PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2017-D28

PROVIDER –
Valley Hospital Medical Center
Las Vegas, Nevada

Provider No.: 29-0021

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

HEARING DATE –
April 28, 2016

Cost Reporting Period Ended -
December 31, 2006

CASE NO.: 09-0454

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ISSUE STATEMENT

Whether the Medicare Contractor's exclusion of Medicare Advantage/HMO charges and days from the calculation of the direct graduate medical education ("DGME") payment for Valley Hospital Medical Center ("Valley" or "Provider") for its fiscal year ending December 31, 2006 ("FY 2006") was proper.[1]

DECISION

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Provider Reimbursement Review Board ("Board") concludes that the Medicare Contractor improperly excluded Medicare Advantage/HMO charges and days from Valley's DGME payment for FY 2006. Accordingly, consistent with this finding, the Board directs the Medicare Contractor to include the Medicare Advantage/HMO charges and days on Worksheets S-3 and D-4 to reimburse Valley for its reasonable costs for DGME.

INTRODUCTION

Valley is an acute care hospital located in Las Vegas, Nevada that began a new teaching program effective July 1, 2006 at the midpoint of its FY 2006 cost reporting period (*i.e*, prior to July 1, 2006, Valley did not have residents on duty). Valley's designated Medicare contractor[2] is Novitas Solutions, Inc. ("Medicare Contractor").

Valley claimed reimbursement for its direct graduate medical education ("DGME") costs associated with Medicare Part A beneficiaries and Medicare Advantage/HMO enrollees (*i.e.*, those Medicare beneficiaries enrolled in a Medicare Part C managed care plan).[3] At audit, the Medicare Contractor allowed DGME costs associated with Medicare Part A beneficiaries but removed the Medicare Advantage/HMO charges and any corresponding patient days from the DGME calculation through a FY 2006 Notice of Program Reimbursement ("NPR").

Valley timely appealed this decision and met the jurisdictional requirements for a hearing before the Board. The Board held a hearing on the record. Edward A. Moore of Universal Health Services, Inc. represented Valley. Arthur E. Peabody, Jr., Esq. of Blue Cross and Blue Shield Association represented the Medicare Contractor.

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[1] *See* Parties' Stipulations of Fact and Legal Principles (Mar. 11, 2015) ("Parties Stipulations").

[2] Fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs") will be referred to as Medicare contractors.

[3] The Medicare Advantage program, also known as "Medicare Part C," provides an alternative to the traditional Medicare "fee for service" program and allows Medicare beneficiaries to enroll in a health maintenance organization ("HMO"), preferred provider organization ("PPO") or other private managed care plans. If an individual with Medicare enrolls in a Medicare Advantage plan, the Secretary makes payments to the plan instead of making payments to other providers under Parts A or B. *See* 42 U.S.C. §§ 1395w-21–1395w-29.

STATEMENT OF FACTS

Valley began a new teaching program on July 1, 2006, and did not have residents on duty during the first six months of the cost reporting period under appeal. The parties dispute the extent to which the DGME and reasonable cost regulations are to be interpreted and applied to Medicare reimbursement of Valley's DGME costs during the first year of its teaching program (*i.e.,* FY 2006).

The Medicare program pays for DGME costs for the initial fiscal year that a new graduate medical program begins. The Centers for Medicare and Medicaid Services ("CMS") established this policy in 1989 and it is currently codified at 42 C.F.R. § 413.77(e)(1).[4] Prior to 1998, § 413.77(e)(1) clearly applied only to Medicare Part A enrollees because during this time period Medicare made payment to Medicare Advantage[5] plans to cover DGME costs.[6]

However, effective in 1998, Congress changed the way the Medicare program reimburses DGME costs associated with Medicare Advantage enrollees. Specifically, in § 4624 of the Balanced Budget Act ("BBA") of 1997,[7] Congress required the Medicare program to pay hospitals directly for DGME costs associated with Medicare Advantage enrollees. As a result changes were made to Schedule E-3 Part IV of the Medicare cost report to reimburse providers for DGME costs related to Medicare Advantage patients. However, to be reimbursed through Schedule E-3 Part IV the provider must have established a "per resident amount." Before a hospital can establish a per resident amount, the hospital must have one full year of DGME costs which are reported on Schedule E-3, Part IV of the cost report. If a provider does not yet have a per resident amount, its payment is based only on DGME reasonable costs.

