PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2005-D34

PROVIDER -
Brackenridge Hospital
Austin, Texas

Provider No.: 45-0124

vs.

INTERMEDIARY-
BlueCross BlueShield Association/
TrailBlazer Health Enterprises, LLC

DATE OF HEARING -
October 29, 2004

Cost Reporting Period Ended -
September 30, 1994

CASE NO.: 98-1658

INDEX

ISSUE:

Whether the Intermediary properly applied the "Pickle Amendment" in calculating the Provider's Disproportionate Share Hospital (DSH) adjustment.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the 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. §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.

When Congress established the Medicare Prospective Payment system (PPS) in 1983, it authorized the Secretary to provide an adjustment to PPS payments for hospitals that serve a disproportionate share of low income patients. See Social Security Amendments of 1983, Pub. L. No. 98-21, §601(e), codified at 42 U.S.C. §1395ww(d)(5)(C)(i) (1983).

In 1986, the Medicare statute was amended to prescribe statutory definitions of disproportionate share hospitals. Comprehensive Omnibus Budget Reconciliation Act of 1986 ("COBRA"), Pub. L. No. 99-272, 100 stat. 82, 158-60 (1986), §9105; Samaritan Health Ctr. v. Bowen, 646 F. Supp. 343, 345-47 (D.D.C. 1986). The language which now comprises the so-called "Pickle Amendment" was enacted subsequently as part of the Omnibus Budget Reconciliation Act ("OBRA") of 1987, Pub. L. No. 100-203, §4009(j)(3)(A), 101 Stat. 1330, 1330-59 (1987).

The method for establishing DSH "Pickle Amendment" qualification, at issue in this case, is set forth in 42 U.S.C. §1395ww(d)(5)(F)(i)(II). Under this amendment, a hospital may qualify for a disproportionate share adjustment based on net inpatient care revenues

received from state and local government sources for indigent care. 42 U.S.C. §1395ww(d)(5)(F)(i)(II). Specifically, it provides payment adjustment for a PPS hospital that:

> . . . is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this subchapter or State plans approved under subchapter XIX of this chapter), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

Id.

The subchapters referred in the above statute are those establishing the Medicare and Medicaid programs.

Thus, determining whether a hospital qualifies for Pickle Amendment payments essentially involves the calculation of a fraction. The statute establishes a common pool of "revenues" from which both the numerator and the denominator of the fraction are drawn, i.e., "net inpatient care revenues (excluding any of such revenues attributable to [Medicare] or [Medicaid]." The numerator consists of the net inpatient care revenues from this pool that are "for indigent care from state and local government sources." The denominator consists of the "total of such net inpatient care revenues," i.e., the total pool, and is the subject of the instant controversy.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Brackenridge Hospital (Provider) is an acute care hospital located in and owned by the city of Austin, Texas. As a public hospital during the year at issue in this case, it provided a substantial amount of services to indigent patients and received significant funding from state and local governments to help cover the costs of such services.

On its as-filed Medicare cost report for fiscal 1994, the Provider claimed that it was entitled to a DSH payment under the "Pickle Amendment" provision discussed above. The Intermediary denied the Provider's claim, resulting in a disallowance of approximately $296,000 in reimbursement to the Provider.

The parties, Brackenridge Hospital (Provider) and TrailBlazer Health Enterprises, LLC (Intermediary), jointly stipulate the following:

1. The Provider claims that it is entitled to a DSH adjustment under the Pickle Amendment (Section 1886(d)(5)(F)(i)(II) of the Social Security Act).

2. The parties agree on the methodology for determining qualification for the Pickle Amendment DSH adjustment with one significant exception. The Intermediary contends that net inpatient care revenues attributable to Medicare and Medicaid must be included in the net inpatient care revenues used for the denominator of the fraction which determines the Hospital's eligibility for the Pickle Amendment adjustment under section 1886(d)(5)(F)(i)(II) of the Social Security Act, 42 U.S.C. §1395www(d)(5)(F)(i)(II). The Provider contends that net inpatient care revenues attributable to Medicare and Medicaid must be excluded from the net inpatient care revenues used for the denominator.

