PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D46

PROVIDERS –
Borgess Medical Center **and**
Bronson Methodist Hospital
Kalamazoo, Michigan

Provider Nos.: Various - See Appendix I

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services, Inc.

DATES OF HEARING -
February 22, 2010 and February 23, 2010

Cost Reporting Periods Ended-
Various - See Appendix I

CASE NOs.: 08-1452, 08-1800, 08-2699, 08-2533, 08-2534, 08-1156, 08-2532 and 09-0914

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ISSUES:

1. Whether the Intermediary's adjustment to the direct graduate medical education and indirect medical education counts for residents training at the Kalamazoo Center for Medical Studies/Michigan State University nonhospital site clinics was proper.

2. Whether the Intermediary's calculation of Borgess Medical Center's Supplemental Security Income percentage, the proportion of the patients eligible for Medicare Part A or Part C who are also eligible for supplemental security income, for cost reporting period ending June 30, 2003 was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. *See* 42 U.S.C. §§ 1395 *et seq*. 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 administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FI) and Medicare administrative contractors (MAC). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulations and interpretative guidelines published by CMS. 42 U.S.C. § 1395h, 42 C.F.R. §§ 413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. 42 C.F.R. § 413.20. 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). 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(a); 42 C.F.R. § 405.1835.

The Medicare regulation at 42 C.F.R. §405.1885(a) provides that a determination of an intermediary may be reopened with respect to findings on matters at issue in a cost report. A request to reopen must be made within three years of the date of the notice of the intermediary determination. No reopening of an intermediary determination is permitted after three years unless it is determined to have been procured by fraud or similar fault. 42 C.F.R. §405.1885(d). Additional rules concerning reopening and correction of intermediary determinations are addressed in CMS Pub. 15-1 §§2930, 2931 and 2932. With regard to notices of reopening and correction, CMS Pub. 15-1 §2932(A) states: "[t]he provider or other party will be advised in the notice as to the circumstances surrounding the reopening, i.e., why it was necessary to take such action, and the opportunity to comment, object, or submit evidence in rebuttal."

[1] FIs and MACs are hereinafter referred to as intermediaries.

Direct Graduate Medical Education (GME) and Indirect Medical Education (IME)

The Medicare program reimburses teaching hospitals for their share of costs associated with direct GME and IME. Since 1986, the statute authorizing direct GME reimbursement for residency programs has provided that all of the time a resident spends in training under an approved medical residency training program, regardless of the setting, shall be counted towards the determination of full-time equivalent resident counts so long as (1) the resident is involved in patient care activities and (2) the hospital incurs "all, or substantially all, of the costs for the training program" in the nonhospital setting. 42 U.S.C. §1395ww(h)(4)(E). In 1997, Congress authorized IME reimbursement for residents in nonhospital settings. 42 U.S.C. §1395ww(d)(5)(B)(iv).

During the fiscal years at issue, in addition to the two statutory requirements the Secretary imposed an additional administrative requirement, namely, that the hospital have a written agreement with the nonhospital site. The regulations established three conditions that a provider must meet in order to count residents' training time in nonhospital settings for direct GME and IME payment purposes.

> (i) The resident spends his or her time in patient care activities.
>
> (ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.
>
> (iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

42 C.F.R. § 413.86(f)(4) (1999).[2] *See also* 42 C.F.R. § 412.105(f)(1)(ii)(C) (2000) (incorporating the above direct GME standards by reference to IME).

With respect to subparagraph (iii), the regulations provide a definition for "all or substantially all of the costs for the training program in the nonhospital setting" as follows:

> All or substantially all of the costs for the training program in the nonhospital setting means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.[3]

42 C.F.R. § 413.86(b)(3).

[2] The regulation 42 C.F.R. § 413.86 was re-designated 42 C.F.R. § 413.78(d) on August 11, 2004. *See*, 69 Fed. Reg. 49,254 (Aug. 11, 2004).

[3] 42 C.F.R. §413.86(f)(4)(iii) was added effective October 1, 1999.

