PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D7

PROVIDER -
St. Joseph Regional Health Center
Bryan, Texas

Provider No.: 45-0011

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
TrailBlazer Health Enterprises, LLC

DATE OF HEARING -
April 13, 2004

Cost Reporting Periods Ended -
December 31, 1996 and
December 31, 1997

CASE NOs.: 01-1443 and 01-1444

INDEX

ISSUE:

Whether the Intermediary's made a proper determination that Provider should be paid at the prospective payment rate for rural providers after it was certified as a provider-based entity of a hospital entitled to receive the higher urban prospective payment rate.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This dispute arises under the Federal Medicare program administered by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (CMS). The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. CMS is the agency of the Department of Health and Human Services responsible for administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies know as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law, regulations and interpretative guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20-413.24.

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 final determination. 42 U.S.C. §1395oo(a), 42 C.F.R. §405.1835.

Multi-campus Hospitals

Some hospitals receiving payment under the prospective payment system (PPS) are multi-campus hospitals; i.e., they consist of two or more separately located inpatient hospital facilities. In the September 30, 1988 Federal Register, CMS addressed its rationale for how it determined the prospective payment system rate (PPS) for these multi-campus hospital facilities that were located in areas with different PPS rates or wage indices. 53 Fed. Reg. 38476, 38501 (September 30, 1988).

CMS explained that 42 U.S.C. §1395ww(d)(3)(D) provides that prospective payment rates are established "for hospitals located in large urban areas or other urban areas . . ." and "for hospitals located in a rural area." This means that the prospective payment rate is based on the geographic location of the hospital at which the discharge occurs rather than another location such as that of the main hospital. As a result of this reasoning, CMS amended 42 C.F.R. §412.63 to provide that a multi-campus hospital that participates in the program as a single provider must be paid prospective rates that are determined by the geographic location of each individual hospital facility. Id.

Provider-based Facilities

The Medicare law, 42 U.C.S. §1395x, lists the types of facilities that are regarded as providers of services but does not define the term "provider-based." However, from the beginning of the Medicare program, CMS has referred to providers which owned or operated other facilities, such as skilled nursing facilities or home health agencies as being "main providers." The subordinate facilities may be located on the campus of the main provider or at some other site. In order to accommodate the financial integration of the two facilities without creating an administrative burden, CMS has permitted the subordinate facility to be considered provider-based. To the extent that overhead costs of the main provider were shared by the subsidiary facility, these costs were allowed to flow to the subordinate facility through the cost allocation process in the cost report. CMS considers this appropriate because the facilities are operationally integrated, and the provider-based facility shares the overhead costs and revenue-producing services controlled by the main provider. 65 Fed. Reg. 18434, 18504 (April 7, 2000).

Since the implementation of PPS in 1983, the number of provider-based facilities increased as the result of the financial and organizational incentives of that payment system. CMS recognized the need to have rules for identifying provider-based and free-standing facilities and issued Provider Memorandum (PM) 96-7 on August 27, 1996. This PM consolidated previously published documents for specific types of entities and created general instructions for designation as a provider-based facility. The PM was subsequently reissued without changes until section 2446 was created for the Provider Reimbursement Manual (CMS Pub. 15-1) in 1999.[1] The Program Memorandum and Manual Provisions were the only guidance relevant to provider based status until the issuance of a regulation effective January 10, 2001, 42 C.F.R. §413.65.[2]

The regulation, 42 C.F.R. §413.65(i)(2) (2000) permits CMS[3] to recoup overpayments where payments were made as if the facility was provider-based, even though CMS had not made a determination regarding the provider's status. This section also permits CMS to forego collection for cost reporting periods prior to January 1, 2001, if the management of the organization made a good faith effort to operate as a provider-based facility as described in § 413.65(i)(2)(2000). Section 413.65(d) (2000) deals with requirements for licensure, public awareness, billing and physician services.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Joseph Regional Health Care Center (Provider) is an acute care hospital located in Bryan, Texas. In August of 1996 the Provider submitted a Notification of Change of

[1] The State Operations Manual (CMS Pub.7) was also amended by replacing section 2003 and adding section 2004 which dealt with provider-based status.

