PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2000-D27

PROVIDER -
The Ohio State University Hospital
Columbus, Ohio

DATE OF HEARING-
December 22, 1999

Provider No. 36-0085

Cost Reporting Period Ended -
June 30, 1993

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
AdminaStar Federal

CASE NO. 96-0036

INDEX

ISSUE:

Was the Intermediary's adjustment to the outlier payments proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Ohio State University Hospital ("Provider") is a not-for-profit, acute care teaching hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations. It provides Medicare services under the Federal Health Insurance for the Aged and Disabled Act. The Provider filed a Medicare cost report for its fiscal year ended June 30, 1993 ("FYE 93") in which it claimed reimbursement for its outlier costs based upon the Provider Statistical and Reimbursement System ("PS&R") reports for the Provider.[1] AdminaStar Federal ("Intermediary") audited the cost report and issued a Notice of Program Reimbursement ("NPR") on April 11, 1995.[2] The NPR contained numerous adjustments to the PS&R including an adjustment to the outlier payments.

On October 6, 1995, the Provider appealed the Intermediary's adjustments to its cost report to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§405.1835-.1841. On April 7, 1998, the Provider amended its list of issues to dispute the adjustment to its outlier payments. Except for adjustment number 102 pertaining to the outlier payment, the Provider and Intermediary have tentatively reached agreement on the list of issues previously submitted in this matter subject to the Provider receiving the agreed upon payments.

The Provider disputes the outlier payments as calculated by the Intermediary because they did not result in an aggregate national outlier payment of at least five percent of total Prospective Payment System ("PPS") payment as required by Medicare. Moreover, because of the underpayment of the FY 1993 outlier payments, the amount of the indirect medical education payments and disproportionate share payments were also understated. The Provider is represented by David C. Levine, Esquire, of Baker & Hostetler, LLP. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that in order to protect hospitals and Medicare patients against the potentially harsh incentives imposed under PPS, Congress provided for additional payments for outlier cases. 42 U. S. C. § 1395ww(d)(5)(A). Under the outlier payment provisions adopted by Congress, the Secretary of the United States Department of Health and Human Services ("Secretary") is required for each federal fiscal year to establish thresholds for determining the point at

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[1] See Provider Exhibit 1.

[2] See Provider Exhibit 2.

which a specific case qualifies for an additional outlier payment due to an unusual length of stay or extraordinary cost. 42 U.S.C. § 1395ww(d)(5)(A)(I). The statute specifically requires:

> The total amount of the additional payments for discharges in a fiscal year may not be less than five percent (5%) nor more than six percent (6%) of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

42 U.S.C. §1395ww(d)(5)(A)(iv).

To comply with the statute, each fiscal year the Secretary sets the outlier threshold level which she estimates will result in outlier payments being five to six percent of total Medicare payments projected to be made that fiscal year. In fiscal years 1992 and 1993, the outlier thresholds were set at the level which the Secretary projected would result in outlier payments representing 5.1%. However, in fiscal years 1992 and 1993, actual outlier payments were less than 5% of the respective yearly DRG payments. The Provider argues that it is entitled to additional outlier payments for its FYE 93 because the statute states that the actual outlier payments for a fiscal year must represent no less than five percent nor more than six percent of estimated total Medicare payments for discharges in that year.

The Provider notes that the Secretary publicly acknowledged the shortfalls in the required outlier payments for these years. 57 Fed. Reg. 23645 (1992); 58 Fed. Reg. 46270 (1993). HCFA anticipated that fiscal year 1992 outlier payments and fiscal year 1993 outlier payments would be less than the 5.1% that HCFA estimated when the outlier thresholds were set, but HCFA chose not to revise the outlier thresholds to reflect the estimated outlier shortfall. 58 Fed. Reg. 46270 (1993).

HCFA later estimated that the actual fiscal year 1992 outlier payments would be approximately 3.6% of fiscal year 1992 total DRG payment. Id. This shortfall resulted in outlier underpayments in fiscal year 1992 in an amount equal to 38.9% of the actual outlier payments made to the Provider. In addition, HCFA estimated that the actual fiscal year 1993 outlier payments would be approximately 4.50% of fiscal year DRG payments. Id. However, HCFA later revised this estimate and stated that the fiscal year 1993 outlier payments would approximate 4.2% of the total DRG payments. 59 Fed. Reg. 45330 (1994). Again, this shortfall resulted in outlier underpayments in fiscal year 1993 in an amount equal to 19.0% of the actual outlier payments made to the Provider.

