PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D33

PROVIDER -
Winn Parish Medical Center
Winnfield, Louisiana

Provider No.: 19-0090

vs.

INTERMEDIARY -
Wisconsin Physicians Service
(formerly Mutual of Omaha)

DATE OF HEARING -
March 18, 2010

Cost Reporting Periods Ended -
December 31, 2001 ; December 31, 2002;
December 31, 2003; December 31, 2004;
December 31, 2005; March 31, 2007;
March 31, 2008

CASE NOs.: 08-1168; 08-1169; 08-1170; 08-1171; 09-0911; 09-0130 and 09-1195

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ISSUE:

Whether the Provider is eligible to be classified and reimbursed as a Medicare Dependent Hospital (MDH) for the fiscal years ended (FYEs) 12/31/01, 12/31/02, 12/31/03, 12/31/04, 12/31/05, 03/31/07, and 03/31/08.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the Provider's eligibility for classification as an MDH and its impact on 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 *et seq*. The Centers for Medicare & 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 to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[1] determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. *See* 42 U.S.C. §§1395h,1395kk-1, 42 C.F.R. §§ 413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the 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 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 receipt of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

Section 6003(f) of Pub. L. No.101-239, the Omnibus Budget Reconciliation Act of 1989 (OBRA-89), created a new category of hospitals called Medicare –Dependent, Small Rural Hospitals effective for cost reporting periods beginning on or after April 1, 1990. MDHs are eligible for a special payment adjustment under the acute care hospital inpatient prospective payment system (IPPS).

The MDH statute in effect for all the years under appeal stated the qualifying criteria as follows:

> The term "medicare-dependent, small rural hospital" means, with respect to any cost reporting period to which clause (i) applies, any

[1] FIs and MACs are hereinafter referred to as intermediaries.

> hospital—
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> (I) located in a rural area,
> (II) that has not more that 100 beds,
> (III) that is not classified as a sole community hospital under subparagraph (D), and
> (IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, or 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A of the subchapter.

42 U.S.C. § 1395ww(d)(5)(G)(iv). The CMS regulation similarly laid out the MDH qualifying criteria. *See* 42 C.F.R. § 412.108(a).

For cost reporting periods beginning on or after April 1, 2001, § 212 of the Benefits Improvement Act of 2000 (BIPA), Pub. L. No. 106-554, added the language to 42 U.S.C. § 1395ww(d)(5)(G)(iv)(IV), "or 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report." This added language allowed hospitals the option of basing their MDH eligibility on two of the three most recently audited cost reporting periods for which CMS had a settled cost report, rather than on the cost reporting period that began during FY 1987.

In implementing BIPA 2000 the regulations at 42 C.F.R. § 412.108 had several changes including the addition of subparagraph (b)(4) which states:

> (4) A determination of MDH status made by the fiscal intermediary is effective 30 days after the date the fiscal intermediary provides written notification to the hospital. An approved MDH status determination remains in effect unless there is a change in the circumstances under which the status was approved.

Prior to the above addition, a hospital which qualified under the MDH criteria using the FY 1987 utilization rate would receive MDH payments starting with the first day of the Medicare cost reporting period for which it initially qualified as a MDH.[2]

[2] See 58 Fed. Reg. 15155 (April 20, 1990).

Finally, the Medicare regulations provide that a determination of an intermediary may be reopened with respect to findings on matters at issue in such determination. 42 C.F.R. §405.1885(a). A request to reopen must be made within three years of the date of the notice of the intermediary determination. No reopening of an intermediary determination is permitted after three years unless it is determined to have been procured by fraud or similar fault. 42 C.F.R. §405.1885(d).

The criteria to be used to determine MDH qualification, the effective date for MDH payment, and whether there is jurisdiction for all fiscal years are at issue in this case.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Winn Parish Medical Center (the Provider) is a general acute care hospital located in Winnfield, Louisiana. The Intermediary is Wisconsin Physicians Service.[3] The cost reporting periods at issue are the fiscal years ended December 31, 2001, December 31, 2002, December 31, 2003, December 31, 2004, December 31, 2005, March 31, 2007 and March 31, 2008.