[2] The Secretary published the final rule for provider-based status on April 7, 2000, and stated that the rule would be effective on October 10, 2000. 65 Fed. Reg. at 18504. On October 3, 2000, the Secretary delayed the effective date of the provider-based regulations until January 10, 2001. 65 Fed. Reg. 58919 (October 3, 2000).

[3] The Agency name changed to CMS before publication of this regulation.

Ownership[4] stating that it planned to assume the ownership of Navasota Regional Hospital (Navasota) and operate it as a satellite. CMS approved the Provider's request for single provider status. When the transaction was complete, Navasota's name was changed to Grimes St. Joseph (Grimes). The two facilities, located 20 miles apart, operated under a single provider number[5] with central governance, administrative support and chief executive officer.

Initially, the Provider billed claims for itself and Grimes under its provider number and was reimbursed at an urban rate for purposes of PPS. On February 18, 1998, the Intermediary notified the Provider that Grimes was a separate campus and should be reimbursed under a rural rate for purposes of PPS. The Provider was to append an R to the provider number for all claims submitted on or after March 18, 1998 from the Grimes facility.[6] The Provider requested that the Intermediary reconsider its position with regard to the billing of claims from Grimes.[7] CMS responded by reaffirming the Intermediary's previous requirement and advised the Provider that it would need to seek geographic reclassification for Grimes.[8]

The Provider filed an appeal with the Board. The Medicare reimbursement effect of the issue for 1996 is $360,000 and $135,000 for 1997.

PARTIES' CONTENTIONS:

The Provider contends that there is no dispute that the Grimes facility met the provider-based criteria set forth in PM A-96-7. Consequently, once an entity is determined to be provider-based, its reimbursement is tied to that of the main provider. The Provider argues that CMS's attempt to classify the Grimes facility as a separate inpatient facility fails, because it does not independently meet all of the requirements for Medicare certification. Further, CMS concluded that the Grimes campus was an extension of the Bryan, Texas campus and that the main purpose of this designation is to accommodate the appropriate accounting and allocation of costs. CMS recognized that in provider-based facilities, the cost allocation and reimbursement more often than not results in Medicare payments that exceed what would have been paid if the same services were rendered by a free-standing entity.[9] The Provider states that the increased reimbursement is the reason for seeking provider-based status, and CMS recognized that appropriate cases warrant increased reimbursement. The provider-based designation controls not only cost allocation but also the prospective rate paid the Provider.

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[4] Provider Position Paper Ex. A.

[5] Provider Position Paper Ex. D Health Care Financing Administration Regional VI Office Letter dated February 19, 1997 ("St Joseph Regional Health Center now operates the former Navasota Regional Hospital campus as an extension of the Health Center's Bryan, Texas campus. Effective September 17, 1996, provider number 45-0011 should be used on all Medicare claims. . .")

[6] Provider Position Paper Ex. E.

[7] Provider Position Paper Ex. G.

[8] Provider Position Paper Ex. H.

[9] Program Memorandum A-96-7 (August 1, 1996), Medicare and Medicaid Guide (CCH) ¶ 44,569

In the alternative, the Provider argues that if the Grimes facility was incorrectly determined to be a provider-based facility, the Provider acted in good faith as defined in 42 C.F.R. §413.65. Accordingly, CMS is not entitled to recover overpayments. The regulation applies to facilities that did not seek provider-based status but made a good-faith effort to operate in that manner, as did the Provider. Consequently, CMS should be precluded from recouping any overpayments for cost reporting periods prior to January 10, 2001.

