PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D19

PROVIDER –
River Region Medical Center
Vicksburg, MS

Provider No.: 25-0031

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Novitas Solutions, Inc.

DATE OF HEARING –
February 4, 2011

Cost Reporting Period Ended -
June 30, 1999

CASE NO: 03-1339

INDEX

ISSUE:

Did the Intermediary correctly determine the Provider's disproportionate share hospital ("DSH") payment for the fiscal period November 1, 1998 to June 30, 1999?

MEDICARE STATUTORY AND PROCEDURAL HISTORY:

This is a dispute over the proper amount of Medicare reimbursement due to a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. 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 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, regulations and under interpretive guidelines published by CMS.[2]

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs to be allocated to the Medicare program.[3] 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").[4] 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.[5]

BACKGROUND ON CHOWS

A provider participating in the Medicare program must execute a written agreement outlining the specific Medicare program requirements it meets in order to qualify and participate in the Medicare program as a Medicare provider.[6] This agreement is referred to as a "provider agreement." If a provider undergoes a change in ownership ("CHOW"),[7] the provider agreement is automatically assigned to the new owner.[8]

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[3] *See* 42 C.F.R. § 413.20.
[4] 42 C.F.R. § 405.1803.
[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.
[6] 42 U.S.C. § 1395cc(a)(1), 42 C.F.R § 489.11.
[7] A CHOW is defined as "[t]he merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. 42 C.F.R. § 489.18(a)(3).
[8] 42 C.F.R. § 489.18(c).

A provider that experiences a CHOW must file a final or "close-out" cost report pursuant to 42 C.F.R. § 413.24(f)(1) which states in pertinent part:

> (1) *Cost reports—Terminated providers and changes in ownership.* A provider that . . . experiences a change of ownership must file a cost report for that period under the program beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement or change of ownership.

BACKGROUND RELATED TO DSH AND OTHER RULES

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("IPPS").[9] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[10] Each discharge is categorized into a Diagnosis-Related Group ("DRG"), which is based on the patient's diagnoses and procedures. In the aggregate, these discharges establish the DRG payment amount which may be adjusted based on certain hospital-specific factors.[11] This case involves the hospital-specific DSH adjustment which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[12]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[13] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification for a DSH adjustment, and it also determines the amount of the DSH payment to such a qualifying hospital.[14]

The DPP is defined as the sum of two fractions expressed as percentages.[15] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

The Medicare statute defines the Medicare/SSI fraction as:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to

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[9] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[10] *Id.*
[11] *See* 42 U.S.C. § 1395ww(d)(5).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[13] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[14] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[15] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter....[16]

The Medicare/SSI fraction is computed annually by CMS, and the Medicare fiscal intermediaries use CMS' calculation to compute a hospital's DSH payment adjustment.[17]

The Medicare statute defines the Medicaid fraction as:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[18]

The fiscal intermediary determines the number of the hospital's patient days for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[19]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

River Region Medical Center ("Provider") is an acute care hospital in Vicksburg, Mississippi. The Provider is a result of the 1998 merger between the former Vicksburg Medical Center (Provider No. 25-0031) ("VMC") and the former Parkview Regional Medical Center (Provider No. 25-0032) ("PRMC"). The Provider timely appealed its December 26, 2002 NPR on June 20, 2003 challenging the Intermediary's calculation of the DSH payment as improper. This dispute centers on the merger of VMC and PRMC into the Provider, and whether the DSH payment was properly calculated given the business merger and the emerging status of the Provider.

The parties in this case have reached the following stipulations:

1. Up until October 29, 1998, Parkview Regional Medical Center ("PRMC") was an acute-care hospital owned by the Vicksburg Clinic, Inc. and was a participant in the Medicare Program under Provider No. 25-0032. Pursuant to an AGREEMENT and PLAN OF MERGER, the Vicksburg Clinic, Inc. merged into River Region Medical Corporation, with River Region Medical Corporation identified as the "Surviving Corporation" and Vicksburg Clinic, Inc. identified as the "Merging Corporation." The date of the

[16] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added).
[17] 42 C.F.R. § 412.106(b)(2)-(3).
[18] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added).
[19] 42 C.F.R. § 412.106(b)(4).