For the years under appeal the Provider was not a Sole Community Hospital (SCH), was located in a rural area, and had fewer than 100 beds.[4] During the Provider's cost reporting period beginning during federal fiscal year 1987, over 60% of the Provider's inpatient days were attributable to Medicare beneficiaries.[5]

The Provider requested MDH status through reopening requests which the Intermediary denied. The Provider sought reconsideration of the Intermediary denials and the Intermediary denied the reconsideration requests. The following is a list of dates of NPRs, MDH requests, Intermediary Denials and Hearing Requests by fiscal year:

[3] Formerly Mutual of Omaha.

[4] During the FYE 8/31/1988 cost report the Provider did not qualify as a MDH as it exceeded the allowable bed count of 100 beds. That year's cost report shows 103 beds. *See* Provider Exhibit P-21.

[5] *See* Patient days on FYE 8/31/1988 cost report at Provider Exhibit P-21

Year	NPR Date	MDH Reopening Request[6]	Intermediary 1st Denial[7]	Intermediary 2nd Denial[8]	Hearing Request[9]
2001	03/26/2004	08/24/2007	09/13/2007	11/02/2007	02/15/2008
2002	04/25/2005	08/24/2007	09/13/2007	11/02/2007	02/15/2008
2003	08/25/2005	08/24/2007	09/13/2007	11/02/2007	02/15/2008
2004	09/05/2006	08/24/2007	09/13/2007	11/02/2007	02/15/2008
2005	01/19/2007	10/01/2008	10/09/2008	01/19/2009	02/19/2009
2007	05/02/2008	10/01/2008	10/09/2008	01/19/2009	10/22/2008
2008	(not finalized)	10/01/2008	10/09/2008	01/19/2009	03/18/2009

The Provider filed the appeals from the Intermediary's denial of MDH status under 42 C.F.R. § 412.108(b)(9) which states:

> (9) The fiscal intermediary's initial and ongoing determination is subject to review under subpart R of part 405 of this chapter. The time required by the fiscal intermediary to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for that review.

The Provider met the jurisdictional requirements of 42 U.S.C. § 1395oo(a). *See also* 42 C.F.R. §§ 405.1835-405.1839.[10]

The Provider was represented by Jon P. Neustadter, Esquire, of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by Stacey Hayes and Joseph O. Aydt of Wisconsin Physicians Service.

THE PARTIES' CONTENTIONS:

The Provider asserts it is entitled to MDH status and payment for each of the years under appeal pursuant to the original criteria. Specifically it was a rural hospital, not an SCH, had fewer than

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[6] *See* Provider Exhibit P-16 for the August 24, 2007 letter and Provider Exhibit P-1 for the October 1, 2008 letter.

[7] *See* Provider Exhibit P-17 for the September 13, 2007 denial letter and Provider Exhibit P-2 for the October 9, 2008 denial letter.

[8] *See* Provider Exhibit P-20 for the November 2, 2007 denial letter and Provider Exhibit P-4 for the January 19, 2009 denial letter.

[9] *See* Intermediary Exhibit I-1 (2001, 2002, 2003,2004), Exhibit I-2 (2007), Exhibit I-3 (2005), and Exhibit I-4 (2008).

[10] The Intermediary filed a jurisdictional challenge on January 15, 2009. On June 3, 2009 the Board determined it has jurisdiction over the MDH classification issue.