The Intermediary argues that it lacks the authority to make a determination regarding urban and rural payment rates under appeal in this case. 42 C.F.R. §412.63(b)(5) requires that two or more separately located hospital facilities be paid the PPS rate based on their geographic location. At all times this Provider was furnishing inpatient services at two locations, 20 miles apart; therefore, the regulation applies. The Intermediary notes that there is nothing in the correspondence between the Provider and CMS that could be construed to permit the Grimes facility to be paid at an urban rate once the provider-based designation was granted.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law, parties' contentions, and evidence presented, the Board finds and concludes that 42 C.F.R. §412.63(b)(5) does not apply to facilities which have been designated as provider-based. Consequently, the services provided at the Grimes facility should be paid at the urban rate.

The Provider sought and was granted the right to treat the Grimes facility as an extension of its Bryan campus rather than as a separate hospital facility. The application process and the designation are consistent with what is commonly known as "provider-based status" as reflected in PM 96-7. The requirements for designation as a provider-based facility require major organizational changes, including accreditation under the umbrella of the main provider, financial integration and that patients treated at the provider-based facility be considered patients of the main provider. These changes and others must be reviewed and approved by CMS.

Under the PM and the later codification of those guidelines in the regulation, 42 C.F.R. §413.65, a provider-based designation means that the hospital and the provider-based facility are no longer treated as separate facilities, but rather are treated as a single inpatient hospital facility. Therefore, 42 C.F.R. §412.63(b)(5), the regulation regarding inpatient facilities located in separate locations, does not apply.

The Intermediary's argument that a provider-based designation does not change how claims of the separate locations are billed subsequent to the change in status is inconsistent with PM 96-7. The Intermediary's position that §412.63(b)(5) applies to provider based facilities is further undermined by the adoption of 42 C.F.R. §413.65(i)(2) in 2000. Although this regulation was published after the fiscal period in issue, it is consistent with the PM in effect at the time of the Grimes transaction and clearly reflects

CMS' expectation that provider-based status carries with it billing ramifications, specifically that the provider must bill as a single entity.[10]

Section 413.65(i)(2) and (3)(2000) also provides that if a provider failed to apply for and receive designation regarding its provider-based status but met certain good-faith requirements, CMS would not recoup overpayments made based on the failure to achieve provider-based status. It is illogical that a provider that went through the provider-based application process and was approved by CMS as a provider-based facility would be given less consideration than those that failed to even seek the appropriate legal status.

With CMS' explicit approval, the Grimes facility participated in the Medicare program, not as a separate hospital but as an integral and subordinate part of the main campus. The Board notes that CMS' position with regard to the inpatient hospital portion of the Grimes facility is also inconsistent with its treatment of the skilled nursing facility (SNF) portion of the same facility. In response to the Intermediary's questions to CMS about the Provider's reimbursement, CMS responded that the 12-bed SNF at the Grimes facility should be paid the urban rate of the main provider.[11]

DECISION AND ORDER:

The Intermediary's adjustment is reversed. The Board hereby orders the Intermediary to recalculate the reimbursement for the inpatient hospital portion of the Grimes facility at the same urban rate as the main hospital facility.

Board Members Participating

Suzanne Cochran, Esq.
Martin W. Hoover, Jr., Esq.
Gary B. Blodgett, DDS
Elaine Crew Powell, CPA, (Dissenting)
Anjali Mulchandani-West

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[10] See, e.g., 42 C.F.R. 413.65(i)(3)(ii)(2000) [a]ll facility services were billed as if they had been furnished by a department of a provider, a remote location of a hospital, a satellite facility or a provider-based entity of the main provider.

[11] Provider Position Paper Ex. F-Copy of a March 31, 1998 e-mail from Virginia McKissick of CMS to the Intermediary's employee Lee Maloney, p. 04/04. (See also, Provider Ex. D CMS's February 19, 1997 letter to Provider, page 2- St. Joseph Regional Hospital acquired the Navasota Regional Hospital SNF)

> [Intermediary's question] They have a 12-bed SNF at the Navasota facility that bills with the SNF number from Bryan (455720). Their costs are always more than the routine cost limit. How will we account for this?
>
> [CMS response] The CHHP Division of Post Acute Care has told us that patients in all SNF beds would be paid according to the location of the SNF in the surviving entity, in this case the urban facility. The cost would be treated as the same as if the beds were all located at the urban facility.

