PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
99-D40

PROVIDER -
Doctor's Hospital Medical Center
Colorado Springs, Colorado

Provider No. 06-0098

vs.

INTERMEDIARY -Blue Cross of Texas

DATE OF HEARING-
March 3, 1999

Cost Reporting Period Ended -
December 31, 1984 &
December 31, 1985

CASE NO. 88-0373

INDEX

ISSUE:

Was the DRG amount, other than outlier payments, calculated correctly under Medicare law and PPS regulations?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case is comprised of two appeals that were originally filed separately. One appeal, designated as CN:88-0450, pertained to the Provider's 1984 cost reporting period, and the other, with the present designation of CN:88-0373, pertained to the Provider's 1985 cost reporting period. These two appeals were consolidated under the present case designation since the issue to be decided is fundamental to both periods. However, references contained herein are made to evidence submitted in each of the initial, individually filed appeals as it is pertinent to the case.

Doctor's Hospital Medical Center ("Provider") is a 122-bed acute care facility located in Colorado Springs, Colorado. As such, the Provider is reimbursed under Medicare's prospective payment system ("PPS") for inpatient hospital services.

The Provider's base period under PPS was its cost reporting period July 1, 1982 through June 30, 1983, and its first cost reporting period under PPS began on July 1, 1984. During it's first year under PPS, on August 14, 1984, the Provider was acquired by a new owner. Along with the change of ownership the Provider changed its cost reporting year end from June 30 to December 31. Therefore, two short period cost reports were filed within the Provider's first six months under PPS reimbursement, one for the period July 1, 1984 to August 13, 1984, under the prior ownership, and the other from August 14, 1984 to December 31, 1984, under the new ownership.[1]

New Mexico Blue Cross and Blue Shield ("Intermediary") audited the Provider's cost report for its reporting period ended December 31, 1984, and made an adjustment to the Provider's diagnostic related group ("DRG") amount. Specifically, the Intermediary updated the PPS payment rate for inflation using an adjustment factor of 1.08648. Because the cost reporting period was less than twelve months, the Intermediary could not use the update factor published in the Federal Register. Therefore, the Intermediary obtained the update factor from the Health Care Financing Administration ("HCFA") in accordance with program instructions.[2]

On July 27, 1987, the Intermediary issued a Notice of Program Reimbursement ("NPR") for the Provider's cost reporting period ended December 31, 1984, which reflected the

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[1] Provider Position Paper, CN:88-0450, at 1.

[2] Id.

application of the 1.08648 update factor. On January 20, 1988, the Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. § § 405. 1835-.1841, and met the jurisdictional requirements of those regulations.[3] The amount of Medicare reimbursement in controversy is approximately $63, 915.[4]

Also, since the DRG rate is adjusted every year, the Provider appealed the Intermediary's determination of its DRG amount in the 1985 cost reporting period as it considers the base period update to be incorrect. The pertinent NPR for this reporting period was issued on July 2, 1987, and the Provider's appeal was timely filed on December 29, 1987.[5] The estimated amount of program reimbursement in controversy for the Provider's 1985 cost reporting period is $200,000.[6]

The Provider was represented by Steve Dominguez, Vice President, Tenet Healthcare Corporation. The Intermediary was represented by Bernard M. Talbert, Associate Counsel, Blue Cross and Blue Shield Association.[7]

PROVIDER'S CONTENTIONS:

The Provider contends that the update factor of 1.08648 used by the Intermediary is improper. It was calculated by compounding the monthly target rate percentage over an 18 month period rather than an average period of 21.78 months. The 18 month period reflects the time that elapsed between the end of the Provider's PPS base period, June 30, 1983, and the end of its cost reporting period of December 31, 1984. The 21.78 month period reflects the time that elapsed between the midpoint of the Provider's PPS base period, July 1, 1982 through June 30, 1983, and the midpoint of the subject cost reporting period of August 14, 1984 through

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3 Intermediary's Position Paper, CN:88-0450, at 1.

