PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2002-D7

PROVIDER -
University of Virginia Medical Center
Charlottesville, VA

Provider No. 49-0009

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
United Government Services, LLC

DATE OF HEARING-
October 23, 2001

Cost Reporting Period Ended -
June 30, 1995

CASE NO. 98-0490

INDEX

ISSUE:

Was the Intermediary's computation of the Provider's graduate medical education cost proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The University of Virginia Medical Center ("Provider") is an acute care teaching hospital located in Charlottesville, Virginia. As a teaching hospital, the Provider is reimbursed for the costs of its medical education activities.

For its cost reporting period ended June 30, 1995, the Provider calculated its graduate medical education ("GME") costs in accordance with program rules by multiplying its established per resident amount times its weighted number of interns and residents. Next, in accordance with program rules, the Provider determined its "Medicare patient load" and applied it to its GME costs to determine Medicare's share of those expenses.

United Government Services, LLC ("Intermediary") reviewed the Provider's cost report and found that the Provider included Medicare Secondary Payer ("MSP") days that were reimbursed under Medicare's lower of cost or charges provisions ("MSP-LCC") in its patient load determination. The Intermediary effectuated an adjustment removing these days from the Provider's GME determination reducing its program reimbursement.

On June 17, 1997, the Intermediary issued a Notice of Program Reimbursement reflecting the subject adjustment. On December 4, 1997, the Provider appealed the adjustment to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount of program funds in controversy is approximately $70,000.[1]

The Provider was represented by Dennis M. Barry, Esq., of Vinson & Elkins. The Intermediary was represented by Eileen Bradley, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

[1] Provider Position Paper at 1. Intermediary Position Paper at 2.

The Provider contends that Medicare has paid for GME costs on the basis of a per resident amount since 1985.[2] The amount allowed by Medicare is determined by taking the per resident amount multiplied by the weighted number of residents in accordance with the formula set forth at 42 C.F.R. § 413.86. The portion of that total allowable amount that is paid by Medicare is determined by the percentage of Medicare inpatients to total inpatients, which is the Medicare patient load.

The Provider cites 42 U.S.C. § 1395ww(h)(3)(C), which states in part:

> the term "Medicare patient load" means. . . the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A.

42 U.S.C. § 1395ww(h)(3)(C).

Also, regulations at 42 C.F.R. § 413.86(b) state:

> Medicare patient load means. . . the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded.

42 C.F.R. § 413.86(b).

Respectively, the Provider contends that there is no dispute that the patient days at issue relate to patients covered under Medicare Part A, and there is no dispute that the payments to the Provider for those patients came from the Medicare Part A trust fund. Accordingly, the patient days in dispute are for "patients with respect to whom payment may be made under Part A" as defined in the regulation and, therefore, must be included in determining Medicare's share of GME costs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it is correct to exclude MSP-LCC patient days from the calculation of the program's share of the Provider's GME costs. The Intermediary asserts that including MSP-LCC days in the GME calculation results in improper program payments and is inconsistent

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[2] Provider Position Paper at 24.

with Medicare's cost reporting instructions.[3]

The Intermediary contends that when a claim is paid under Medicare's MSP-LCC provisions a determination has been made that charges are lower than the payment amount that would be due on a cost basis. 42 C.F.R. § 411.33. When costs are compared to charges for this determination they include all components of a cost-based payment such as DRG liability, capital, indirect medical education ("IME"), and GME. Therefore, once the determination is made that charges are lower than costs for an MSP claim, the charges represent the total payment due the Provider in compliance with Medicare regulations and no additional amount for costs of services should be added to the charge-based payment. Notably, if MSP-LCC patient days were included in the number of Medicare inpatient days used to apportion GME costs, the program would consequently pay the Provider GME costs related to services that are supposed to be reimbursed on the basis of charges.