FOR THE BOARD:

DATE: December 7, 2006

Suzanne Cochran, Esq.
Chairman

Dissenting Opinion of Elaine Crews Powell

Jurisdiction – FYE 12/31/96

The majority exercised its authority to accept jurisdiction in this case, finding that the Provider did, in fact, have good cause for failing to request an appeal within 180 days of the original Notice of Program Reimbursement (NPR). I respectfully dissent.

The majority concluded that correspondence from CMS created confusion regarding the treatment of reimbursement for inpatient services at the Grimes satellite facility, noting an e-mail message transmitted by the Intermediary to the Provider on April 22, 1998 and a CMS letter dated September 6, 2000. Notwithstanding any confusion that may have arisen because of this correspondence, I find that the Provider was well aware of the Intermediary's decision – payment for Grimes' inpatient services at the rural rate – long before the appeal request was due, and well in advance of the issuance of the 1996 NPR.

The record shows (Provider Exhibit E) that the Provider was notified on February 18, 1998 that the Intermediary had identified the error in how the inpatient services had been billed and that the overpayment would be recouped. The Intermediary referenced the controlling regulation at 42 Code of Federal Regulations (C.F.R.) §412.63(b)(5) which states:

> For discharges occurring on or after October 1, 1998, for hospitals that consist of two or more separately located inpatient hospital facilities the national adjusted prospective payment rate is based on the geographic location of the hospital facility at which the discharge occurs.

The Provider was notified by the Intermediary on April 20, 1998 of the decision by the CMS Regional Office that the rural rate was applicable to the inpatient discharges at Grimes. (Provider Exhibit F)

When the 1996 NPR was issued on September 9, 1999, the Provider received definitive proof that the PPS rate per discharge for inpatient services at Grimes was reduced to the rural rate. The Provider's appeal request for 1996 was due on or before March 7, 2000 so that any confusion that may have been created by the earlier correspondence (August 1998) would have been certainly been cleared up by the time the NPR was issued, let alone by the time the appeal request was due.

I find that the issuance of subsequent correspondence had no impact on the Provider's responsibility for filing a timely appeal because by the time the "confusing" correspondence was issued (September 2000), the appeal period had passed. There is no basis in fact or program policy to conclude that the subsequent correspondence from CMS somehow led the Provider to believe that the deadline for filing its appeal had been suspended.

Substantive Issue – FYE 12/31/97 PRRB Case No. 01-1444

The majority found that the Provider was entitled to reimbursement at the urban rate for inpatient services at Grimes. Again, I dissent.

My dissent is based upon my understanding of the explicit language in 42 C.F.R. §412.63(b)(5) quoted above. This case is controlled by the referenced regulation, and the Board is bound without the authority to find contrary to the regulation. Accordingly, the case should have been expedited for judicial review.

The majority concluded that 42 C.F.R. § 412.63(b)(5) is not applicable to facilities that have been designated a "provider based," finding instead that Program Memorandum 96-7, codified in 2000, is controlling. I find that the majority's reference to language contained in 42 C.F.R. §413.65(j) (2000) and its discussion of CMS' intent in the language of the PM is trumped by the regulation in force at the time the services were rendered. I see no need whatsoever to defer to a PM when the situation in this case is exactly that envisioned in the regulation – a single hospital with multiple physical plants providing inpatient services in one urban and one rural location. Clearly, separate rates are to be applied to those services based upon the location in which they were provided.

Based upon this conclusion, I do not reach the good-faith language of the 2000 Code of Federal Regulations.

The Intermediary's adjustment is supported by the controlling regulation.

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Elaine Crews Powell, C.P.A.