PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D15

PROVIDER -
St. Francis Medical Center
Cape Girardeau, Missouri

Provider No.: 26-0183

vs.

INTERMEDIARY –
Wisconsin Physician Services

DATE OF HEARING –
January 12, 2012

Cost Reporting Period Ended -
June 30, 2004

CASE NO.: 07-0235

INDEX

ISSUE:

Whether the Intermediary used the correct number of days when computing the disproportionate share percentage when the cost-reporting periods overlapped April 1, 2004.[1]

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 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[2] determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS.[3]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. A cost report shows the costs incurred during the relevant period and the portion of those costs allocated to the Medicare program.[4] The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues a Notice of Program Reimbursement ("NPR") to the provider.[5]

A provider dissatisfied with the intermediary's final determination of total reimbursement (*i.e.*, the NPR) may file an appeal with the Provider Reimbursement Review Board ("Board") provided it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[6]

For cost reporting periods beginning before October 1, 1983, the Medicare program reimbursed short-term acute care hospitals based upon the reasonable costs that they incurred to furnish health care services to Medicare beneficiaries. For cost reporting periods beginning on or after October 1, 1983, these hospitals became subject to the Medicare program's prospective payment system for reimbursement of operating costs for inpatient hospital services ("IPPS"). Under IPPS, Medicare discharges are classified into diagnostic related groups ("DRGs") and a fixed payment rate is established for each group based upon resource use or intensity.[7]

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[1] Transcript ("Tr.") at 5-6.
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* 42 U.S.C. § 1395h; 42 C.F.R. §§ 413.20(b) and 413.24(b).
[4] *See* 42 C.F.R. § 413.20.
[5] *See* 42 C.F.R. § 405.1803.
[6] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.
[7] *See* 42 U.S.C.§1395ww(d); 42 C.F.R. §412.60.

IPPS payments may be adjusted based on certain hospital-specific factors.[8] This case involves one of the hospital-specific adjustments, specifically the "disproportionate share hospital," or "DSH" adjustment. The Secretary is required to provide increased IPPS payments to hospitals that serve a "significantly disproportionate number of low-income patients."[9] Whether a hospital qualifies for the DSH adjustment and how large an adjustment it receives, depends on the hospital's classification as urban versus rural, the number of beds available for patients, and the hospital's "disproportionate patient percentage" or "DPP."[10]

The DPP is the sum of two fractions, the "Medicare and Medicaid fractions," expressed as a percentage for a hospital's cost reporting period.[11] For the Medicare fraction, the numerator is the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income, excluding patients receiving State supplementation only, and the denominator is the number of hospital patient days for patients entitled to Medicare Part A.[12] For the Medicaid fraction, the numerator is the number of hospital patient days for patients who were eligible for medical assistance under a State plan approved under Title XIX of the Act[13] for such period but not entitled to benefits under Medicare Part A, and the denominator is the total number of the hospital's patient days for such period.[14] The Medicaid fraction is frequently referred to as the "Medicaid Proxy" and is the only fraction at issue in this case.

Guidance for the DSH calculation is codified at 42 C.F.R. § 412.106. In particular, subsection (b) provides the specific rules for determining a hospital's DPP and stated the following, in pertinent part, during the time at issue:

> (b) *Determination of a hospital's disproportionate patient percentage*. (1) *General Rule*. A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
> (2) *First Computation*: *Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS–
> (i) Determines the number of patient days that–
> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;
> (ii) Adds the results for the whole period; and
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patient days that–

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[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §1395ww(d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[11] 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[12] *Id.*
[13] Codified at 42 U.S.C. Ch. 7, Subch. XIX.
[14] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi). *See also* 42 C.F.R. § 412.106(b)(4).

> (A) Are associated with discharges that occur during that period; and
> (B) Are furnished to patients entitled to Medicare Part A. . . .
> (4) *Second Computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of services 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. . . .
> (5) *Disproportionate patient percentage*. The intermediary adds the results of the first computation made under either paragraph (b)(2) or (b)(3) of this section and the second computation made under paragraph (b)(4) of this section and expresses that sum as a percentage. This is the hospital's disproportionate patient percentage . . . .[15]

If a provider qualifies for DSH under subsection (b), then the amount of the DSH adjustment payment is determined under subsection (d). In this regard, § 412.106(d)(1) states: "if a hospital serves a disproportionate number of low-income patients [*i.e.*, qualifies as DSH], its DRG revenues for inpatient operating costs are increased by an adjustment factor as specified in paragraph (d)(2) of this section." The § 412.106(d)(2) payment adjustment factors relevant to this case are:

> (2) *Payment adjustment factors*. . . .
> (ii) If the hospital meets the criteria of paragraph (c)(1)(ii) of this section, the payment adjustment factor is equal to one of the following:
> (A) If the hospital is classified as a rural referral center– . . . .
> (2) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies: . . . .
> (ii) If the hospital's disproportionate patient percentage is greater than 19.3 percent and less than 30 percent, the applicable payment adjustment factor is 5.25 percent. . . .
> (3) For discharges occurring on or after April 1, 2004, the following applies: . . . .
> (ii) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.[16]

There is no dispute that the regulation at 42 C.F.R. § 412.106 is the controlling regulation in this case. The dispute centers on the interpretation of this regulation.

