PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D51

PROVIDER -
St. Barnabas Hospital
Bronx, New York

Provider No. 33-0399

vs.

INTERMEDIARY -
Empire Medicare Services/Blue Cross Blue Shield Association

DATE OF HEARING-
April 6, 2000

Cost Reporting Period Ended -
December 31, 1992

CASE NO. 95-2202

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ISSUE:

Was the Intermediary=s adjustment reducing the allowable cost to charge ratio that should be applied to outpatient charges proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Barnabas Hospital (AProvider@) is a Medicare and Medicaid certified 433 bed acute care facility located in the Bronx, New York. During its fiscal year ended December 31, 1992, the Provider incurred costs for both inpatient Part B services and outpatient Part B services. Empire Medicare Services (AIntermediary@) settled the charges for inpatient Part B services with the outpatient charges as set forth on the Provider=s as-filed cost report, and made a reduction of 5.8% in both inpatient and outpatient Part B costs. Specifically, because the Intermediary interpreted the Medicare regulations to require a reduction of 5.8% of the outpatient costs before calculating the costs to charge ratio for each reimbursable area, the Intermediary converted the charges for inpatient Part B services to cost based on the same ratio of cost to charges as the outpatient Part B charges. 42 C.F.R. ' 413.124; See Also Provider Reimbursement Manual (HCFA Pub. 15-2), ''2813.2 and 2814.5 (Intermediary Exhibits 1-4 and 1-5).

It is the Provider=s position that the Intermediary improperly applied to hospital inpatient Part B services the 5.8 percent reduction that it believes was only intended to apply to outpatient hospital services. The Provider asserts that the statute at 42 U.S.C. '1395(x)(v)(1)(S)(ii)(II) applies only to outpatient hospital services and any (Part B) charges generated by inpatients should not be subject to the reduction factor.

The Provider appealed the Intermediary=s adjustment to the Provider Reimbursement Review Board (ABoard@) in a timely manner and has met the jurisdictional requirements of 42 C.F.R. '' 405.1835-.1841. The other issues in the original appeal have either been withdrawn or transferred to a group appeal. The reimbursement effect of the issue is approximately $25,000.[1] The Provider is represented by Murry J. Klein, Esquire, of Reed Smith Shaw & McClay LLP. The Intermediary is represented by Eileen Bradley, Esquire, of the Blue Cross and Blue Shield Association.

STATUTORY AND REGULATORY BACKGROUND:

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[1] Provider Supplemental Position Paper at 4; Intermediary Position Paper at 4.

Congress provided for a 5.8 percent reduction in the reasonable costs of hospital outpatient services attributable to cost reporting periods in certain years. Specifically, 42 U.S.C. ' 1395(x)(v)(1)(S)(ii)(II) provides as follows:

> The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise determined pursuant to section 1833(a)(2)(B)(I)(I) [42 U.S.C. 1395l(a)(2)(B)(I)(I)] of this title to be 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 through 1999 and, during fiscal years 2000 before January l, 2000.

Id.

Similarly, the Secretary=s regulations indicate that the 5.8 percent reduction only applies to outpatient services:

> [T]he reasonable costs of outpatient hospital services (other than capital related costs of such services) are reduced by 5.8 percent for services rendered during portions of cost reporting periods occurring on or after October 1, 1990 and before October 1, 1998.

42 C.F.R. ' 413.124.

PROVIDER=S CONTENTIONS:

The Provider contends that the Intermediary improperly applied to hospital inpatient Part B services a 5.8 percent reduction that it believes was only intended to apply to outpatient hospital services. The Provider acknowledges that the error and the resultant reduction in reimbursement to which the Provider was properly entitled was unintended by either the Intermediary or HCFA.[2] The improper reduction resulted from the inclusion of certain inpatient Part B services, together with outpatient services, on a particular line of the cost report, and the resultant application of the 5.8 percent reduction to that line. The Provider points out that in response, the Intermediary simply notes that the form was approved by HCFA, and therefore the Provider is not entitled to relief. The Provider argues that although it is clear from the statutory and regulatory language that the 5.8 percent reduction applies only

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[2] Provider Supplemental Position Paper at 1.

to outpatient hospital services, the reduction has also been applied improperly to certain inpatient Part B services. It is the Provider=s opinion that this result was unintentional.

The Provider asserts that the 5.8 percent cost reduction takes place on worksheets C and D of the Medicare Form 2552. The Provider explains that this is done by calculating cost to charge ratios that reflect the 5.8 percent reduction in reasonable costs of hospital outpatient services and applying those reduced ratios to the Medicare Program charges on worksheet D. The Provider points out that included in the Program charges columns on worksheet D is a column titled AAll other Part B@ The Provider asserts that this column is designated for reporting Program Inpatient Part B and Other Outpatient Part B charges. Thus, the Provider contends that because of the mechanics of the Medicare Form 2552 settlement process, the 5.8 percent reduction is being applied to inpatient Part B charges, in addition to outpatient charges.