The Provider observes that a U.S. district court case provides additional authority to support the Provider's position that 42 U.S.C. § 1395ww(d)(5)(A)(iv) requires that the total outlier payments made in a particular year fall between five and six percent of the total payments projected or estimated to be made for discharges in that year. In County of Los Angeles, et al v. Donna E. Shalala, Secretary of Health and Human Services, 990 F. Supp. 26 (D.D.C. 1998) the court "County of Los Angeles"), ruled in favor of the provider as follows:

> Underpayment to the Provider..... The language of 42 U.S.C. §1395ww(d)(5)(A)(iv) clearly requires that the total outlier payments made in a particular year fall between five and six percent of the total

> payments projected or estimated to be made for discharges in that year. The Secretary, therefore, violated her statutory duty in years in which the total outlier payments made did not fall within the mandated range and in which she refused to make retroactive payments to comply with the statute. Because the language of the statute is unambiguous, the court need not address the reasonableness of the Secretary's interpretation under the second step of Chevron or the statute's legislative history. Those issues are relevant only if the statute is not clear on its face ... The court ordered that the Secretary ... ensure that the actual outlier payments made for a federal fiscal year are not less than 5 percent or more than 6 percent of the estimate or projection of total DRG payments for that year. If they are not, the Secretary must make appropriate retroactive adjustments to the outlier payments for that fiscal year.

Calculation of the Underpayment. In the judgment entered April 30, 1998, the Secretary is required to compute retroactive adjustments consisting of the following:

(a) for each plaintiff provider ... an additional payment amount equal to 66.7% of the actual amount of outlier payments made to each plaintiff provider pursuant to 42 U.S.C. §1395ww(d)(5)(A) for discharges which occurred during the portion of each such hospital cost reporting period falling within federal fiscal year 1985;

(b) for each plaintiff provider... an additional payment amount equal to 13.6% of the actual amount of outlier payments made to each plaintiff provider pursuant to 42 U.S.C. §1395ww(d)(5)(A) for discharges which occurred during the portion of each such hospital cost reporting period failing within federal fiscal year 1986; and

an adjustment to indirect medical education payments made pursuant to 42 U.S.C. §1395ww(d)(5)(B) and disproportionate share payments made pursuant to 42 U.S.C. 1395ww(d)(5)(F) based on the additional outlier payments made pursuant to (a) and (b) above.

In lieu of computing the actual amount of outlier payments made for discharges during the periods described in paragraphs (a) and (b), the Secretary may compute an estimate of such payments utilizing such data as may be available. Payment of retroactive adjustments, along with interest as required by 42 U.S.C. § 1395oo shall be made to the provider in accordance with the parties stipulation dated April 20, 1998.

Id.

In summary, the Provider received final payment for outlier cases for its fiscal year ending June 30, 1993, on the basis of the threshold established by the Secretary. If the Secretary had adjusted the outlier thresholds so that total outlier payments made in fiscal years 1992 and 1993 were between five and six percent of the total payments projected or estimated to be made for discharges in those years, the Provider would have received substantially more in outlier payments.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that each year the Secretary establishes thresholds for determining when a specific case qualifies as an outlier. 42 U.S.C. §1395ww(d)(5)(A)(i)(ii). The statute further provides that the outlier payment shall approximate the marginal cost of care beyond the thresholds. The implementing regulations related to outlier payments are located at 42 C.F.R. §§ 412.80, 412.84, and 412.86. These regulations require HCFA to provide for additional payment approximating a provider's marginal cost of care beyond thresholds specified by HCFA.

The Intermediary contends that it reimbursed the Provider's outlier cases in accordance with the aforementioned regulations. The outlier payments were properly summarized in the PS&R used to settle the Provider's Medicare cost report. Using these reports for cost reporting purposes is in accordance with HCFA Pub. 13-2, §§ 2241, 2242, 2243.

