PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2008-D9

PROVIDER –
Medical Park Hospital
Hope, Arkansas

Provider No.: 04-0091

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Arkansas BlueCross & BlueShield

DATE OF HEARING –
August 28, 2007

Cost Reporting Period Ended -
June 30, 2000

CASE NO.: 03-0811

INDEX

ISSUE:

Whether the Provider's Disproportionate Share Hospital (DSH) adjustment was correctly calculated.

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.

Pursuant to 42 CFR §412.92(a), CMS can classify a hospital as a sole community hospital (SCH) if it is located more than 35 miles from other like hospitals, or if it is located in a rural area (as defined in §412.83(b))[1] and meets one of three additional conditions. A hospital must make its request for classification as a SCH to its fiscal intermediary. The intermediary reviews the request and forwards its recommendation for approval or disapproval to CMS. CMS reviews the request and the intermediary's recommendation and forwards its approval or disapproval to the intermediary. If approved, SCH status is effective 30 days after the date of CMS' written notification of approval. 42 C.F.R §412.92(d) and other provisions identify benefits to which SCHs are entitled.

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

[1] The Board notes the regulatory reference in 42 C.F.R. §412.92(a) to §412.83(b) is to a nonexistent section. However, whether the hospital is located in a rural area is not controversy in this case.

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 a DSH adjustment, and how large an adjustment it receives, depends on numerous factors such as whether the hospital is in an urban versus a rural area, the number of beds available for patient care, and the hospital's "disproportionate patient percentage (DPP)." See 42 U.S.C. §1395ww(d)(5)(F). The DPP is the sum of two fractions: the Medicare fraction and Medicaid fraction, 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 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).

A hospital is deemed to have served "a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a DPP for that period that exceeds a specific threshold. For the period in question, the DPP for rural hospitals with less than 100 beds was 45% and the DPP for SCHs was 30%. 42 U.S.C. §1395ww(d)(5)(F)(v).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Medical Park Hospital (Provider) is a 67 bed acute care hospital located in Hope, Arkansas. The Provider received SCH designation on March 3, 2000, approximately eight months into its June 30, 2000 fiscal year end (FYE). In its as-filed cost report, the Provider included a 12-month claim for disproportionate share payments based on the fact that the DSH qualification criteria, as applied to SCH status, had been met as of the end of the cost reporting period. Arkansas Blue Cross Blue Shield (Intermediary) disagreed with the Provider's calculation and settled the cost report by making two separate computations for the DSH reimbursement, one prior to SCH status (July 1, 1999-March 2, 2000) and one post SCH status (March 3, 2000-June 30, 2000). The Intermediary's adjustments resulted in a reduction of Medicare reimbursement of approximately $169,600.

The Provider appealed the adjustments to the Board and met the jurisdictional requirements of 42 C.F.R §§405.1835- 405.1841. The Provider was represented by Jonathan L. Rue, Esquire of Parker, Hudson, Rainer & Dobbs L.L.P. The Intermediary was represented by Bernard M. Talbert Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Intermediary argues that the Provider's DPP, as calculated for the entire year, was 38.249%. Since the Provider's DPP did not meet the qualifying threshold (45%) prior to the Provider being redesignated as a SCH on March 3, 2000, the Provider should not receive DSH payments prior to that date. The Intermediary argues that law, regulation and administrative decisions support its position.

The Intermediary argues that 42 C.F.R. §412.106(d)(2)(i)(A) are replete with examples where the DPP would change during a provider's fiscal period thereby requiring that a "split" calculation be made as follows:

> (2) ***Payment adjustment factors.***
>
> (i) If the hospital meets the criteria of paragraph (c)(1)(i) of this section, the payment adjustment factor is equal to one of the following:
>
> (A) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is as follows:
>
> (1) For discharges occurring on or after April 1, 1990, and before January 1, 1991, 5.62 percent plus 65 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.
>
> (2) For discharges occurring on or after January 1, 1991, and before October 1, 1993, 5.62 percent plus 70 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.
>
> (3) For discharges occurring on or after October 1, 1993, and before October 1, 1994, 5.88 percent plus 80 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

For example, every hospital with either a December 30, 1993 FYE or a June 30, 1994 FYE will have the same DPP for its fiscal year, but different disproportionate share payment percentages would apply to DRG revenues applicable to discharges before and after 10/1/1993.

The Intermediary argues that the Board's analysis in Western Arizona Regional Medical Center vs. Blue Cross Blue Shield Association/Blue Cross & Blue Shield of Arizona, Dec. No. 2006-D19 and the Administrator's decision reversing the decision support sustaining the Intermediary's calculation here. Western Arizona also dealt with a mid-

fiscal period change in the disproportionate share hospital qualifying percentage, although the issue in dispute was not how it was applied, as in this case, but whether the provider's DPP calculation should be split before and after the date of the change in qualifying percentage or be calculated for the entire fiscal period.[2] However, both the Board's and the Administrator's decisions recognized the need for a split calculation before and after the change in the disproportionate share qualifying percentage.

The Provider contends that the Intermediary improperly limited its DSH adjustment claim to the period of time after the Provider obtained SCH status. The Provider asserts that because it met the 30% qualification percentage prior to the end of its cost reporting period, it is entitled to apply the SCH disproportionate share percentage to all Medicare discharges including those prior to the effective date of SCH status.[3] The Provider maintains that it relied on 42 CFR §412.106 when it filed its cost report, and nothing in the applicable regulation supports the Intermediary's position that the DSH adjustment must be split between the pre and post SCH periods.

