology for offsetting investment income against interest expense.

The Provider was represented by Kathleen H. Drummy, Esq., of Davis Wright Tremaine LLP. The Intermediary was represented by Bernard M. Talbert, Esq., of the Blue Cross Blue Shield Association.

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[17] *See* Provider's Final Position Paper at 2.
[18] *See* Tr. at 14
[19] *See* Tr. at 17-19.
[20] *See* Provider's Final Revised Position Paper at 6; Provider's Post Hearing Brief at 8.
[21] *See* Intermediary's Supplemental Position Paper at 2.

PROVIDER'S CONTENTIONS:

The Provider states it specifically identified investment income directly associated with its capital investments and with its Administrative and General ("A&G") area on the cost reports at issue. The Provider claims that, when such identification is possible, the income associated with capital should first directly offset capital interest and the income associated with A&G should directly offset A&G interest expense. The Provider contends this method is consistent with long accepted notions of matching revenue and expense, and relies on PRM 15-1 §§ 202.2C and 2150.3 related to determination of reasonable costs for hospitals that are not reimbursed under the IPPS. In the event there is a balance of unapplied investment income after such direct offsets, the Provider believes the balance could be apportioned based on a pooled methodology, using the ratio of capital interest to total interest.[22]

The Provider asserts 42 C.F.R. § 413.130(g)(2) and PRM 15-1 § 2806.1(g) apply only to IPPS providers, and were not intended by CMS to be applied to TEFRA providers. Therefore, the Intermediary's methodology to offset investment income against operating and capital-related interest applies only to IPPS providers. As a TEFRA provider is not subject to IPPS, the Intermediary erred in applying this methodology to the Provider. The Provider indicates that PRM 15-2 Chapter 2 does not mandate the use of the methodology used by the Intermediary, and PRM 15-2 Chapter 30 (specifically relating to TEFRA Hospitals) does not mandate use of a particular income offset methodology in determining allowable interest expense.

The Provider further contends that, under the IPPS capital system, "Old Capital" is distinguished from "New Capital" and subjected to different rules. The Provider states the 1991 Rulemaking pointed out the distinction between determination of capital costs to be paid on a prospective payment basis to IPPS hospitals and those which would continue to be paid on a reasonable cost basis. The Provider claims the Home Office provisions impose the ratio utilized by the Intermediary only in dealing with "Old Capital," but classify capital costs of TEFRA providers as "New Capital," for purposes of completing the Home Office Cost Report. The Provider notes that PRM 15-1 § 202.2C entitled "Offset By Investment Income" refers only IPPS providers to § 2806.1, upon which the Intermediary based its adjustment.

INTERMEDIARY'S CONTENTIONS:

The Intermediary's position requires the identification of the following three amounts: (1) total investment income available for offset; (2) total operating (A&G) interest expense; and (3) total capital-related interest expense. The Intermediary argues that once the respective ratios of capital-related interest and operating interest against total interest are computed, these ratios are then applied to total investment income to identify the offset allocation to each class of interest expense. This calculation is simple and straightforward.[23]
In support of its position, the Intermediary uses the following dollar amounts for FY 2006 to

[22] *See* Provider's Post Hearing Brief at 3-4.
[23] *See* Intermediary's Supplemental Position Paper at 3.

illustrate how to apply 413.130(g)(2)[24]:

A) Total investment income to be offset		$ 2,891,697.91
B) Total interest expense		$10,615,580.00
B1) Operating (A&G) interest (12.05% of B)	$1,278,920.00	
B2) Capital interest (87.95% of B)	$9,336,660.00	

It is the Intermediary's position that applying 42 C.F.R. § 413.130(g)(2) results in "A" in the above table being offset against the total B, according to the percentages of "B1" and "B2." Utilizing this method, the Intermediary asserts that the allowable interest expense for FY 2006 is as follows:

	Total (100%)	**Operating (12.05%)**	**Capital (87.95%)**
Interest	$10,615,580.00	$1,278,420.00	$9,336,660.00
Offset	($2,891,697.91)	($348,379.48)	($2,543,318.43)
Net Allowable Interest		$930,040.52	$6,793,341.57[25]

The Intermediary states that, upon the application of 42 C.F.R. § 413.130(g)(2), allowable capital interest would be $6,793,084.57 and operating interest would be included in the operating costs subject to the TEFRA ceiling. This method of calculation is different than the Provider's method which applies income by category to interest by category. The Intermediary asserts that the Provider's method results in the following for FY 2006:

	Total	Operating	Capital
Interest	$10,615,580	$1,278,920	$9,336,660
Offset by Source below	($2,891,697)		
• Capital from Bond Funds			($923,759)
• Operating All other		($1,967,939)	
Subtotal		($689,019)	$8,412,901
Apply Operating remainder to Capital		$689,019	($689,019)
Allowable Interest		-0-	$7,723,882[26]

The Intermediary asserts the regulation at 42 C.F.R. § 413.130 applies to any Medicare class of Providers, including TEFRA providers, and that it properly offset investment income against operating and capital-related interest expense for FYs 2004, 2005, and 2006.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the parties' contentions and the

[24] *Id.*, at 4
[25] *Id.*
[26] *See* Intermediary's Supplemental Position Paper at 4-5.

evidence presented, the Board has set forth below its findings and conclusions.

