PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D15

PROVIDER -
Medical University Hospital Authority

Provider No.: 42-0004

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc.

HEARING DATE –
April 4, 2018

Cost Reporting Periods Ended –
June 30, 2007 and June 30, 2008

CASE NOS. : 13-0820 and 13-1873

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ISSUE STATEMENTS[1]:

Issue 1: Whether the Medicare Administrative Contractor's decision to reclassify the costs and statistics out of the paramedical pass-through cost center was proper. This issue applies to the fiscal years ending June 30, 2007 ("FY 2007") and June 30, 2008 ("FY 2008").

Issue 2: Whether the Medicare Administrative Contractor's decision to classify certain Cornea tissue expense, charges, statistics, and program charges on Line 59.04 rather than Line 60.05 on several worksheets was proper.[2] This issue applies to FYs 2007 and 2008.

Issue 3: Whether the Medicare Administrative Contractor's decision to classify certain Bone Marrow expenses, charges, statistics and program charges on Line 86 (as an organ acquisition cost) rather than Line 60.07 on several worksheets was proper.[3] This issue applies to FY 2008.

DECISION:

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

1. The Medicare Contractor's adjustments to reclassify the costs and statistics out of the paramedical pass-through cost center was proper because Medical University Hospital Authority ("MUHA" or "Provider") did not meet the requirements of 42 C.F.R. § 413.85(f)(1) for the Pharmacy Residency Program ("PRP") and, therefore, did not qualify for paramedical pass-through reimbursement for FYs 2007 and 2008.

2. Jurisdiction is granted under 42 C.F.R §1395oo(a) for the Cornea tissue issue for FYs 2007 and 2008.

3. Jurisdiction is granted under 42 C.F.R §1395oo(a) for the Bone Marrow issue for FY 2008.

Accordingly, the Board remands the cost reports back to the Medicare Contractor to properly reimburse MUHA for its FYs 2007 and 2008 Cornea costs and its FY 2008 Bone Marrow costs.

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[1] Transcript ("Tr,") at 6-8.
[2] The Medicare Contractor has challenged the Board's jurisdiction over this issue. *See* Medicare Administrative Contractor's Jurisdictional Challenge (Feb. 22, 2018). *See also* Tr. at 358-63.
[3] The Medicare Contractor has challenged the Board's jurisdiction over this issue. *Id.*

INTRODUCTION:

MUHA is an acute care hospital located in Charleston, South Carolina.[4] For the cost years at issue, MUHA was a component of the Medical University of South Carolina ("MUSC") and was legally separate from MUSC.[5] MUHA's designated Medicare administrative contractor is Palmetto GBA c/o National Government Services, Inc. ("Medicare Contractor").

MUHA claimed pass-through reimbursement for a Pharmacy Residency Program ("PRP") on its FY 2007 and FY 2008 cost reports.[6] The Medicare Contractor removed the pass-through reimbursement from the cost reports by reclassifying these costs from the paramedical education cost center to the serviced cost centers, as the Medicare Contractor determined that MUHA was not the operator of the program and did not directly incur the costs of the PRP, pursuant to the regulatory requirements.[7]

Additionally, MUHA reported Cornea (FYs 2007 and 2008) and Bone Marrow (FY 2008) costs incorrectly on its submitted cost reports. Prior to cost report settlements, MUHA notified the Medicare Contractor that these issues had been reported incorrectly and provided the Medicare Contractor with adjustments to correct the reporting of these costs. The Medicare Contractor made the adjustments requested by MUHA as part of the cost report settlements. Subsequent to the issuance of the Notice of Program Reimbursement ("NPR"), MUHA discovered further errors and appealed the Cornea tissue issue from its FY 2007 and 2008 NPRs and the Bone Marrow issue from its FY 2008 NPR.[8]

MUHA filed timely its appeals to the Board. There is no dispute that MUHA met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1840 as related to Issue 1 – . However the Medicare Contractor challenged the Board's jurisdiction for Issues 2 and 3 – the Cornea and Bone Marrow issues.[9] These jurisdictional challenges will be addressed as part of this decision.