4 Provider Position Paper, CN:88-0450, at 1. See Footnote 7 below regarding Amount in Controversy.

5 Intermediary's Position Paper, CN:88-0373, at 1.

6 Provider Position Paper, CN:88-0373, at Issue C.

7 The Board notes that the current intermediary is Blue Cross of Texas. Also, the amount of program funds in controversy for both cost reporting periods at issue are considered overstated; their estimates include the Provider's challenge to the treatment of malpractice insurance costs which had subsequently been resolved.

December 31, 1984. By compounding the monthly target rate percentage over the average monthly period of 21.78 months the update factor increases to 1.109558.[8]

The Provider contends that the purpose of applying the initial PPS update factor to the base period cost per discharge is to recognize the allowable rate of increase in a provider's costs between its base period and its first PPS year. Following the intent of the enabling statute, the only proper application of the initial PPS update factor is one which recognizes actual time elapsed between the date when the average monthly cost was incurred in the base period and the date when the average monthly cost was incurred during the PPS reporting period. Moreover, the average monthly cost occurs at the midpoint of a hospital's cost reporting periods.[9]

The Provider explains that 42 U.S.C. § 1395ww(d)(2)(B) requires the PPS rate to be updated for fiscal year 1984 by: "(ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1984." Id. And, since subsection (b)(3)(B) defines the applicable percentage increase for purposes of the rate of increase ceiling, the Provider concludes that the pertinent statute requires the calculation of the PPS update factor to be governed by the methodology established for the rate of increase ceiling.[10]

In this regard, the Provider explains that 42 C.F.R. § 405.463, which implements the target rate of increase ceiling, does not specifically address the methodology used to determine the percentage increases applied to particular hospitals, except to indicate that such increases will be based on the annual market basket percentage and will be prorated for fiscal years which span two calendar years. 42 C.F.R. § 405.463(c) (5). The preamble to the notice in the Federal Register which established 42 C.F.R. § 405.463 also does not contain a detailed discussion of the methodology to use. However, the notice does incorporate by reference the methodology used to update the case-mix adjusted cost per discharge limits ("cost limits") which replaced the routine cost limits in 1982. Referring to the update factors for the rate of increase ceiling, the notice states: "the case mix adjusted limits established under 1886(a) [42 U.S.C. § 1395 ww(a)] must also use such an increased percentage. We will use the same data, methodology, and adjustment factors for both purposes." 47 Fed. Reg. 43282 at 43287 (September 30, 1982).[11] Thus, the Provider maintains that the rules for calculating the appropriate update factor to be used in this case are actually those rules that were established for updating the cost limits.

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[8] Provider Position Paper, CN:88-0450, at 3 and 9, and Exhibits 4 and 11.

[9] Provider Position Paper, CN:88-0450, at 3.

[10] Provider Position Paper, CN:88-0450, at 6.

[11] Provider Position Paper, CN:88-0450, at Exhibit 9.

Respectively, the Provider explains that the notice which implements the cost limits provides a detailed description of how the update factor is to be determined. According to the preamble, hospitals' costs are updated from the midpoint of their actual cost reporting periods to April 1, 1983, the midpoint of the federal fiscal year. 47 Fed. Reg. 43296 at 43301(September 30, 1982). These basic limits are then made hospital-specific by inflating them again for costs incurred during that portion of the hospital's cost reporting period which occurs after the end of the federal fiscal year. With respect to this second revision, the Federal Register notice once more makes clear that the increase is calculated from the midpoint of the federal fiscal year to the midpoint of the hospital's fiscal year. For cost reporting periods which were less than twelve months, the Federal Register expressly states: "the calculation [of the update factor] must be done specifically from the midpoint of the cost reporting period." 47 Fed. Reg. 43296 at 43310.[12]

The Provider asserts that HCFA referred to the methodology established for the rate of increase ceiling when determining the update factor at issue in this case, but did not follow that methodology. Essentially, the Provider argues that HCFA's update factor is not supported by HCFA's own citation of law.[13]

The letter issued by HCFA advising the Intermediary of the 1.08648 update factor references 48 Fed. Reg. 39842 dated September 1, 1983, 49 Fed. Reg. 328 dated January 3, 1984, and 49 Fed. Reg. 34776 dated August 31, 1984.[14] Each of these notices refers to the methodology used to update the target rate of increase ceiling found at 42 C.F.R. § 405.463. For example, 48 Fed. Reg. 39842 states, in part:

> [t]he hospital specific rate is calculated by increasing the case-mix adjusted base year costs . . . by an applicable updating factor in accordance with sections 1886(d)(2)(B) and 1886(e)(1)(A). For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, the updating factor is equal to the compounded applicable target rate percentage (as used for the rate-of-increase ceiling under revised 42 CFR 405.463) multiplied by the adjustment factor for budget neutrality (.984) and added to 1.

