PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2009-D15

PROVIDER - St. Joseph's Hospital and Health Center Paris, Texas	**DATE OF HEARING -** June 18, 2008
Provider No.: 45-0196	Cost Reporting Periods Ended - June 30, 1987 and June 30, 1988
vs.	
INTERMEDIARY - BlueCross BlueShield Association/ BlueCross BlueShield of Texas	**CASE NOs.:** 92-1212 and 92-1522

INDEX

	Page No.
Issue	**2**
Medicare Statutory and Regulatory Background	**2**
Statement of the Case and Procedural History	**3**
Parties' Contentions	**4**
Findings of Fact, Conclusions of Law and Discussion	**6**
Decision and Order	**7**

ISSUE:

Whether the denial of the Provider's request for an exception to the Tax Equity and Fiscal Responsibility Act (TEFRA) rate for its rehabilitation unit was proper.

MEDICARE STATUTORY AND PROCEDURAL HISTORY:

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 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.

From the Medicare program's inception in 1965 until 1982, hospitals were reimbursed the lower of their reasonable costs or customary charges for services provided to Medicare beneficiaries. 42 U.S.C. §1395f(b)(1); see generally Good Samaritan Hospital v. Shalala, 508 U.S. 402 (1993). The statute at 42 U.S.C. §1395x(v)(1)(A) defines reasonable costs as "the costs actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services."

In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act, Pub. L. 97-248, modifying the reasonable cost reimbursement methodology in order to create incentives for providers to render services more efficiently and economically. TEFRA imposed a ceiling on the rate-of-increase in inpatient operating costs per case recoverable by a hospital. Generally, the TEFRA ceiling amount, or target amount, is calculated based upon the allowable Medicare operating costs in a hospital's base year divided by the number of Medicare discharges in that year. The TEFRA target amount is updated annually based on CMS' projection of the annual percentage increase in hospital inpatient operating costs. If a provider incurs costs below the applicable TEFRA target amount in a given cost reporting year, it is entitled to reimbursement for its reasonable costs plus an

additional incentive payment. Because the TEFRA target amount serves as a ceiling, a provider may not be reimbursed for its costs above the applicable TEFRA target amount for a particular year. The regulation implementing TEFRA, 42 C.F.R. §413.40, establishes the procedure and criteria for providers to make requests to CMS for exemptions from and adjustments to the TEFRA ceiling.

In 1983, Congress enacted the Social Security Amendments, P. L. No. 98-21, which created the Prospective Payment System (PPS) for hospital inpatient operating costs. After the implementation of PPS, only providers and units within providers exempt from PPS that continued to be paid under the reasonable cost system were subject to the TEFRA rate-of-increase limit. In this case, the Provider's rehabilitation unit, exempt from PPS, continued to be subject to TEFRA and its rate-of-increase limit.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Joseph’s Hospital and Healthcare Center (Provider) is a 212-bed acute care hospital located in Paris, Texas. The Provider operated a rehabilitation unit that is subject to the TEFRA limits. Blue Cross and Blue Shield of Texas[1] (Intermediary) issued original Notices of Program Reimbursement (NPRs) for the Provider’s fiscal years ended (FYEs) 6/30/87 and 6/30/88 on May 24, 1989 and July 16, 1990, respectively. In those NPRs the costs in the Provider’s rehabilitation unit were in excess of the TEFRA rate-of increase ceiling by $191,035 for FY 1987 and by $180,301 for FY 1988.[2] The Provider did not file an exception request within 180 days of the date of the original NPRs as required by 42 C.F.R. §413.40.

The Intermediary initially established the Provider’s TEFRA target rates for FYs 1987 and 1988 using base year cost data from a FY 1986 NPR dated 9/22/88. The Intermediary subsequently revised the TEFRA target rates using base year cost data from an amended FY 1986 NPR dated 9/24/91. Per the initial base year cost report, the target rate was identified as $2,565.15 and the updated target rates were set for FYE 6/30/87 at $2,570.49 and for FYE 6/30/88 at $2,607.32. Using the amended base year data, the TEFRA target rate for the base year was revised to $4,777.69 and the updated target rates were set for 6/30/87 at $4,787.63 and for FYE 6/30/88 at $4,856.79. These revised target rates were incorporated into revised notices of program reimbursement (RNPRs) for FYEs 6/30/87 and 6/30/88, both of which were issued on 9/24/91.

The Provider filed timely appeals to the Board from the revised NPRs on March 18, 1992 for FY 1987 and on March 19, 1992 for FY 1988. In both appeals, the Provider included in its “list of issues” the TEFRA rate exception request for its rehabilitation unit. The Provider also filed a request for an exception to the TEFRA rate for the rehabilitation unit for both FYs 1987 and 1988 on March 16, 1992. Exhibit P-6. All other issues appealed from the revised NPRs, other than the TEFRA issue, are resolved. See Provider Position Papers at 2.