The Intermediary explains that a provider's GME costs are calculated on Worksheet E-3, Part IV of the Medicare cost report. According to the instructions for this worksheet, Provider Reimbursement Manual, Part II ("HCFA Pub. 15-2") § 2832.4, Medicare's share of a provider's GME costs are determined by multiplying the Medicare patient load, i.e., the ratio of Medicare Part A inpatient days to total inpatient days, times total GME costs. In accordance with these instructions, the number of Medicare days used in the ratio is the sum of the Medicare Part A inpatient days reported on Worksheet S-3, Part I, column 4, lines 1.01, 2 through 6 and 9, of a provider's cost report. Respectively, the Intermediary asserts that Medicare Part A inpatient days reported on Worksheet S-3, Part I do not include MSP-LCC days, nor are they reflected on Worksheet E-3, Part IV.

Finally, the Intermediary contends that the exclusion of MSP-LCC inpatient days from the GME calculation is consistent with the treatment of MSP-LCC data in the cost report settlement determination. Specifically, the Intermediary asserts that the reimbursement data for MSP-LCC services, i.e., inpatient days, discharges, payments, deductibles and coinsurance, are not included in the settlement data reported in the cost report. In part, instructions at HCFA Pub. 15-2 § 2817, state:

> NOTE: When charges are less than Medicare secondary payer (MSP) and diagnosis related group (DRG), then do not include days, charges or discharges for Medicare purposes. Report these statistics in the total only.
>
> In example 1, if DRG is equal to $1,000, primary payer is equal to $900, but the charges are equal to

[3] Intermediary Position Paper at 29.

$850, then base the payment on the charges of $850. Therefore, no Medicare payment is made.

In example 2, if DRG is equal to $1,000, primary payer is equal to $450, and the MSP paid is $400, but the charges are $850, then base the payment on the charges of $850. Therefore, no additional Medicare payment is made.

HCFA Pub. 15-2 § 2817.

The Intermediary maintains that it was never the intent of Medicare's MSP regulations to reimburse providers the lower of cost or charges by paying MSP-LCC claims on the basis of both cost and charges.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395ww(h)(3)(C)	-	Direct Medical Education Costs-Medicare Patient Load

2. Regulations - 42 C.F.R.:

§ 405.1835-.1841	-	Board Jurisdiction
§ 411.33	-	Amount of Medicare Secondary Payment
§ 413.86 et seq.	-	Direct Graduate Medical Education-Definitions

3. Program Instructions-Provider Reimbursement Manual, Part II ("HCFA Pub. 15-2"):

§ 2806	-	Form HCFA 2552-92 Cost Report Instructions - Worksheet S-3-Hospital and Hospital Health Care Complex Statistical Data and Hospital Wage Index Information
§ 2817	-	Form HCFA 2552-92 Cost report Instructions-Worksheet E-Calculation of Reimbursement Settlement
§ 2832.4	-	Form HCFA 2552-92 Cost report

Instructions-Computation of Total
Direct GME Amount

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Medicare's share of a provider's GME costs are determined by applying its "Medicare patient load" to its total GME expenses. In general, the "Medicare patient load" is the ratio or fraction of Medicare Part A inpatient days divided by total inpatient days. At issue in this case is the number of Medicare Part A inpatient days used in this calculation.

In particular, the Provider included MSP-LCC days in its Medicare Part A inpatient day count. These are days of Part A services to inpatients where Medicare was the secondary payer and where reimbursement was limited to charges pursuant to the program's lower-of-cost or charges provisions. The Intermediary disallowed these days, however, arguing that reimbursement based upon charges represents payment-in-full, presumably because providers set their charges at levels high enough to recover all of their costs including, for example, capital costs, indirect medical education and GME expenses. The Intermediary implies, therefore, that including MSP-LCC days in the Provider's "Medicare patient load" would duplicate payments.