AGREEMENT and PLAN OF MERGER was October 29, 1998. *Reference*: Intermediary Exhibit 2, pp. 3-4.

2. Up until October 29, 1998, Vicksburg Medical Center ("VMC") was owned by HTI Health Services, Inc. ("HTI") and participated in the Medicare Program under Provider No. 25-0031. Pursuant to a CONTRIBUTION AGREEMENT dated October 30, 1998, River Region Medical Corporation and HTI transferred their respective interests (including VMC and PRMC) to Vicksburg Healthcare, LLC (d/b/a River Region Health System)("Provider"). *Reference*: Provider Exhibits 8 and 9. The execution of the AGREEMENT and PLAN OF MERGER and CONTRIBUTION AGREEMENT will be referred as the "Merger."

3. Prior to the merger, VMC was geographically reclassified from "rural" to "other urban"—Jackson, Mississippi, for the period from October 1, 1998 through September 30, 1999, by virtue of a decision from the Medicare Geographic Classification Review Board dated January 28, 1998 ("MGCRB Letter"). *Reference*: Provider Exhibit 7.

4. At the time the fiscal period ending June 30, 1999 Notice of Program Reimbursement ("NPR") was issued and at the time this appeal was originally filed, the fiscal intermediary was TriSpan Health Services. Novitas Solutions, Inc. is currently the fiscal intermediary for Mississippi hospitals under a contract with the Secretary of the Department of Health and Human Services. TriSpan Health Services and Novitas Solutions, Inc. are collectively referred to herein as "Intermediary." Also in 2001, the Health Care Financing Administration ("HCFA") was changed to the Centers for Medicare and Medicaid (sic Services) ("CMS"). Agency documents straddle this change. For convenience, all references will be to CMS.

5. Prior to the merger, PRMC was designated as a "rural referral center" by the Medicare Program. *Reference*: Provider Exhibit 6.

6. The transactions that merged the two hospitals into Vicksburg HealthCare, LLC, constituted "change of ownership" of the hospitals under Medicare Program rules, effective November 1, 1998. *Reference*: Provider Exhibits 15 and 26.

7. Documentation was submitted to the Intermediary and to CMS in connection with the approval of the "change in ownership" based on the transaction described in Paragraph 2. *Reference*: Provider Exhibits 15 and 16. Consistent with recognition of change of ownership requirements, terminating cost reports were filed for Provider Numbers 25-0031 and 25-0032 for the partial year fiscal periods ending 10/31/1998. *Reference*: Provider Exhibit 22.

8. By letter dated December 22, 1999, CMS recognized the change of ownership for VMC, effective November 1, 1998. The letter indicated that it replaced the "Provider Tie-In Notice." *Reference*: Provider Exhibit 14.

9. No similar letter (contemporaneous to the Merger) has been located for PRMC. A copy bearing a print date of December 17, 2010 has been submitted as Intermediary Exhibit 4, but there is no stipulation that an earlier one was issued.

10. By letter dated August 8, 2000 to the Mississippi Department of Health, the Provider wrote to "document and confirm" that VMC and PRMC "have met, and continue to meet, the applicable requirements to be certified as a single hospital as of November 1, 1998." *Reference*: Provider Exhibit 27.

11. By letter dated August 29, 2000, CMS stated, "we are in receipt of the recommendation from the Mississippi Department of Health," and that VMC and PRMC would be "combined under provider number 25-0031 effective July 1, 2000, as a multiple campus facility." *Reference*: Intermediary Exhibit 6.

12. The Mississippi Department of Health's recommendation to CMS, referenced in the August 29, 2000 letter, has not been located.

13. The Mississippi Department of Health issued a Hospital license to the Provider for 294 acute beds, effective January 1, 1999. *Reference*: Provider Exhibit 27.

14. A single cost report was submitted for the Provider under Provider No. 25-0031 for the November 1, 1998 to June 30, 1999 fiscal period under appeal. It was submitted with a "Re:" of "Vicksburg Health Systems," and identified a provider name of River Region Medical Corp. *Reference*: Provider Exhibits 17, 18 and 23.