Furthermore, CMS published in the preamble to the 2003 final rule the following comment and response:

> *Comment:* Several commenters objected to the sentence in the preamble to the proposed rule that stated " . . . a hospital is required to assume financial responsibility for the full complement of residents training in a nonhospital site in a particular program in order to count any FTE residents training there for purposes of IME."
>
> *****
>
> *Response:* We understand the concerns of the commenters about the requirement for a hospital to incur "all or substantially all of the cost" of training residents in a training *program* at a nonhospital site. However, we *do not* believe this is a *change* in policy. We believe that the policy that requires a hospital to incur the cost of "the program" in the nonhospital site has existed since the passage of the direct GME provisions, section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509), and the passage of the IME provision, section 4621(b)(2) of the Balanced Budget Act of 1997 (Pub. L. 105-33), that permitted hospitals to continue to count residents in nonhospital sites, for purposes of direct GME and IME payment, if the hospital incurred "all or substantially all of the cost"of residents training in the program.
>
> *****
>
> However, we believe the statutory provisions cited above require hospitals to assume the cost of the full complement of residents training in the program at the nonhospital sites in order to count any FTE residents training at that site. . . .

68 Fed. Reg. 45346, 45449-50 (Aug. 1, 2003)(emphasis in original).

Disproportionate Share Hospital (DSH)/Supplemental Security Income (SSI) Percentage

The operating costs of inpatient hospital services are paid by Medicare primarily through the Prospective Payment System (PPS). 42 U.S.C. §1395ww(d). The PPS statute contains a number of provisions that adjust payment based on hospital-specific factors. 42 U.S.C. §1395ww(d)(5). This case involves one of the hospital-specific adjustments, specifically the DSH adjustment. The Secretary is required to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. §1395ww(d)(5)(F)(i)(I).

Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage." 42 U.S.C. §1395ww(d)(5)(F)(v). The "disproportionate patient percentage" is the sum of two fractions, the "Medicare and Medicaid fractions," expressed as a percentage for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi). A provider whose DSH percentage meets certain thresholds receives an adjustment which results in increased PPS payment for inpatient hospital

services. 42 U.S.C. §1395ww(d)(5)(F)(ii).

The Medicare fraction's numerator is the number of hospital patient days for patients entitled to both Medicare Part A and SSI, excluding patients receiving state supplementation only, and the denominator is the number of hospital patient days for patients entitled to Medicare Part A. *Id. See also,* 42 C.F.R. §412.106(b)(2). The Medicare fraction is also referred to as the Medicare proxy or the SSI fraction. The Medicaid fraction's numerator is the number of hospital patient days for patients who were "eligible for medical assistance under a State plan approved under … [Title] XIX" for such period but not entitled to benefits under Medicare Part A, and the denominator is the total number of the hospital's patient days for such period. *Id. See also,* 42 C.F.R. §412.106(b)(4). The Medicaid fraction is also referred to as the Medicaid proxy.

From the inception of the DSH adjustment in 1986, CMS has calculated the SSI fraction for each acute care hospital paid under the inpatient PPs. The Intermediary then uses the SSI fraction along with the Medicaid fraction, to determine whether the hospital qualifies for a DSH payment adjustment and the amount of any such payment. 51 Fed. Reg. 16772, 16777 (May 6, 1986).

In determining the number of inpatient days for individuals entitled to both Medicare Part A and SSI, as required to calculate the numerator of the SSI fraction, CMS matches the Medicare records and SSI eligibility records for each hospital's patients during the Federal fiscal year, (although a provider may elect to have its SSI fraction determined on the basis of its own cost reporting period.) 42 C.F.R. § 412.106(b)(2)-(3). Hospitals filed numerous appeals contesting the CMS calculation of the SSI fraction. In *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d, 37, 44 (D.D.C. 2008), the district court ruled that in certain respects CMS did not use the best available data in matching Medicare and SSI eligibility data. The court ordered the agency to recalculate the hospital's SSI fractions and DSH adjustments.