48 Fed. Reg. 39842 (1983).[15]

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[12] Provider Position Paper, CN:88-0450, at 7 and Exhibit 10.

[13] Provider Position Paper, CN:88-0450, at 4.

[14] Provider Position Paper, CN:88-0450, at Exhibit 4.

[15] Provider Position Paper, CN:88-0450, at Exhibit 5.

While 49 Fed. Reg. 328 repeats the same requirement, changing only the amount of the budget neutrality factor, as follows:

> [t]he hospital-specific rate is calculated by increasing the case-mix adjusted base year costs by an applicable updating factor in accordance with sections 1886(d)(2)(B) and 1886(e)(1)(A). . . For discharges occurring after 30 days following publication of this final rule for cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, the updating factor is equal to the compounded applicable target rate percentage (as used for the rate of increase ceiling under revised 42 CFR 405.463), multiplied by the modified adjustment factor for budget neutrality (.983).

49 Fed. Reg. 328 (1984).[16]

The Provider also contends that using the midpoint of the subject cost reporting periods as the place to both begin and end the inflation calculation is proper because the goal of the update factor is to recognize an allowable increase in costs throughout the fiscal year.[17] The cost per discharge which was used to establish the hospital-specific rate is actually an average of the costs for the entire base period. Costs incurred for discharges at the beginning of the base period were lower than the costs for discharges occurring at the end of the base period. Presumably, the average cost per discharge was incurred at the midpoint of the base period. Thus, the unadjusted PPS rate calculated for the provider in this case reflects costs as of December 31, 1982. Accordingly, that is the date at which inflation for the subsequent period must begin.

Similarly, the midpoint of the PPS year is the logical place to stop updating the rate. Under PPS the same rate must be applied all year long although costs will actually be lower at the beginning of the period and higher at the end. By inflating the payment rate to the middle of the period payments will be made at a rate which reflects higher than actual increases during the first half of the year. However, this will be balanced by payments at a rate which is lower than actual cost increases in the second half of the year. Therefore, adjusting to the midpoint assures proper payment for the year as a whole. Accordingly, HCFA should have calculated the appropriate monthly adjustment through October 22, 1984.

The provider contends that the validity of using midpoints as the basis for updating payment rates has recently been reaffirmed by HCFA in connection with the update factors used for the hospital-specific portion of the capital prospective payment rate. Unlike the PPS rates for

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[16] Provider Position Paper, CN:88-0450, at Exhibit 6.

[17] Provider Position Paper, CN:88-0450, at 7.

operating costs, the capital cost rates are calculated using a federal fiscal year. However, again, HCFA has used midpoints as the beginning and ending places for determining the hospital-specific inflation factor. As noted in the preamble to the Federal Register: "[w]e propose to update the base period costs per discharge from the midpoint of the hospital-based cost reporting period to March 31, 1992 (the midpoint of [Federal] FYE 1992)." 56 Fed. Reg. 43390 (August 30, 1991).[18]

The Provider contends that determining the midpoint of cost reporting periods is not a problem when both periods are of equal 12 month time frames because the average or midpoint is the same. However, this is not true when the two periods are of different length.[19] The short cost reporting period at issue in this case began on August 14, 1984 as opposed to July 1, 1984, because of the change of ownership. Also, this cost reporting period ended on December 31, 1984, as apposed to June 30, 1985, because of the change in fiscal year ends. HCFA's update calculation based upon 18 months elapsed time recognizes the fact that the cost reporting period ended 18 months after the base year end, however, it does not consider the fact that the cost reporting period began over 25 months after the base year beginning. By not applying the monthly rate of increase over the time between the midpoints of both fiscal periods, HCFA recognizes only the move up in the year ending date, but not the late start of the cost reporting period. Essentially, HCFA's determination adjusts the PPS update factor for a cost reporting period that began on January 1, 1984, rather than the actual start date of August 14.