15. The costs and statistics of the campus that was PRMC and the costs and statistics of the campus that was VMC combined on the single cost report using provider number 25-0031.

16. No separate cost report was filed for PRMC using provider number 25-0032 for the fiscal year ending June 30, 1999, or thereafter.

17. Permission was sought and received by the Provider to submit claims under the separate PRMC and VMC provider numbers while the change of ownership materials were processed. *Reference*: Provider Exhibits 12, 13 and 17.

18. The cost report filed for FYE [*i.e.*, fiscal year end] 06/30/1999 reflected a "rural" geographic classification, without reference to the redesignation to urban granted by the MGCRB Letter. *Reference*: Provider Exhibit 3.

19. The Intermediary adjusted the cost report to reflect provider number 25-0031's urban geographic reclassification, effective October 1, 1998 through September 30, 1999. *Reference*: Provider Exhibits 3 and 18.

20. The Intermediary noted on the cost report workpapers that: "The 25-0031 is the surviving number; therefore, the characteristics of the surviving number will be used in the DSH calculation, including SSI Ratio; Capital Exception Percentage on A-5/10; and Accumulated Capital Carryover on A-5/10." *Reference*: Provider Exhibit 4, p. 11.

21. On the FYE 06/30/1999 cost report, a single DSH payment percentage of 30.9 percent was reported. *Reference*: Provider Exhibits 3 and 18.

22. Through audit adjustment number 18, the Intermediary reduced the claimed 30.9 percent DSH patient percentage calculation to 23.023956 percent. *Reference*: Provider Exhibits 3 and 18.

23. For purposes of the finalized cost report, the Intermediary calculated the DSH payment by conducting two separate DSH calculations and resulting allowable DSH payment percentages—one for the campus that was VMC (utilizing the methodology applicable to urban providers), and one for the campus that was PRMC (utilizing the methodology applicable to rural referral centers). The Intermediary then averaged the two separate allowable DSH payment percentages to reach the combined allowable DSH payment percentage for the Provider of 23.023956 percent. *Reference*: Provider Exhibit 4.

24. When determining the VMC campus's FYE 06/30/1999 DSH payment eligibility and adjustment, the Intermediary utilized the combined bed count of 270 for the VMC campus and PRMC campus. *Reference*: Provider Exhibit 4.

25. The VMC campus's SSI Ratio for FYE 06/30/1999 was 24.20%. The Intermediary utilized this SSI Ratio of 24.20% when calculating the VMC campus's DSH patient percentage for the period from 11/01/1998 to 06/30/1999. *Reference*: Provider Exhibit 4.

26. The Intermediary utilized a Medicaid eligible day count of 3,109 when calculating the Medicaid Fraction portion of the DSH patient percentage calculation for the VMC campus for FYE 06/30/1999. The resulting Medicaid Fraction calculated by the Intermediary for the VMC campus was 21.074%. *Reference*: Provider Exhibit 4.

27. The Intermediary calculated a total qualifying DSH patient percentage of 45.278% and an allowable DSH payment percentage of 26.57% for the VMC campus. *Reference*: Provider Exhibit 4.

28. When determining the PRMC campus's FYE 06/30/1999 DSH payment eligibility and adjustment, the Intermediary utilized the combined bed count of 270 for the VMC campus and PRMC campus. *Reference*: Provider Exhibit 4.

29. The PRMC campus's published DSH SSI Ratio was 22.41%. However, the Intermediary utilized the VMC campus's SSI Ratio (24.20%) when calculating the separate DSH patient percentage for the PRMC campus. *Reference*: Provider Exhibit 4.

30. The Intermediary utilized a Medicaid eligible day count of 8,496 when calculating the Medicaid Fraction portion of the DSH patient percentage calculation for the PRMC campus for FYE 06/30/1999. The resulting Medicaid Fraction calculated by the Intermediary for the PRMC campus was 33.566%. *Reference*: Provider Exhibit 4.

