PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D36

PROVIDER -
Cedars-Sinai Medical Center
Los Angeles, California

Provider No.: 05-0625

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services

DATE OF HEARING -
July 11, 2007

Cost Reporting Periods Ended -
March 31, 1987; March 31, 1988
and March 31, 1989

CASE NO.: 99-3519M

INDEX

ISSUE:

Whether the Intermediary may refuse to apply a revised graduate medical education base year average per resident amount to the subsequent cost years that fall outside the three-year reopening period set forth in 42 C.F.R. §405.1885.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal 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). 42 C.F.R. §405.1803. 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 issuance of the NPR. 42 U.S.C. §1395oo; 42 C.F.R. §405.1835.

Medicare reimbursement is governed by 42 U.S.C. §1395x(v)(1)(A). In part, the statute provides that the "reasonable cost" of any service shall be the actual cost incurred excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The implementing regulation at 42 C.F.R. §413.9 provides that reasonable cost includes all "necessary and proper" costs incurred in furnishing healthcare services, subject to principles relating to specific items of revenue and cost.

Hospitals were reimbursed under a reasonable cost payment methodology until 1983 when Congress implemented the Medicare prospective payment system (PPS). Under PPS, hospital inpatient operating costs were no longer reimbursed on the basis of reasonable cost but were paid based upon a prospectively determined rate per discharge. Certain costs, however, including the costs of approved graduate medical education (GME) programs were specifically excluded from the definition of inpatient operating costs and continued to be reimbursed on the reasonable cost basis.

In 1986, Congress amended 42 U.S.C. §1395ww establishing a new prospective payment methodology for GME costs, effective for cost reporting periods beginning on or after July 1, 1985.[1] Under this methodology hospitals are reimbursed for their GME costs based upon an "average per resident amount (APRA)" determined from a GME base period cost report. The APRA is adjusted for inflation and used to calculate GME reimbursement in all future years.

42 U.S.C. §1395ww(h)(2)(A) states:

> (A) DETERMINING ALLOWABLE AVERAGE COST PER FTE [full-time equivalent] RESIDENT IN A HOSPITAL'S BASE PERIOD. —The Secretary [of DHHS] shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this sub-chapter for direct graduate medical education costs for each full-time-equivalent resident.

Regulations implementing the new GME payment methodology were promulgated three and one-half years later in 1989 (42 C.F.R. §413.86). Consistent with the statute, the regulations were effective for all cost reporting periods beginning on or after July 1, 1985.

Pursuant to 42 C.F.R. §413.86(e)(1) intermediaries were required to determine a GME base-year per resident amount for each affected hospital. Re-audits were performed to ensure the accuracy of GME costs included in the base year and to ensure that nonallowable or misclassified costs were eliminated from those costs. The re-audit process also included a determination of the number of FTE residents in the base year. HCFA stated in the preamble of the GME regulations that the intent of the re-audit was to ensure the reimbursement principles in effect for the GME base year were correctly applied. Therefore, no new reimbursement principles would be applied in the re-audit. Once the re-audit was complete and the correct base year costs and resident counts were determined, the intermediary computed each provider's APRA and issued a formal Notice of Average Per-Resident Amount.

In subsequent years, a provider's direct GME reimbursement was determined by multiplying its Medicare inpatient load[2] by the inflation-adjusted APRA multiplied by the weighted average number of FTE residents in the hospital's GME program that year. 42 C.F.R. §413.86.

42 C.F.R. §413.86(e)(1)(v) states:

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[1] Section 9202(a) of Public Law 99-272.

[2] Medicare patient load is the ratio of a hospital's Medicare Part A inpatient days that occurred during the cost reporting period divided by the hospital's total inpatient days.