On April 28, 2010, subsequent to the hearing dates for these appeals, CMS issued Ruling No. CMS-1498-R (Ruling). Rulings are decisions of the Administrator that serve as "precedent final opinions or orders or statements of policy or interpretation" and are binding on all CMS components and on all HHS components that adjudicate matters under the jurisdiction of CMS. 42 C.F.R. § 401.108(c). The Board is one of these adjudicatory bodies. CMS-1498-R deals with a change in the data matching process used to calculate the SSI fraction. It also addresses the DSH treatment for two types of patient days: (1) non-covered inpatient hospital days for patients entitled to Medicare Part A, and days for which a patient's part A inpatient hospital benefits are exhausted (referred to as dual eligible days); and (2) labor/delivery room inpatient days. These cases here involve only the Ruling's directives as to the data matching process.

According to the Ruling, CMS advised that the Board and other Medicare administrative tribunals lack jurisdiction over provider appeals related to the data matching process used to calculate the SSI fraction. The Ruling requires the pertinent administrative appeals tribunal to remand each qualifying appeal to the appropriate fiscal intermediary. The Ruling also explains how CMS will recalculate the hospital's DSH adjustment and make any payment deemed owing.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Borgess Medical Center (Borgess) and Bronson Methodist Hospital (Bronson) (collectively referred to as "Providers") are non-profit acute care hospitals located in Kalamazoo, Michigan. The Providers train residents participating in various residency programs operated by Michigan State University/Kalamazoo Center for Medical Studies (KCMS), a nonhospital setting. For the cost reporting periods under appeal, the Providers' claimed FTEs for residents' time at the nonhospital clinics owned and operated by KCMS. National Government Services Inc. (Intermediary) issued NPRs disallowing the FTEs claimed by the Providers for resident time spent at KCMS. Subsequently, the Intermediary re-opened several of the initial NPRs and issued Notices of Corrected Amount of Program Reimbursement for the following cost reporting periods:

Provider/ Cost Reporting Period Ended	Initial NPR	Notice of Re-opening	Reason for Re-opening	Date of Notice of Correction of Program Reimbursement
Borgess/ 6/30/2001[4]	5/25/2007	11/19/2007	To remove the rotations which occur at KCMS in accordance with 42 CFR § 413.86(f)(4) as the hospital did not incur all or substantially all of the cost of training in that setting.	5/12/2008
Borgess/ 6/30/2002[5]	10/31/2007	11/19/2007	To remove the rotations which occur at KCMS in accordance with 42 CFR § 413.86(f)(4) as the hospital did not incur all or substantially all of the cost of training in that setting.	5/12/2008
Borgess/ 6/30/2003[6]	9/20/2007	1/17/2008	Adjustments to prior and penultimate years resident FTE count for Direct and Indirect Medical Education payments per 42 CFR 413.79.	6/19/2008
Bronson/ 12/31/2000[7]	9/21/2005	11/19/2007	To remove the rotations which occur at KCMS in accordance with 42 CFR 413.86(f)(4) as the hospital did not incur all or substantially all of the cost of training in that setting.	5/12/2008
Bronson/ 12/31/2001[8]	8/21/2007	11/19/2007	To remove the rotations which occur at KCMS in accordance with 42 CFR 413.86(f)(4) as the hospital did not incur all or substantially all of the cost of training in that setting.	5/12/2008
Bronson/ 12/31/2002[9]	8/28/2007	Not in Record	Not in Record	6/19/2008

[4] Case No. 08-2699 Provider's Exhibit P-1.
[5] Case No. 08-1800 Provider's Exhibits P-3 and P-4. In this case, the Intermediary re-opened a Notice of Correction Program Reimbursement dated October 31, 2007.
[6] Case No. 08-1452 Provider's Exhibits P-1, P-3, and P-4.
[7] Case No. 08-2533 Provider's Exhibits P-1 and P-71.
[8] Case No. 08-2534 Provider's Exhibits P-1 and P-71. In this case, the Intermediary re-opened a Notice of Correction Program Reimbursement dated August 21, 2007.
[9] Case No. 08-1156, Provider's Exhibits P-2 and P-3.