The Provider concludes that given HCFA's repeated recognition of the appropriateness of using the midpoint of the fiscal years as the beginning and ending point for inflation, HCFA has acted inappropriately by calculating the allowable increase for the Provider's 1984 rate using only the number of months which elapsed between the end of its base period and the end of the fiscal year at issue.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the subject update factor is correct. It was determined by HCFA by dividing the monthly target rate percentage by 12 and compounding that result over an 18 month period. HCFA used 18 months since it reflects the actual period of time that elapsed from the end of the Provider's PPS base period to the end of the subject cost reporting period, i.e., July 1, 1983 through December 31, 1984.

The Intermediary acknowledges the Provider's argument that the facility had two short cost reporting periods during its first six months under PPS and, therefore, the update factor should be determined by compounding the monthly target rate percentage by the "average

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[18] Provider Position Paper, CN:88-0450, at 9 and Exhibit 12.

[19] Provider Position Paper, CN:88-0373, at Issue C.

elapsed time" of 21.78 months rather than the actual elapsed time used by HCFA. The Intermediary, however, disagrees with this argument.

The Intermediary asserts that the Provider's costs are the same whether there were several cost reporting periods within the 18 month time span used by HCFA or just one cost reporting period. The Intermediary fails to see any logic in the Provider's apparent argument that costs incurred in two short periods are different than costs incurred in the aggregate over the same period. The Intermediary concludes, therefore, that since 18 months had actually elapsed between the end of the Provider's base period and the end of the subject cost reporting period, that using an average elapsed time to determine the update factor would distort costs.[20]

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§1395ww(a)	-	Limits on Operating Costs for Inpatient Hospital Services
§1395ww(b)(3)(B)	-	Rate of Increase in Target Amounts for Inpatient Hospital Services
§1395ww(d)(2)(B)	-	PPS Transition Periods; DRG Classification System; Exceptions and Adjustments to PPS

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

§ 405.463 et. seq. (Redesignated at § 413.40)	-	Ceiling on the Rate of Increase in Hospital Inpatient Costs
§ § 405. 1835-.1841	-	Board Jurisdiction
§ 412 et. seq.	-	Prospective Payment System for Inpatient Hospital Services

3. Other:

47 Fed. Reg. 43282 (September 30, 1982).

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[20] Intermediary's Position Paper, CN:88-0450, at 6.

47 Fed. Reg. 43296 (September 30, 1982).

48 Fed. Reg. 39842 (September 1, 1983).

49 Fed. Reg. 328 (January 3, 1984).

49 Fed. Reg. 34776 (August 31, 1984).

56 Fed. Reg. 43390 (August 30, 1991).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented finds and concludes that the Intermediary properly calculated the DRG portion of the Provider's reimbursement.

The Board finds that the fundamental argument in this case is the methodology used to update the Provider's base period costs under PPS to its cost reporting period ended in fiscal year 1984, the initial period subject to PPS reimbursement. In particular, the Provider argues that the update factor should be determined by compounding the monthly target rate percentage over the time elapsed from the midpoint in the PPS base period to the midpoint of its 1984 cost reporting period. The Provider demonstrates that basing the update factor determination on midpoints rather than cost reporting period ending dates, as used by HCFA, can produce significantly different results when the base period ending date is different than the ending date of the 1984 cost reporting period, e.g., a June 30, 1983 base period year end compared to a December 31, 1984 PPS year end.

The Board finds that 42 U.S.C. § 1395ww(d)(2)(B) controls the update of PPS amounts to fiscal year 1984. In part, the statute requires base period amounts to be updated to fiscal year 1984 by applying the "applicable percentage increase" defined at 42 U.S.C. § 1395ww(b)(3)(B). The statute, however, does not prescribe the methodology to be used for this purpose.

