PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD

99-D63

PROVIDER -
The Ohio State University Hospital
Columbus, Ohio

Provider No. 36-0085

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association /
AdminaStar Federal

DATE OF HEARING-
June 3, 1999

Cost Reporting Period Ended -
June 30, 1992

CASE NO. 94-3180

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ISSUE:

Was the Intermediary's adjustment to the outlier payments proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Ohio State University Hospitals ("Provider") is a not-for-profit, acute care teaching hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations. It provides Medicare services under the Federal Health Insurance for the Aged and Disabled Act. The Provider filed a Medicare cost report for its fiscal year ended June 30, 1992 ("FYE 92") in which it claimed reimbursement for its outlier costs based upon the Provider Statistical and Reimbursement System ("PS&R") reports for the Provider.[1] AdminaStar Federal ("Intermediary") audited the cost report and issued a Notice of Program Reimbursement ("NPR") on February 28, 1994.[2] The NPR contained numerous adjustments to the PS&R including an adjustment to the outlier payments.

On August 16, 1994, the Provider appealed the Intermediary's adjustments to its cost report to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§405.1835-.1841. On April 15, 1998, the Provider amended its list of issues in accordance with 42 C.F.R. §405.1835 (sic) disputing the adjustment to its outlier payments. Except for adjustment number 94 pertaining to the outlier payment, the Provider and Intermediary have tentatively reached agreement on the list of issues previously submitted in this matter subject to the Provider receiving the agreed upon payments.

The Provider disputes the outlier payments as calculated by the Intermediary because they did not result in an aggregate national outlier payment of at least five percent of total Prospective Payment System ("PPS") payment as required by Medicare. Moreover, because of the underpayment of the outlier payments for Provider's FYE 92, the amount of the indirect medical education payments and disproportionate share payments were also understated. The Provider is represented by David C. Levine, Esquire, of Baker & Hostetler, LLP. The Intermediary is represented by Bernard M.Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that in order to protect hospitals and Medicare patients against the potentially harsh incentives imposed under PPS, Congress provided for additional payments for outlier cases. 42 U.S.C. §1395ww(d)(5)(A). Under the outlier payment provisions adopted by Congress, the Secretary of the United States Department of Health and Human Services ("Secretary") is required for each

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[1] See Provider Exhibit 1.

[2] See Provider Exhibit 2.

federal fiscal year to establish thresholds for determining the point at which a specific case qualifies for an additional outlier payment due to an unusual length of stay or extraordinary cost. 42 U.S.C. § 1395ww(d)(5)(A)(I)-(ii). The statute specifically requires:

> The total amount of the additional payments for discharges in a [f]iscal year may not be less than five percent (5%) nor more than six percent (6%) of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

42 U.S.C. §1395ww(d)(5)(A)(iv).

To comply with the statute, each fiscal year the Secretary sets the outlier threshold level which she estimates will result in outlier payments being five to six percent of total Medicare payments projected to be made that fiscal year. In fiscal years 1991 and 1992, the outlier threshold were set at the level which the Secretary projected would result in outlier payments representing 5.1%. 55 Fed. Reg. 35990 (1990) (sic). However, in fiscal years 1991 and 1992, actual outlier payments were less than 5% of the total DRG respective payments. The Provider argues that it is entitled to additional outlier payments for its FYE 92 because the statute states that the actual outlier payments for a fiscal year must represent no less than five percent nor more than six percent of estimated total Medicare payments for discharges in that year.

The Provider notes that the Secretary publicly acknowledged the shortfalls in the required outlier payments for these years. 57 Fed. Reg. 23645 (1993). The actual outlier percentage for fiscal year 1991 was 4.24%. 57 Fed. Reg. 39746 (1992). This shortfall resulted in outlier underpayments equal to 17.9% of the actual outlier payments made to the Provider. In addition, the Health Care Financing Administration ("HCFA") anticipated that fiscal year 1992 outlier payments would be less than the 5. 1 % that HCFA estimated when the outlier threshold was set. However, HCFA chose not to revise the outlier pool of thresholds to reflect the estimated outlier shortfall. HCFA later estimated that the actual fiscal year 1992 outlier payments would be approximately 3.6% of fiscal year 1992 total DRG payments. 58 Fed. Reg. 46347 (1994). As a result of the shortfalls, a significant amount of the outlier pool that was set aside as a result of the reduction in the average PPS rate was not paid to providers but was instead retained by the Medicare program. The latter shortfall resulted in outlier underpayments equal to 38.9% of the actual outlier payments made to the Provider.