The Board held a live hearing on April 4, 2018. MUHA was represented by Daniel J. Hettich, Esq., and Elizabeth N. Swayne, Esq., of King & Spalding, LLP. The Medicare Contractor was represented by Edward Y. Lau, Esq., of Federal Specialized Services.

[4] Provider's Final Position Paper, 1 (Mar. 20, 2018).
[5] Provider's Final Position Paper at 13.
[6] *Id.*at 18.
[7] *See id.* at 1, 18. *See also* Medicare Administrative Contractor's Final Position Paper, 10-11 (Mar. 28, 2018).
[8] Provider's Final Position Paper at 32-34.
[9] *See* Medicare Administrative Contractor's Jurisdictional Challenge.

STATEMENT OF THE FACTS:

MUSC is a state-supported public institution that receives annual appropriations for operating purposes, as authorized by the South Carolina General Assembly.[10] MUSC includes six different educational departments within its academic division, including the South Carolina College of Pharmacy ("SCCP").[11] Prior to July 1, 2000, MUSC Medical Center operated as a division of the broader MUSC entity. Both the academic division (and its associated educational departments, such as the SCCP) and the Medical Center did business as MUSC under a single federal tax identification number and a single Medicare provider number.[12] Effective July 1, 2000, the South Carolina legislature approved a resolution changing the way in which the Medical Center was associated with MUSC.[13] Through that resolution, MUSC Medical Center ceased to exist, and in its stead MUHA was created. MUHA, operates under the same Medicare provider number previously assigned to the Medical Center.[14]

Since the 1950s, MUSC and the MUSC College of Pharmacy have operated an accredited PRP.[15] The clinical training portion of the MUSC PRP was provided by the Medical Center until July 1, 2000. As of July 1, 2000, the clinical training portion of this same program has been provided by MUHA.[16] Both before and after the reorganization in July 2000, the entity providing the clinical training portion of the PRP (the Medical Center before July 2000, and MUHA since July 2000) has always fully reimbursed the MUSC College of Pharmacy for the training costs of the residency programs through intra-division or intra-component transfers.[17]

The Medicare Contractor for FYs 2007 and 2008 determined that MUHA was the not the legal operator of the program and made several adjustments denying Medicare reimbursement for the PRP.[18] The Provider disagrees with these adjustments.

Additionally, as MUHA filed its cornea tissue (FYs 2007 and 2008) and bone marrow (FY 2008) costs incorrectly on its cost reports, it asked the Medicare Contractor to correct these mistakes supplying the correcting adjustments to the Medicare Contractor. The Medicare Contractor incorporated these adjustment into the settlement of MUHA's FYs 2007 and 2008 cost reports. MUHA discovered errors in these adjustments an appealed the Cornea issue from its FYs 2007 and 2008 NPRs and the bone marrow issue from its FY 2008 NPR.[19] The Medicare contractor

[10] Provider's Final Position Paper at 11 & Exhibit P-3 at 8.
[11] Exhibit P-3 at 3.
[12] Provider's Post-Hearing Brief, 4 (June 4, 2018).
[13] Exhibit P-6.
[14] Provider's Post-Hearing Brief at 4.
[15] *Id.* at 6.
[16] *See id.* at 4.
[17] *Id*. at 10.
[18] *See* Provider's Final Position Paper at 1, 18. *See also* Medicare Administrative Contractor's Final Position Paper at 10-11. The Provider acknowledged that the postgraduate year 2 ("PGY2") of training should not be reimbursed and withdrew its request for PGY2 reimbursement. *See* Provider's Post-Hearing Brief at 8.
[19] Provider's Final Position Paper at 32-34.

disagrees that Board has jurisdiction over the Cornea and Bone Marrow issues as the adjustments were made at MUHA's request based on itemized documentation submitted by MUHA and therefore don't support dissatisfaction with the Medicare Contractor's actions.[20]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