---

[1] The current Intermediary is TrailBlazer Health Enterprises, LLC.
[2] See Intermediary’s Exhibit I-4.

On April 5, 1993, HCFA denied the Provider's exception request for both years. Exhibit I-3 at 2. It stated that:

> We agree with your [the Intermediary's] recommendation that the requests be denied because [the Provider] did not file timely appeals, as required by §413.40(e)(1).
>
> The Medicare regulations at §405.1889 provide that, following a reopening, where a fiscal intermediary (FI) revises a determination on the amount of program payment, such as the revised NPRs dated September 24, 1991, this revision is considered to be a separate and distinct determination which may be appealed. That is, a hospital is entitled to appeal only the specific adjustments made by the FI in its revised NPR. The circumstances cited by the hospital for exceeding the target existed when the initial NPRs were issued and were not a result of the reopenings of the cost reports involved.

The Provider was represented by Mitchell A. Dzwonek, of Certus Corporation. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider asserts that there are two different and distinct TEFRA target rates. The Intermediary has denied the Provider's request for exception not on the merits of the case but based on the untimely filing from the original target rate implemented in the initial NPRs. The Provider contends that its target rates were substantially modified in the revised cost reports for both years and they should be permitted to appeal these modifications that were made in the revised cost reports. While there is no audit adjustment to show the change from the original to the revised target rates, it is the revised target amounts that the Provider is appealing that were first implemented in the revised NPRs. It is these target rates that are addressed in the Provider's request for exception.

The Provider relies on CMS Pub. 15-1 §2909, titled Issuance of Notice of Base Period Costs/Target Amount. It states:

> Upon determination of the base period costs and target amount relative to prospective payment . . . the intermediary sends the hospital a written notice setting forth the amounts arrived at in its determination . . . [The] intermediary's written notice of base period costs/target amount . . . is neither an intermediary determination (§2905) nor a Notice of Amount of Program Reimbursement (NPR) (§2906) for purposes of the appeals process . . . [M]atters at issue in the notice . . . may not be appealed until such time as the hospital seeking appeal has received its NPR for the cost reporting period involved.

The Provider states that this provision should also apply when a revised TEFRA target rate is established. The revised target rates signify a material change in the relationship between the Provider's actual costs and the ceiling, determined by target rate increase in operating costs per case. In effect, the original target rate should be considered an interim rate that was replaced. No valid exception could have been determined at that time because the true cost structure and cost per limit were newly established when the revised NPRs were issued. When the revised rates were established in the revised NPRs, the Provider submitted its request for relief within 180 days of the revised NPR.

In the revised NPRs for both years, the Provider's costs exceeded the TEFRA limits. This was the result of various amended audit adjustments which affected costs, cost allocations and other settlement issues as well as the revised TEFRA target rates implemented on Worksheet D-1 of the cost report for which no audit adjustment was made. The mixture of the revised TEFRA target rates and audit adjustments produced costs which were subject to limitation but significantly lower than on the previously audited cost reports as reflected on the original NPRs. Additionally, the costs subject to the limitations were not comparable because the cost mix and TEFRA target rates were materially different.

The Provider presented a schedule, Exhibit P-11, which summarizes the relative cost limitation data for FYs 1987 and 1988. The effect of the revised limits to the old cost structure was a net incentive of approximately $15,000[3] to the Provider for both years. This demonstrates that if the revised rates were applied to the old costs there would be a negligible impact on reimbursement. It is the cost changes in both revised cost reports (as the result of various audit adjustments) that, combined with the revised limits, produce this new limitation issue.

The Provider argues that CMS should not deny its request for relief from a revised cost report in which a revised limit is implemented. This newly implemented rate stands on its own merits and should be the basis for exception relief. There are new measures of efficiency and cost mix to support an exception request from the new rate.

The Provider believes the Intermediary's reliance on the decision in Foothill Presbyterian Hospital v. Shalala, 153 F.3d 1132 (9th Cir 1998) (Foothill) is misplaced. In that case, the provider failed to appeal from the initial NPR and could not appeal from a revised NPR that did not cause the provider's costs to exceed the TEFRA limit. In the present case, the Provider's TEFRA target rates were drastically changed in the revised NPR and therefore, it has a basis to appeal the revised TEFRA limits from the revised NPRs.