3. To qualify for a Pickle Amendment DSH adjustment, a hospital's Pickle Amendment percentage must exceed 30%. The parties stipulate and agree that if the net inpatient care revenues attributable to Medicare and Medicaid are excluded from the net inpatient care revenues used for the denominator of the Pickle Amendment calculation, the Provider qualifies for the Pickle Amendment adjustment for its fiscal year ending September 30, 1994.

4. The controlling question in this case is whether net inpatient care revenues attributable to Medicare and Medicaid are properly included in the denominator of the Pickle Amendment computation. If the answer to this question is yes, the Provider is not entitled to Pickle Amendment DSH adjustments. If the answer to this question is no, the Provider is entitled to Pickle Amendment DSH adjustments.

The Provider appealed to the Provider Reimbursement Review Board (Board) the Intermediary's adjustment of the DSH denominator used in applying the Pickle Amendment and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Mary Susan Philp, Esquire, of Powers, Pyles, Sutter & Verville, P.C. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and program instructions, evidence submitted and parties' contentions, finds and concludes that the Intermediary properly included Medicare and Medicaid revenues in the denominator of the Provider's DSH calculation using the "Pickle Amendment" to determine the Provider's DSH reimbursement. The Board notes that the joint stipulation in this case completely defines the issue and states that there is no dispute as to the facts in this case. The issue is whether to include or exclude Medicare and Medicaid revenues in the denominator of the "Pickle Amendment" fraction.

The Board notes that a similar case concerning this issue has been decided in the United States District and Circuit Courts. North Broward Hospital District et al v. Shalala, 172 F. 3d. 90 (D.C. Cir. 1999). The Board is persuaded by the arguments and conclusions of the Circuit Court decision which found that the denominator of the fraction should

include all Medicare and Medicaid revenues. This conclusion is further supported by the Board's analysis of the legislative history of the issue, which states in part:[1]

> The Secretary would be required to include all such inpatient care payments in determining whether a hospital meets the threshold for the exceptions. . . . The Committee further intends that the denominator of this equation, net inpatient care revenue, be defined according to the general accepted accounting principles in the hospital industry, i.e., this factor should represent gross patient care revenues less deductions from revenue (other than contractual allowances), as those terms are generally used.[2]

The Board notes that there is no apparent intent to exclude Medicare and Medicaid revenues from the denominator of the fraction, but the statute is ambiguous on this point. However, the Medicare regulation requires the use of total revenue.

The Board finds that the Pickle Amendment was intended to be a limited exception and not to replace the original DSH calculations. It was an alternative method of calculating DSH reimbursement for only a limited number of hospitals. This finding is substantiated by the following:

The Legislative history[3] states:

> Because of concern that this proxy measure of low-income patients in some hospitals, most particularly public hospitals in states where the Medicaid eligibility standards are stringent, this provision also includes a limited exceptions process for such hospitals.

The regulation states:

> A hospital is classified as a "disproportionate share" hospital under any of the following:
>
> * * * * *
>
> (2) The hospital is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and Local government payments for care furnished to indigent patients.

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[1] 99th Congress Second Session 1986 Volume 3, Public Laws 99-591 to 99-664 [Stat. Pages 3341 to 4309] legislative History Public Laws 99-272.P. 596-597.

[2] University Medical Center of Southern Nevada (Las Vegas, Nev.) v. Mutual of Omaha Insurance Company, 2001-D26, (May 10, 2001).

[3] 99th Congress Second Session 1986 Volume 3, Public Laws 99-664 [Stat. Pages 3341 to 4309] legislative History Public Laws 99-272.P. 596-597.

42 C.F.R. §412.106(c)(2)

The Board concludes that the Intermediary properly included Medicare and Medicaid revenues in the denominator of the fractional calculation of the Provider's DSH reimbursement and, therefore, properly computed the Provider's DSH adjustments.

DECISION AND ORDER:

The Intermediary properly included Medicare and Medicaid revenues in the denominator of the fractional calculation of the Provider's DSH adjustment using the Pickle Amendment criteria. The Intermediary's adjustment is upheld.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Gary B. Blodgett, D.D.S
Elaine Crews Powell, C.P.A.

FOR THE BOARD:

DATE: April 11, 2005

Suzanne Cochran, Esquire
Chairperson