For Bronson's cost reporting periods ended December 31, 2003 and December 31, 2004, the Intermediary issued NPRs dated May 8, 2008 and August 21, 2008 respectively, disallowing the FTEs claimed by the Providers for resident time spent at KCMS.[10] The Providers timely appealed the Intermediary's adjustments to the Board. Borgess also appealed the Intermediary's calculation of the SSI percentage in determining the DSH payment for cost reporting period ended June 30, 2003. The Providers have met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 - 405.1840 (2008).

The Providers were represented by Chris Rossman, Esquire and Jeffrey Bates, Esquire of Foley & Lardner, LLP. The Intermediary was represented by James R. Grimes, Esquire of Blue Cross Blue Shield Association.

Issue # 1 - FTE resident counts at nonhospital sites

PARTIES' STIPULATIONS:

The Providers and Intermediary stipulated to the following pertinent facts[11]:

- The Provider, [Borgess Medical Center] and the Intermediary agree that the number of FTE residents in dispute for the issue regarding residents training at nonhospital sites operated by the Kalamazoo Center for Medical Studies ("KCMS") for [direct] GME and IME for the current year for the appeal years is as follows:

Fiscal Year	Case No.	FTE Residents
6/30/01	08-2699	3.3726
6/30/02	08-1800	2.6054
6/30/03	08-1452	3.56

- The Provider, [Bronson Methodist Hospital] and the Intermediary agree that the number of FTE residents in dispute for the issue regarding residents training at nonhospital sites operated by the Kalamazoo Center for Medical Studies ("KCMS") for [direct] GME and IME for the current year for the appeal years is as follows:

Fiscal Year	Case No.	GME Count	IME Count
12/31/00	08-2533	4.24	4.24
12/31/01	08-2534	4.70	4.70
12/31/02	08-1156	4.57	4.57
12/31/03	08-2532	10.27	10.27
12/31/04	08-0914	4.34	4.34

- The parties stipulate that if the Provider Reimbursement Review Board, CMS Administrator, or court ultimately rules that the residents training at the nonhospital

[10] Case Nos. 08-2532 and 09-0914, Provider's Exhibits P-1 and P-2.
[11] Joint Stipulation Regarding Residents at Issue for Nonhospital Site Issue, signed by Provider Representative dated April 5, 2010, and Intermediary Representative dated April 6, 2010.

> sites operated by KCMS are allowable and should be included in Borgess' and Bronson's FTE resident count, the Intermediary will increase the current year FTE resident count for [direct] GME and IME for each year by the above-referenced numbers. The Intermediary will also make appropriate adjustments to the subsequent year cost reports to revise the prior year and the penultimate year FTE resident counts for the three-year rolling average for [direct] GME and IME.

PARTIES' CONTENTIONS:

The Providers contend that the disallowance of the FTE rotations to KCMS clinics because of the lack of a written agreement is the Intermediary's attempt to enforce an interpretation of the regulations that is a change in the rule and practice, which cannot be applied retroactively.[12] Until 2007, the Intermediary allowed the FTE rotations to KCMS as claimed, without requesting a written agreement or proof of costs pertaining to the FTE rotations.[13] The Providers maintain that, after the Intermediary's audits and issuances of NPRs, they are entitled to rely on the Intermediary's approval of the nonhospital site rotations. The Medicare cost report auditing process is used by providers to learn of any potential problems and correct them in future years. The Providers never had a chance to make such corrections because they reasonably believed the Intermediary, by allowing all of the KCMS rotations claimed in each of the fiscal years before 2008, did not consider the KCMS clinic to be a nonhospital site and thus subject to the nonhospital rules.