HCFA Pub. 13-2, §2242 states in part:

> Provider Summary Report. -Use information about charges, Medicare patient days, coinsurance days, etc., from the provider summary report in the cost settlement process unless the provider furnishes proof that inaccuracies exist.

Id.

The Provider is not disputing the accuracy of the PS&R but is disputing an issue which is related to HCFA policy. Because HCFA sets the thresholds for outlier payments annually in accordance with the regulations at 42 C.F.R. §412.80, the revision of the thresholds is beyond the authority of the Intermediary. Finally, the Intermediary contends that the Board must comply with the provisions of 42 C.F.R. §405.1867, which states:

> In exercising its authority to conduct the hearings described herein, the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as HCFA Rulings issued under the authority of the Administrator of the Health Care Financing Administration (see §405. 1801 (sic) of this subchapter). The Board shall afford great weight to interpretive rules, general statements of

> policy, and rules of agency organization, procedure, or practice established by HCFA.

Id.

The Intermediary asserts that the thresholds for outlier payments are set annually by HCFA. The revision of these thresholds is beyond the authority of intermediaries. Pending HCFA amending its determination of the outlier thresholds, the Intermediary requests the Board to affirm its adjustment.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395ww(d)(5) et. seq.	-	Inpatient Hospital Service Payments on Basis of Prospective Rates

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1867	-	Sources of Board's Authority
§ 412.80	-	General Provisions
§ 412.84	-	Payment for Extraordinary High-Cost Cases (Cost Outliers)
§ 412.86	-	Payment for Extraordinary High-Cost Day Outlier Cases

3. Program Instructions -Intermediary Manual (HCFA Pub. 13-2):

§ 2241	-	Provider Statistical and Reimbursement System
§ 2242	-	Intermediary Use of PS & R System Reports In Cost Settlement Process
§ 2243	-	Description of Reports Available for Standard PS & R System

4. Cases:

County of Los Angeles, et al v. Donna E. Shalala, Secretary of Health and Human Services, 990 F. Supp. 26 (D.D.C.) 1998).

5. Other:

57 Fed. Reg. 23645 (1992) FY 1992 Outlier Payments
58 Fed. Reg. 46270 (1993)FY 1993 Outlier Payments
59 Fed. Reg. 45330 (1994) FY 1993 Outlier Payments-Revised

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The majority of the Board ("majority"), after considering the law, regulations, program instructions, facts, evidence and parties' contentions finds that the Intermediary properly followed the regulation at 42 C.F.R. § 412.80 and used the outlier rates published by HCFA in the appropriate Federal Register documents. Since the Board is bound by the law and regulations, the majority finds for the Intermediary.

The majority does note that the Federal statute at 42 U.S.C. § 1395ww(d)(5)(A) established a minimum payment of five percent of DRGs as the outlier threshold. It notes that the Secretary acknowledged that the outlier payments were below the statutory limit in the Federal Register at 58 Fed. Reg. 46270 (1993). Finally, the majority acknowledges the reasoning and analysis in the County of Los Angeles United States district court decision which decided that the regulation application with its resulting outlier rate specifically conflicted with the statute "on its face." However, the Board, as noted above, is limited to following both the law and regulations and must therefore rule in the Intermediary's favor.

DECISION AND ORDER:

The Intermediary properly applied the outlier regulation at 42 C.F.R. § 412.80. Its adjustments are sustained.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire (dissenting)
Charles R. Barker

Date of Decision: March 8, 2000

For The Board

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover, Jr.

I respectfully dissent:

The Board majority findings included a finding that the Board is bound by the law and regulations. The Board majority applied the regulation at 42 C.F.R. § 412.80 and sustained the Intermediary's adjustment.

The law at 42 U.S.C. 1395ww(d)(5)(a)(iv) requires that the total outlier payments made in a particular year fall between five and six percent of the total payments projected or estimated to be made for discharges in the year. The Provider contends that for the fiscal year 1993, it was underpaid since actual outlier payments were less than 5%.

It is my opinion that the law should be applied rather than the regulation; therefore the Intermediary's adjustment should be reversed.

Martin W. Hoover, Jr., Esquire.