31. The Intermediary calculated a total qualifying DSH patient percentage of 57.77% and an allowable DSH payment percentage of 20.66% for the PRMC campus. *Reference:* Provider Exhibit 4. The Intermediary applied the averaged allowable DSH payment percentage of 23.02% to the Provider's total DRG payments for a DSH payment of $2,565,218. *Reference*: Provider Exhibit 4.

32. The Intermediary based its decision to calculate separate allowable DSH payment percentages for the VMC campus and PRMC campus and then averaged the amounts to reach an allowable DSH payment percentage for the Provider (the "Averaged Allowable DSH Payment Percentage Methodology") on e-mail communications from CMS. *Reference:* Provider Exhibits 4, 24, and 25.

33. No representative or employee affiliated with the Provider was copied on the emails from CMS upon which the Intermediary based its decision to utilize the Averaged Allowable DSH Payment Percentage Methodology.

34. CMS classified Provider No. 25-0031 as a "rural referral center," effective July 1, 2000. *Reference*: Provider Exhibit 19.

35. The request for classification to a "rural referral center" for periods effective prior to July 1, 2000, was rejected by CMS. *Reference*: Provider Exhibit 20.

36. On the FYE 6/30/1999 NPR, the Intermediary recognized a combined total (for the VMC campus and PRMC campus) of 11,605 Medicaid eligible days. *Reference*: Provider Exhibits 4 and 5.

37. Following the Provider's appeal of the Notice of Program Reimbursement (Provider Exhibit 2), and a review of additional documentation supporting Medicaid eligibility, the Provider and Intermediary agree that accurate total of Medicaid eligible days is 12,286. The Intermediary agrees to utilize the 12,286 Medicaid eligible days as the numerator of the DSH Medicaid fraction and agrees to recalculate the DSH payment using such number based upon whatever DSH payment methodology is determined to be proper by a final, non-appealable decision of the PRRB, the CMS Administrator, or a federal court.
38. The Provider's appeal of the Intermediary's adjustments to the FYE 6/30/1999 Notice of Program Reimbursement was timely filed. The amount in controversy exceeds $10,000. The parties agree that the Board's jurisdiction over the appeal is proper.

39. The parties agree that the Provider's Exhibits 1-27 (to the Provider's January 26, 2011 Supplemental Position Paper), the Intermediary's Exhibits A-G (to the Intermediary's

January 7, 2004 Final Position Paper), and the Intermediary's Exhibits 1-6 (to the Intermediary's January 21, 2011 Supplemental Position Paper) are true and correct copies, and that there is no dispute as to the authenticity of these exhibits.[20]

The Provider was represented by Gregory N. Etzel, Esquire, and Krista Barnes, Esquire, of King & Spaulding, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of the BlueCross BlueShield Association.

PARTIES' CONTENTIONS:

The Provider claims that, effective November 1, 1998, PRMC and VMC merged to become a single entity and that the Medicare program permitted this single entity to file a single cost report under the one surviving Medicare provider number assigned to that single entity — Provider No. 25-0031. The Provider argues that separate providers must file separate cost reports pursuant to 42 C.F.R. §§ 413.20(b) and 413.24(f), and in this instance the newly formed Provider filed one cost report for the reporting period of November 1, 1998 to June 30, 1999. The Provider adds that PRMC and VMC filed "close out" cost reports consistent with 42 C.F.R. § 413.24(f)(1) which reflected shortened cost reporting periods ending the day before the effective date of the CHOW. The Provider explains that the Intermediary accepted the single cost report for November 1, 1998 to June 30, 1999, and issued a single NPR containing the final Medicare reimbursement determination for both the PRMC and VMC campuses using the surviving provider number — Provider No. 25-0031.[21]

The Provider contends that the Intermediary improperly calculated its DSH payment for the cost report covering November 1, 1998 to June 30, 1999 by "averaging" two separate DSH payment percentages for the newly established Provider[22] and that "the Intermediary simply invented a DSH computation methodology."[23] The two percentages the Intermediary utilized were based upon the characteristics of the two former entities - PRMC and VMC. For PRMC, the Intermediary utilized a rural referral center methodology, and, for VMC, the Intermediary utilized an urban methodology. However, in calculating PRMC's DSH calculation, the Provider asserts that the Intermediary utilized the Provider's combined bed count, the SSI Ratio for the surviving provider number (VMC's former provider number), and an estimated Medicaid eligible day count attributable to patients seen at the PRMC campus. Similarly, in calculating VMC's portion of the DSH calculation, the Provider asserts that the Intermediary utilized the Provider's combined bed count, the SSI Ratio for the surviving provider number (VMC's former provider number), and an estimated Medicaid eligible day count attributable to patients seen at the VMC campus. As a result, the Provider asserts that the Intermediary's DSH methodology is arbitrary and contrary to Medicare statutes and regulations.[24]

The Provider asserts that, because PRMC and VMC merged on November 1, 1998 and filed a

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[20] Stipulation Agreement (Feb. 4, 2011).
[21] *See* Provider's Supplemental Position Paper at 9-12.
[22] Provider's Supplemental Position Paper at 15.
[23] Provider's Post Hearing Brief at 16.
[24] *See id.* at 16-18.

single cost report under one provider number (Provider No. 25-0031), the Provider's DSH payment percentage for the cost reporting period of November 1, 1998 to June 30, 1999 should have been calculated utilizing the characteristics of the single surviving entity. The Provider argues that a single DSH calculation under the urban methodology is required for the Provider because the surviving provider number was urban. The Provider concludes that the Intermediary's DSH calculation for the November 1, 1998 to June 30, 1999 period resulted in an inaccurate payment.[25]

The Intermediary agrees that a Contribution Agreement and Plan of Merger were consummated on November 1, 1998 that this resulted in the Provider owning PRMC and VMC, two previously independent hospitals. However, the Intermediary contends that an ownership merger of two separate hospitals does not by itself create a new single facility for Medicare cost reporting purposes. The Intermediary states that, even though the November 1, 1998 to June 30, 1999 cost report was filed under one provider number, this fact does not necessarily "establish the combination of two hospitals into one at the start of the fiscal year or that the entity associated with the [provider] number [on the cost report] was the merger survivor and the other one lost its identity and its existence."[26]

While the Intermediary acknowledges that the merger resulted in the reassignment of PRMC and VMC's provider agreements, as well as the issuance of the related tie-in notices, it maintains that the two providers did not actually merge into one facility until CMS recognized date of July 1, 2000.[27] The Intermediary explains that, even though the Provider filed one cost report, the Provider continued to file claims with the Medicare program under the separate VMC and PRMC provider numbers for Medicare services provided during the June 30, 1999 cost year. Also, the Intermediary asserts that the Mississippi Department of Health did not approve the combination of providers until July 1, 2000, and, as a result, prior to this date, two providers existed.[28] In this regard, the Intermediary notes that CMS agreed to accept the Mississippi Department of Health's recommendation that PRMC and VMC be combined under provider number 25-0031 effective June 30, 2000.[29]

The Intermediary concludes that separate DSH calculations were correct under this particular set of circumstances. Although not apparent from a reading of the cost report, the Intermediary explains that the separate DSH calculations were done based on the Medicaid proxy and payment status of the two hospitals that existed on November 1, 1998. The cost report at issue was filed under Provider No. 25-0031 which was assigned to VMC prior to the merger, and this cost report included costs, statistics, and schedules combining PRMC and VMC and their sub-providers.[30]

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[25] *Id.*
[26] Transcript ("Tr.") at 81.
[27] Intermediary's Supplemental Position Paper at 4-5.
[28] *See* Provider Exhibit P-27.
[29] *See* Intermediary Exhibit I-6.
[30] Intermediary's Post Hearing Summary at 3.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has reviewed and considered the Medicare law and guidelines, the parties' contentions, testimony and other evidence presented. The Board finds and concludes the Intermediary correctly determined the Provider's DSH payment for the fiscal period November 1, 1998 to June 30, 1999.

There is no question in this appeal that effective November 1, 1998, an Agreement and Plan of Merger and Contribution Agreement went into effect which declared a CHOW for PRMC and VMC. However, the Board finds that the corporate merger did not automatically create a single provider facility. The record indicates the process of creating a single provider entity took well over a year, and that, for Medicare reimbursement purposes, the Provider was not a single hospital entity during the fiscal period November 1, 1998 to June 30, 1999.

The Provider contends that CMS recognized River Region Medical Center as one provider for the short FYE June 30, 1999. However, during the short FYE June 30, 1999, VMC continued to bill claims under Provider No. 25-0031 and PRMC continued to bill claims under Provider No. 25-0032.[31] The record suggests that, by letter dated November 24, 1998, the Provider requested that CMS allow the Provider to continue billing under the PRMC and VMC providers numbers and that, by letter dated January 13, 1999, CMS responded to that request to confirm that the Provider could continue to so bill.[32] Unfortunately, the Provider's November 24, 1998 letter is not available from either the Provider or Intermediary and it remains unclear why the Provider requested that the claims continued to be billed in this manner.

The record further suggests that the Provider continued discussions with CMS regarding the continued use of these billing numbers as characterized by the Provider in a letter to CMS dated November 3, 1999. The Provider's November 3, 1999 letter confirms the Provider's understanding that CMS had made "determinations . . . regarding Medicare provider numbers and billing in connection with the acquisition" and that the Provider "will continue to bill under their existing Medicare provider numbers [for PRMC and VMC] until July 1, 2000."[33] Similarly, in a letter from CMS to the Provider also dated November 3, 1999, CMS states:

> Following the approval of the HCFA – 855s the State Agency will recommend to us that the *change of ownership* for all the affected provider numbers be approved effective November 1, 1998. We will issue change of ownership letters for all the provider numbers.

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[31] Tr. at 21-22; Provider Exhibits P-12 and P-13. There appears to have been discussions between the Provider and CMS regarding the continued billing under the PRMC and VMC providers numbers. For example, the initial permission for continued billing occurred in January 1999. Provider Exhibit P-12. Subsequent discussions caused CMS to make "determinations" regarding Medicare provider numbers and billing" and issue a letter months later in November 1999 confirming that the Provider "will continue to bill under their existing Medicare provider numbers [for PRMC and VMC] until July 1, 2000." Provider Exhibit P-13. Unfortunately, the full record is not available from either the Provider or Intermediary.

[32] Provider Exhibit P-12.

[33] Provider Exhibit P-13.

> It is our understanding that a request will be made to consolidate both hosptials under the provider number of VMC (25-0031) with a Medicare fiscal year end of June 30. *Since Medicare billings have continued under both hospital's provider numbers, the consolidation should take place prospectively*. The decision as to the effective date of the consolidation rests with the hospital, but making it effective on July 1, 2000, the beginning of the cost period for 25-0031, would allow for a smoother transition.

While the exact reason why the Provider continued to use the PRMC and VMC provider numbers is unclear, the fact remains that the Provider specifically requested to continue to use the separate provider number and, in fact, continued to do so until July 1, 2000. After this date, Medicare services began to be billed through VMC's surviving provider number of 25-0031. Moreover, the Provider conveyed its understanding of the effect of its continued use of the multiple provider numbers in its November 3, 1999 letter to the Intermediary.[34] Specifically, the Provider stated that it was aware it must "meet the applicable requirements for operating as a single hospital system with multiple campuses..." before being considered a single provider, and it also stated it "will be able to meet them" indicating that these requirements had not yet been met as of November 3, 1999.[35]

In addition to PRMC and VMC's continued use of separate provider numbers beyond the November 1, 1998 merger date, the providers maintained distinct Medicare geographic classifications. Beginning on July 1, 1991, PRMC was geographically classified as a Rural Referral Center ("RRC").[36] Effective January 26, 1998, VMC was classified as "urban" for the time period of October 1, 1998 through September 30, 1999.[37] The Provider requested a combined RRC status for PRMC and VMC in September 1999.[38] However, CMS did not grant the request until December 19, 2000 and that grant was effective retroactively only to July 1, 2000.[39] The separate geographic classifications during the fiscal year at issue support the Intermediary's contention that PRMC and VMC were not yet qualified as a single provider facility.

The Board notes that the DSH adjustment calculation was not the sole reimbursement issue that treated or considered PRMC and VMC separate facilities on the cost report. The DRG payments themselves were for separate facilities as well. Indeed, the DSH payment is an add-on to that DRG payment. As previously noted, the Provider specifically requested to continue to be able to bill separately under the PRMC number in order to continue to benefit from the RRC status for purposes of the DRG payments. As a result, the Board agrees with the Intermediary that the PRMC discharges should be consistently treated for both DRG and DSH payment purposes, particularly since the DSH is an add-on payment to the DRG payment. As such, the PRMC

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[34] Provider Exhibit P-13.
[35] *Id.* at 2.
[36] Provider Exhibit P-6.
[37] Provider's Post Hearing Brief at 4; Provider Exhibit P-7.
[38] Provider's Post Hearing Brief at 5.
[39] Provider Exhibit P-19.

discharges should be considered RRC for DSH purposes.

As the Board found it was appropriate for the Intermediary to make two separate DSH adjustment calculations for PRMC and VMC, the Board next reviewed the methodology that the Intermediary used to make these calculations as described and documented in the Intermediary's workpapers.[40] The Provider contends that "the Intermediary simply invented a DSH computation methodology" and that the DSH calculations were "arbitrary and capricious."[41] This contention is in essence based on its assertion that, while the Intermediary claimed that PRMC and VMC should have separate DSH adjustment calculations, the Intermediary did not perform fully separate calculations but rather combined some of the provider-specific statistics through certain "averaging," used estimates, and/or used certain VMC-specific data when calculating PRMC's DSH adjustment.

The Board disagrees with the Provider's assessment. In particular, the Board notes that the use of the word "averaging" in the Provider's position papers and "averaged" in ¶ 23 of the stipulations is misleading and does not reflect what the Intermediary actually did as documented in the Intermediary's workpapers that are part of the record before the Board. The Board discusses below each of the variables discussed by the Provider, namely the SSI percentage, Medicaid eligible days, and bed count.

The Intermediary states the following in its workpapers regarding its calculation of the DSH adjustment:

> [T]he two individual providers [*i.e.*, PRMC and VMC] are being separated in the DSH calculation for purposes of calculating the payment percentage based on the Rural Referral Center status. This is being done based on the emails from CMS on . . . A-5/12-1.
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> The provider now states that they do not believe that their discharges under the 25-0032 number should be considered RRC for DSH purposes. However, per the correspondence with CMS on A-12/5, it appears that these discharges should be RRC for DSH. In addition, it is important to note that Mr. Scott Hammond at the facility originally requested that I revise my DSH calculation to make the 25-0032 discharges RRC (per phone contact on 9/13/2002). Therefore, a split was done and DSH was run separately for the discharges under the RRC (25-0032) and discharges under the urban classification (25-0031). Beds and SSI ratio were used from the surviving provider, but the RRC portion of the calculation was separated.

[40] *See* Provider Exhibit P-4 at 7 and 11 (part of Intermediary workpaper s).
[41] *See* Provider's Post-Hearing Brief at 16 and 18.

> Medicaid days had to be spread, based on original state Medicaid PS&Rs obtained from the provider (see A-5/9-3) to get a breakdown of the RRC discharges (25-0032) and the Urban (25-0031). The state has gone back and moved claims under the individual provider numbers into a single provider number as of the current Medicaid PS&Rs. . . .
>
> Note: The DSH Payment percentage used in the cost report was backed into based on the calculated DSH payment for the RRC and the Urban discharges. This is the only way the correct amount will be calculated in the Compu-Max audit software.[42]

The Intermediary's workpapers reflect that only provider-specific data was used to calculate the DSH adjustment payments for PRMC and VMC with one exception involving the SSI percentage and this was to the Provider's benefit. Specifically, in connection with the SSI percentage, the Intermediary used VMC's SSI percentage instead of PRMC's SSI percentage when calculating PRMC's DSH adjustment payment. As PRMC's SSI percentage of 0.22441 was lower than VMC's SSI percentage of 0.24204, PRMC's DSH adjustment payment ended up being higher than it would have been had the Intermediary used PRMC's actual SSI percentage.

In connection with the Medicaid eligible days used as part of the DSH adjustment calculations, the Board recognizes that the Intermediary used provider-specific estimates rather than the actual Medicaid days for PRMC and VMC; however, the Board finds that, under the circumstances, the Intermediary's use of these estimates was reasonable and justified given the evolving, yet still distinctly separate, provider status of PRMC and VMC during the fiscal period of November 1, 1998, through June 30, 1999. Specifically, the above quote from the workpapers confirms that initial PS&R report reflected state-reported Medicaid days separately for PRMC and VMC but that the final PS&R report listed only a combined Medicaid eligible days because the state had stopped reporting these days separately for PRMC and VMC. As a result, the Intermediary divided the updated Medicaid days using the initial proportional break out between PRMC and VMC. The Intermediary's estimates were based on what appears to be the best provider-specific data available from the state[43] and the Provider has not presented any evidence suggesting that the Intermediary division of the Medicaid days is not accurate.[44]

In connection with the bed count, the Board notes that the bed count has no bearing on the calculation of the actual DSH adjustment payment but rather is only relevant for determining a provider's classification as a disproportionate share hospital and the formula that is used to calculate the DSH adjustment payment based on that classification. The rules for DSH classification are located in 42 C.F.R. § 412.106(c) and, during the time period at issue, this

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[42] Provider Exhibit P-4 at 11 (part of Intermediary workpapers).

[43] While it is unclear why the Intermediary opted to benefit PRMC by using VMC's SSI percentage in calculating PRMC's DSH adjustment payment, it may have been to ensure that the estimates used for the Medicaid eligible days affect the Provider.

[44] Examples of evidence that the Provider might have presented include more recent provider-specific data from the state, provider-specific claims data, or provider-specific internal discharge records.

subsection only had three classifications that were relevant to providers such as PRMC that were located in a rural area: (1) hospital in an urban area with 100 beds or more or in rural area with 500 beds or more; (2) hospital in rural area with 100 or more beds but fewer than 500 beds or a hospital classified as a sole community hospital; and (3) hospital in an urban area with fewer than 100 beds.[45] The record reflects that PRMC had 231 beds and that VMC had 154 beds.[46] As a result, usage of a combined bed count (*i.e.*, 231 plus 154) made no difference on PRMC's classification. The Board notes that, for similar reasons, the usage of a combined bed count for VMC had no bearing on VMC's classification because VMC on its own as well as in combination with PRMC had a bed count between 100 and 500.

The Board believes that the confusion created by the use of the words "averaging" or "averaged" may stem from the fact that the Intermediary had to figure a way to report these two separately calculated provider-specific DSH adjustment payments as a *single* DSH adjustment on the cost report at issue. As noted above, the single DSH adjustment listed on the cost report "was backed into based on the calculated DSH payment for the RRC and the Urban discharges" because "[t]his is the only way the correct amount will be calculated in the Compu-Max audit software."[47]

Based on the above, the Board concludes that, contrary to the Provider's assertions, the record before the Board demonstrates that the methodology utilized by the Intermediary to calculate the DSH payment for the fiscal period at issue was consistent with the statute and regulations.

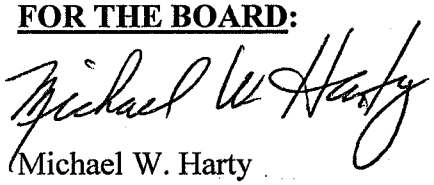
DECISION AND ORDER:

The Board finds the Intermediary correctly determined the Provider's disproportionate share hospital ("DSH") payment for the fiscal period November 1, 1998 to June 30, 1999.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty, Chairman
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

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[45] *See* 42 C.F.R. 412.106(c) (1999).
[46] *See* Intermediary Exhibit I-3 at 1-2 (a description of the bed counts for PRMC and VMC is located in the beginning of the Contribution Agreement).
[47] Provider Exhibit P-4 at 11 (part of Intermediary workpapers).

DATE: JUN 0 5 2013