The Providers contend that they satisfied the regulatory criteria at 42 C.F.R. 413.86(f) in calculating the FTE residents at KCMS.[14] First, it is undisputed that the residents' time was spent in patient care activities.[15] Next, the written agreement requirement does not apply to these appeals because the Providers and KCMS are related parties.[16] The Providers assert that since Bronson, Borgess and Michigan State University (MSU) each have a one-third ownership interest in KCMS, and have the right to appoint one-third of the KCMS Board of Directors, demonstrates that they are related under the Medicare related party rule. Notwithstanding the related party status, the Providers advise that the record contains master affiliation agreements (MAAs) with KCMS, in which the Providers agreed to incur all the teaching costs, including the residents' salaries and fringe benefits associated with the nonhospital site. Those MAAs satisfy the written agreement requirement.[17] The presence of those written agreements distinguishes these appeals from *Covenant Medical Center, Inc. vs. Kathleen Sebelius*, No. 07-15108, 2009 WL 2926442 (E.D. Mich. Sept. 10, 2009) (Hospital not entitled to reimbursement under Medicare for certain costs associated with the training of residents in nonhospital settings as hospital failed to obtain a written agreement with nonhospital site.).[18] Finally, as indicated in KCMS's financial statements, the Providers assert they satisfied the statutory and regulatory

[12] Providers' Position Paper Case No. 08-1452 at 19 and 22. The parties have agreed that the position papers filed in Case No. 08-1452 serves as the lead position paper in the eight cases consolidated in this decision. *See*, Transcript (Tr.) dated February 22, 2010 at 12.
[13] Providers' Position Paper at 18 -19.
[14] Provider Position Paper at 18 -20; Tr. dated February 22, 2010 at 17 – 19.
[15] Tr. dated February 22, 2010 at 17-18.
[16] Providers' Position Paper at 16-18; Tr. dated February 22, 2010 at 19 – 20.
[17] Providers' Exhibit P-25.
[18] Provider's Position Paper at 23-25; Tr. at 25 and 26.

requirement of incurring "all or substantially all of the costs" of the training program at the nonhospital sites.[19]

The Intermediary responds that the Providers do not have written agreements with KCMS as required under 42 C.F.R. 413.86(f)(4)(ii).[20] The Intermediary maintains that the regulation requires written agreements be executed by the hospital and the off-site provider, identify the off-site location, specify the cost of the resident training, and state that the hospital will incur such cost. The Intermediary contends that MAAs submitted by the Providers do not include the information required by the regulations.[21] Specifically, the MAAs do not address resident training at KCMS, and instead address residents training at the hospital. Moreover, the agreements do not specify whether the Providers will incur the cost of the residents' salary and fringe benefits or the teaching costs of the supervisory physicians for the residents' rotations at KCMS, nor what the amount of the costs of supervisory services are at the offsite location.

The Intermediary further contends that neither Provider established that it incurred all or substantially all of the costs for the training program in the nonhospital setting as required by 42 C.F.R. § 413.86(f)(4)(iii).[22] In order to meet the "all or substantially all" test, a hospital must prove it is paying 100% of the training costs for each particular residency training program.[23] While the Providers each funded KCMS, there is no detail in the budgets or financial statements as to how the funds are allocated to a particular training program.[24] The Providers acknowledged that they were unable to document the cost of the off-site training by residency program.[25] Consequently, since neither Provider could prove that it incurred all or substantially all of the cost of the training, the Intermediary asserts the adjustments to the Providers' FTE resident counts were proper.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

The issue in this case is whether the Providers have complied with the statutory and regulatory requirements to claim FTEs in a nonhospital setting.

1) *Patient Care Activities*

The statutes and the regulations require that the residents spend their time in patient care activities. In these cases, both parties agree that the FTE residents claimed by the Providers spent their time in patient care activities.

2) *Written Agreement*

[19] Providers' Position Paper at 20.
[20] Intermediary's Position Paper at 6; Tr. dated February 22, 2010 at 35 and 36.
[21] Tr. dated February 22, 2010 at 36 – 37; 308 - 09.
[22] Intermediary's Position Paper at 6 and 7.
[23] Tr. dated February 22, 2010 at 315.
[24] *Id.* at 316 -17.
[25] *Id*. at 118.