The Provider points out that the September 24, 1991 NPR was issued as a result of a reopening that altered virtually every aspect of the rehabilitation unit's operations, including factors utilized to justify the exception request.[4] The Medicare and non-Medicare case mix, length of stay, indirect costs and TEFRA rate were all changed. As a

---

[3] Per "PRO FORMA" column which shows impact based on revised Target rates only FY 87 - ($7014) and FY 88 $22,308

[4] See Provider's Exhibit P-8 for each year.

result of the change in the Provider's case mix, the rehabilitation unit's ancillary apportionment was affected.

There were 24 reopening adjustments. The Provider documented the relationship of the adjustments to the exception request as follows in FYE 6/30/88:

(1) The Medicare length of stay was reduced from 17.47 to 16.87 for a decrease of .60 days or over 3.4 percent.
(2) The TEFRA target rate increased from $2,607.62 to $4,856.79 or 86.25 percent.
(3) The actual cost per case increased from $4,410.63 to $5,018.07 or 13.7 percent.
(4) The number of Medicare cases/discharges increased from 100 to 102, or 2 percent.
(5) The rehabilitation unit indirect costs increased due to a 128 percent increase in rehabilitation unit square footage and the inclusion of rehabilitation unit statistics for Housekeeping, Nurse Administration, Medical Records, Social Service and Laundry statistics.

The Provider documented similar relationships for FYE 6/30/87. See Provider Position Paper for FY 1997 at 5.

The Provider asserts that the magnitude of the reopening adjustments to the rehabilitation unit's operating results cannot be overstated. The reopening adjustments so altered the Provider's rehabilitation unit's Medicare case mix that an exception was then necessary.

The Intermediary responds that the plain language of the regulation is clear that the Provider must submit a request for an exception within 180 days of its initial NPR. The Provider filed from a revised NPR. The Intermediary relies on the court's decision in Foothill which interpreted the regulation as allowing exception requests only from the initial NPR. The Court noted its interpretation was consistent with the reopening regulation that allows only appeals of adjustments made in the reopening. The Board's decision in The Brattleboro Retreat v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of New Hampshire-Vermont, PRRB Dec. No. 98-D24, January 27, 1998, Medicare & Medicaid Guide (CCH) ¶46,069, is consistent with the Foothill holding.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes that the Provider is entitled to pursue an exception request associated with its revised TEFRA limit.

Prior to 1993, the regulation for filing an exception from the TEFRA limit, 42 C.F.R. §413.40(e), did not distinguish between an original NPR and a revised NPR. However, in 1993 the regulation was amended to explicitly require that a hospital's request be

received within 180 days of the initial NPR. 58 Fed. Reg. 46270, 46323, 46342 (1993). The Secretary indicated the change was made to clarify the regulation and that there was no substantive change intended.

In interpreting the regulation prior to the change, the CMS administrator indicated that the regulation must be read in a manner that is consistent with the scope of the Board's jurisdiction as set forth in the statute and regulations. A provider has a right to a hearing before the Board if the provider filed a written request for a hearing within 180 days of the intermediary's determination. 42 C.F.R. §405.1835(a) and 42 C.F.R. §405.1841(a)(1). Thus, a provider's failure to timely appeal an original NPR deprives the Board of jurisdiction over a claim based on that NPR.

At the same time, the CMS Administrator noted that the regulations at 42 C.F.R. §405.1885 allow for a cost report to be reopened, and that when an NPR is revised, the regulation at 42 C.F.R. §405.1889 allows a provider to appeal from the determinations made in the reopening. Thus, if a specific reimbursement matter is reopened and revised, a provider's appeals rights are limited to that particular matter, and do not extend to other matters that were not subsequently reopened or revised. In Foothill, the only matter changed in the revised NPR involved malpractice costs and there were no additional disallowances under the TEFRA limit. As a result, the provider's requests for adjustments to its TEFRA limits were not related to the matters changed in the revised NPR.

The Board finds that the facts in this case are different from those in Foothill in that the Provider's TEFRA limit was substantially changed in the revised NPR. The Provider's base year costs were audited and a revised base year TEFRA rate was established. This revised rate was updated using the applicable percentages for cost reporting periods at issue in this case. At the same time that the Provider's TEFRA rate was increased, the base year adjustments also increased the indirect costs considered in establishing the revised limit. While the Provider received additional funds due to its increased limits, the Provider may nevertheless be entitled to TEFRA relief from the additional indirect costs, if it can establish that they resulted from some atypical reason for which the regulations allow an exception. The Board remands this case to the Intermediary and CMS to consider whether the Provider's exception request is justified and whether additional indirect costs should be added to the TEFRA limit.

DECISION AND ORDER:

The Board finds the Provider's appeal of its revised TEFRA target amount from its revised NPRs was proper. The Board remands this case to the Intermediary to determine if the Provider's exception request is justified on the merits.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman

DATE: April 1, 2009