A. ISSUE 1 – PARAMEDICAL EDUCATION COSTS

MUHA contends that it meets the requirements specified in 42 C.F.R. § 413.85(f) pertaining to the PRP and should receive pass-through costs pursuant to the requirements of 42 C.F.R. § 413.85(d). Specifically MUHA argues that it was the operator of the PRP and directly incurred the costs of training.[21]

In 1983, Congress enacted the Medicare Inpatient Prospective Payment System ("IPPS").[22] In 1990, it began to allow for the payment of certain approved nursing and allied education activities on a reasonable cost or "pass-through" basis when, among other conditions, a provider is the operator of the program.[23] In order to be considered the operator of an approved nursing or allied health program, a provider must meet *all* of the following criteria:

(i) Directly incur the training costs.
(ii) Have direct control of the program curriculum. (A provider may enter into an agreement with an educational institution to furnish basic academic courses required for completion of the program, but the provider must provide all of the courses relating to the theory and practice of the nursing or allied health profession involved that are required for the degree, diploma, or certificate awarded at the completion of the program.)
(iii) Control the administration of the program, including collection of tuition (where applicable), control the maintenance of payroll records of teaching staff or students, or both (where applicable), and be responsible for day-to-day program operation. (A provider may contract with another entity to perform some administrative functions, but the provider must maintain control over all aspects of the contracted functions.)
(iv) Employ the teaching staff.

[20] Medicare Administrative Contractor's Jurisdictional Challenge at unnumbered pages 4-5.
[21] Provider's Post-Hearing Brief at 20-21.
[22] Effective October 1, 1983, Congress amended the Social Security Act and adopted a new payment system known as the Prospective Payment System for the operating costs of inpatient hospital services. *See* Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 65, 152 (1983) (codified as amended at 42 U.S.C. § 1395ww(d)).
[23] *See* Omnibus Reconciliation Act of 1990, Pub. L. No. 101-508, § 4004(b), 104 Stat. 1388, 1388-39 to 1388-40 (1990) (codified as amended at 42 U.S.C. § 1395ww(a)(4)); 42 C.F.R. § 413.85(d).

> (v) Provide and control classroom instruction and clinical training (where classroom instruction is a requirement for program completion), subject to the parenthetical sentence in paragraph (f)(1)(ii) of this section.[24]

MUHA contends that it was the operator of the PRP, as it had full, ultimate authority and control over the PRP.[25] MUHA provided support for this contention by explaining that, for example, the program was run by an MUHA employee.[26] Specifically, Paul W. Bush, Pharm. D., served as MUHA Director of Pharmacy Services and Director of Graduate Pharmacy Education during the time periods at issue in this appeal.[27] Although Dr. Bush had a faculty appointment in the College of Pharmacy, he reported through MUHA, including reporting to the Administrator of Clinical Services for MUHA, Dr. Marilyn Schaffner.[28] As Director of Graduate Pharmacy Education, Dr. Bush was responsible for the "on-going operation and coordination of the [PRP.]"[29] Through his roles, Dr. Bush controlled the PRP budget, including approving all expenditures. Although certain administrative functions (including portions of the payroll system) were contracted to MUSC, MUHA argues that it retained control and oversight for those functions. Dr. Bush also gave final approval for all human capital decisions, including the offering of residency positions and disciplinary action against residents.[30]

MUHA also contends that it directly incurred the costs of the PRP because "[a]ll that is required . . . is that the costs appear on the provider's 'books and records,' not that the provider have incurred the costs first." The Provider argues "the use of the word 'before' strongly suggests that the cost *does not* have to appear on the provider's books 'first'; it merely must appear on the provider's books 'before' it will be allowed."[31] Ultimately, MUHA believes it did "directly" incur the costs as it "fully reimbursed MUSC for all outstanding costs, and those payments were reflected on the hospital's general ledger."[32]

The Board disagrees that MUHA is the operator of the PRP because MUHA did not meet all the criteria in 42 C.F.R. § 413.85(f)(1). Specifically, MUHA did not directly incur the costs of the PRP program. Rather, MUSC directly incurred the PRP costs and MUHA reimbursed MUSC for those costs. The Board finds the Provider's argument on this issue to be unpersuasive as