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[15] 42 C.F.R. § 412.106(b) (2004).
[16] 42 C.F.R. § 412.106(d)(2) (2004).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Francis Medical Center ("Provider") is a nonprofit, acute care, IPPS hospital located in Cape Girardeau, Missouri. The Provider is a rural facility with more than 100 beds but fewer than 500[17] and carries a rural referral center designation under the Medicare Program. In order to determine the DSH adjustment payment reported on its as-filed cost report for its fiscal year ending ("FYE") June 30, 2004, the Provider calculated two distinct DPPs: (1) one DPP based on that portion of the cost reporting period attributable to discharges occurring on or after July 1, 2003 and prior to April 1, 2004; and (2) another DPP based on the remaining portion of the cost reporting period (*i.e.*, that portion attributable to discharges occurring on and between April 1, 2004 and June 30, 2004).

The Provider's designated intermediary, Wisconsin Physicians Service ("Intermediary"), did not calculate two distinct DPPs in order to determine the Provider's DSH adjustment payment for FYE June 30, 2004. Rather, the Intermediary calculated a single DPP based on the Provider's total discharges for the cost reporting period. That DPP was used to calculate the payment adjustment factors for discharges before and after April 1, 2004. This resulted in an adjustment of the Provider's as-filed DSH adjustment payment by approximately $24,000. The Provider disputes this adjustment and filed an appeal with the Board. The dispute between the parties centers on the proper interpretation of 42 C.F.R. § 412.106.

The Provider's appeal was timely filed pursuant to 42 C.F.R. §§ 405.1835, and met the jurisdictional requirements of that regulation. The Provider was represented by Randal D. Schmitt, CPA, of Jacobson & Associates, LLC. The Intermediary was represented by Joseph O. Aydt of Wisconsin Physicians Service.

PROVIDERS' CONTENTIONS:

The Provider contends that the language of 42 C.F.R. § 412.106(b) requires that the calculation of the DPP for a cost reporting period that encompasses service dates prior to and after April 1, 2004 should be split into two distinct DPP calculations. The Provider argues that the first DPP should use a Medicaid fraction where the numerator is those Medicaid eligible days occurring on or between July 1, 2003 to March 31, 2004 and the denominator is the total days for that same period. Specifically, the numerator of the Medicaid fraction in the first DPP should be of 5,678 Medicaid eligible days while the denominator should be 35,595 total days. Pursuant to 42 C.F.R. § 412.106(d)(2)(ii)(A)(2)(ii), the first DPP would result in a DSH adjustment payment percentage of 5.25 percent, applied to DRG payments for discharges occurring on or between July 1, 2003 and March 31, 2004.[18] This DSH adjustment payment percentage is not in dispute.[19]

Similarly, the Provider argues that the second DPP should use a Medicaid fraction where the numerator is those Medicaid eligible days occurring on or between April 1, 2004 and June 30,

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[17] *See* Tr. at 11-12 (stating that Provider qualified for a DSH adjustment pursuant 412.106(c)(1)(ii)).
[18] *See* Provider Exhibit P-2.
[19] The Intermediary's audited DSH adjustment payment percentage for this same time period was also 5.25 percent. *See id.*

2004 and the denominator is the total days for that same period. Specifically, the numerator of the Medicaid fraction for the second DPP should be 1,975 Medicaid eligible days while the denominator should be 12,082 total days. Pursuant to 42 C.F.R. § 412.106(d)(2)(ii)(A)(3)(ii), the second DPP would result in a DSH adjustment payment percentage of 9.23 percent applied to DRG payments for discharges occurring on or between April 1, 2004 and June 30, 2004.[20]

The Provider asserts that the Intermediary's treatment of the entire cost reporting period as a single period for purposes of calculating the DPP under 42 C.F.R. § 412.106(b) is inconsistent with the language of the regulation and that the Intermediary's subsequent segregation of the single period into two different periods for purposes of calculating the final DSH adjustment payment under § 412.106(d) contradicts the theory of a single period.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the regulations clearly provide that only one period exists for the entire cost reporting period for purposes of the DSH percentage determinations. 42 C.F.R. § 412.106(b) provides the specific guidelines for the determination of a hospital's DPP. The Intermediary argues that the language of § 412.106(d) makes clear that the variables to be used in the DSH adjustment payment percentage determinations must be based on a DPP calculated for the Provider's entire cost reporting period and that the Provider's interpretation of the regulation is incorrect.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions, and the evidence presented at the hearing, finds and concludes that the Intermediary's adjustment was proper.