The Provider observes that a U.S. District Court case provides additional authority to support the Provider's position that 42 U.S.C. §1395ww(d)(5)(A)(iv) requires that the total outlier payments made in a particular year fall between five and six percent of the total payments projected or estimated to be made for discharges in that year. In County of Los Angeles, et al v. Donna E. Shalala, Secretary of Health and Human Services, the U.S. District Court for the District of Columbia, No. 93-146, January 20, 1998 ("County of Los Angeles"), ruled in favor of the provider as follows:

> Underpayment to the Provider..... The language of 42 U.S.C. §1395ww(d)(5)(A)(iv) clearly requires that the total outlier payments

made in a particular year fall between five and six percent of the total payments projected or estimated to be made for discharges in that year. The Secretary, therefore, violated her statutory duty in years in which the total outlier payments made did not fall within the mandated range and in which she refused to make retroactive payments to comply with the statute ... Because the language of the statute is unambiguous, the court need not address the reasonableness of the Secretary's interpretation under the second step of Chevron or the statute's legislative history. Those issues are relevant only if the statue is not clear on its face ... The court ordered that the Secretary ... ensure that the actual outlier payments made for a federal fiscal year are not less than 5 percent or more than 6 percent of the estimate or projection of total DRG payments for that year. If they are not, the Secretary must make appropriate retroactive adjustments to the outlier payments for that fiscal year.

Calculation of the Underpayment. In the judgment entered April 30, 1998, the Secretary is required to compute retroactive adjustments consisting of the following:

(a) for each plaintiff provider ... an additional payment amount equal to 66.7% of the actual amount of outlier payments made to each plaintiff provider pursuant to 42 U.S.C. §1395ww(d)(5)(A) for discharges which occurred during the portion of each such hospital cost reporting period falling within federal-al fiscal year 1985;

(b) for each plaintiff provider ... an additional payment amount equal to 13.6% of the actual amount of outlier payments made to each plaintiff provider pursuant to 42 U.S.C. §1395ww(d)(5)(A) for discharges which occurred during the portion of each such hospital cost reporting period failing within federal fiscal year 1986; and

(c) an adjustment to indirect medical education payments made pursuant to 42 U.S.C. §1395ww(d)(5)(B) and disproportionate share payments made pursuant to 42 U.S.C. §1395ww(d)(5)(F) based on the additional outlier payments made pursuant to (a) and (b) above.

In lieu of computing the actual amount of outlier payments made for discharges during the periods described in paragraphs (a) and (b), the Secretary may compute an estimate of such payments utilizing such data as may be available. Payment of retroactive adjustments, along with interest as required by 42 U.S.C. §1395oo shall be made to the

> provider in accordance with the parties stipulation dated April 20, 1998.

Id.

In summary, the Provider received final payment for outlier cases for its fiscal year ending June 30, 1992, on the basis of the threshold established by the Secretary. If the Secretary had adjusted the outlier thresholds so that total outlier payments made in fiscal years 1991 and 1992 were between five and six percent of the total payments projected or estimated to be made for discharges in those years, the Provider would have received substantially more in outlier payments.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that each year the Secretary establishes thresholds for determining when a specific case qualifies as an outlier. 42 U.S.C. 1395ww(d)(5)(A)(i)(ii). The statute further provides that the outlier payment shall approximate the marginal cost of care beyond the thresholds. The implementing regulations related to outlier payments are located at 42 C.F.R. §§412.80, 412.84, and 412.86. These regulations require HCFA to provide for additional payment approximating a provider's marginal cost of care beyond thresholds specified by HCFA.

The Intermediary contends that it reimbursed the Provider's outlier cases in accordance with the aforementioned regulations. The outlier payments were properly summarized in the PS&R used to settle the Provider's Medicare cost report. Using these reports for cost reporting purposes is in accordance with HCFA Pub. 13-2, §§2241, 2242, & 2243.

HCFA Pub. 13-2, §2242 states in part:

> Provider Summary Report. -Use information about charges, Medicare patient days, coinsurance days, etc., from the provider summary report in the cost settlement process unless the provider furnishes proof that inaccuracies exist.