Absent statutory guidance, the Board turns to regulations at 42 C.F.R. § 412ff, which pertain to PPS reimbursement. The Board finds that 42 C.F.R. § 412.62(c) addresses the fiscal year 1984 update of the Federal PPS rate. This rule essentially restates the language of the enabling statute except that it refers to the definition of "applicable percentage increase" found at 42 C.F.R. § 405.463(c)(3) rather than the statutory reference of 42 U.S.C. § 1395ww(b)(3)(B) noted above. However, like the statute, the rule does not prescribe an update methodology.

Similarly, the Board finds that 42 C.F.R. § 412.73(c)(1) addresses the fiscal year 1984 update of the hospital-specific rate. In general, this regulation explains that a provider's base period

cost per discharge is updated by applying the appropriate target rate percentage as defined at 42 C.F.R. § 405.463(c)(3), in conjunction with the Federal rate requirement. However, there is again no methodology provided for applying the target rate percentage.

The Board finds that 42 C.F.R. § 405.463(c)(3) also does not prescribe the methodology for updating PPS rates. However, it does explain that applicable target rate percentages will be published by HCFA. In this context, the Board finds that HCFA published fiscal year 1984 PPS update factors in the Federal Register on September 1, 1983 (48 Fed. Reg. 39842). These update factors are assigned to a provider's base period costs in accordance with the ending date of the base period and the corresponding ending date (month and day) of the fiscal year 1984 cost reporting period, e.g., September 30, 1982 and September 30, 1984.

Accordingly, the Board finds that absent statutory and regulatory guidance, HCFA used its discretionary authority and established the methodology for updating PPS rates to 1984. Therefore, the matter immediately before the Board is HCFA's application of its own update methodology to the Provider's 1984 cost reporting period considering it is a short period with an ending date that does not correspond to the ending date of the base period.

Respectively, the Board finds that HCFA properly applied the established PPS update methodology to determine the update factor applicable to the Provider's 1984 cost reporting period. This determination was made by compounding the monthly target rate percentage over 18 months which reflects the period of time that elapsed from the end of the Provider's base period to the end of the 1984 cost reporting period at issue. This application is consistent with the methodology used to assign update factors to all other providers which, as noted above, is based upon year end dates.

The Board rejects the principal argument raised by the Provider in opposition to its findings. Specifically, the Provider asserts that PPS updates must be determined by compounding the monthly target rate percentage over the period of time that elapses from the midpoint of the base period to the midpoint of the 1984 cost reporting period because that is the methodology used by HCFA to account for inflation when establishing cost limits under the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"). Essentially, the Provider relates the PPS update methodology to that of the cost limits by the fact that 42 U.S.C. § 1395ww(d)(2)(B), the enabling statute, requires the 1984 PPS update to rely upon the applicable percentage increase "as defined in subsection (b)(3)(B) [42 U.S.C. § 1395ww(b)(3)(B)]." The Provider explains that subsection (b)(3)(B) defines the "applicable percentage increase" for the purpose of the target rate of increase ceiling. The Provider concludes, therefore, that the pertinent statute requires the calculation of the PPS update factor to be governed by the methodology established for the target rate of increase ceiling. From this point, the Provider shows that while no specific methodology is provided to establish the percentage update for the rate of increase ceiling, 47 Fed. Reg. 43287 explains that the same percentage increase methodology will be used for the target amount as is used to establish the TEFRA cost limits. From here, the Provider shows that HCFA established the cost limits, in part, by using hospital cost per

discharge data that it updated to April 1, 1983, which is the midpoint of the first cost reporting period to which the limits would apply (47 Fed. Reg. 43299).

The Board, however, disagrees with the Provider's construction of 42 U.S.C. § 1395ww(d)(2)(B). The Board finds that a plain reading of the statute does not require the calculation of the PPS update factor to be governed by the methodology established for the TEFRA limits. The statute requires the PPS update methodology to employ the "applicable percentage increase" as defined in the cost limits section of the law. However, the language of the statute is clear; it establishes no relationship between the methodology used to update PPS base period costs and the methodology used for the TEFRA limits other than the fact that they both use the same "applicable percentage increase."

DECISION AND ORDER:

The Provider's DRG amount was correctly calculated under Medicare law and PPS regulations. The Intermediary's adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: April 28, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman