PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D19

PROVIDER –
Western Arizona Regional Medical Center
Bullhead City, Arizona

Provider No.: 03-0101

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Blue Cross Blue Shield of Arizona

DATE OF HEARING -
February 4, 2005

Cost Reporting Period Ended -
August 31, 2001

CASE NO.: 04-0133

INDEX

ISSUE:

Whether the Intermediary's adjustment of the Provider's disproportionate share (DSH) calculation was based upon a proper interpretation of the Medicare DSH statute as amended by the Benefits Improvement and Protection Act of 2000.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal 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.

In 1983 Congress changed hospital reimbursement under the Medicare program by enacting Public Law 98-21, which created the Prospective Payment System (PPS). PPS contains a number of provisions that adjust reimbursement based on hospital-specific factors. See 42 U.S.C. §1395ww(d)(5). This case involves one of the hospital-specific adjustments; specifically, the disproportionate share adjustment (DSH), which requires the Secretary to provide additional PPS reimbursements 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 whether the hospital is in an urban v. a rural area, the number of beds available for patients, and the hospital's "disproportionate patient percentage." See 42 U.S.C. §1395ww(d)(5)(F)(v). The "disproportionate patient percentage" is the sum of two fractions, the "Medicare and Medicaid fractions," for a hospital's fiscal period. 42 U.S.C. §1395ww(d)(5)(F)(vi). The Medicare fraction's numerator is the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income, excluding

patients receiving state supplementation only. The denominator is the number of patient days for patients entitled to Medicare Part A. Id. 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 who were not eligible for benefits under Medicare Part A. 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 second fraction is frequently referred to as the Medicaid Proxy. Providers whose DSH percentages meet certain thresholds receive an adjustment which results in additional PPS payments for inpatient hospital services. SSA §1886(d)(5)(F)(ii).

In December 2000 Congress passed the Benefits Improvements and Protection Act of 2000 (BIPA) (P.L. 106-554). BIPA reduced the disproportionate share percentage eligibility threshold for urban hospitals with fewer than 100 beds for discharges occurring on or after April 1, 2001. The issue in this case involves the application and interpretation of those changes to the Provider's operating circumstances.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Western Arizona Regional Medical Center (Provider) is a general acute care hospital located in Bullhead City, Arizona. The Provider operated 90 licensed and available beds during the cost reporting year at issue. Prior to the enactment of BIPA, urban hospitals with fewer than 100 available beds were eligible for DSH only if their DSH patient percentage exceeded 40%. Under BIPA, urban hospitals with fewer than 100 beds became eligible for DSH if their DSH inpatient percentage for discharges on or after April 1, 2001 was greater than 15%. The Provider calculated its DSH percentage for its discharges occurring on or after April 1, 2001 through the end of its cost reporting year (8/31/01) and determined a DSH percentage of 18.7%. The Provider applied that percentage to its Medicare payments for discharges on or after April 1, 2001. Blue Cross Blue Shield of Arizona (Intermediary) disallowed the calculation, claiming that the Provider's DSH percentage for the entire cost reporting period (including dates prior to April 1, 2001) was less than 15%, and the Provider was therefore not entitled to a DSH adjustment of its 2001 cost report. The issue in dispute is the effective date for development/application of the 15% threshold.

PARTIES' CONTENTIONS:

The Provider contends that the plain language of the statute[1] establishes the threshold for DSH participation at "40%, (or 15 % for discharges occurring on or after April 1, 2001) if the hospital is located in an urban area and has less than 100 beds . . ." The Provider argues that the amendment's language and use of parentheticals draws a clear line separating those discharges occurring before April 1, 2001 from those occurring on or after that date for the specific purpose of applying the two patient percentage thresholds during an applicable cost reporting period. Accordingly, the Provider argues that this language requires the calculation of a separate DSH

[1] 42 U.S.C. §1395ww(d)(5)(F)(v)(III)

percentage for discharges occurring on or after April 1, 2001 through the end of the cost reporting period.

CMS' conforming changes to the DSH regulation[2] set the threshold for DSH participation at "40% for discharges occurring before April 1, 2001 and 15% for discharges occurring on or after April 1, 2001." The Provider contends that substitution of the word "and" in the regulation for the word "or" in the statute makes regulation inconsistent with the statute and adds an additional requirement for participation. The Provider also contends that the text of the regulation contemplates two different DSH patient percentages, i.e., one for discharges occurring before April 1, 2001, and a separate one for discharges occurring on or after April 1, 2001. Like the statute, the regulation requires the calculation to be predicated upon the date of discharge.

The Provider also contends that CMS' preamble[3] to the new regulation supports a reading of the regulation as requiring two separate DSH patient percentage calculations. CMS stated:

> [BIPA] amended section 1886(d)(5)(F) of the Act to change the qualifying thresholds for the DSH payment adjustment to 15 percent for all hospital types**, effective with discharges occurring on or after April 1, 2001. This means that the legislation is effective with discharges occurring on or after April 1, 2001, but not before.**

The Provider argues that the fact that CMS highlighted the effective date and inserted the term "discharges" suggests that both Congress and CMS intended that two separate patient percentage calculations should be performed for the single transition year.

The Intermediary contends that the plain language of the statute[4] states that a hospital "serves a disproportionate number of low income patients for a cost reporting period" if the 40% or 15% thresholds exist. The Intermediary contends further that the explanation of the calculation of the DSH percentage in the next paragraph of the statute[5] begins with "in this subparagraph, the term "disproportionate patient percentage" means with respect to a cost reporting period of a hospital . . . " The Intermediary argues that the language of the statute requires that both the determination and the calculation of a qualifying DSH percentage be based upon a cost reporting period.

The Intermediary also contends that the CMS regulation is consistent with the statute's concept of reimbursement for a cost reporting period. The regulation[6] presents the formula for the determination of a hospital's disproportionate patient percentage and calls for the use of the hospital's cost reporting period in its application. Neither the statute nor the regulation hints that

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[2] 42 C.F.R. §412.106(c)
[3] Fed.Reg. Vol.66, No.148 @39882
[4] SSA §1886(d)(5)(f)(v)
[5] SSA §1886(d)(5)(f)(vi)
[6] 42 CFR §106(b)

a cost reporting period may be bifurcated and a separate disproportionate patient percentage calculated for each.

The Intermediary further contends that the CMS instructions speak to a single application, which is consistent with long-standing Medicare practice when the entitlement thresholds change mid-year. The Intermediary contends that the preamble section quoted by the Provider[7] continues as follows:

> Therefore, fiscal Intermediaries are required to determine whether a hospital meets the thresholds in place either before or after April 1, 2001, by applying the DSH patient percentage in the formula to each separate period. Days are counted based on the date of discharge. In other words, a hospital stay would be counted in the cost reporting year during which the patient was discharged.

The Intermediary argues that the language refers to the DSH patient percentage in the singular and, just as the statute and the regulation, CMS' guidance requires one disproportionate patient percentage to be applied to two thresholds. Since that percentage was under 15% when the calculation is made using the entire cost report period, the Provider is not entitled to DSH.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions, oral argument at the hearing, and post-hearings briefs, the Board majority finds and concludes as follows:

The pivotal issue offered for the Board's consideration is the proper interpretation/application of the DSH statute as amended by BIPA. In 2000 BIPA amended the DSH statute to allow urban hospitals with less that 100 beds to qualify for DSH adjustments if their DSH patient percentage met a 15% threshold rather than the previous 40% threshold. The amendment,[8] which took place on April 1, 2001, stated:

> In this subparagraph, a hospital serves "a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate share patient percentage . . . for the period which equals or exceeds—
>
> > (III) 40 percent, (or 15 percent, for discharges occurring on or after April 1, 2001) if the hospital is located in an urban area and has less than 100 beds . . . "

The Board majority finds that this amendment contemplates two different disproportionate share patient percentages for each provider, i.e., one for discharges occurring before April 1, 2001 and one for discharges occurring on or after April 1, 2001. The Board majority further finds that the

[7] Fed.Reg. Vol.66, No.148 @39882
[8] 42 U.S.C. §1395ww(d)(5)(F)(v)(III)

patient percentage for the period before April 1, 2001 should be applied to the 40% threshold while the patient percentage for the post-April 1, 2001 period should be applied to the new 15% threshold. If either of the patient percentages exceeds its respective threshold, the provider would be eligible for the DSH adjustment for that portion of the cost reporting period.

In its discussion of the amendment in the August 1, 2001 Federal Register/Vol. 66, No. 148 (Provider Exhibit P-8), CMS stated:

> This mean that the legislation is effective with discharges occurring on or after April 1, 2001, but not before. Therefore, fiscal intermediaries are required to determine whether a hospital meets the thresholds in place either before or after April 1, 2001 by applying the DSH patient percentage in the formula to each separate period.

In an analogous situation having to do with the counting of section 1115 waiver days in the DSH payment adjustment calculation wherein a policy change became effective for discharges occurring on or after January 20, 2000, CMS explained in the August 1, 2000 Federal Register (65 FR 47086):

> Therefore, it is possible that a hospital will qualify for DSH payments as of January 20, 2000, whereas it did not qualify before January 20, 2000, and it should be paid accordingly. In other words, a hospital in that situation would receive Medicare DSH payments beginning January 20, 2000.

The Board majority finds that the Provider was correct in applying its disproportionate share patient percentage to the 15% threshold for its discharges occurring on or after April 1, 2001.

The Board majority finds that the Intermediary's use of a single aggregated patient percentage ignores the impact of the BIPA amendment and is inconsistent with the language of the amended statute. Accordingly, the Board majority finds the Intermediary's methodology and the adjustment resulting from its application to be improper.

The Board majority concludes that the Provider is entitled to a DSH adjustment on its 2001 cost report for discharges occurring from April 1, 2001 to the end of the cost reporting period.

DECISION AND ORDER:

The Intermediary's adjustment of the Provider's disproportionate share (DSH) calculation was based upon an incorrect interpretation of the Medicare DSH Statute as amended by the Benefits Improvement and Protection Act of 2000. The Provider is entitled to a DSH adjustment on its 2001 cost report for the discharges occurring on April 1, 2001 to the end of the cost reporting period.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Yvette Hayes
Elaine Crews Powell, C.P.A. (Dissenting Opinion)
Anjali Mulchandani-West (Dissenting Opinion)

FOR THE BOARD:

DATE: March 3, 2006

Suzanne Cochran, Esquire
Chairperson

Dissenting Opinion of Anjali Mulchandani-West and Elaine Crews Powell

We respectfully dissent.

The language of the governing statute at 1886(d)(5)(f)(v) states that the determination and calculation of the disproportionate share percentage (DPP) is based on a single cost reporting period. The language is clear that the statute envisions the calculation of a single DPP for a single cost reporting year. If the intent of the statute was to split the cost reporting period into two parts (pre and post April 1), then the legislation would have overtly specified so. The relevant regulation at 42 CFR 412.106(b) similarly is clear that the computation of the DPP is based on a single exercise of adding together the results of the first and second computations. There is no basis in the regulation to bifurcate a cost reporting period and calculate a separate DPP for each segment due to a mid-period change in the qualifying thresholds. Even CMS, in its Federal Register discussion accompanying the implementing legislation, refers to the DPP in the singular. We cannot extract from the statute, regulation or commentary that Congress intended to split the DPP. Only one DPP is required and should be compared to the two thresholds.

Anjali Mulchandani-West

Elaine Crews Powell