PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D46

PROVIDER -
Our Lady of the Lake Regional Medical Center

Provider No.: 19-0064

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

HEARING DATE –
July 19, 2017

Cost Reporting Periods Ended –
June 30, 2007; June 30, 2008;
June 30, 2009; June 30, 2010

CASE NOS. : 13-2321; 13-2323;
13-3154; 15-3191

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ISSUE STATEMENT:

When the Medicare Contractor recalculates the Provider's per-resident amount ("PRA"), whether it is consistent with the law to use 1998 census region hospital data to determine the cap on the Provider's recalculated PRA?[1]

DECISION:

The Board finds the base year PRA was not properly calculated, and remands these cases to the Medicare Contractor to determine the correct PRA by applying 42 C.F.R. § 413.77(e)(1)(iii)[2] and the 1998 census region hospital data.

INTRODUCTION:

Our Lady of the Lake Regional Medical Center (the "Provider") is an acute care hospital located in Baton Rouge, Louisiana. Novitas Solutions, Inc. serves as the Provider's Medicare Contractor.[3] Both the Provider and the Medicare Contractor agree that the Provider's base year PRA was not correctly calculated on the Provider's 2007 cost report,[4] but they cannot agree on the correct methodology for calculating this PRA. The Medicare Contractor believes it must use 1998 census region hospital data from the May 14, 1999 bulletin (the "99 Bulletin") issued by the Centers for Medicare & Medicaid Services ("CMS") for the base year PRA calculation[5] and the Provider believes the PRA must be calculated using data from the most recently settled cost reports as outlined in the August 1, 2002 Inpatient Prospective Payment System Final Rule.[6]

The Provider appealed its fiscal year ("FY") 2007 cost report, as well as the three subsequent cost reporting years which use the base year PRA. In each of the appeals, the Provider has met the jurisdictional requirements for a hearing. The Board held a hearing on July 19, 2017. The Provider was represented by Andrew Ruskin, Esq., of Morgan, Lewis and Bockius. The Medicare Contractor was represented by Scott Berends, Esq., of Federal Specialized Services.

STATEMENT OF FACTS:

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

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[1] Transcript ("Tr.") at 5-6.
[2] In 2004, 42 C.F.R. § 413.86(e)(5) was redesignated to 42 C.F.R. § 413.77(e), pursuant to 69 Fed. Reg. 48916, 49235, 49257-58 (Aug. 11, 2004).
[3] Formerly known as Fiscal Intermediaries, CMS' payment and audit functions under the Medicare program are now contracted to organizations known as Medicare Administrative Contractors. However, the term "intermediary" is still used in various statutes and regulations, and is interchangeable with the terms "Medicare Administrative Contractor" or "Medicare contractor."
[4] *See* Medicare Contractor's Final Position Paper at 8-9 for an explanation on why the original PRA was calculated incorrectly.
[5] Stipulation of the Parties at 2, Stipulation 6.
[6] Provider's Post-Hearing Brief at 8-10.

Medicare's share of the hospital's inpatient days.[7]

In general, a hospital's PRA,[8] is determined by dividing the hospital's base year GME program costs by the average number of FTE residents working at the hospital in the base year.[9] For most hospitals, the base year PRA is the hospital's fiscal year beginning during the federal fiscal year 1984. However, if a hospital did not have residents or did not participate in the Medicare program during the 1984 base period, 42 U.S.C. § 1395ww(h)(2)(F) specifies that the Secretary of Health and Human Services shall determine the PRA based on approved FTE resident amounts for comparable programs.

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

CMS modified these regulations effective October 1, 1997. The revised regulation required Medicare contractors to establish the PRA for all new teaching hospitals. 42 C.F.R. § 413.86(e)(4)(i) (1997) required the contractor to make the PRA calculation based on the lower of the following:

(A) The hospital's actual costs, incurred in connection with the graduate medical education program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.
(B) The mean value of per resident amounts of hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter, for cost reporting periods beginning in the same fiscal years. If there are fewer than three amounts that can be used to calculate the mean value, the calculation of the per resident amounts includes all hospitals in the hospital's region as that term is used in § 412.62(f)(1)(i).

The Balance Budget Refinement Act of 1999 ("BBRA")[10] and the Medicare, Medicaid, and State Children's Health Insurance Program ("SCHIP") Benefits Improvement and Protection Act of 2000 ("BIPA")[11] temporarily made changes to how GME payments were calculated by establishing a "floor" and a "ceiling" based on a locality-adjusted, updated, weighted average PRA calculated using fiscal year 1997 data.[12] This methodology compared a hospital's PRA to

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[7] 42 U.S.C. § 1395ww(h)(3)(A).
[8] The PRA is also referred to as the "approved FTE resident amount." *See* 42 U.S.C. § 1395ww(h)(2).
[9] 42 C.F.R. § 413.77(a) (2004).
[10] Pub. L. No. 106-113, 113 Stat. 1501 (Nov. 29, 1999).
[11] Pub. L. No. 106-554, § 511, 114 Stat. 2763, 2763A-533 (Dec. 21, 2000).
[12] 42 C.F.R. § 413.86(e)(4) (2000). *See also* 65 Fed. Reg. 47054, 47091-93 (Aug. 1, 2000).

the floor and ceiling to determine whether its PRA should be revised. This change was implemented via regulation at 42 C.F.R. § 413.86(e)(4).