The regulations require a written agreement between the hospital and the nonhospital site indicating that the hospital will incur the cost of the residents' salary and fringe benefits while the residents are training in the nonhospital site and that the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities. The Intermediary contends that the MAAs submitted by the Providers do not satisfy the regulatory requirements because such agreements do not specify the residents' training is at KCMS or that the Providers will incur the costs of the residents compensation and those of the supervisory physicians.

The Board finds that the Intermediary is barred from raising the issue of the written agreement requirement for several of the cost reporting periods because the cost reports were never reopened for that reason. Specifically, for Borgess' cost reporting periods ended June 30, 2001, June 30, 2002, and Bronson's cost reporting periods ended December 31, 2000 and December 31, 2001, the Intermediary issued notices of reopening, dated November 19, 2007, "…to remove the rotations which occur at the Kalamazoo Center for Medical Studies/Michigan State University (KCMS) in accordance with 42 C.F.R. §413.86(f)(4) **as the hospital did not incur all or substantially all of the cost of training in that setting.**"(emphasis added)[26]. Next, for Borgess' cost reporting period ended June 30, 2003, the Intermediary issued a notice of reopening in order, dated January 17, 2008 "…to incorporate adjustments to the prior and penultimate years resident FTE count for Direct and Indirect Medical Education payments per 42 C.F.R. §413.79."[27] There was no mention of the lack of, or deficiency in, any written agreements.

The regulation at 42 C.F.R. § 405.1885(a) provides that any request to reopen must be made within three years of the date of notice of the intermediary determination. The regulation at 42 C.F.R. § 405.1887(a) provides that all parties to any reopening shall be given written notice of the reopening with a complete explanation of the basis for the revision. 42 C.F.R. § 405.1887(b) provides that the parties shall be allowed a reasonable period of time in which to present any additional evidence or arguments in support of their position. CMS Pub. 15-1 §2932.A states the following with regard to notices of reopening and correction: "[t]he provider or other party will be advised in the notice as to the circumstances surrounding the reopening, i.e., why it was necessary to take such action, and the opportunity to comment, object, or submit evidence in rebuttal."

The Board finds that the aforementioned notices of re-opening were timely issued and indicated the reason for the re-opening was limited to the "all or substantially all" requirement under 42 CFR § 413.86(f)(4) or to incorporate adjustments to the prior and penultimate years FTE counts. There was no reference to written agreements. At the hearing, the Intermediary acknowledged that it is held to the reason specified in the reopening notice.[28] The Board finds the Intermediary is barred from raising the issue of the written agreement requirement for cost reporting periods

[26] *See*, CN 08-2699 Provider Exhibit P-1 at 7; CN 08-1800 Provider Exhibit P-4 at 12; CNs. 08-2533 and 08-2534 Provider Exhibit P-71.
[27] *See*, CN 08-1452 Provider Exhibit P-3 at 5.
[28] Tr. dated February 22, 2010 at 366.

ended June 30, 2001, June 30, 2002, and June 30, 2003 for Borgess; and December 31, 2000 and December 31, 2001 for Bronson, because it is beyond the scope of the re-opening notices, and therefore not the focus of Intermediary's review.

For Bronson's cost reporting period ended December 31, 2002, the Intermediary issued on June 19, 2008 a Correction to a Notice of Program Reimbursement Amount.[29] The Board notes the record does not include the requisite notice of reopening specifying the reasons for the revision and the opportunity for the Providers to comment or submit evidence in rebuttal. Therefore, there is no evidence that the Intermediary followed the reopening procedures as required in the regulations and manual provisions. The Board finds the Intermediary is also barred from raising the issue of written agreement requirement for the cost reporting period ended December 31, 2002.

