PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D59

PROVIDER -
Mountains Community Hospital
Lake Arrowhead, California

Provider No.: 05-0260

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services, LLC - CA

DATE OF HEARING -
May 9, 2007

Cost Reporting Period Ended -
June 30, 2001

CASE NO.: 05-1792

INDEX

ISSUE:

Whether the Intermediary properly required the use of a full year's Medicaid days in the Disproportionate Share Hospital (DSH) calculation based on its interpretation of the Benefit Improvements and Protection Act (BIPA) of 2000.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due 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. §1395h, 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 portion 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 hospital (DSH) adjustment, which requires the Secretary to provide additional PPS reimbursement 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 versus a rural area, the number of beds available for patients, and the hospital's "disproportionate patient percentage (DPP)." See 42 U.S.C. §1395ww(d)(5)(F). The "disproportionate patient percentage (DDP)" 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, and 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, and 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 payment 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:

Mountains Community Hospital (Provider) is a general acute care hospital located in Lake Arrowhead, California. The Provider operated 17 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 submitted DSH documentation for the three months (April 1 – June 30, 2001) of fiscal year ended June 30, 2001 for which the Provider was eligible for DSH reimbursement under BIPA, and the Intermediary found this documentation acceptable. However, during the review of the DSH appeal, the Intermediary found that it had not reviewed the Provider's Medicaid days for the entire fiscal year. The Provider was notified that the Medicaid patient day review would have to be redone to account for the entire 12-month cost reporting period. The Intermediary subsequently denied DSH reimbursement for the Provider, and this action resulted in a reduction of Medicare reimbursement of approximately $6,000.

The Provider appealed the Intermediary's adjustment to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The amount in dispute is less than the regulatory requirement of $10,000. However, other issues that were appealed in this case but later resolved, when combined with the DSH issue, resulted in the total amount in dispute to be in excess of the regulatory requirement. The Provider was represented by Mr. Joseph H. Gemperline, President of Healthcare Management Solutions, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider disagrees with the Intermediary's position that the DSH documentation to be audited must cover the entire 12-month fiscal period. The Provider contends that its opinion is supported by BIPA and upheld at the Board level in Western Arizona Regional Medical Center, Bullhead City, Arizona v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Arizona, PRRB Hearing Dec. No. 2006-D19, March 3, 2006, Medicare & Medicaid Guide (CCH) ¶81,505, rev'd by CMS Administrator Dec, April 20, 2006, Medicare & Medicaid Guide (CCH) ¶81,523 (Western Arizona). The Provider contends that using documentation that specifically covers the three months for which the Provider was eligible for DSH reimbursement is more accurate than using 12-month DSH documentation.

The Intermediary argues that after determining the number of covered patient days that are associated with a hospital's discharges each month, 42 C.F.R. §412.106(b)(2)(ii) states that the determination of the hospital's disproportionate patient percentage requires that the results be added "for the whole period." The Intermediary maintains that because the regulation specifically states that the DPP is "for the whole period," the Intermediary is required to create one percentage for the cost reporting period.

The Intermediary points out that CMS, in response to comments about section 1886(d)(F)(v) of the Social Security Act as amended by BIPA, CMS stated that "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 maintains that if the intent of the regulations was to make separate DSH percentages for those periods straddling April 1, 2001, CMS would have to compute separate SSI percentages for those periods that straddle April 1, 2001 as well. However, that issue has never been raised.

Finally, the Intermediary argues that the CMS Administrator overturned the Board's decision in Western Arizona and stated, "Only one DPP is to be calculated for the entire cost reporting period, regardless of whether the hospital became eligible as of Apri1 1, 2001."

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines and the parties' contentions, 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 a

DSH adjustment if their DSH patient percentage met a 15% threshold rather than the previous 40% threshold. The amendment,[1] which took effect 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 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, CMS stated:

> This means 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 pertaining to 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

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

April 1, 2001. 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 Intermediary's methodology and the adjustment resulting from its application is 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 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 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 C. Hayes
Elaine Crews Powell, C.P.A. (Dissenting Opinion)
Anjali Mulchandani-West (Dissenting Opinion)

DATE: August 9, 2007

FOR THE BOARD:

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.

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Anjali Mulchandani-West

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Elaine Crews Powell