The Provider has performed an analysis that isolates charges in the AAll other Part B@ column on Worksheet D that relates solely to inpatient Part B charges, and then excludes them from the application of the 5.8 percent reduction.[3] In its analysis, the Provider notes that on Schedule C, Part II, an Aoutpatient@ cost-to-charge ratio is developed that is to be multiplied against actual charges to determine allowable cost (i.e. reimbursement). The cost-to-charge ratios are reflected in column 8 of Schedule C, Part II.[4] It is Provider=s position that the development of this cost-to-charge ratio is the central issue in this case.

As noted above, the statute requires a 5.8 percent reduction of operating costs as applied to outpatient charges. The Provider contends that under the current procedure, one ratio is computed and then (because of the mechanics of the cost report) eventually applied to inpatient Part B charges as well.

The Provider's two-page analysis, therefore, computes two cost-to-charge ratios.[5] One includes the 5.8 percent reduction (column 8), and the other does not. The modified cost-to-charge ratio is found in column 8A.[6] That new cost-to-charge ratio is multiplied against inpatient Part B charges which are accumulated by Medicare in the AProvider Statistical and Reimbursement Summary@ (APS&R@) report.[7] The new result is then compared to the current reimbursement impact,

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[3] See Provider Supplemental Position Paper at Exhibit 1.

[4] See Provider Supplemental Position Paper at Exhibit 2.

[5] See Provider Supplemental Position Paper at Exhibit 1.

[6] Id.

[7] See Provider Supplemental Position Paper at Exhibit 3.

which the Provider contends, uses the wrong cost-to-charge ratio. The increase in reimbursement is then reflected, by department and in total, in the last column of the two-page analysis.[8]

In conclusion, the Provider notes that the methodology by which HCFA applies the statutory mandated 5.8 percent reduction to outpatient charges also is applied (apparently unintended by HCFA) to inpatient Part B charges. The Provider contends that this application violates the clear statutory and regulatory mandate.

INTERMEDIARY=S CONTENTIONS:

The Intermediary points out that Medicare regulations authorize payment for certain inpatient hospital ancillary services under Part B when Part A coverage is no longer available. Such services are known as and commonly referred to as Ainpatient Part B services.@ When including Medicare charges on the cost report, inpatient Part B charges and outpatient Part B charges are combined because they are paid from the same Part B trust fund.

In addition, the Intermediary notes that the Omnibus Budget Reconciliation Act (AOBRA@) of 1990 ' 1861 (v)(1)(S)(ii)(II) to the Social Security Act, required reasonable costs of noncapital-related outpatient hospital services to be reduced by 5.8%. The change in the law led to revisions in the Hospital cost reporting forms. Pertinent to this case, the Intermediary contends that the forms were modified to reduce reasonable costs for all hospital Part B services, both inpatient and outpatient.

The Intermediary refers to HCFA Pub. 15-2, ' 2814.5, which states:

> This worksheet provides for apportionment of costs applicable to outpatient services reimbursable under titles V, XVIII, and XIX, as well as inpatient services reimbursable under title XVIII, Part B. (Emphasis added)

Id.

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[8] See Provider Supplemental Position Paper at Exhibit 1.

Based on this section, the Intermediary contends that it properly applied the weighted outpatient ratio of cost to charges, per HCFA Pub. 15-2 ' 2813.2, to the inpatient Part B Medicare charges.[9]

The Intermediary also argues that there is no statutory entitlement to Medicare payment under Part B for inpatient services when Part A benefits are exhausted. Thus, the Intermediary believes that the Secretary has full discretion to establish the payment levels under the Medicare program for such services, including reducing payments by 5.8%, cutting such payments in half or even providing for no payment for such services. The Intermediary asserts that inpatient Part B benefits have generally been combined with outpatient Part B benefits for cost reporting purposes as a matter of administrative discretion and convenience.[10] The Intermediary contends that when Congress elected to reduce outpatient Part B noncapital-related reasonable costs by 5.8%, the Secretary, by regulation, 42 C.F.R. ' 413.124, also reduced inpatient Part B noncapital-related reasonable costs by 5.8%. Thus, the Intermediary concludes that whatever changes affect Part B outpatient services, costs and reimbursement also affect Part B inpatient reimbursement.

The Intermediary notes the Provider=s assertion that OBRA 1990 applies only to outpatient hospital services and any (Part B) charges generated by inpatients should not be subject to the reduction factor. While the Intermediary acknowledges that this assertion may be true, it does not alter the Secretary=s power to pay whatever she feels is appropriate for inpatient Part B services.[11] The Intermediary argues that merely because the legislation mandated a reduction in outpatient Part B costs does not also mean the Secretary is barred from making the reduction factor apply as well to inpatient Part B costs. The Intermediary contends that because any payment for inpatient Part B services is solely at the discretion of the Secretary, then the conditions under which such payments are made, including the amount, is also within the Secretary=s discretion.