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[24] 42 C.F.R. § 413.85(f)(1).
[25] *See* Provider's Post-Hearing Brief at 22 & Exhibit P-40 at ¶ 4 (Easterling Decl.).
[26] *See* Provider's Post-Hearing Brief at 24.
[27] *See* Exhibits P-25 & P-26 (showing Dr. Bush as paid by MUHA in FYs 2007 and 2008, respectively). *See also* Exhibit P-40 at ¶ 5.
[28] Exhibit P-40 at ¶ 6 (since Dr. Bush is no longer an employee of MUHA (or MUSC), this declaration has been made by Dr. Easterling, who has firsthand knowledge of these matters as explained in her declaration. *See also* Tr. at 66-68.). Dr. Bush signed the Affiliation Agreement on behalf of MUHA as Director of Pharmacy Services. Exhibit P-24 at 3.
[29] Exhibit P-24 at ¶ 2 (copy of the Affiliation Agreement).
[30] *See* Exhibit P-40 at ¶¶ 5-6.
[31] Provider's Post-Hearing Brief at 23 (emphasis in original).
[32] *Id.* at 24.

reimbursement of costs to another entity, even a related entity, is not the equivalent of directly incurring the costs.

The Board's finding is mandated by the plain language of § 413.85(f)(1)(i) – the claimed costs must be "directly incur[red]," not merely incurred, before a provider may be considered to be the operator of the training program. CMS's interpretation of the regulation has been clear from its promulgation: "With respect to educational costs . . . our policy has been that the provider, rather than the related organization, must *directly incur the costs on its books and records* before the costs will be recognized for Medicare payment purposes. Otherwise, the principle that Medicare payment for medical education costs should not result in a redistribution of costs from the educational institution to the provider would be violated."[33]

The Board's finding is also consistent with longstanding rules of statutory and regulatory construction. Where the HHS Secretary includes particular language in one section of a regulation, but omits it in another, it is generally presumed that the Secretary acts intentionally and purposely in the disparate inclusion or exclusion.[34] Similarly, a basic principle of statutory or regulatory interpretation is that courts should "give effect, if possible, to every clause and word of a statute[.]"[35] "A statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant . . . ."[36] Here, the Secretary has included the word "directly" in the regulation setting out the mandatory criteria for a finding that a training program is provider-operated: a provider must "directly incur the training costs."[37]

This same provision of the regulations clearly contemplates that a provider may contract with another entity regarding certain aspects of the training program. However, the Secretary has mandated – within his rulemaking authority – that if a provider wishes to be paid on a pass-through basis for allied health training costs, even if some of the functions related to that training program are legitimately contracted to a non-provider entity, the provider must *directly* incur in the first instance those costs it claims for reimbursement. To find otherwise would require ignoring the word "directly," which the Board cannot do.

The Board also finds that MUHA did not control the administration of the PRP, as required under § 413.85(f)(1)(iii). Specifically the Affiliation Agreement states that the Dean of the School of Pharmacy, a MUSC employee, has ultimate control of the PRP, while MUHA exercises day to day control.[38]

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[33] 66 Fed. Reg. 3357, 3367 (Jan. 12, 2001) (emphasis added).
[34] *See Keene Corp. v. United States*, 508 U.S. 200, 208 (1993) (quoting *Russello v. United States*, 464 U.S. 16, 23 (1983)). *See also Black & Decker Corp. v. C.I.R.*, 986 F.2d 60, 65 (4th Cir. 1993) ("Regulations, like statutes, are interpreted according to canons of construction.").
[35] *U.S. v. Menasche*, 348 U.S. 528, 538-39 (quoting *Montclair v. Ramsdell*, 107 U.S. 147, 152 (1883)).
[36] *Corley v. United States*, 556 U.S. 303, 314 (2009) (quoting *Hibbs v. Winn*, 542 U.S. 88, 101 (2004)).
[37] 42 C.F.R. § 413.85(f)(1)(i).
[38] Exhibit P-24 at 1.