> [t]he intermediary notifies each hospital that either had direct graduate medical education costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1984 and before October 1, 1985 of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice. (Emphasis added).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Cedars-Sinai Medical Center (Provider) is a short-term, acute care, teaching hospital located in Los Angeles, California. As a teaching hospital the Provider was subject to a re-audit of its GME base period cost report for the purpose of determining its APRA. Blue Cross of California (Intermediary)[3] performed the GME re-audit and issued a Notice of Average Per Resident Amount (NAPRA) advising the Provider of its APRA.[4] The Provider appealed the Intermediary's determination to the Board, and the appeal was designated as PRRB Case No. 91-2595M. Subsequent to the Provider's appeal filing, the Provider and Intermediary entered into a partial administrative resolution of the issues raised in the appeal, and the Intermediary issued a second (revised) NAPRA on December 17, 1998. Based upon this notice, the Provider requested that the Intermediary apply its recalculated APRA to all cost years subject to the new GME payment methodology. However, the Intermediary refused to apply the recalculated APRA to cost reports that were not within the three-year reopening period specified in 42 C.F.R. §405.1885 but agreed to apply the new APRA to cost years considered "open" by virtue of the Provider having filed separate appeals for those years.

Ultimately, the Intermediary did not apply the recalculated APRA to the Provider's 1987, 1988, and 1989 cost reports, and the Provider appealed this matter to the Board asserting that the revised APRA should be applied to all cost reports subject to the new GME payment methodology. This appeal is designated as PRRB Case No. 99-3519M.[5]

On September 10, 1999, the Intermediary challenged the Board's jurisdiction to hear the Provider's appeal of the revised APRA, and the Provider responded to this challenge on October 12, 1999. This matter is before the Board.[6]

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[3] Subsequently, United Government Services became the Provider's Intermediary, and it is now known as National Government Services.

[4] Exhibit P-1. NOTE: All references to Provider Exhibits refer to "Provider's Post-Hearing Position Paper."

[5] Initially the Board's July 11, 2007 hearing was to address case nos. 91-2595M and 99-3519M pertaining to the Provider's GME base period cost report, and case no. 96-2142 which pertained to the Provider's cost reporting period ended June 30, 1990. However, the partial administrative resolution resolved all issues in case no. 91-2595M except for a malpractice insurance cost issue which the Provider ultimately withdrew (Transcript (Tr.) at 12), and case no. 96-2142 was administratively resolved and has been closed (Exhibit P-12).

[6] Exhibits I-2 and P-5, respectively. NOTE: All references to Intermediary documents refer to the Intermediary's Supplemental Position Paper.

The Provider was represented by David L. Volk, Esquire, of Sonnenschein Nath & Rosenthal. The Intermediary was represented by James R. Grimes, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Board does not have jurisdiction to decide the case because the revised NAPRA is not a "final determination" with respect to the cost years for which the Provider seeks relief. 42 C.F.R. §405.1801. The revised NAPRA pertains to the Provider's GME base period cost report yet the Provider challenges program payments in its subsequent cost reporting periods ended in 1987, 1988, and 1989. The Intermediary cites 54 Fed. Reg. 40286, 40288, September 29, 1989, explaining that an appeal of an APRA must be an appeal to the 1984 base period cost report, and page 40303 of that issuance explains that an appeal of an APRA is separate from an appeal of GME payments made on or after July 1, 1985.[7] The Intermediary cites Ellis Hospital v. Empire Blue Cross Blue Shield, PRRB Decision No. 98-D31, Feb. 27, 1998, Medicare & Medicaid Guide (CCH) ¶ 46,101, aff'd., CMS Admin., April 30, 1998, Medicare & Medicaid Guide (CCH) ¶ 46,354, where the Board found the only year at issue was the GME base year, and not the base year and the rate years.[8]

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's revised NAPRA as well as its decision not to apply the recalculated base year APRA to its 1987-1989 cost years are "final determinations" pursuant 42 C.F.R. §405.1801 and 42 C.F.R. §405.1835.[9] The Intermediary's determination not to apply the recalculated APRA to all cost years was the only notice that the Provider would not receive full benefit of the new rate. Since the reimbursement affect of the Intermediary's decision not to apply the recalculated APRA exceeds $10,000 per cost year and the Provider timely appealed this matter to the Board within 180 days of the revised NAPRA, the Provider has met the jurisdictional requirements for a Board hearing. The Provider cites Providence Hospital, Inc. v. Bowen, U.S. District Court, ND Ohio (1986), not reported, Medicare & Medicaid Guide (CCH) ¶35,430, where the court found an agency's decision to deny a hospital's request for rural referral center status was a final determination that could be appealed to the Board. The Provider cites 54 Fed. Reg. 40303 where HCFA states:

> [o]nce the intermediary computes a per resident amount that the intermediary believes is correct, the intermediary will notify the hospital that this is HCFA's final determination. Upon receipt of this notification, the

[7] Tr. at 21. Exhibit I-3.
[8] Intermediary's Supplemental Position Paper at 5. Tr. at 26.
[9] Provider's Post Hearing Brief at 5.

> hospital has 180 days in which to appeal the intermediary's determination.

The Provider also contends that the Intermediary's refusal to apply the recalculated APRA to the subject cost reporting periods is inconsistent with the 1989 GME regulation. In the preamble to the rule, HCFA states: "[f]or settlement of GME payments made on or after July 1, 1985, the hospital can still appeal the count of residents for the cost reporting year in question or the application of the update factor in the settlement of GME payments." 54 Fed. Reg. 40303. Therefore, hospitals were expressly prohibited from filing an appeal of their base year APRA in cost years after July 1985, yet the Intermediary refuses to apply the revised APRA to cost years beyond the three-year reopening period, except where a provider filed a separate cost year appeal. The Provider cites Georgetown University v. Bowen, 862 F.2d 323 (D.C.Cir. 1988) where the court found that because Congress had directed the Secretary to make PPS payments for the transition years based on "allowable" costs, once the amount of allowable costs increased as a result of a successful appeal, the payments based on the allowable costs must also increase.

The Provider also argues that the three-year reopening rule at 42 C.F.R. §405.1885 does not establish a limitation on the application of the APRA; if HCFA intended it to be a limitation it could have stated that in the 1989 regulation. It was clear that base year disputes would extend well beyond the earlier cost reporting periods subject to the new GME payment methodology.

Finally, the Provider disagrees with the Intermediary's argument that it could have preserved its right to have a revised APRA applied to all otherwise applicable cost reports by appealing its GME reimbursement in those periods. The Provider explains that according to the preamble of the 1989 GME rule, providers could only appeal the update factor used to adjust the APRA or the count of residents.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds and concludes that it does not have jurisdiction over the Provider's appeal. Furthermore, even if the Board found that it had jurisdiction over the appeal, based upon the merits, the Board could not grant the Provider the relief it seeks; that is, the Provider's revised APRA cannot be applied to its 1987, 1988, and 1989 cost reports because they are "closed" and beyond the three-year reopening provision of 42 C.F.R. §405.1885.

The Intermediary argues that the Board lacks jurisdiction because there was no "final determination" upon which the Provider could base its appeal as required by 42 C.F.R. §405.1801(a)(1). It contends that the Provider's appeal stems from a revised NAPRA applicable to its GME base period cost report (fiscal year ended March 31, 1985) and not from a reimbursement determination applicable to the subject 1987-1989 cost reports. The Provider responds that a "GME Tracking Report" included as part of the

Intermediary's revised NAPRA demonstrates that the Intermediary made a final determination refusing to apply the revised APRA to the subject cost reporting periods and that the report establishes the basis for its appeal.[10]

The Board disagrees with the Provider. It is undisputed that a NAPRA, or a revised NAPRA in this instance, are "final determinations" establishing provider appeal rights.[11] However, pursuant to 42 U.S.C. 1395oo and 42 C.F.R. 405.1835-1841, a final determination that may lead to a Board appeal must represent an "amount" in dispute for a particular cost reporting period. With respect to the instant case, the amount that could be appealed is the Provider's revised APRA. The Provider did not challenge this amount, rather, it challenged the application of the revised APRA to future cost reporting periods.

