# CENTERS FOR MEDICARE AND MEDICAID SERVICES

## *Decision of the Administrator*

| In the case of: | Claim for: |
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| **Methodist Hospitals of Memphis**<br><br>**Provider**<br><br>**vs.**<br><br>**Blue Cross Blue Shield Association/ TriSpan Health Services**<br><br>**Intermediary** | **Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 12/31/1995; 12/31/1996; 12/31/1997; 12/31/1998 12/31/1999**<br><br>**Review of:**<br><br>**PRRB Dec. No. 2007-D50**<br>**Dated: July 19, 2007** |

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The Provider submitted comments requesting affirmation of the Board's decision. The CMS' Center for Medicare Management (CMM) submitted comments requesting reversal of the Board's decision. Accordingly, this case is now before the Administrator for final administrative review.

## ISSUE AND BOARD DECISION

The issue before the Board was whether the Intermediary's adjustment to the Provider's graduate medical education (GME) per resident amount (PRA) was proper. The Board noted that the handling of a PRA for two teaching hospitals that merge is not explicitly addressed in the statute or the regulations. However, the Board explained that the controlling regulation is 42 C.F.R. §413.86. The Board further explained that 42 C.F.R. §413.86(e)(4) identified exceptions to the above provision which establishes a hospital's base year PRA. The Board noted that, while

it is foreseeable that there may be many changes for a provider once a PRA is established, the regulation does not allow for any other modification to the PRA.

The Board found that, after the merger of the Provider and LeBonheur, LeBonhuer ceased to exist and the only "hospital" that remained was Methodist. The Board noted that the exception provisions of 42 C.F.R. §413.86(e)(4) do not address the factual situation in this case and, therefore, concluded that 42 C.F.R. §413.86(e)(1)(i)(B) controlled. That regulation prescribed how the Provider's PRA is to be computed by dividing the costs by the average number of FTE residents of "the hospital." The only surviving hospital was Methodist, the Provider. Nevertheless, the Board concluded that, even if it were to find the averaging of the two PRAs to be appropriate, the methodology utilized by the Intermediary did not accurately and separately accumulate FTEs by facility location. This methodology negates the rationale for creating a weighted average PRA. Thus, the Board found the Intermediary's adjustment to the PRA for the Provider was improper.

## SUMMARY OF COMMENTS

The Provider commented that the Board correctly found that the Intermediary's adjustment of the Provider's GME PRA amount was improper. Specifically, the Provider argued that the Intermediary's use of a weighted average PRA, after the Provider's merger with LeBonheur, was incorrect. The pre-merger PRA of the Provider, the surviving entity, should have been used. The Provider agreed with the Board's reasoning, as the controlling regulation at 42 C.F.R. §413.86(e)(1) provides that a base period PRA must be established for each "hospital." After the merger, the only "hospital" that still existed was the Provider. The Provider contended that, using the weighted average PRA, rather than the Provider's pre-merger PRA, was an improper policy for the following reasons: it was contrary to the Medicare statute and regulations; it violated APA notice and comment rulemaking requirements; it was inconsistent with general CMS policy regarding changes in ownership; the Provider did not have notice of the weighted average methodology; and it cannot be applied retroactively. Accordingly, the Provider requested that the Board's decision be affirmed.

CMM commented that CMS policy has always been that, when two or more teaching hospitals merge, a weighted average PRA is determined for the surviving merged hospital using direct GME costs and resident data from the base year cost report for each teaching hospital involved in the merger. CMM also noted that in the May 12, 1998 Federal Register (63 Fed. Reg. 26239), it was emphasized that the methodology to determine a weighted average PRA for merged hospitals was not a new policy but a restatement of existing CMS policy. CMM argued that this is an equitable way to determine a PRA for the surviving merged hospital, because it is

based on the relative costs and sizes of the GME training programs in the respective facilities.

CMM disagreed with the Board's finding that, after the merger of Methodist Healthcare of Memphis and LeBonheur, LeBonheur ceased to exist, and the only "hospital" that remains is Methodist. CMM argued that the hospital was not the same entity, after October 1995. The hospital that is Methodist Hospitals after October 1995 is actually a merger of two hospitals for which two PRAs had been determined in the base year.

CMM also noted that the approach of determining a "weighted average" in the case of mergers is not unique to determining PRAs and has been used in other comparable situations. CMM contended that the policy used to calculate a weighted average PRA for the surviving merged hospital is also consistent with the policy allowing teaching hospitals to combine their FTE residents for GME and indirect medical education (IME) adjustment payment. CMM concluded that the policy for using weighted average PRAs for merged hospitals is an appropriate and well-established policy, and it disagreed with the Board's conclusion that the regulations do not allow for any other modification to the PRA that is not expressly specified at 42 C.F.R. §413.86(e)(recodified at 42 C.F.R. §413.77(e)(2004).

## DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. Comments timely submitted have been included in the record and have been considered.

Until 1983, Medicare paid for covered hospital inpatient services on the basis of "reasonable cost." Section 1861(v)(1)(A) of the Act defines "reasonable cost" as "the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." While §1861(v)(1)(A) does not prescribe specific procedures for calculating reasonable cost, it authorizes the Secretary to promulgate regulations setting forth the methods to determine reasonable cost and the items to be included in reimbursable services.

In addition, Medicare historically has paid a share of the net costs of "approved medical education activities" under the reasonable cost provisions.[1] The Secretary's regulations define approved educational activities as formally organized or planned programs of study, usually engaged in by providers to enhance the quality of care in

[1] 20 C.F.R. §405.421 (1966); 42 C.F.R. §405.421 (1977); 42 C.F.R. §413.85 (1986).

an institution.[2] The activities include approved training programs for physicians, nurses and certain paramedical health professionals. Under the reasonable cost system, the allowable costs of the activities included: the direct costs of salaries and fringe benefits of interns and residents, the salaries attributable to teaching physicians' supervisory time, other teachers' salaries; and indirect or institutional overhead costs, including employee health and welfare benefits, that were appropriately allocated to the proper cost center on a provider's Medicare cost report.[3]

In 1982, Congress modified the Medicare program to provide hospitals with better incentives to render services more efficiently. Pursuant to the Tax Equity and Fiscal Responsibility Act (TEFRA),[4] Congress amended the Act by imposing a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. Payments made pursuant to the TEFRA ceiling on the rate-of-increase are determined based upon the target amount which is derived from the hospital's allowable net Medicare operating costs[5] in the hospital's base year. However, under § 1886(a)(4), GME costs were excluded from the definition of inpatient operating costs for purposes of the TEFRA base year and, thus, were not included in the hospital's TEFRA base year costs for purposes of determining the hospital's target amount.

In 1983, § 1886(d) was added to the statute to establish an inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital services furnished to Medicare beneficiaries.[6] Under IPPS, providers are reimbursed their inpatient operating costs based on prospectively determined national and regional rates for each patient discharge, rather than on the basis of reasonableness. Graduate medical education costs continued to be paid on a reasonable cost "pass-through."

However, applicable for all periods beginning on, or after, July 1, 1985, pursuant to §1886(h) of the Act,[7] Congress established a new payment policy for direct GME costs. Section 1886(h)(2)(A) of the Act provides that:

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[2] 42 C.F.R. §413.85(b).
[3] 54 Fed. Reg. 40286 (Sept. 27, 1989).
[4] Pub. L. 97-248.
[5] "Operating costs" are defined in § 1886(a)(4) of the Act as including: "all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services."
[6] Section 601(e) of the Social Security Amendments of 1983. Pub. L. No. 98-21 (1983).
[7] Section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

> The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this title for direct graduate medical education costs of the hospital for each full-time equivalent resident.

As a result of the legislative change, the Secretary established a new payment policy for direct GME costs for all periods beginning on, or after, July 1, 1985.[8] To implement the new payment policy, the Secretary promulgated regulations at 42 C.F.R. §413.86, et seq.

The regulation at 42 C.F.R. §413.86 (e)(1)(i) (1995) specifically states that to determine a base-period average PRA for each hospital, an intermediary must:

> (A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, graduate medical education costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and graduate medical education costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.
> (B) Divide the costs calculated in paragraph (e)(1)(i)(A) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (e)(1)(i)(A) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

Pursuant to 42 C.F.R. §413.86 (e)(1)(ii) in determining the base-period per resident amount under (e)(1)(i) of this section, the intermediary:

> (A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

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[8] 54 Fed. Reg. at 40297. (Revised payment method applies to all hospitals regardless of status under PPS.) See 50 Fed. Reg. 27722 (July 1985)(Final rule that hospitals would be reimbursed lesser of allowable costs for current year or hospitals' approved GME costs incurred during 1984 FY; nullified by Section 1861(v)(1)(Q) pursuant to Section 9202 of COBRA 1985). Section 9314 of Omnibus Budget Reconciliation Act of 1986 (Pub. Law 99-509) added Section 1886(h)(4)(E).

(B) Excludes from the base-period graduate medical education costs any nonallowable or misclassified costs, including those previously allowed under §412.113(b)(3); and
(C) Upon the hospital's request, includes graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under §412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(2) of this section.

To ensure that the average per resident amount (APRA) would accurately reflect legitimate GME costs incurred during the base period, 42 C.F.R. §413.86(e)(1) authorized intermediaries to re-audit and verify providers' base year cost reports; exclude non-allowable costs; and, to include GME costs that were misclassified as operating costs in the GME base period. The regulation further instructed intermediaries to issue a notice of average per resident amount (NAPRA) to each provider after completing the re-audit of the base year.