Id.

The Provider is not disputing the accuracy of the PS&R but is disputing an issue which is related to HCFA policy. Because HCFA sets the thresholds for outlier payments annually in accordance with the regulations at 42 C.F.R. §412. 80, the revision of the thresholds is beyond the authority of the Intermediary. Finally, the Intermediary contends that the Board must comply with the provisions of 42 C.F.R. §405.1867, which states:

> In exercising its authority to conduct the hearings described herein, the Board must comply with all the provisions of title XVIII of the Act and

> regulations issued thereunder, as well as HCFA Rulings issued under the authority of the Administrator of the Health Care Financing Administration (see §405. 1801 (sic) of this subchapter). The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by HCFA.

Id.

The Intermediary asserts that the thresholds for outlier payments are set annually by HCFA. The revision of these thresholds is beyond the authority of intermediaries. Pending HCFA amending its determination of the outlier thresholds, the Intermediary requests the Board to affirm its adjustment.

CITATION OF PROGRAM LAWS, REGULATIONS AND INSTRUCTIONS:

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

§ 1395oo	-	Board Jurisdiction
§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395ww(d)(5), et al	-	Inpatient Hospital Service Payments on Basis of Prospective Rates

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

§ 405.1801	-	Introduction
§ 405.1835	-	Right to a Board Hearing
§§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1867	-	Sources of Board's Authority
§ 412.80	-	General Provisions
§ 412.84	-	Payment for Extraordinary High-Cost Cases (Cost Outliers)
§ 412.86	-	Payment for Extraordinary High-Cost Day Outlier Cases

3. Program Instructions --Intermediary Manual (HCFA Pub. 13-2):

§ 2241	-	Provider Statistical and Reimbursement System
§ 2242	-	Intermediary Use of PS & R System Reports In Cost Settlement Process
§ 2243	-	Description of Reports Available for Standard PS & R System

4. Cases:

County of Los Angeles, et al v. Donna E. Shalala, Secretary of Health and Human Services, the U.S. District Court for the District of Columbia, No. 93-146, January 20, 1998.

5. Federal Register

55 Fed. Reg.

¶ 35990	-	FY 1991 Outlier Payments

57 Fed. Reg.

¶ 23645	-	FY 1992 Outlier Payments
¶ 39746	-	FY 1993 Outlier Payments

58 Fed. Reg.

¶ 46347	-	FY 1994 Outlier Payments

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The majority of the Board ("majority"), after considering the law, regulations, program instructions, facts, evidence and parties' contentions finds that the Intermediary properly followed the regulation at 42 C.F.R. § 412.80 and used the outlier rates published by HCFA in the appropriate Federal Registers. Since the Board is bound by the law and regulations, the majority finds for the Intermediary.

The majority does note that the Federal statute at 42 U.S.C. § 1395ww(d)(5)(A)(i)-(e) established a minimum payment of five percent of DRGs as the outlier threshold. It notes that the Secretary acknowledged that the outlier payments were below the statutory limit in the Federal Register at 57 Fed. Reg. 23645 (1992). Finally, the majority acknowledges the reasoning and analysis in the County of Los Angeles United States District Court decision which decided that the regulation application with

its resulting outlier rate specifically conflicted with the statute "on its face." However, the Board, as noted above, is limited to both the law and regulations and must therefore rule in the Intermediary's favor.

DECISION AND ORDER:

The Intermediary properly applied the outlier regulation at 42 C.F.R. § 412.80. Its adjustments are sustained.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire (dissenting)
Charles R. Barker

Date of Decision: August 24, 1999

For The Board

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover, Jr.

I respectfully dissent:

The Board majority findings included a finding that the Board is bound by the law and regulations. The Board majority applied the regulation at 42 C.F.R. § 412.80 and sustained the Intermediary's adjustment.

The law at 42 U.S.C. 1395ww(d)(5)(A)(iv) requires that the total outlier payments made in a particular year fall between five and six percent of the total payments projected or estimated to be made for discharges in that year. The Provider contends that for the fiscal year 92, it was underpaid since actual outlier payments were less than 5%.

It is my opinion that the law should be applied rather than the regulation; therefore, the Intermediary's adjustment should be reversed.

Martin W. Hoover, Jr., Esquire