The Intermediary contends that it properly applied the 5.8 percent reduction factor to both Part B inpatient and outpatient services by following the applicable regulations, manual provisions and cost reporting instructions. The Intermediary asserts that the Provider=s challenge to the Secretary=s authority to apply the 5.8 percent reduction factor to inpatient as well as the legislatively compelled outpatient Part B services is without merit. It is the Intermediary=s position that if the Secretary can authorize payment for inpatient Part B services in the first instance where there is no statutory mandate to do so, she can also set the parameters for such payments as she has done here. The Intermediary urges the Board to uphold the Intermediary=s settlement of the cost report on this issue.

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9 Intermediary Position Paper at 8, See Intermediary Exhibit I-4.

10 Intermediary Supplemental Position Paper at 3.

11 Id.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII of the Social Security Act:

' 1833(a) et seq.	-	Amount of Payment
' 1861(v)(1)et seq.	-	Reasonable Cost

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

' 1395 (x)(v)(1) et seq	-	Reasonable Cost
' 1395l (a) et seq	-	Amount of Payment

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

'' 405.1835-.1841	-	Board Jurisdiction
' 413.124	-	Reduction to Hospital Outpatient Operating Costs

4. Program Instructions- Provider Reimbursement Manual (HCFA Pub. 15-2):

' 2813.2	-	Part II - Calculation of Outpatient Cost to Charge Ratios Net of Reductions
' 2814.5	-	Part V - Apportionment of Medical and Other Health Services Costs

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, and evidence submitted, finds and concludes that based on the plain language of the applicable statute and the Secretary=s own regulation, the outpatient reduction factor at issue in this case may not be applied to inpatient Part B services. The Board notes that the applicable statute, 42 U.S.C. '1395(x)(v)(1)(S)(ii)(II) provides as follows:

> The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise

> determined pursuant to section 1833(a)(2)(B)(I)(I) [42 U.S.C. 1395l(a)(2)(B)(II)] of this title to be 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 through 1999 and, during fiscal years 2000 before January l, 2000.

Id. (Emphasis added).

Similarly, the Secretary=s regulation at 42 C.F.R. ' 413.124 indicates that the 5.8 percent reduction only applies to outpatient services:

> [T]he reasonable costs of outpatient hospital services (other than capital related costs of such services) are reduced by 5.8 percent for services rendered during portions of cost reporting periods occurring on or after October 1, 1990 and before October 1, 1998.

Id. (Emphasis added).

The Board finds that the above statute and regulation specifically refer to the reduction of outpatient services. The Board notes that there was nothing in evidence of notice given by the Secretary of her intent to reduce inpatient Part B costs.

The Board further notes that the Intermediary did not challenge the Provider=s claim that the inpatient Part B services at issue were in fact furnished to hospital inpatients, not hospital outpatients, and therefore, constitute hospital inpatient services, not hospital outpatient services. Accordingly, as noted above, the Board concludes that based on the plain language of the statute and regulation, the outpatient cost reduction factor may not be applied to inpatient Part B services.

The Board also finds that its conclusion is supported by the language in the statute instructing the Secretary to adopt a prospective payment system for hospital outpatient services. The Board believes that Congress was aware that hospital outpatient services and inpatient Part B services were different by the definition of covered outpatient department services. Covered outpatient department services include: (1) hospital outpatient services designated by the Secretary; and (2) inpatient hospital services designated by the Secretary that are covered under Part B and furnished to a hospital inpatient . . . (See 42 U.S.C ' 1395l(t)(1)(D).) By separately designating hospital outpatient services and inpatient hospital services covered under Part B, Congress indicated clearly that hospital outpatient services and inpatient hospital services covered under Part B are different.

The Board rejects the Intermediary=s contention that because of the statute requiring the 5.8 percent

reduction necessitated a change in cost report forms and instructions, it was correct in using those forms to apply the reduction factor to inpatient Part B services in addition to outpatient services. The Board believes that to the extent that cost report forms and instructions require the resultant reduction to inpatient Part B services, the forms and instructions are contrary to statute and regulation at 42 U.S.C. '1395(x)(v)(1)(S)(ii)(II) and 42 C.F.R. ' 413.124 respectively, and are therefore invalid. The Board believes that if the forms and instructions are wrong and contrary to the statute and regulation, HCFA should correct them.

Regarding the Intermediary=s argument that Athe Secretary has full discretion to establish the payment levels under the Medicare program for such services (inpatient Part B), including reducing payments by 5.8%, cutting such payments in half or even providing for no payment for such services,@[12] the Board notes that this argument was not supported by any statutory or regulatory authority.

DECISION AND ORDER:

The Intermediary improperly applied the outpatient cost reduction factor to the Provider=s inpatient Part B services. The Intermediary is ordered to compute an adjustment to the Provider=s Medicare reimbursement to remove the application of the outpatient Part B reduction factor from the Provider=s inpatient Part B costs.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. , Esquire
Charles R. Barker
Stanley J. Sokolove

FOR THE RECORD

Irvin W. Kues
Chairman

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[12] Intermediary Supplemental Position Paper at 3.