PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D5

PROVIDER -
Mayo Clinic Hospital
Phoenix, Arizona

Provider No.: 03-0103

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Noridian Administrative Services

DATE OF HEARING -
January 25, 2008

Cost Reporting Periods Ended -
December 31, 2000; December 31, 2001
and December 31, 2002

CASE NOs.: 06-1300; 06-1301; 06-1307

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ISSUE:

Whether the Intermediary used proper cost to charge ratios in calculating the Provider's outlier payments.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over 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. §§1395-1395cc. 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 under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 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 fiscal 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 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.

Medicare reasonable cost reimbursement is governed by 42 U.S.C. §1395x(v)(1)(A). In part, the statute provides that the "reasonable cost" of any service shall be the actual cost incurred but excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The implementing regulation at 42 C.F.R. §413.9 provides that reasonable cost includes all "necessary and proper" costs incurred in furnishing healthcare services.

Effective with cost reporting periods beginning on or after October 1, 1983, short-term acute care hospitals became subject to Medicare's Prospective Payment System (PPS). Under this system Medicare's payment for inpatient Part A operating costs is made on prospectively set rates per discharge. In general, Medicare discharges are classified into diagnostic related groups (DRG) and a specific payment weight is assigned to each DRG based on resource use or intensity.

Payments made to hospitals under PPS are adjusted (increased) when certain conditions exist. For example, DRG payments are increased when a hospital provides care to a

disproportionate number of low income patients, or when a hospital incurs the indirect costs of graduate medical education programs. Relevant to the instant cases is the increase in PPS payments for "outliers," i.e. discharges for which resource use is unusually high. To qualify for outlier payments a case must have costs above a fixed-loss threshold established by CMS. In general, the ratios of a hospital's costs to its charges (i.e., the ratio of operating costs to charges in addition to the ratio of capital costs and charges) are applied to the "covered charges" of a particular costly case to determine if it exceeds the fixed-loss threshold.

42 C.F.R. §412.84(h) provides the rules for applying cost-to-charge ratios in outlier determinations. Prior to 2003, this regulation stated:

> The operating cost-to-charge ratio and, effective with cost reporting periods beginning on or after October 1, 1991, the capital cost-to-charge ratio used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. Statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. HCFA sets forth these parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published under §412.8(b). (Emphasis added).

In 2003, 42 C.F.R. §412.84(h) was modified, in part, addressing cost to charge ratios applicable to outlier determinations for new hospitals. In pertinent part, the regulation states:

> (h) For discharges occurring before October 1, 2003, the operating and capital cost-to-charge ratios used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. For discharges occurring before August 8, 2003, statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. CMS sets forth the reasonable parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published in the FEDERAL REGISTER in accordance with §412.8(b). (Emphasis added).

> (i) (1) For discharges occurring on or after August 8, 2003, CMS may specify an alternative to the ratios otherwise applicable under paragraphs (h) or (i)(2) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. Such a request must be approved by the CMS Regional Office.
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> (2) For discharges occurring on or after October 1, 2003, the operating and capital cost-to-charge ratios applied at the time a claim is processed are based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period.
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> (3) For discharges occurring on or after August 8, 2003, the fiscal intermediary may use a statewide average cost-to-charge ratio if it is unable to determine an accurate operating or capital cost-to-charge ratio for a hospital in one of the following circumstances:
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> (i) New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with §489.18 of this chapter.) (Emphasis added).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mayo Clinic Hospital (Provider) is an acute care teaching facility located in Phoenix, Arizona. It began operations effective October 28, 1998, and subsequently filed Medicare cost reports for its fiscal years ended December 31, 2000, 2001, and 2002.[1] Blue Cross and Blue Shield of Arizona (Intermediary)[2] reviewed the cost reports but did not issue an NPR for these three fiscal periods until September 2005. Since the Provider did not have "settled" cost reports available until the NPRs were issued, the Intermediary determined the Provider's outlier payments by applying statewide cost-to-charge ratios to the Provider's covered charges. The Intermediary's decision to use the statewide cost-to-charge ratios was based upon its interpretation of 42 C.F.R. §412.84(h) in effect prior to 2003, i.e., the Intermediary concluded that the statewide cost-to-charge ratios were the only alternative to determine outlier payments absent a settled cost report.