For Bronson's cost reporting periods ended December 31, 2003 and 2004, the Board finds the Provider has satisfied the regulatory requirement. Specifically, the record contains several documents, including the May 4, 1973 Agreement, Articles of Incorporation, KCMS Bylaws, Master Affiliation Agreement and KCMS' financial statements. The Board finds that considered collectively, these documents satisfy the regulatory requirements for a written agreement. The thrust of the regulation is that the written agreement must be between the provider and the nonhospital site and must specify who bears the cost. According to the May 4, 1973 Agreement, the Providers entered into an agreement to form KCMS for the purpose of operating and managing medical education and training programs. While the document does not speak to hospital/nonhospital sites, it does address the financial support the parties are to furnish in carrying out the corporation's purpose in the operation and management of medical education programs. The KCMS Bylaws utilize similar language, indicating that the Providers agree to share jointly and equally in the responsibility of providing the corporation sufficient financing to carry out its purpose. Next, the MAAs in effect during the cost reporting periods at issue, specify the arrangement which the Providers had with KCMS to incur all the teaching costs, including residents' salaries and fringe benefits associated with rotations to the nonhospital site. While the MAAs did not address who would be responsible for compensating the teaching physicians cost, if any, for supervisory duties, KCMS's financial statements demonstrate that the Providers covered all of the costs of the medical teaching program. When considered collectively, these documents meet the regulation's requirement for a written agreement.

3) *"All Or Substantially All" Requirement*

The final statutory and regulatory requirement is that a hospital must incur "all or substantially all" of the costs for the training program in the nonhospital setting. The Intermediary maintains that the Providers failed to satisfy this requirement because neither Provider could prove that it had incurred 100 % of the training costs for the residents at KCMS. The Providers counter that CMS's policy is contrary to the plain meaning and intent of the GME and IME payment statutes and rules. The Providers assert that neither the statute nor the regulation require a single hospital to pay for and claim all of the residents in a medical residency training program. Specifically, there was a substantive change in policy when CMS began prohibiting hospitals from sharing

[29] See, CN 08-1156 Provider Exhibit P-3.

total costs of a medical residency training program, after previously allowing such sharing of those costs between hospitals. *Medcenter One Health Systems and St. Alexius Medical Center vs. Michael O. Levitt*, 666 F. Supp 2d 1043 (D. N.D. Oct. 13, 2009) ("*Medcenter*") *rev'd* 2011 WL 668111 (C.A.8 (N.D.) Feb. 25, 2011) (holding the lack of a written agreement alone sustains HHS's action, without deciding whether HHS correctly interpreted the statute as barring the hospitals' cost-sharing arrangement).

The Board agrees with the Provider. In *Medcenter*, noting that the statute and the regulation were virtually identical,[30] the District Court held that the Medicare Act did not require a single hospital to pay for and claim all of the residents in a medical residency training program, in order to be eligible for reimbursement of direct and indirect costs of residency training. The first time that the Secretary published the requirement for a single hospital to incur the costs for the full complement of residents was in 2003. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates, [2004 IPPS Final Rule] 68 Fed. Reg. 45346, 45450 (Aug. 1, 2003):

> [W]e believe the statutory provisions cited above require hospitals to assume the cost of the full complement of residents training in the program at the nonhospital sites in order to count any [full-time equivalent] residents training at that site.[31]

The District Court noted that the comments to the preamble clearly indicate there was a change or departure in the policy that had existed for years, and specifically emphasized CMS' response to the comments:

> *We note that the policy that requires the hospital to incur the cost of the program does appear to be somewhat of a departure from other current Medicare policies on graduate medical education that focus on the resident rather than the program, as the commenter suggests."* However, we believe the statutory provisions cited above require hospitals to assume the cost of the full complement of residents training in the program at the nonhospital sites in order to count any [full-time equivalent] residents training at that site. 68 Fed. Reg. at 45449, 45450 (emphasis added).[32]

In summary, the Board finds that neither the statute nor regulation clearly requires the interpretation stated in the preamble to the 2004 IPPS Final Rule. The Board also finds that, in practice, this policy was not being applied as stated in the preamble. There was no clear communication from CMS of its policy during the period in dispute and the only policy or interpretation providers could rely on was the intermediaries' practice which was to permit hospitals to share the costs of training programs.