The Provider argues that it first directly identified investment income associated with capital and the income generated from operations. Those amounts were directly offset against capital interest expense and operating interest expense respectively. That offset has a superficial appeal because it matches capital investment income and capital interest expense, while also matching operating interest income and operating interest expense. However, the accounting concept of "matching" capital interest income against capital interest expense is not appropriate in this case. The implicit assumption in the Provider's proposed methodology is that capital investment income can be used only for capital expense purposes, while operating investment income can be used only for operating expense purposes. This is clearly not the case in this instance. The operating investment income is not restricted or limited and can be used to meet a capital debt obligation. The Board, therefore, finds that there is no compelling rationale for using the Provider's proposed methodology.

The Board also finds that there is a regulation that deals specifically with the offset of investment income against capital-related interest expense. That regulation, 42 C.F.R. 413.130(g)(2), states the following in pertinent part:

> If investment income offset is required . . . only that portion of investment income that bears the same relationship to total investment income, as the portion of capital-related interest bears to total interest expense, is offset against capital-related costs.

Pursuant to that regulation, the offset against capital-related interest should be as follows:

Capital-related interest	A
Total interest expense	B
Total investment income	C
Ratio of capital-related interest to total interest	(A/B)
Investment income to be offset against capital related costs	C * (A/B)[27]

Finally, the Board considered the Provider's argument that 42 C.F.R. § 413.130 did not apply to providers subject to TEFRA limits. The Board has reviewed the regulation and finds no indication that it does not apply to TEFRA facilities. Moreover, the regulatory history confirms it was intended to be applied to TEFRA facilities. This regulation was originally promulgated at 42 C.F.R. § 405.414(f)(2) as part of the final rule issued on September 1, 1983 ("September 1983 Final Rule").[28] In the preamble to the September 1983 Final Rule, CMS explains that all

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[27] These calculations with the actual figures are included in the Intermediary's Supplemental Position Paper at 4; however, in one of the calculations the operating interest expense appears to be misstated due to a minor clerical error.

[28] 48 Fed. Reg. 39752, 39810-39811 (Sept. 1, 1983). *See also* 51 Fed. Reg. 34790 (Sept. 30, 1986) (relocating 42 C.F.R. § 405.414 to 42 C.F.R. § 413.130).

hospitals paid on a reasonable cost basis would be subject to the new regulation:

> Section 1886(a)(4) of the Act, as amended, excludes capital-related costs and costs of direct medical education from the definition of inpatient operating costs. Therefore, payment for these costs will continue on a reasonable cost basis.
>
> a. Capital-Related Costs
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> The rules applying to capital-related costs for purposes of the prospective payment system [*i.e.*, IPPS] also will apply for purposes of determining such costs under the rate of increase limit at § 405.463 [*i.e.*, the TEFRA ceiling] . . . .
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> As a result, *all hospitals reimbursed under Subpart D* [*i.e.*, 42 C.F.R. Part 405, Subpart D now located at 42 C.F.R. Part 413] *will need to identify their capital-related costs. Therefore, we are establishing in these interim final rules a new section 405.414* of Subpart D, *which identifies in detail costs that are includable in a hospital's capital-related costs.* Generally, the following items are treated as capital-related costs and will be reimbursed under the reasonable cost method.
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> . . . .
>
> *All hospitals, whether paid under the prospective payment system* [*i.e.*, IPPS] ***or excluded**, must treat capital-related costs in a manner consistent with the way identical or similar costs were treated in the base period.* This is necessary since the target amount is established on the basis of a hospital's base year costs. If costs were included as patient operating costs for purposes of the target amount computation and considered as capital-related costs in a subsequent year, there would be an unfair and inaccurate distortion in the year-to-year comparison.[29]

Accordingly, the Board disagrees with the Provider and concludes that the regulation clearly applies to all hospitals.

DECISION AND ORDER:

The Board finds that the regulation relates specifically to the facts and circumstances relating to the Provider. The Intermediary's methodology applied the regulation correctly and properly

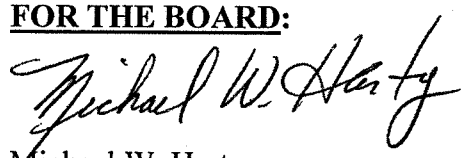
[29] *Id.* at 39802.

offset the interest income against operating and capital-related interest expense.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty, Chairman
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

DATE: JUN 19 2014