[1] The Provider also submitted a cost report for its fiscal year ended December 31, 1999, but it is not at issue in these cases.

[2] Noridian Administrative Services subsequently replaced Blue Cross and Blue Shield of Arizona as the Provider's intermediary.

The Provider appealed the Intermediary's outlier determinations to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $6,176,184 ($1,506,850 applicable to fiscal year 2000, $2,743,399 for 2001, and $1,925,935 for 2002).[3]

The Provider was represented by Ronald W. Grousky, Medicare Coordinator, Mayo Clinic. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that 42 C.F.R. §412.84(h), in effect prior to 2003, does not specifically address how to handle new hospitals that have filed a cost report but have not yet received settled cost reports. However, contrary to the Intermediary's interpretation, the regulation authorizes the use of statewide cost-to-charge ratios for determining outlier payments only when a provider's cost-to-charge ratios fall outside reasonable parameters. Furthermore, based upon the changes made to 42 C.F.R. §412.84 in 2003, it is clear that longstanding Medicare policy dictates that the Intermediary should have used the cost-to-charge ratios from the Provider's filed (yet unsettled) cost reports.

The Provider refers to 42 C.F.R. §412.84(i)(3) and (i)(3)(i) which states that intermediaries may use a statewide average cost-to-charge ratio if they are unable to determine an accurate operating or capital cost-to-charge ratio because a hospital has "not yet submitted their first Medicare cost report." Language used by CMS in the preamble to the 2003 rule (68 Fed. Reg. 34,494, 34,500 June 9, 2003) supports this position, stating in part:

> . . . hospitals that have not yet filed their first Medicare cost reports . . . would still receive the statewide average cost-to-charge ratios.

In addition, language used by CMS in 1988 illustrates this policy is longstanding. A discussion about PPS (53 Fed. Reg. 38,476, 38,503, Sept. 30, 1988), states in part:

> [f]or hospitals that have not yet filed their first Medicare cost report with their fiscal intermediary or for which the intermediary is unable to compute a reasonable cost-to-charge ratio, we computed statewide average cost-to-charge ratios. . .

The Provider notes that the Intermediary recognized this policy, and on January 23, 2003, prior to the changes made to 42 C.F.R. §412.84, began using cost-to-charge ratios from the Provider's as filed cost reports. Notably, using the "best available data" to establish payments under PPS is consistent with CMS policy.

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[3] Provider's Revised Final Position Paper at 4.

The Provider also disagrees with the Intermediary's argument that there is no authority to retroactively adjust the subject outlier payments. The Intermediary relies on 42 C.F.R. §412.116(e), which states: "[p]ayments for outlier cases . . . are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment" and 53 Fed. Reg. 38,476, Sept. 30, 1998 which states: [w]e proposed to continue our policy that outlier payments would be final and not subject to recalculation based on later data that would affect the hospital specific cost-to-charge ratios." The Provider argues that it is not requesting a recalculation based upon later data, but is disputing the propriety of the data used.

The Intermediary relies on the regulation in effect during the subject cost reporting periods that says the cost-to-charge ratio is based on the latest available settled cost report for a hospital. Since there was no settled cost report available during these periods, and since the regulation provides no discussion to default to a filed cost report, the only other option discussed is the use of statewide ratios.[4]

The Intermediary also contends that it had no authority to retroactively adjust outlier payments for the period in question. CMS did not revise its policy at 42 C.F.R. §412.116(e), stated above, until August 8, 2003. (68 Fed. Reg. 34,494, June 9, 2003). The Intermediary points out that CMS previously denied the Provider's request to have their outlier payments retroactively revised based upon the June 9, 2003 final rule.[5]

In addition, the Intermediary rejects the Provider's argument that CMS consistently relies upon the "best data available" to determine program payments under PPS. In the example cited by the Provider, and contrary to the instant case, CMS relied upon the best data available to support a regulatory methodology.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds and concludes that the Intermediary incorrectly determined the Provider's outlier payments. The Intermediary made its determinations by applying statewide cost-to-charge ratios to the Provider's covered charges. However, the Provider is entitled to have its outlier payments calculated by having cost-to charge ratios determined from its "as filed" cost reports applied to covered charges.