The revised APRA was recalculated for the GME base year. It is updated for each subsequent fiscal year by an adjustment factor established by the Secretary. The Intermediary's NAPRA included a schedule projecting the Provider's APRA through 1999, along with the GME Tracking Report. However, each of these documents is informational; they set forth the adjustment to the base year rate and identify cost reporting periods subject to reopening. Neither document calculates an amount of reimbursement due the Provider for any of the cost reporting periods challenged by the Provider. Except for the APRA itself, as conveyed in the Intermediary's revised notice, a NPR or a revised NPR conveying an amount of GME reimbursement due the Provider is required to establish appeal rights for the 1987-1989 cost reporting periods.

Based upon the merits of the case, the Board finds that the pertinent statute, 42 U.S.C. 1395ww(h), is silent regarding the application of a hospital's APRA to cost reporting periods beyond Medicare's three year reopening rule. 42 C.F.R. §405.1885. The enabling regulation at 42 C.F.R.§413.86(e)(1)(iii) states:

> [i]f the hospital's cost report for its GME base period is no longer subject to reopening under §405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for the purposes of computing the per resident amount.

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[10] Exhibit P-3 at 3.

[11] 42 C.F.R. §413.86(e)(1)(v) states: [t]he intermediary notifies each hospital that either had direct graduate medical education costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1984 and before October 1, 1985 of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of this notice . (Emphasis added). At 54 Fed. Reg. 40303, HCFA states: [o]nce the intermediary computes a per resident amount that the intermediary believes is correct, the intermediary will notify the hospital that this is HCFA's final determination. Upon receipt of this notification, the hospital has 180 days in which to appeal the intermediary's determination. Although the hospital must appeal to the PRRB, it can continue to negotiate with the intermediary to resolve any disputes with respect to the intermediary's determination. The hospital has no appeal rights after 180 days have elapsed since its receipt of the original notice or any revised notice of its per resident amount. (Emphasis added).

HCFA's position on this issue was upheld by U.S. Court of Appeals for the Eighth Circuit in Regions Hospital v. Shalala, 91 F. 3d 57, affirmed by the Supreme Court of the United States, No. 96-1375 Feb. 24, 1998, 522 U.S. 448, (1998) (Regions). The Court of Appeal's decision makes clear that cost reporting periods that are beyond the program's three-year reopening rule are left intact, as they were finally settled with respect to the re-audit of GME base period cost reports as well as the application of APRAs. In part, the court states:

> [t]he reaudit rule permits no recoupment of excess reimbursement for years in which the reimbursement determination has become final. Rather, the rule seeks to prevent future overpayments and to permit recoupment of prior excess reimbursement only for years within the three-year reopening window.
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> Furthermore, the reaudits leave undisturbed the actual reimbursements for 1984 and any later reporting years on which the three-year reopening window had closed. The adjusted reasonable cost figures resulting from the reaudits are to be used solely to calculate reimbursements for still open future years.

The Provider believes the Supreme Court's affirmation shows the understanding that HCFA was so concerned with calculating accurate APRAs, it authorized intermediaries to reopen GME base period cost reports that had been closed for more than three years. Upon this reasoning, the Provider asserts it is ironic to reopen cost reports closed beyond three years to calculate accurate rates but deny applying those rates to cost reporting periods closed for more than three years to help assure accurate payments. However, the Supreme Court stated: "the Secretary's reaudits leave undisturbed the actual 1984 reimbursements and reimbursements for any later cost-reporting year on which the three-year reopening window had closed. The adjusted reasonable cost figures resulting from the reaudits are to be used solely to calculate reimbursements for still open and future years." The Provider fails to recognize that sustaining the three-year reopening rule in all circumstances except for the specific rate determinations discussed herein, means that improper overpayments that may have been made under reasonable cost principles will also not be recouped. There is clearly an equitable correlation between the accuracy of GME payments made under the APRA methodology and payments left intact under Medicare's reasonable cost principles.

DECISION AND ORDER:

The Board lacks jurisdiction over the Provider's fiscal years ended March 31, 1987, 1988, and 1989 because they were not revised by the final determination which forms the basis of the Provider's appeal.

Board Members Participating:

Suzanne Cochran, Esq.
Elaine Crews Powell, C.P.A
Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 19, 2008