The regulations at 42 C.F.R. § 412.106 specify a two-step process for determining the DSH adjustment payment. The first step is to the determination of a hospital's DPP in order to establish whether a provider qualifies as DSH.[21] If the provider qualifies, then the second step is to calculate the DSH adjustment payment percentage that is to be applied to the relevant DRG payments for that provider.

Under the first step, a provider must first qualify for DSH by determining whether the provider's DPP as calculated in § 412.106(b) is above the relevant threshold specified in 412.106(c). Pursuant to § 412.106(b), the Medicare fraction of the DPP is calculated using the specified patient service days that are "the results for the whole period" where the "period" is "the Federal fiscal year in which the hospital's cost reporting period begins." Similarly, the Medicaid fraction is calculated using the specified patient days "for the same cost reporting period used for the first computation [*i.e.*, the Medicare fraction]." Thus, in calculating the DPP and determining whether a provider qualifies for DSH, the relevant 12-month period is viewed as a *single* period.

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[20] *See id.* In contrast, the Intermediary's audited DSH adjustment payment percentage for this same time period was 8.99.

[21] Step one is reflected in the titles for 42 C.F.R. § 412.106(b) and (c), "Determination of a hospital's disproportionate patient percentage" and "Criteria for classification" respectively.

This is consistent with 42 U.S.C. § 1395ww(d)(5)(F)(vi) which specifies that the DPP is calculated "with respect to a cost reporting period" and that each of the relevant patient days used in both the Medicare and Medicaid fractions are days "for such period." Based on this DPP calculation, the Provider qualified for a DSH payment adjustment for FYE June 30, 2004 because the Provider's DPP for that cost reporting period exceeded the 15 percent threshold specified in § 412.106(c)(1)(ii) for rural hospitals such as the Provider that have more than 100 beds but fewer than 500 beds.

Under the second step, a provider's DSH adjustment payment is determined based on the adjustment factors specified in 42 C.F.R. § 412.106(d)(2). The "adjustment factor" assigned to a particular DRG payment can vary depending on the date of the discharge and how high the provider's DPP is (*i.e.*, how high the relative burden of its DSH population is). As the Provider qualified for a DSH adjustment under § 412.106(c)(1)(ii) and is designated as a rural referral center, then the provisions of § 412.106(d)(2) that are relevant to calculating the Provider's DSH adjustment payment during the time period at issue are located at:

1. Subparagraphs (ii)(A)(2)(ii) which applies to "discharges occurring on or after April 1, 2001, and before April 1, 2004"; and
2. Subparagraph (ii)(A)(3)(ii) which applies to "discharges occurring on or after April 1, 2004."

Thus, the second step does in fact separate discharges by periods to accurately adjust for DSH activity for payment adjustment purposes. However, determining which adjustment factor is relevant during these specified periods is determined by the DPP. Specifically, the adjustment factors specified in these subparagraphs are only triggered "[i]f the hospital's disproportionate patient percentage is greater than" a specified amount. As discussed above, the "disproportionate patient percentage" or DPP is defined and determined in § 412.106(b) using a single period.

The Board is aware that certain adjustment factors are calculated using a formula that includes the DPP. For example, § 412.106(d)(2)(ii)(3)(ii) sets forth the following formula for the adjustment factor: "5.88 plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage [*i.e.*, DPP]." However, the Board notes again that DPP is defined and determined in § 412.106(b) based on a single period.

The Board can find nothing in the regulation at 42 C.F.R. § 412.106(d) or relevant statutory provisions that countermands the use of the single period data for the initial calculation of the Provider's DSH eligibility. Further, the Board can find no basis in the language of the regulation that supports the Provider's position. As a result, the Board finds that the Intermediary calculated the Provider's disproportionate share adjustment in a manner consistent with the requirements of 42 C.F.R. § 412.106(b) and that the Intermediary's subsequent adjustment was proper.[22]

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[22] The Board's decision is consistent with the Administrator's decision in *Western Ariz. Reg. Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Administrator Decision (Apr. 20, 2006), *rev'g*, PRRB Dec. No. 2006-D19 (2006).

DECISION AND ORDER:

The Intermediary calculated the Provider's disproportionate share adjustment in a manner consistent with the requirements of 42 C.F.R. §§ 412.106(b) to 412.106(d). The Intermediary's subsequent adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. `Braganza, CPA
J. Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty

Michel W. Harty
Chairman

DATE: MAY 08 2013