100 beds, and had a Medicare utilization rate of at least 60 percent in its FYE 8/31/88. The Provider argues that classification as an MDH under the original qualifying criteria is mandatory and that the Intermediary had the responsibility to make the determination on its own. The Provider believes that the original qualifying criteria remain viable to this day, as is clear from the plain language of the MDH statute. Under the original criteria, the Provider contends, CMS made it clear that the effective date of MDH status is the start of any cost reporting period when a provider meets all criteria. Finally, the Provider contends that the Intermediary has erroneously suggested that the Provider can only qualify for MDH status using the newer, optional method of reviewing Medicare utilization in the three most recently audited cost reports. However, the Provider asserts it is not seeking classification as an MDH under this newer optional criteria because it qualifies under the initial mandatory criteria set forth in 42 C.F.R. §412.108(a)(1)(iii)(A). As such, the Provider contends that the regulatory provisions requiring a written request for MDH status and setting an effective date for MDH status at 30 days after MDH approval are not applicable to these cases.

The Intermediary contends the designation as a MDH is a two-step process. First, a provider must meet all the criteria set out in 42 C.F.R. § 412.108(a). Then the provider is designated by its intermediary in accordance with the classification process at 42 C.F.R. § 412.108(b). The Intermediary believes the subparagraphs of 42 C.F.R. § 412.108(b) must be met by a provider which qualifies as an MDH under 42 C.F.R. § 412.108(a). In particular the Intermediary points to subparagraphs (b)(2) which requires a hospital to submit a written request, (b)(1) which requires the intermediary to determine whether a hospital meets the criteria specified in paragraph (a), (b)(3) establishing a time table for the intermediary to follow, and (b)(4) which makes the effective date of the MDH status determination 30 days after the date the fiscal intermediary sends the provider written notification.

The Intermediary asserts for cost report year 2002 and after CMS' proposed Interim Final Rules established that a provider must request MDH status.[11] The Intermediary believes the new criteria for obtaining MDH status based on two of the three most recently audited and settled cost reporting periods is mandatory for providers who never before were designated as a MDH. To support this position the Intermediary refers to 67 Fed. Reg. 50063 (August 1, 2002)[12] which states:

> We agree that hospitals that qualify based on the original criteria were not required to requalify based on more recent data, since the original criteria, as dictated by law, was based on a specified period, here the 1987 data. However, the law was amended and specifies the new, additional criterion: "two of the last three most

[11] The Intermediary references 66 Fed. Reg. 32172 at 32175 (June 13, 2001). *See* Provider Exhibit P-10.

[12] *See* Intermediary Exhibit I-9.

> recently audited cost reporting periods for which the Secretary has a settled cost report." We believe this language supports an interpretation that a hospital is to qualify as an MDH based on its most recent data, not based on a one-time qualification, as is the case with the original criteria, (which was based on data from a set period of time, the hospital's FY 1987 cost reporting period.)
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> *Id.* (Emphasis added).

The Intermediary believes ongoing reviews of MDH status would be only for existing MDH hospitals. *See* 67 Fed. Reg. 50063. The Intermediary asserts it is undisputed that the Provider did not meet the available criteria until the appeal years. Thus the Provider was not subject to any ongoing review by the Intermediary. The Intermediary concludes it was the responsibility of the Provider to request MDH status prospectively rather than retroactively.

The Intermediary believes the Provider's reliance on "Federal Registers of the 1990's" is unfounded for several reasons including; they were superseded by new regulations; payment adjustment arguments regarding 42 C.F.R. § 412.108(c) are not an issue in this appeal; mandatory provisions relied on only apply to hospitals designated as MDHs in 1994; and filing a cost report is not notice of meeting MDH criteria.[13]

Finally, since the reopening/MDH classification request for FYE 2001 was not made within three years of the date of issuance of the NPR, the Intermediary believes the Provider's request for MDH status for the 2001 cost report is untimely. Under regulations at 42 C.F.R. § 405.1885(a) a reopening request must be made within 3 years of a final determination. After the 3-year period has expired the determination cannot be reopened except in the case of fraud or similar fault.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, and the parties' contentions and the evidence submitted, the Board finds the Provider qualifies for MDH payments for FYEs December 31, 2001, December 31, 2002, December 31, 2003, December 31, 2004, December 31, 2005, March 31, 2007 and March 31, 2008. However, since the reopening request was made more than 3 years after the date of the NPR for the FYE December 31, 2001, it cannot be reopened and no MDH payment may be made for that year.