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[30] *Medcenter* at 1057.
[31] *Id.* at 1061.
[32] *Id.* at 1065.

The evidence establishes the Providers satisfied the "all or substantially all" requirement. For the cost reporting periods at issue, KCMS's financial statements provide a detailed accounting of the total costs related to the medical education training program, including supervisory personnel costs, house office personnel costs, clinic operating costs and direct program costs,[33] as summarized in the following table:

Fiscal Years (FY)	Total Cost Medical Education Training Program (excludes Administrative and General expenses).	50/50 Member Institution Contribution
FY 2000	23,460,912	24,521,430
FY 2001	23,899,641	21,438,340
FY 2002	26,478,002	20,061,142
FY 2003	29,835,416	24,094,922
FY 2004	30,912,557	27,016,412

It is noted the reduction in the Providers' overall proportional contributions during the FY 2001 through FY 2004 is attributed to a new billing system implemented by KCMS. [34] It is intended the amount of support received from the Providers will be reduced and eventually eliminated once KCMS becomes self-sufficient. Nevertheless, for the fiscal years at issue, the Providers contributions substantiate that they "jointly and equally" fully supported the cost of the medical education training programs operated by KCMS at hospital/nonhospital sites. Accordingly, the Board finds and concludes the evidence demonstrates the Providers incurred "all or substantially all" of the residency training program costs, and thus the regulatory requirement at 42 C.F.R. § 413.86(f)(4) has been satisfied.

Issue #2- DSH /SSI Percentage Case No. 08-1452

PARTIES CONTENTIONS:

Borgess contests CMS's calculation of its SSI percentage for the cost reporting period ended June 30, 2003 on the basis that CMS understated the number of SSI eligible days.[35] Borgess asserts that the data report prepared by outside consultants, RSM McGladrey, Inc. reflects the most accurate data to support its SSI percentage, and it is this data that should be used by the Intermediary to re-calculate the SSI percentage.[36]

The Intermediary responded that the issue be remanded to CMS for recalculation.[37]

[33] Providers' Exhibit P-26.
[34] *Id.* at 25.
[35] Provider's Position Paper at 33; Tr. dated February 23, 2010 at 11.
[36] Provider's Position Paper at 33; Provider's Exhibits P-42, P-72 and P-73; Tr. dated February 23, 2010 at 11.
[37] Tr. dated February 23, 2010 at 17.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes that the DSH/SSI Percentage issue be remanded to CMS for recalculation.

The appeal includes a challenge to the data matching process used in calculating the SSI fraction. This issue is remanded to CMS under the terms of CMS Ruling CMS-1498-R for recalculation of the disproportionate share hospital (DSH) payment adjustment.

DECISION AND ORDER:

Issue 1- FTE resident counts at nonhospital sites

The Intermediary's determination of the Provider's direct GME and IME payments was improper because it excluded residents' time spent training at nonhospital sites that met all the statutory and regulatory requirements. The Intermediary's adjustments reducing the Providers' number of resident full-time equivalents used for purposes of Medicare direct GME and IME payments are reversed.

Issue 2- DSH/SSI Percentage Case No. 08-1452

The Board remands the issue to CMS for recalculation of the Provider's DSH payment adjustment consistent with the terms of CMS Ruling CMS-1498-R.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Yvette C. Hayes,
Acting Chairperson

DATE: SEPTEMBER 27, 2011

APPENDIX I

PROVIDER	PROVIDER NO.	COST REPORTING PERIOD ENDED
Borgess Medical Center	23-0117	06/30/2001, 06/30/2002, 06/30/03
Bronson Methodist Hospital	23-0017	12/31/2000, 12/31/2001, 12/31/2002, 12/31/2003, and 12/31/2004