Further revisions were made to the GME regulations in 2002. In the May 9, 2002 Federal Register, CMS explained that it had become administratively burdensome to recreate base year information and proposed to simplify and revise the weighted average PRA methodology under 42 C.F.R. § 413.86(e)(5)(i)(B)[13] to reflect the average of all PRAs in a metropolitan statistical area ("MSA")[14] using data from the most recently settled cost reports. The new regulation at 42 C.F.R. § 413.86(e)(5)(2002), was amended to read:

> *Exceptions* – (i) *Base period for certain hospitals*. If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period . . . . The per resident amount is based on the lower of . . . [the following:]
>
> (A) The hospital's actual costs, incurred in connection with the graduate medical education program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.
>
> (B) Except as specified in paragraph (e)(5)(i)(C) of this section–
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> ***
>
> (2) For base periods beginning on or after October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts . . . and FTE resident counts from the most recently settled cost reports of those teaching hospitals.
>
> (C) If, under paragraph (e)(5)(i)(B)(1) or (e)(5)(i)(B)(2) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value per resident amounts of all hospitals located in the same census region as that term is used in § 412.62(f)(1)(i) of this chapter.

The parties have stipulated that the base year for the Provider's PRA was FY 2007 and there were fewer than three teaching hospitals in the Provider's geographic wage area.[15] They also stipulated that the former Medicare contractor calculated the Provider's base year PRA

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[13] In 2004, 42 C.F.R. § 413.86(e)(5) was redesignated to 42 C.F.R. § 413.77(e), pursuant to 69 Fed. Reg. at 49235, 49257-58.
[14] 67 Fed. Reg. 31404, 31467 (May 9, 2002). The term geographic wage area and MSA are interchangeable.
[15] Stipulation of the Parties at 1, Stipulations 2 and 4.

incorrectly on the 2007 cost report[16] and the current Medicare Contractor intends to recalculate the Provider's base year PRA using census region data from federal fiscal year 1998 updated solely by the applicable "GME update factor," pursuant to the 99 Bulletin.[17]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Provider argues that using the 99 Bulletin updated for inflation to derive the census area weighted average PRA for 2007 does not reflect the changes in the mix of teaching hospitals in the census region over time and does not reflect any updates for the BBRA and BIPA floors.[18] Further, the Provider points out the Medicare Contractor's methodology does not include the most current PRAs as reflected in the most recently settled cost reports, which the Provider asserts is required by CMS regulations.[19] The Provider is requesting that its base year PRA be calculated based upon the census region PRA cap calculated using cost report data for the most recently settled cost reports prior to the Provider's fiscal year 2007.[20]

As stated by the Provider, the overarching goal of Social Security Act, Section 1886(h)(2)(F) is to ensure that new teaching hospitals are paid a reasonable amount based on the PRAs that peer hospitals currently receive.[21] The BBRA and BIPA floors established for 2001 and 2002 benefited comparable programs. The Provider asserts that the most recent settled cost reports should be used in determining its PRA so it can also benefit from the floors established by BBRA and BIPA.[22]

The Provider contends that the 99 Bulletin was not distributed to the hospitals, but only to the Medicare contractors and cannot be used in the computation of the Provider's PRA because using the 99 Bulletin constitutes impermissible retrospective rulemaking, and violates all notions of fair rulemaking.[23] The Provider also asserts that updating the PRA based upon a weighted average per resident amount established in 1997 does not reflect the PRAs of newly established hospitals nor does it include the PRAs that were adjusted in 2001 and 2002 to equal a base floor. Finally, the Provider believes the use of outdated data, as in the 99 Bulletin, is not a reasonable reading of the statutory term "comparable programs."[24]

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

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[16] *Id.*, Stipulation 3.
[17] *Id.* at 2, Stipulation 6. *See also* Provider's Final Position Paper, Exhibit P-5.
[18] Provider's Post-Hearing Brief at 5.
[19] *Id.* at 6.
[20] Provider's Reply Brief at 10.
[21] *Id.* at 4.
[22] *Id.* at 8.
[23] Provider's Post-Hearing Brief at 27-28.
[24] *Id.* at 26.

