PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D46

PROVIDER –
Sisters of Charity Hospital
Buffalo, NY

Provider No.: 33-0078

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Empire Medicare Services

DATE OF HEARING -
March 11, 2005

Cost Reporting Period Ended -
December 31, 1999

CASE NO.: 03-0940

INDEX

ISSUE:

Whether the Intermediary properly calculated the Provider's indirect medical education (IME) reimbursement for its fiscal year ending December 31, 1999.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

IME reimbursement is driven by the ratio of interns and residents to available beds (the IRB ratio). The Balanced Budget Act of 1997 (BBA-97) requires that, for cost reporting periods beginning after 10/1/97, the IRB ratio is limited to the lower of the ratio for the hospital's current cost reporting period or the provider's prior cost reporting period. This appeal involves the development of the IRB ratio for the provider's prior cost reporting period.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Sisters of Charity Hospital of Buffalo, New York, (Provider) is a non-profit, tax exempt corporation that is part of the Catholic Health System of Western New York. For the fiscal periods ended 12/31/98 and 12/31/99, the Provider reported 398 available beds on its Medicare cost reports. This was the number of certified beds on the hospital's operating certificate. Empire Medicare Services (Intermediary) used the 398 bed figure in its calculation of the IRB ratios and, ultimately, the IME reimbursement for both years. The Provider subsequently challenged the use of the 398 bed count figure and argued

that the appropriate count should be based upon the number of beds permanently maintained and available for lodging inpatients. The Provider further argued that for 1998 and 1999, the proper counts were 270 and 262 beds, respectively. The Intermediary examined the 1998 and 1999 bed counts and stipulated that the bed count for 1998 was 291.35 and 272.97 for 1999. The Provider contends that the stipulated bed counts should be used to calculate both the IRB ratio for 1999 (the year under appeal) and the IRB ratio for 1998 (the prior cost reporting period that will be the basis for the comparison required by BBA-97). The Intermediary counter contends that the statute requires the use of the finalized number (398 beds) from the prior period (1998) for the 1999 IRB ratio comparison. The 1998 cost report was finalized using 398 beds and is not subject to reopening, nor is it the subject of this appeal. At issue is whether the stipulated count from 1998 may be used to calculate the 1998 IRB ratio used in the determination of the Provider's IME payment.

The Provider filed an appeal on March 23, 2003 with the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Christopher Keough, Esq., and Andrew Ruskin, Esq., of Vinson and Elkins, LLP. The Intermediary was represented by Bernard Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider argues that the correct application of the BBA-97 comparison in FY 1999 requires the use of the stipulated bed count from 1998. The Provider contends that Section 1878(d) of the Social Security Act allows the Board to modify any determination reached by the Intermediary in any respect.[1] This authority extends to matters not previously considered by the Intermediary in a cost report settlement. The Provider argues further that nothing in the IME statute or regulation requires the Intermediary or the Secretary to use a clearly erroneous bed count from the prior year.[2] The Provider also contends that precedent in analogous cases does not support the use of the incorrect count.[3]

INTERMEDIARY'S CONTENTIONS:

The Intermediary has challenged the Board's jurisdiction to hear this appeal on the grounds that no adverse determination was made to the Provider's bed count.

On the merits, the Intermediary argues that the language of the statute and the regulation requires the use of the finalized number from the prior period cost report for the correct application of the BBA-97 comparison.[4] The Intermediary is bound by that language and has no latitude in its application. The Intermediary argues that the 1998 cost report

[1] 42 U.SC. §1395oo(d); see also 42 C.F.R. §405.1869
[2] 42 U.S.C.§1395ww(d)(5)(B)(vi)(I); see also 42 C.F.R.§412.105
[3] *Regions Hospital v. Shalala*, 522 U.S. 448, 118 S.Ct. 909 (1998); *Healtheast Bethesda Lutheran Hospital and Rehabilitation Center*, 164 F.3d 415 (1998).
[4] 42 U.S.C.§1395ww(d)(5)(B)(vi)(I); see also 42 C.F.R.§412.105

was finalized using a 398 bed count which went unchallenged by either a PRRB appeal or a reopening request. Accordingly, CMS guidance requires that the Intermediary apply the exact language of the statute and use the finalized bed count in the BBA-97 comparison.[5]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions, and evidence presented at the hearing, the Board majority finds and concludes that it has jurisdiction of this appeal and that the Intermediary's calculation of the Provider's IME reimbursement was improper.

The Intermediary challenged the Board's jurisdiction on this issue, contending that no audit adjustment was made to the number of beds claimed by the Provider. The Board majority finds that although the Intermediary did not adjust the Provider's bed count, it did adjust other components of the Provider's IBR, and the Board does have jurisdiction in this appeal.

42 U.S.C. §1395oo(d) delineates the broad scope of the Board's power to review and revise ANY cost incurred by the provider during the period encompassed by a cost report, even if the cost had not been claimed for reimbursement:

The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

C.F.R. §405.1869 also addresses the scope of the Board's decision-making authority:

> The Board shall have the power to affirm, modify, or reverse a determination of an intermediary with respect to a cost report and to make any other modification on matters covered by such cost report (including modifications adverse to the provider or other parties) even though such matters were not considered in the intermediary's determination. The opinion of the majority of those Board members deciding the case will constitute the Board's decision.

The Board majority notes that Medicare intermediaries were required to recalculate providers' 1998 IRB ratios as they related to the determination of providers' IME payments for 1999, and in the present case the Intermediary made adjustments to the Provider's 1998 IRB ratio.