In October of 1995, Methodist Healthcare of Memphis merged with LeBonheur Children's Medical Center (LeBonheur). Both hospitals operated distinct GME programs prior to the merger. However, after the merger, the provider number for LeBonheur was terminated and the provider number of Methodist Healthcare was retained. The merged facilities were certified as a single provider called Methodist Hospitals of Memphis, the Provider in this case. During the audit of the Provider's fiscal year 1995 cost report, the Intermediary calculated the Provider's Medicare GME payment by using a weighted per resident amount (PRA) based on the two different GME PRAs for the respective pre-merger hospitals. The Provider argued that the pre-merger PRA for Methodist Hospitals should be based on the PRA of the former pre-merger Methodist Healthcare only for all of the FTEs located on both campuses.

The Administrator finds that the policy applied in this case was detailed in Questions and Answers on Medicare GME payments issued on November 8, 1990, which stated that "[when] two hospitals merge and file one cost report … the merged hospital's per resident amount would be based on the weighted average of the per resident amount of both hospitals. Weights are applied based upon the numbers of FTE residents in each hospital…" As reflected in this agency issuance, this policy was implemented prior to the two facilities merger in this case and as indicated below, was consistently applied for all the years following.

The policy was further discussed in the preamble of the final rule published May 12, 1998 in the Federal Register.[9] The preamble specifically stated that:

> In implementing the COBRA 1985 provision establishing a hospital-specific per resident amount in the situation of a merger, we have calculated the revised per resident amount for the merged hospital using an FTE weighted average of each of the respective hospital's per resident amount which is part of the merger.[10]

Furthermore, the rationale for the historical policy was reiterated, as recently as the inpatient prospective payment system final rule published August 18, 2006, in the Federal Register.[11] The Secretary noted that it is not appropriate to provide a merged hospital the option of adopting the surviving hospital's PRA, instead of the average weighted PRA. Adopting the surviving hospital's PRA would ignore the fact that the merger is a result of multiple hospitals with pre-existing and statutorily established PRAs joining together and could inappropriately provide an incentive to choose the surviving hospital based on which surviving hospital's PRA would yield the highest reimbursement.[12]

The Administrator finds that calculating a weighted average PRA for the surviving merged entity is not an attempt to re-determine a new PRA as the Board suggests. Rather, this policy is an accurate adjustment to account for the fact that the Provider is comprised of two merged hospitals with two statutorily determined PRAs as established in accordance with the law. Specifically, a weighted average PRA was required in order to reflect the fact that the Provider was comprised of the two campuses of two teaching hospitals that had established PRAs (reflecting their respective base year costs and FTEs prior to the merger). The weighted average PRA is calculated by adding the product of each hospital's base year PRA and its base year FTE resident count divided by the total number of the base year FTE residents for those hospitals.[13] The PRAs are then updated using the CPI-U inflation factor to coincide with the fiscal year end of the surviving teaching hospital. The Administrator finds that it is appropriate that the FTEs of each of the hospitals

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[9] 63 Fed. Reg. 26239 (May 12, 1998).

[10] 63 Fed. Reg. at 26318. The preamble noted that this method of handling the per resident amount for merged facilities set the precedent for determining the FTE cap for merged hospitals.

[11] 71 Fed. Reg. at 47870 (August 18, 2006).

[12] 71 Fed. Reg. at 48076.

[13] For example, the calculation may look like the following for merged Hospitals A and B: Adjusted PRA = (PRA (A) x FTE (A)/ FTE A+B) ) + (PRA (B) x FTE (B) / FTE (A+B) )

should be counted and used to weigh the combined average PRA. After the merger, the FTE residents on both campuses are counted and paid under the weighted average PRA on the same cost report filed by the surviving entity.

The Administrator finds that the weighing of the PRA to reflect the merger of the two hospitals is consistent with Section 1886(d) of the Act and the regulation at 42 C.F.R 413.86(e). The weighing of the established PRAs of the hospitals involved in the merger which were developed from the respective GME base years is a reasonable application of the regulation and statute to the circumstances at hand. That is, the weighing of the FTEs reflects the statutorily established GME base year costs and FTEs for the two entities (and two campuses) that now comprise the surviving entity. In addition, this policy is reasonable as it ensures that, where there is a merger, neither the hospital, nor the Medicare program, will receive a windfall or be penalized, depending upon the assignment of the provider number and, thus, makes the assignment of the provider agreement and choice of the surviving entity payment neutral with respect to the PRA.

Accordingly, the Administrator finds that the Intermediary properly determined that as a result of the merger, the Provider's PRA should be based on the weighted average of the PRA of both hospitals. Thus, the Administrator reverses the Board's decision and upholds the Intermediary's calculation of the Provider's PRA for purposes of the GME payment.

## DECISION

The Administrator reverses the decision of the Board in accordance with the foregoing opinion.

**THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES**

Date: 9/17/07 /s/

Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services