Effective October 1, 1997, when Medicare contractors began calculating the PRAs for all new teaching hospitals, CMS modified its regulations such that a new teaching hospital's PRA was calculated "based on the lower of the new teaching hospital's actual cost per resident in its base period or a weighted average of all the PRAs of existing teaching hospitals in the same MSA." However, if there were less than three existing teaching hospitals with PRAs within the new teaching hospital's MSA, effective for cost reporting period beginning October 1, 1997, the Medicare contractor was to use the updated regional weighted average PRA determined for the census region, when calculating the new teaching hospital's PRA.[25]

Subsequently, in the August 1, 2002 final rule[26] CMS established a revised methodology to be used to determine the PRA for new teaching hospitals.[27] In proposing this new regulation, the agency explained the change was being made because the "current methodology is particularly problematic in instances where there are large numbers of teaching hospitals in an MSA."[28] As a result, the agency proposed to simplify and revise the weighted average PRA methodology under 42 C.F.R. § 413.86(e)(5)(i)(B) to reflect the average of all PRAs within an MSA. This new methodology continued to calculate a weighted average PRA, but rather than use 1984 base year data, it used PRA and FTE data from the most recently settled cost reports of teaching hospitals in an MSA.[29]

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

Specifically, the Board points out that the language in the regulations pertaining to hospitals that use census region data remained relatively unchanged and states:

> If, under paragraph (e)(5)(i)(B)(1) or (e)(5)(i)(B)(2) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region . . . .[30]

This language is clearly different than the revised language in section (e)(5)(i)(B)(2) which specifically states that data from the most recently settled cost reports is used to calculate the updated weighted mean value PRA for base periods beginning October 1, 2002. The Board reviewed the May 9, 2002 proposed rule[31] and the August 1, 2002 final rule[32] implementing

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[25] 67 Fed. Reg. at 31467 (citing 62 Fed. Reg. 46004 (Aug. 29, 1997)).
[26] 67 Fed. Reg. 49982, 50068 (Aug. 1, 2002).
[27] 42 C.F.R. § 413.86(e)(5)(i)(B).
[28] 67 Fed. Reg. at 31467.
[29] *Id.*
[30] 42 C.F.R. § 413.86 (e)(5)(i)(C) (2002).
[31] 67 Fed. Reg. at 31467-68.
[32] 67 Fed. Reg. at 50067-69.

these revised regulations and finds no support for the Provider's position that the most recent settled cost report data should be used to determine the weighted average PRA for the census region.

The Board further points out the new weighted average calculation was effective for cost reporting periods with GME base years that started after October 1, 2002.[33] Although 42 C.F.R § 413.86(e)(5)(i)(B)(2)(2002) was revised stating "for base periods beginning on or after October 1, 2002," section (e)(5)(i)(C) still applies "for base periods beginning on or after October 1, 1997." The Board is convinced that CMS intended the new methodology to be used for calculations under section (e)(5)(i)(B)(2) only and not under section (e)(5)(i)(C).

Finally, as identified in the May 9, 2002 proposed rule, CMS made the change to use data from the most recently settled cost report in part because it had become "administratively burdensome" for CMS and the Medicare contractors to calculated the weighted average PRA of teaching hospitals within a particular MSA, particularly where there are numerous hospitals in the MSA.[34] The Board notes that a similar administrative burden would not have existed for a census region because CMS published the 99 Bulletin with the weighted average PRAs for each of the nine census regions.[35] The Medicare contractors were instructed to apply the applicable GME update factor to these census region amounts. Had CMS changed it regulations to require data from the most recently settled cost reports to be used in calculating the weighted mean value of PRAs for all hospitals in a census region, this would have created an additional administrative burden each time a new teaching hospital, with less than three hospitals with PRAs in its MSA, needed a base year PRA calculated.

The Board concludes that the Medicare Contractor's decision to use the 99 Bulletin[36] conforms to Medicare regulations and CMS instructions. Additionally, the Board disagrees with the Provider's contention that use of the 99 Bulletin constitutes impermissible retrospective rulemaking and finds the 99 Bulletin was published by CMS in response to the FY 1998 Inpatient Prospective Payment Systems ("IPPS") Final Rule[37] providing the weighted average per resident amount for the nine census regions for cost reporting periods beginning on or after October 1, 1997 and ending before October 1, 1998. The Board understands that use of the 99 Bulletin may not produce the exact same results as data from the most recently settled cost reports and may not accurately reflect the PRAs of hospitals that were impacted by the floor and/or ceiling calculations required by BBRA and BIPA. However, this is the methodology adopted by CMS to eliminate much of the administrative burden on its contractors.

Since the parties have stipulated that there are less than three existing hospitals with PRAs in the Provider's MSA, the Board finds the Medicare Contractor should recalculate the Provider's base year PRA for 2007 by applying 42 C.F.R. § 413.77(e)(1)(iii)[38] and CMS' instruction in the 99 Bulletin.

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[33] *Id.*
[34] 67 Fed. Reg. at 31467.
[35] *See* Provider's Final Position Paper, Exhibit P-5.
[36] *See id.*
[37] 67 Fed. Reg. at 50067.
[38] In 2004, 42 C.F.R. § 413.86(e)(5) was redesignated to 42 C.F.R. § 413.77(e), pursuant to 69 Fed. Reg. at 49235, 49257-58.

DECISION:

The Board finds the Provider's base year PRA was not properly calculated, and these cases are remanded to the Medicare Contractor to determine a correct PRA by applying 42 C.F.R. § 413.77(e)(1)(iii) and the 1998 census region hospital data.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

/s/
Charlotte F. Benson, CPA
Board Member

DATE: July 31, 2018