The NPR at issue constitutes the Intermediary's final determination regarding Provider's IME payment for 1999, and that IME payment determination incorporated a

[5] 62 FR 26317, 26324.

determination of an IRB ratio derived, in part, from the 1998 cost reporting period. The IME payment calculation for 1999, including the 1998 IRB ratio, is a matter covered by the 1999 cost report; and the Provider timely appealed its IME payment determination from its NPR for 1999. Accordingly, the Board majority finds that the Intermediary's adjustments impacted the determination of the Provider's 1999 IRB ratio, and the relevant statute and regulation clearly support the finding that the Board has jurisdiction to decide this issue.

The substantive dispute in this case involves the proper application of the IRB comparisons mandated by BBA-97. The Act requires that the IRB ratio for cost reporting periods beginning on or after 10/1/1997 be compared to the IRB ratio derived from the immediately preceding (prior) cost reporting period and limits reimbursement to the lower of the two ratios. The pivotal issue in this dispute centers on the proper identification of available beds from the prior cost reporting period for use in the comparison.

There is no dispute that the Provider filed and finalized its 1998 and 1999 cost reports using the number of certified beds (398) on its operating certificate, and that this number was substantially higher than the actual number of beds permanently maintained and available for lodging inpatients. The parties addressed the disparity in a joint stipulation that identified the actual number of beds at 291.35 for 1998 and 272.97 for 1999. The Intermediary considered the revised count appropriate to calculate the 1999 ratio but inappropriate to recalculate the 1998 ratio for use in the fiscal year 1999 IRB comparisons. The Intermediary considers itself statutorily bound to use the 1998 ratio as finalized in the 1998 settled cost report.

The Board majority finds nothing in the statute that requires the Intermediary to knowingly use an incorrect bed count in the comparison. Further, the Board's examination of case precedent indicates that the Board, lower courts and the Supreme Court have collectively held that the inadvertent use of previous erroneous information does not mean that a correction cannot be made and applied later, after the original information is learned to be erroneous.[6] The holdings are both applicable and persuasive in this case. The Board believes that the continued use of erroneous information in a case that is under appeal is inconsistent with the holdings of the courts and compromises both the appeal and the settlement process. Accordingly, the Board finds the Intermediary's continued use of the original 1998 IRB ratio in the 1999 ratio comparison improper. The Board considers the stipulated bed counts for both 1998 and 1999 appropriate for the 1999 ratio analysis and remands the calculation of the Provider's IME reimbursement to the Intermediary for the incorporation of those counts.

The Board understands that Provider's 1998 cost report has been settled and is not the subject of any challenge or appeal. Accordingly, the Board expects that the use of the

[6] Regions Hospital v. Shalala, 522 U.S. 448, 457-60; 118 S.Ct. 909, 914-915 (1998); Healtheast Bethesda Lutheran Hospital and Rehabilitation Center,164 F.3d 415, 417-18 (8th Cir. 1998); Larkin Chase Nursing & Restorative Ctr. V Mutual of Omaha Ins. Co., Medicare and Medicaid Guide (CCH ¶ 80,647 (2000).

stipulated 1998 bed counts will be limited to the 1999 ratio comparison and will have no impact on the Provider's NPR for 1998.

DECISION AND ORDER:

The Board has jurisdiction of this appeal.

The Intermediary's calculation of the Provider's IME reimbursement was improper. The stipulated bed counts for both 1998 and 1999 are the appropriate counts to be used for the 1999 ratio analysis and, accordingly, the calculation of the Provider's IME reimbursement is remanded to the Intermediary for the incorporation of those counts.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire (Dissenting Opinion as to jurisdiction)
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A. (Dissenting Opinion as to jurisdiction)
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: September 7, 2006

Suzanne Cochran, Esquire
Chairperson

Dissenting Opinion of Elaine Crews Powell and Suzanne Cochran

We disagree with the majority's conclusion that the Board has jurisdiction of this case.

The majority granted jurisdiction over this case and found not only that the 1999 cost report was properly appealed but also that the Provider was entitled to a revision of the bed count used for 1998 to compute the three year rolling average Intern to Bed Ratio (IBR) applicable to its 1999 cost report.

The Provider filed its 1999 cost report claiming that it had 398 available beds, a figure used in part to calculate the Provider's IBR ratio. The Intermediary did not challenge the bed count; however, the Intermediary did adjust other components of the IBR. Later the Provider discovered that it had overstated not only its 1999 bed count but also its 1998 bed count which impacted its IBR for 1999. It is clear from the record that for both years the Provider filed its cost report with 398 available beds and that the bed count was not appealed. The Provider sought to change its claim for the lower bed count as an added issue to its other appeal issues. The majority found that the adjustment to the IBR's other components opened up any component, specifically the bed count, to appeal. We respectfully dissent.

The count of available beds is a component of the IBR computation that is uniquely within the Provider's knowledge and control. The adjustments made by the Intermediary to other aspects of the IBR ratio did not affect the bed count itself. If an adjustment to an *independent* component of a calculation opened up other *independent* components to appeal, the cost report's finality would be undermined.

We find that the Provider demonstrated satisfaction with the number of its available beds by claiming that number on its as-filed cost reports – a bed count that the Intermediary accepted. The Provider's claim was unencumbered by any law, regulation, program instruction, government interpretation, limitation or confusion about the number of beds that could be claimed. Here the burden was squarely on the Sisters of Charity to properly report an accurate number of available beds – a burden that it failed to meet.

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Elaine Crews Powell Suzanne Cochran