In this case, Valley's medical residency program began in July 2006, in the middle of the cost reporting year. As a result, Valley could not establish a twelve-month per resident amount. In order to be paid its reasonable costs for its medical residency program, Valley reported the DGME costs associated with both its traditional Medicare Part A and its Medicare Advantage enrollees on Worksheet D-4 and the number of Part A days and Medicare Advantage days on Worksheet S-3, line 1.[8]

The Medicare Contractor does not believe the provider can combine the Part A and Medicare Advantage days on S-3 and charges on D-4 in order to be paid DGME cost for its Medicare Advantage patients. The Medicare Contractor does not dispute that Congress intended to pay the DGME costs for Medicare Advantage plans, and that CMS made changes to E-3 Part IV of the Medicare cost report to facilitate this payment once a provider has its per resident amount. The

[4] The Secretary codified this policy at 42 C.F.R. § 413.86(e) in 1989 and later redesignated it to § 413.77(e) in 2004. *See* 54 Fed. Reg. 40286, 40310, 40316-40317 (Sept. 29, 1989); 69 Fed. Reg. 48916, 49234-35, 49255-56 (Aug. 11, 2004).

[5] Previously known as Medicare+Choice or M+C plans. In 2003, Congress changed the name of Medicare Part C plans from Medicare+Choice to Medicare Advantage. *See* Medicare Prescription Drug Improvement Act of 2003, Pub. L. No. 108-173, § 201, 117 Stat. 2066, 2176 (Dec. 8, 2003).

[6] *See* H.R. Rep. No. 105-217 at 658 (1997).

[7] Pub. L. No. 105-33, § 4624, 111 Stat. 251, 478-479 (Aug. 5, 1997).

[8] Provider Final Position Paper at 2 and Medicare Contractor Final Position Paper at 5.

Contractor argues that there is no provision to allow Medicare Advantage days and charges to be included in the reasonable cost calculation for this cost reporting period.[9]

The Medicare Contractor believes that paragraph "3" of the Social Security Act § 1886(h) that was amended by the Balanced Budget Act of 1997 specifically addresses the "Hospital Payment Amount per Resident".[10] According to the Medicare Contractor, this section does not apply to a provider with a new program in which residents do not begin their training at the beginning of the cost report year. The Medicare Contractor believes the Social Security Act § 1861(v) would control[11] and would preclude the provider from combining traditional Medicare and Medicare Advantage days and charges on S-3 and D-4 of the Medicare cost report. As a result, the MAC removed the Medicare Advantage days and charges from S-3 and D-4 of Valley's 2006 cost report.[12]

In contrast, Valley seeks to include the inpatient days attributable to Medicare Advantage patients in the calculation of reasonable costs for DGME purposes. Valley argues that, in calculating its DGME reasonable cost reimbursement for FY 2006, the Medicare Contractor improperly excluded the Medicare Advantage data and, in doing so, failed to meet its congressionally mandated obligation to pay for new residency program DGME costs.[13]

DISCUSSION, FINDINGS OF FACTS, AND CONCLUSIONS OF LAW

By enacting BBA § 4624, Congress changed the way that hospitals are reimbursed for DGME costs associated with Medicare Advantage enrollees. Instead of reimbursing the Medicare Advantage plan for these costs, hospitals would now be reimbursed directly by the Medicare program. Congress codified this change at 42 U.S.C. § 1395ww(h)(3)(D) (2006) which is entitled "Payment for managed care enrollees" and states in pertinent part:

> (I) IN GENERAL. For portions of cost reporting periods occurring on or after January 1, 1998, *the Secretary shall provide for an additional payment* amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1395mm of this title and who are entitled to part A of this subchapter or with a Medicare+Choice [*sic* Medicare Advantage] organization under part C of this subchapter.[14]

CMS implemented BBA § 4624 by promulgating 42 C.F.R. § 413.86(d) in August 1997.[15]

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[9] Medicare Contractor Final Position Paper at 5.
[10] Medicare Contractor's Final position Paper at 6.
[11] *Id.*
[12] Medicare Contractor's Final position paper at 5.
[13] Provider Final Position Paper at 3.
[14] (Emphasis added.)
[15] 62 Fed. Reg. 45966, 46007, 46034 (Aug. 29, 1997). In 2004, CMS subsequently removed §413.86 and added and new Subpart F, including §§413.75-413.83. 69 Fed. Reg. 49112, 49254 (Aug. 11, 2004).

While BBA § 4624 does not specifically address how the new DGME payment methodology for Medicare Advantage enrollees applied to new teaching programs, it is clear that it adopts the same reimbursement methodology that is used for the payment of DGME costs associated with Medicare Part A enrollees (but for a 5-year phase in from 1998 to 2002 that is not relevant to this case). Specifically, DGME costs associated with Medicare Advantage enrollees and Medicare Part A enrollees are apportioned based on the "aggregate approved amount" as defined in 42 U.S.C. § 1395ww(h)(3)(B). The "aggregate approved amount" is product of the "per resident amount" (as determined from the base period and updated by the relevant annual update factors) and the weighted average number of full-time-equivalency ("FTE") residents working in the hospital.[16]

It is not surprising then that, in 1997, CMS opted to implement BBA § 4624 by folding it into its then-existing regulations governing DGME reimbursement for Medicare Part A located at 42 C.F.R. § 413.86(d). As a result of these changes, § 413.86(d) (1998) was entitled "Calculating payment of graduate medical education costs" and encompasses *both* DGME costs associated with Medicare Part A beneficiaries and Medicare Advantage enrollees. By its terms, the calculation of DGME costs under subsection (d) (1998) is dependent on the "updated per resident amount" as determined under paragraph [*sic* subsection] (e).

Subsection (e) (1998) specifies how the per resident amount is established during a hospital's base year and subsequently updated. In particular, subsection (e) (1998) specifies that, for any hospital starting a new teaching program after 1985, its per resident amount is established "using information from the first cost reporting period during which the hospital participates in Medicare *and the residents are on duty during the first month of that period*."[17] CMS further specifies that, if a hospital begins its GME program after the first month of the fiscal year, then the hospital is reimbursed for its DGME costs "on a reasonable cost basis" for that first fiscal year and the base year is established using GME cost data from the second fiscal year when there is a full 12-months of such data.[18] As CMS did not qualify this exception to apply only to DGME costs associated with Medicare Part A beneficiaries when CMS added the Medicare Advantage-related cost reimbursement to subsection (d) in 1997,[19] the Board must conclude that the subsection (e) exception also applied to DGME costs associated with Medicare Advantage

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[16] Specifically, 42 U.S.C. § 1395ww(h)(3)(B) (2006) states:

> As used in Subparagraph (A), the term "aggregate approved amount" means, for a hospital cost reporting period, the product of—
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> (i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and
>
> (ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training program in that period.
>
> The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) of this section for residents included in the hospital's count of full-time equivalent residents.

[17] (Emphasis added.)

[18] *See* 54 Fed. Reg. 40286, 40310 (Sept. 29, 1989).

[19] Indeed, as part of the same 1997 final rule, CMS made unrelated changes to § 413.86(e) but did not make any changes to suggest that the exception only applied to Medicare Part A beneficiaries. *See* 62 Fed. Reg. at 46003-46004, 46007.

enrollees. Indeed, the Board's conclusion is consistent with the following rationale that CMS used to justify its creation of this exception in 1989:

> We believe that the commenters have raised some very valid points about *new GME programs* in that all elements of the program do not fall into place at the same time. Further, *we believe that the applicable provision of section 1886(h) of the Act did not envision a situation in which a hospital's GME program began on July 1 of a given year, while the hospital's cost reporting period began on some other date, such as October 1 or January 1*. In such a situation, the first year of the program would not be reflective of the costs of the program since residents might be on duty and receiving a salary during as few as one or two months of the cost reporting period. Further, a strict application of the law would preclude any recognition of start-up costs incurred in a cost reporting period before the arrival of residents since the counting of residents in the program is the payment vehicle for GME costs. On the other hand, ongoing GME programs often undergo changes with additions and reductions of staff and facilities. There will be many situations in which a hospital's GME payments under the provisions of section 1886(h) of the Act may fall short of a hospital's actual GME costs during a particular cost reporting period. We believe that it is implicit in the revised payment method that Congress intended that no special adjustments be made if this should happen.
>
> However, *we believe that instances in which a hospital begins a GME program for the first time after the GME base period will be rare, and we wish to* ***reach a reasonable accommodation*** *as to the per resident amounts payable to these hospitals*. Accordingly, we are modifying § 413.86(e)(4) (proposed § 413.86(c)(5)) to provide that the base period for determining per resident amounts in hospitals that begin a GME program after the base period will be the first cost reporting period in which residents were on duty in their GME program during the first month of the cost reporting period. *Any GME costs incurred for the prior cost reporting period will be made on a reasonable cost basis under section 1861(v) of the Act* as was the case for cost reporting periods beginning prior to July 1, 1985. We agree that basing payments on an unrepresentative base period could have an adverse effect on a hospital; however, we are also bound by the statutory language of section 1886(h)(2)(E) of the Act, which deals with hospitals that start a GME program only after 1984. We believe that the modifications we are making in § 413.86(e)(4) of the proposed rule represent *a reasonable compromise between these two conflicting objectives but are also consistent with the statutory language*.[20]

As noted, although CMS relocated the regulations governing DGME reimbursement and the per-resident amount from 42 C.F.R. §§ 413.86(d) and 413.86(e) to 42 C.F.R. § 413.76 and 413.77 respectively, it made no substantive changes to these regulations.[21]

Based on the above, the Board concludes that, consistent with 42 C.F.R. § 413.77(e)(1), Medicare Advantage enrollees must be included in calculating the reasonable costs under 42

[20] 54 Fed. Reg. at 40310.
[21] *See* 69 Fed. Reg. 48916, 49234, 49255-49256 (Aug. 11, 2004).

U.S.C. § 1395x (v)(1(A). This outcome is consistent with the intent of Congress in BBA § 4624 that "the Secretary shall provide for an additional payment" for the DGME costs associated with Medicare Advantage enrollees. Indeed, to make no payment for DGME costs associated with Medicare Advantage/HMO enrollees (as advocated by the Medicare Contractor) would contravene this directive. Therefore, the Board concludes that combining the Medicare traditional and Medicare Advantage/HMO days on S-3 and charges on D-4 was reasonable in order to reimburse Valley for DGME costs for its Medicare Advantage/HMO patients for FY 2006.[22]

DECISION AND ORDER

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board concludes that the Medicare Contractor improperly excluded Medicare Advantage/HMO charges and days from Valley's DGME payment for FY 2006. Accordingly, consistent with this finding, the Board directs the Medicare Contractor to include the Medicare Advantage/HMO charges and days on Worksheets S-3 and D-4 to reimburse the Provider for its reasonable costs for DGME.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: September 19, 2017

[22] It should be noted that Valley did not have other cost-based programs such as nursing, allied health or organ acquisition costs which may have been overstated by combining Medicare Part A and Medicare Advantage days on Worksheets S-3 and D-4.