The Board finds, however, that the Intermediary's adjustment is improper. Both the controlling statute and implementing regulation sustain the inclusion of MSP-LCC days in the "Medicare patient load." Specifically, 42 U.S.C. § 1395ww(h)(3)(C) states in part:

> the term "Medicare patient load" means. . . the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A.

42 U.S.C. § 1395ww(h)(3)(C)(emphasis added).

And, 42 C.F.R. § 413.86(b) goes on to state:

> Medicare patient load means. . . the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days.

42 C.F.R. § 413.86(b)(emphasis added).

The Board notes that these authorities are clear. If a patient day is attributable to a patient "for whom payment is made under Medicare Part A," which is precisely the case of MSP-LCC days, then it is included in the "Medicare patient load." There is no distinction made in the controlling

authorities regarding the nature or characteristic of the Part A payment made; that is, whether or not the payment is made based upon provider costs, a prospective payment system rate, or a provider's charges.

The Intermediary also argues that Medicare's cost reporting instructions require MSP-LCC days to be excluded from the "Medicare patient load." Upon analysis its noted that the instructions explain that Medicare Part A inpatient days used in the "Medicare patient load" are those days reported on Worksheet S-3, Part I, column 4, lines 1.01, 2 through 6 and 9, of a provider's cost report. Moreover, the instructions for this site specifically exclude MSP-LCC days stating: "[c]olumn 4 must not include Medicare secondary payer/lesser of reasonable cost or customary charges (MSP-LCC) days." HCFA Pub. 15-2 § 2806.1, Line 1.01.

The Board, however, is not compelled by this argument. The Board does not believe cost reporting instructions are the proper venue for establishing reimbursement policy. This is especially true when that policy can have a material effect on provider payments as in the instant case, and especially when both the statute and implementing regulation are absolutely distinct. Less significant is the fact that the language in the cost reporting instructions which excludes MSP-LCC days from the "Medicare patient load" was not published until September 1995, and does not apply to the subject cost reporting period.

As important, is the fact that the Board finds the cost reporting instructions to be contestable with respect to MSP-LCC days based upon other grounds. Specifically, the Intermediary explains that the exclusion of MSP-LCC days is consistent with the instructions found at HCFA Pub. 15-2 § 2817, which is the cost report worksheet (Worksheet E) used to reach final settlement. The Intermediary asserts that the following language, found under the caption of Application of Lesser of Reasonable Cost or Customary Charges-General, supports its position:

> NOTE: When charges are less than Medicare secondary payer (MSP) and diagnosis related group (DRG), then do not include days, charges or discharges for Medicare purposes. Report these statistics in the total only.

HCFA Pub. 15-2 § 2817.

The Board finds, however, that this note pertains only to services covered under Medicare Part B and does not apply to the issue in this case. Importantly, though, reading further into the instructions to the final settlement of Medicare Part A services, which is applicable, the Board finds language which seems to be directly on point and supports the Provider's argument by indicating that MSP-LCC days are included in Medicare Part A reimbursement statistics. Specifically, instructions at HCFA Pub. 15-1 § 2817.1, Part A - Inpatient Hospital Services Under PPS, Line 17, which deals with MSP, state in pertinent part, the following:

> Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only,

> treat the services if they were non-program services. . . . Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges.
>
> When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. If you are subject to PPS, include the covered days and charges in the program days and charges, and include the total days and charges in the total days and charges for inpatient and pass through cost apportionment.

HCFA Pub. 15-1 § 2817 (emphasis added).

In conclusion, the Board finds no statute, regulation, or program guideline indicating that a program payment based upon a provider's charges represents "payment-in-full" thereby restricting MSP-LCC days from a provider's "Medicare patient load." Rather, the Board finds that the controlling authorities require the inclusion of MSP-LCC days in the patient load determination.

DECISION AND ORDER:

The Intermediary improperly excluded MSP-LCC days from the Provider's "Medicare patient load" determination. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Stanley J. Sokolove
Dr. Gary B. Blodgett

Date of Decision: January 10, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman