PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D22

PROVIDER-Rogue Valley Medical Center
Medford, Oregon

Provider No. 38-0018

vs.

INTERMEDIARY -Medicare Northwest

DATE OF HEARING-
December 19, 1997

Cost Reporting Period Ended - September 30, 1990

CASE NO. 93-1156

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ISSUE:

Was the Provider's request to reopen the calculation of the disproportionate share adjustment to exclude employee self-insured days proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Rogue Valley Medical Center ("Provider") is a nonprofit, 305 bed, general short-term community hospital located in Medford, Oregon.[1] During its Medicare cost reporting period ended September 30, 1990, the Provider furnished health insurance to its employees through an employer sponsored self-insurance plan. The costs, patient days and charges applicable to employee claims were included in the Provider's cost report.[2]

On September 30, 1992, Medicare Northwest ("Intermediary") issued a Notice of Program Reimbursement effectuating final settlement of the Provider's cost report. On March 19, 1993, the Provider appealed several adjustments made by the Intermediary in its final determination to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations.[3]

Subsequently, the Provider resolved all appealed issues except for the Intermediary's inclusion of self-insured employee patient days in the calculation of its disproportionate share hospital ("DSH") adjustment. The other issues were either withdrawn by the Provider or administratively resolved with the Intermediary. The estimated amount of Medicare reimbursement in controversy for the one remaining issue is $20,000.[4]

The Provider was represented by David L. Glazer, Esquire, of Bennett & Bigelow, P.S. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that Medicare reimbursement policy requires charges and patient days related to employees who are covered by a provider's self-insurance plan to be excluded from reimbursement statistics used in the Medicare cost finding process. Provider Reimbursement

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1 Provider's Final Position Paper at 3.

2 Provider's Final Position Paper at 6.

3 Provider's Final Position Paper at 3. Exhibit P-2.

4 Provider's Final Position Paper at 6.

Manual, Part I, ("HCFA Pub. 15-1") § 332.1.[5] In addition, Medicare reimbursement policy requires that in calculating a provider's DSH adjustment that the ratio of Title XIX days to total hospital days be based on patient day totals shown on Worksheet S-3 of the Medicare cost report. The totals on Worksheet S-3 exclude employee self-insured days, in accordance with Medicare cost reporting instructions.[6]

The Provider contends that the exclusion of employee self-insured days from the DSH calculation is consistent with Medicare's overall reimbursement scheme. Medicare instructions direct providers not to consider employee self-insured days as part of the cost finding process, and employee charges and days are specifically excluded from the allocation statistics. The result is that the costs of providing services to employees under a self-insured arrangement are redistributed to all other patients.[7]

Finally, the Provider argues that the DSH calculation is used to determine the extent that a provider incurs a disproportionate amount of costs because of services rendered to poor patients by assessing the ratio of Title XIX days to total days. Because a provider must remove employee self-insured days from the count of total days for the purpose of determining allocation statistics, these employee days should likewise be excluded from total days used to calculate the DSH adjustment. In effect, Medicare's cost reporting instructions and overall reimbursement scheme require that employee self-insured days be treated consistently both for the cost allocation process and for the DSH adjustment.[8]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that 42 U.S.C. § 1395ww(d)(5)(F)(I) authorizes the Secretary to provide for exceptions and adjustments to payments made under Medicare's prospective payment system ("PPS") to take into account the special needs of public or other hospitals that serve a significantly disproportionate number of low income patients. 42 C.F.R. § 412.106.

The Intermediary contends that it properly calculated the Provider's DSH payment pursuant to the statute and enabling regulations. In accordance with 42 C.F.R. § 412.106(a)(ii), the

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5 The Provider notes that the Intermediary had revised its 1989 cost report to exclude "profit" on employee self-insured claims from the Medicare cost finding process, and agreed to apply the same methodology to the subject cost report. See Provider's Final Position Paper at 4.

6 Provider's Final Position Paper at 12.

7 Provider's Final Position Paper at 13.

8 Id.

number of patient days used in the DSH calculation includes only those days attributable to areas of the hospital subject to PPS, and excludes all others. In this regard, the Intermediary asserts that the Provider's self-insured employees and their dependents are "inpatients" as defined in HCFA Pub. 15-1 § 2202.l. These individuals receive care in the routine and special care units of the hospital subject to PPS, and meet the Medicare definition of a PPS inpatient day. The manual instructions do not exclude employee days; an inpatient is defined as follows:

> [a]n inpatient is a person who has been admitted to a hospital or skilled nursing facility for bed occupancy to receive inpatient hospital or skilled nursing services. A person is considered an inpatient if he is formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged, or is transferred to another hospital and does not actually use a hospital bed overnight.

HCFA Pub. 15-1 § 2202.l.

The Intermediary also contends that employee self-insured days should be included in the DSH calculation to assure that Medicare does not overcompensate providers. In effect, if total inpatient days used in the DSH calculation are understated, Medicare would be basing a portion of DSH payments on patients not covered under the Medicare program.

Finally, the Intermediary cites Pacific Hospital of Long Beach v. Ætna Life Insurance Co., PRRB Dec. No. 93-D5, December 16, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,987, aff'd in part, rev'd in part, HCFA Admin. February 11, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,355, in which the Administrator cited HCFA Pub. 15-1 § 2202.1 in defining an "inpatient". The Administrator also relied on HCFA Pub. 15-1 § 2205 for "determining whether a patient day has been generated. Only full days may be used. The day of admission is counted as a full day but the day of discharge is not counted. If, however, admission and discharge occur on the same day a full day must be counted if the patient is admitted as an inpatient with the expectation of remaining overnight and occupying a bed."[9]

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395ww(d)(5)(F)(I)	-	PPS Transition Period; DRG Classification System; Exceptions and Adjustments to PPS

[9] Intermediary's Position Paper at 9-10.

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

§ 405.1835-.1841	-	Board Jurisdiction
§ 412.106	-	Special Treatment: Hospitals that Serve a Disproportionate Share of Low-Income Patients

3. Program Instructions-Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 332.1	-	Method for Including Unrecovered Cost
§ 2202.1	-	Definitions-Inpatient
§ 2205	-	Medicare Patient Days

4. Program Instructions-Provider Reimbursement Manual, Part II (HCFA Pub. 15-II):

§ 2406	-	Worksheet S-3- Hospital and Hospital Health Care Complex Statistical Data and Hospital Wage Index Information

5. Case Law:

Pacific Hospital of Long Beach v. Ætna Life Insurance Co., PRRB Dec. No. 93-D5, December 16, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,987, aff'd in part, rev'd in part, HCFA Admin. February 11, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,355.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes that the Intermediary properly included the Provider's self-insured patient days in the calculation of the Provider's DSH adjustment.

The Board finds the controlling authority for determining DSH adjustments at 42 C.F.R. § 412.106. In part, the regulation describes the factors used in the DSH determination as well as the methodology to be employed. With respect to the "total number of patient days" factor, which is at issue in this appeal, 42 C.F.R. § 412.106(b)(4), the Board finds the regulation silent regarding the inclusion or exclusion of self-insured patient days. The regulation provides only that:

> [t]he number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system [PPS] and excludes all others.

42 C.F.R. § 412.106 (a)(ii).

Since there is no dispute that the subject self-insured patient days are attributable to patient stays in areas of the Provider's operation subject to PPS, and since the Board finds no other program instruction which elaborates upon the definition of total patient days used in the DSH determination, the Board concludes that patient days attributable to the self-insured employees must be used in the DSH calculation.

The Board rejects the Provider's argument that HCFA Pub. 15-1 § 332.1 supports its position because the manual requires charges and patient days related to self-insured plans to be excluded from reimbursement statistics used in the Medicare cost finding process. First, the Board finds no connection between the provisions of HCFA Pub. 15-1 § 332.1 and the calculation of the DSH adjustment. The manual explains how the costs of services furnished to employees as a fringe benefit are recovered through the Medicare cost finding process. While the manual instruction does require an adjustment to "total days used to apportion costs", it is not necessarily applicable to the DSH calculation. The Board notes that the DSH calculation is performed "outside" the Medicare cost report, meaning it is not a function of the Medicare cost finding process.

In addition, the Board finds that even if HCFA Pub. 15-1 § 332.1 were construed to affect the total patient day factor used in the DSH calculation, it would still not support the Provider's argument. The manual explains that charges and patient days applicable to employees are removed from the reimbursement statistics used in the cost finding process when the actual cost of services rendered exceeds the amount the employees were charged. In the instant case, however, there is no evidence that the Provider's costs exceeded its charges. Rather, the evidence shows the opposite, i.e., that the Provider's charges exceeded its costs. As discussed on page 4 of the Provider's Final Position Paper, the Intermediary identified a "profit" made by the Provider on the claims it paid to itself for services rendered to its employees. This clearly indicates that the Provider's charges were greater than its costs. Therefore, no adjustment should be made to the Provider's reimbursement statistics pursuant to HCFA Pub. 15-1 § 332.1, and the Provider's argument based upon this program instruction is dismissed.

Finally, the Board rejects the Provider's argument that Medicare reimbursement policy requires the DSH calculation to be based upon the patient day total shown on Worksheet S-3 of the Medicare cost report, and that that total excludes employee self-insured days. A review of the Medicare cost reporting instructions, HCFA Pub. 15-II § 2406, finds no mention of employee self-insured days.

DECISION AND ORDER:

The Provider's request to have its DSH adjustment reopened in order to have employee self-insured days excluded from the calculation was improper. The Intermediary's calculation of the Provider's DSH adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Teresa B. Devine
Henry C. Wessman, Esquire

FOR THE BOARD:

Irvin W. Kues
Chairman