The questions before the Board to decide are whether the Provider can qualify under the original method for determining MDH status and when does MDH status become effective. The MDH statute in effect for all the years under appeal stated the qualifying criteria as follows:

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[13] *See* Intermediary Post Hearing Position Paper, p. 14-15.

> The term "Medicare-dependent, small rural hospital" means, with respect to any cost reporting period to which clause (i) applies, any hospital—
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> (I) located in a rural area,
> (II) that has not more that 100 beds,
> (III) that is not classified as a sole community hospital under subparagraph (D), and
> (IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, **or** two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A of the subchapter.

42 U.S.C. § 1395ww(d)(5)(G)(iv)(emphasis added).

The Board finds the statutory language clear that under criterion (IV) above there are two options to qualify for MDH status. Option 1, based upon fiscal year 1987 data or option 2, based upon two of the three most recently audited/settled cost reporting periods. The statutory language conflicts with the Intermediary's assertion that option 2 is the only method to be used for providers which were not previously qualified as an MDH prior to the amendment. The Board finds that option 1 was not amended or superseded by the new option but continues to be a valid basis on which to qualify for MDH status. Therefore, the Board finds that elimination of option 1 would be in conflict with the statute and impermissible.

The Board's position that option 1 was maintained is also supported by the Federal Register publications implementing the regulatory changes required by the statute's addition of option 2. The Federal Registers stated:

> effective with cost reporting periods beginning on or after April 1, 2001, hospitals **have the option** to base MDH eligibility on two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, **rather than** on the cost reporting period that began during FY 1987.
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> 67 Fed. Reg. 50062 (August 1, 2002); *See also* 66 Fed. Reg. 32175 (June 13, 2001)(Emphasis added).

The Board finds the word "option" consistent with the statute's use of the word "or" in allowing a provider to continue to qualify as an MDH under the original rules (option 1) "or" the new

optional method (option 2).

The Board notes that historically providers which qualified under MDH criteria found in 42 C.F.R. § 412.108(a)(1)(iii)(A) (option 1) had their payments adjusted as of the first day of the fiscal year that they qualified, as outlined in the Federal Register:

> Whether the intermediary determines a hospital's classification as an MDH based on its own data or after a hospital's request, the classification will be effective with the start of the cost reporting period in which the hospital first meets all the qualifying criteria effective with the first cost reporting period that begins on or after April 1, 1990.
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> 58 Fed. Reg. 15155 (April 20, 1990).

The Board finds the original criteria described above has not changed and is still valid for providers qualifying under option 1. The regulations were modified to add the additional option granted under Section 212 of Public Law 106-554. Those regulatory changes included the implementation of a process for providers to apply for and receive the benefit of MDH status under a new optional method (option 2). The Board finds the additions to the regulations cited by the Intermediary at 42 C.F.R. § 412.108 subparagraphs (b)(1) through (b)(4) were part of the implementation of option 2 and do not change the process for option 1.

The Board also finds the Intermediary misinterprets 67 Fed. Reg. 50063 (August 1, 2002) which states:

> We agree that hospitals that qualify based on the original criteria were not required to requalify based on more recent data, since the original criteria, as dictated by law, was based on a specified period, here the 1987 data. However, the law was amended and specifies the new, additional criterion: "two of the last three most recently audited cost reporting periods for which the Secretary has a settled cost report." We believe this language supports an interpretation that a hospital is to qualify as an MDH based on its most recent data, not based on a one-time qualification, as is the case with the original criteria, (which was based on data from a set period of time, the hospital's FY 1987 cost reporting period.)
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> *Id.* (Emphasis added).

The Board finds this section does not do away with the Provider's ability to qualify for MDH status under option 1. When read together with the comment, this section states that providers

that qualify under option 2 will have to continue to qualify based upon their most recent data. Providers which qualify under the original criteria (option 1) do not need to requalify because their data is based upon a set period of time. The Board notes if this section was interpreted as the Intermediary suggests, it would eliminate option 1 conflicting with the statutory requirement.

The Board finds it is uncontested by the Intermediary and evidenced in the record that the Provider met all of the original (option 1) criteria for qualifying for MDH status for the fiscal years under appeal. The Board finds the Provider was not a Sole Community Hospital (SCH), was located in a rural area, and had fewer than 100 beds,[14] and for the Provider's cost reporting period beginning during federal fiscal year 1987, over 60% of the Provider's inpatient days were attributable to Medicare beneficiaries.[15]

Finally, the Board stands by its previous findings on jurisdiction for all fiscal years. The Board notes the Provider believed in good faith that it would be allowed reimbursement under MDH status for its FYE 2001 even though the NPR for that year was issued more than three years prior to the date the request for MDH status was filed. This good faith belief met the requirement for amount in controversy for jurisdiction. The Board points to the analysis in the D.C. District Court in *Russell-Murray Hospice, Inc. v. Sebelius* which states:

> The "amount in controversy" requirement set forth § 1395oo(a)(2) "is nothing more than a jurisdictional provision, comparable to the $75,000 amount-in-controversy provision applicable to diversity cases under 28 U.S.C § 1332." *Baystate Med. Ctr. v. Leavitt*, 545 F.Supp.2d 20,40 n. 266 (D.D.C.2008), *amended on other grounds*, 587 F.Supp.2d 37 (D.D.C.2008). The Circuit has made clear, in the comparable context of diversity jurisdiction, that no extensive fact-finding is necessary to determine that the amount in controversy exceeds the jurisdictional threshold. *See Rosenboro v. Kim*, 994 F.2d 13, 16-17 (D.D.Cir.1993) (stating that dismissal for failure to satisfy the jurisdictional amount is justified only if "from the face of the pleadings, it is apparent, to a legal certainty, that the plaintiff cannot recover the amount claimed" and that the sum claimed by the plaintiff controls so long as the claim is made in good faith (quoting *St. Paul Mercury Indem. Co. v. Red Cab Co.*, 303 U.S. 283, 288-89, 58 S.Ct. 586, 82 L.Ed 845 (1938))).

*Russell-Murray Hospice, Inc. v. Sebelius***,** F.Supp.2d, 43 (D.D.C. 2010)(July 20, 2010). Based upon this court's analysis, the Board is not to determine whether the Provider's calculation is

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[14] *See* Provider Exhibit P-13 showing fewer than 100 beds available for all fiscal years contested.

[15] *See* Patient days on FYE 8/31/1988 cost report at Provider Exhibit P-21.

right or wrong but whether it was made in good faith for jurisdictional determinations.

The Board finds that the Provider meets the amount in controversy for jurisdiction and the Medicare cost report is the proper mechanism to be used to implement payment for MDH adjustments. At the time the MDH request was made, the Board notes the FYE 2001 NPR that would be used to adjust for MDH payment was beyond the three year reopening period mandated by 42 C.F.R. § 405.1885(a). Therefore, even though the Provider qualified for MDH status in FY 2001, the Board finds the payment adjustment cannot be implemented.

DECISION AND ORDER:

The Provider qualifies for MDH payments for FYEs December 31, 2002, December 31, 2003, December 31, 2004, December 31, 2005, March 31, 2007 and March 31, 2008. The CMS determination is reversed and the Intermediary is to effect payment based upon MDH status for those fiscal years. Even though the Provider qualifies for MDH status in the FYE December 31, 2001, that cost report was beyond the 3 year reopening period when the request for MDH status was made, therefore, the MDH payment adjustment cannot be implemented.

Board Members Participating:

Yvette C. Hayes
Keith E. Braganza, CPA
John Gary Bowers, CPA
Michael W. Harty

FOR THE BOARD

Yvette C. Hayes
Acting Chairperson

DATE: June 15, 2011