The Provider contends that 42 C.F.R. §412.106(a)(2) supports its position that the DSH add-on percentage should be applied to the total amount of DRG revenue for the year, and not just the portion of DRG revenue after it qualified for SCH status. The regulation reads " . . . the payment adjustment is applied to the hospital's total DRG revenues for inpatient operating costs, based on DRG-adjusted prospective payment rates for inpatient operating costs. . ." The Intermediary did not follow the plain language of the regulation and should be required to do so.

Finally, the Provider does not agree with the Intermediary's analysis that the PRRB decision in Western Arizona supports its position that two DSH percentage calculations can be made in the same fiscal year. The Provider asserts that the decision in Western Arizona was based on specific language included within the Benefit Improvement and Protection Act of 2000 (BIPA), which differs from the instant case in which there is no language in either the statute or the regulations that compels a split calculation. The Provider maintains that Western Arizona is not at odds with the Provider's position in this case and, therefore, should not be used as precedent to find for a split calculation.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes as follows:

42 C.F.R. §412.92(b)(2)(i) states that the effective date of the classification of a hospital as a SCH is 30 days after the date of CMS' written notification of approval. It is at that

[2] The Provider's disproportionate patient percentage was calculated over the entire fiscal period in this case, and is not disputed by the Provider.

[3] The Provider's disproportionate patient percentage was 38.429% (based on a full 12 months). Therefore, the Provider did not meet the qualifying threshold prior to March 3, 2000, as the threshold for a rural hospital with less than 100 beds was 45%. Once the hospital qualified for SCH status, the threshold fell to 30% and the Provider qualified. See I-5.

time that hospitals become eligible for the benefits that are available to sole community hospitals. The benefit that is at issue in this case is the lower threshold to qualify for the DSH adjustment. It is undisputed that the Provider did not qualify for the DSH adjustment prior to its reclassification as a SCH.

42 U.S.C. §1395ww(d)(5)(F)(v) and 42 C.F.R §412.106(c)(1)(ii) provide that a hospital classified as a sole community hospital under 42 C.F.R. §412.92 must have a disproportionate patient percentage of at least 30% to be classified a disproportionate share hospital and therefore be eligible to receive the additional disproportionate share payment. 42 C.F.R §412.106(d)(2)(ii)(B) then instructs how to calculate the DSH benefit for a sole community hospital. The Provider had a disproportionate patient percentage of approximately 38%.

It is undisputed that the Provider met the SCH threshold to receive a DSH payment and the parties agree on the DSH payment adjustment factor to be applied. The sole question for the Board is at what point should the DSH payment factor be applied to discharges. The Provider argues that it should apply to discharges for the entire year, and the Intermediary argues that it should apply to discharges after the effective date of the Provider's qualification as a sole community hospital.

The Board finds that the sole community hospital effective date as set forth in 42 C.F.R. §412.92(b)(2)(i) is critical, and it triggers payment for DSH. Any other interpretation would inappropriately extend the benefit to a period for which a provider did not quality as a SCH. The Provider's entitlement to the DSH payment is driven solely by the SCH status effective date.

Our interpretation is supported by the cost report instructions for the DSH adjustment in CMS Pub. 15-2, §3630, which reads:

> Disproportionate Share Adjustment. --Section 1886(d)(5)(F) of the Act, as implemented by 42 CFR 412.106, requires additional Medicare payments to hospitals with a disproportionate share of low income patients. Calculate the amount of the Medicare disproportionate share adjustment on lines 4 through 4.04. Complete this portion only if you answered yes to line 21.01 of Worksheet S-2. For cost reporting periods which overlap January 20, 2000, do not complete lines 4 through 4.03 and enter on line 4.04 the manually calculated DSH payment adjusted by the appropriate reduction. (See intermediary PM A-99-62 for proper determination of DSH adjustment.) For those hospitals experiencing a change in the DSH percentage as a result of the application of the BIPA provisions effective for services on and after April 1, 2001, or as a result of the application of the MMA provisions effective for discharges on and after April 1, 2004, (i.e., geographic reclassification) subscript column 1 (add column 1.01) for lines 1, 1.01, 1.02, 1.07, 4.03 and 4.04 and

> apply the appropriate percentage for the DSH payment and reduction in accordance with the payment dates prescribed above. Review the payment chart on page 137 and lines 1, 1.01, 1.02 and 1.07 for proper reporting of payments. Do not subscript the column for lines 4.03 and 4.04, except as applicable for SCH\MDH and geographic reclassification.

The cost report instructions reflect CMS' interpretation which we find to be consistent with the statute.[4] This section allows for the subscripting of line 4.03 – Allowable disproportionate share percentage and line 4.04 - Disproportionate share adjustment upon a SCH reclassification, thereby splitting the fiscal year between pre-SCH reclassification and post-SCH reclassification. The Intermediary properly applied the split calculation.[5]

DECISION AND ORDER:

The Intermediary properly limited DSH reimbursement to the period of time after the Provider was reclassified as a sole community hospital. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

DATE: November 29, 2007

Suzanne Cochran
Chairperson

[4] Board also notes that the cost report instructions allow for the mechanics to implement this decision.
[5] The Intermediary's reliance on Western Arizona is misplaced, however, in that it dealt with a change in the DSH percentage rather than the qualification requirements.