In summary, as a result of its finding that MUHA does not directly incur the cost of the PHP or have ultimate control of the PHP, the Board concludes, based on 42 C.F.R. § 413.85(f)(1), that MUHA does not qualify for pass-through reimbursement for the reasonable cost of the PRP.[39]

B. ISSUES 2 AND 3 – JURISDICTION OVER CORNEA AND BONE MARROW ISSUES

The Medicare Contractor filed jurisdictional challenges related to MUHA's appeals of the Cornea tissue issue (FYs 2007 and 2008) and Bone Marrow issue (FY 2008). The Medicare Contractor asserts that the Board does not have jurisdiction because MUHA cannot be dissatisfied "when it received exactly what it asked . . . for" and that "the appeals process is not the proper venue for continued Provider error corrections."[40] The Medicare Contractor further states that, if the Board finds jurisdiction, it should be limited to the adjustments that were made to the final settled cost report.[41]

The Board agrees with the Medicare Contractor that the appeals process is not the proper venue for a provider to correct its errors. The Board also recognizes that MUHA incorrectly claimed the cornea tissue and bone marrow costs on its "as filed" cost reports and then requested that the Medicare Contractor make adjustments to these issues, providing incorrect adjustments. When issuing MUHA's NPRs, the Medicare Contractor adjusted the cornea tissue issue on the Provider's FYs 2007 and 2008 cost reports and the bone marrow issue on MUHA's FY 2008 cost report[42] but did not include the costs, statistics and revenue in the correct cost centers. MUHA was dissatisfied and timely appealed to the Board.

The Board reviewed these issues, the related adjustments, and the final settled cost reports for FYs 2007 and 2008 and finds that the adjustments are a sufficient basis for MUHA's dissatisfaction with the Medicare Contractor's determination of the amount of reimbursement for these issues. Specifically, the Board finds that the Medicare Contractor used its discretion and adjusted the cornea tissue issue on MUHA's FYs 2007 and 2008 cost reports and bone marrow issues on MUHA's FY 2008 cost report, but did not properly reflect MUHA's costs, statistics and revenue in the correct cost centers.[43] As the Medicare Contractor's adjustments did not properly reflect costs, statistics and revenue, the Board grants jurisdiction over the cornea tissue issue for FYs 2007 and 2008 and the bone marrow issue for FY 2008.

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[39] If MUHA failed to meet even one of the requirements of 42 C.F.R. § 413.85(f)(1) it would not be considered the operator of the program.
[40] Medicare Administrative Contractor's Post Hearing Brief at 38-39 (July 3, 2018).
[41] *Id.* at 36.
[42] Exhibits P-1 & P-2; Provider's Final Position Paper at 32-34.
[43] The record is clear that MUHA asked for adjustments in order to receive Medicare reimbursement and, in that sense, MUHA did not receive what they asked for.

The Board remands the Cornea tissue issue for FYs 2007 and 2008 and the Bone Marrow issue for FY 2008 back to the Medicare Contractor to adjust these issues to properly reflect costs, statistics and revenue.

DECISION AND ORDER:

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

1. The Medicare Contractor's adjustments to reclassify the costs and statistics out of the paramedical pass-through cost center was proper because MUHA did not meet the requirements of 42 C.F.R. § 413.85(f)(1) for the PRP and, therefore, did not qualify for paramedical pass-through reimbursement for FYs 2007 and 2008.

2. Jurisdiction is granted under 42 C.F.R §1395oo(a) for the Cornea tissue issue for FYs 2007 and 2008.

3. Jurisdiction is granted under 42 C.F.R §1395oo(a) for the Bone Marrow issue for FY 2008.

Accordingly, the Board remands the cost reports back to the Medicare Contractor to properly reimburse MUHA for its FYs 2007 and 2008 Cornea costs and its FY 2008 Bone Marrow costs.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

2/19/2019

X Charlotte F. Benson

Charlotte F. Benson, CPA
Board Member
Signed by: PIV