42 U.S.C. §1395ww(d)(5)(A), the statutory authority for outlier payments under Medicare's inpatient prospective payment system, does not address the circumstances at issue in this case. In pertinent part, the statute provides only that a hospital may receive additional payments where its charges "adjusted to cost" exceed certain dollar values. The statute does not explain how this determination (adjustment to cost) is to be made, however.

[4] Transcript (Tr.) at 36. Intermediary Revised Final Position Paper at 3.
[5] Exhibit I-1.

To address this matter the Secretary of DHHS (the Secretary) promulgated 42 C.F.R. §412.84ff. In part, these rules explain that the ratios of a hospital's costs to its charges are applied to its billed charges to determine outlier status. However, 42 C.F.R. §412.84(h), which explains how the ratios are determined, also does not address the specific circumstances of this case. That is, the regulation explains that a provider's ratios are determined annually based upon the provider's latest available "settled" cost report. If the ratios fall outside reasonable parameters, then statewide cost-to-charge ratios set by CMS are to be used. However, the regulation does not make the use of statewide ratios a default methodology when a settled cost report is unavailable. With respect to the instant case, the Provider had submitted cost reports to the Intermediary, and although these cost reports had not yet been settled, there is no assertion that data produced from these cost reports produced cost-to-charge ratios outside reasonable parameters.

Since both the statute and regulations are silent regarding the data to be used to determine outlier payments when a hospital has filed cost reports with its intermediary that have not yet been settled, the Board looks to the intent of the statute and enabling regulation and secondary authorities. From these sources it is clear that the proper identification of outlier cases and the accuracy of outlier payments are the fundamental objectives of the program. In the preamble to the final rule published on September 30, 1988, Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1989 Rates (53 FR 38476, 38503), HCFA states:

> 3. Hospital Specific Cost-to-Charge Ratios
> [w]e proposed to use hospital-specific cost-to-charge ratios to adjust charges for the purpose of computing cost outlier payments. The use of hospital-specific cost-to-charge ratios should greatly enhance the accuracy with which outlier cases are identified and outlier payments are computed, since there is wide variation among hospitals in these cost-to-charge ratios. The increased emphasis on cost in computing outlier payments heightens the need to use reasonably reliable factors to estimate costs from charges. Therefore, we believe the use of hospital-specific cost-to charge ratios is essential to ensure that outlier payments are made for cases that have extraordinarily high costs, and not merely high charges.
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> [F]or hospitals that have not yet filed their first Medicare cost report with their fiscal intermediary or for which the intermediary is unable to compute a reasonable cost-to-charge ratio, we computed statewide average cost to charge ratios. . . . (Emphasis added).

This language indicates that the Secretary contemplated a scenario in which cost-to-charge data are available although not "settled" by an intermediary. The common theme is that until a hospital files a cost report there is really no data with which to make a reasonable estimation of the cost-to-charge ratios, so statewide average data are used. However, it is implicit in that language that if a cost report is filed, though not yet settled, data of the character the Secretary has found reliable is available from which computation of "reasonable" cost-to-charge ratios can be computed. Moreover, use of the averages conflicts with the principle discussed in the preamble in that it places reliance on averages that the Secretary discarded as being less accurate than hospital specific data. These interpretive statements, coupled with silence in the regulation itself as to the application in the circumstances here, compel rejection of the Intermediary's position that, absent a settled cost report the regulation requires it to "default" to using a statewide average.

Finally, the Board finds that a recalculation of the Provider's outlier payments is not a retroactive adjustment that would be prohibited by 42 C.F.R. §412.116(e). The regulation contemplates an adjustment(s) based upon "later data," or data that was not available at the time the payments were made. With respect to the instant case, the required recalculation is based upon data contemporaneous to the subject cost reporting periods. At the time the Intermediary made its tentative settlement, the cost-to-charge ratios used to calculate the outlier payments should have been updated to the best data available. The data from the as-submitted cost reports comports far more effectively with the intent of the pertinent statute and regulations to properly identify and pay outlier cases, as well as the underlying intent of the program to properly pay providers for services rendered to Medicare beneficiaries.

DECISION AND ORDER:

The Intermediary did not use the proper cost-to-charge ratios to calculate the Provider's outlier payments. The Intermediary is to base the Provider's outlier payments on data found in the Provider's tentatively settled cost reports.

Board Members Participating:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A. (inactive)

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: December 22, 2008