PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D65

PROVIDER -
Baptist Memorial Hospital
Memphis, TN

Provider No.: 44-0048

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Riverbend Government Benefits
Administrators

DATE OF HEARING -
October 24, 2006

Cost Reporting Period Ended -
September 30, 1995

CASE NO.: 03-0132

INDEX

ISSUES:

1. Whether the Centers for Medicare and Medicaid Services (CMS) properly disallowed the Provider's request for an exception to its Skilled Nursing Facility (SNF) Routine Service Cost Limit (RCL).

2. Whether the Provider is entitled under CMS Program Memorandum (PM) A-99-62 to include the Social Security Act, Section 1115 waiver days for the expanded Medicaid populations (a/k/a TennCare) days in the Medicaid component of the disproportionate share hospital (DSH) adjustment calculation.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & 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 the program's administration. 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 interpretative 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 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Baptist Memorial Hospital - Memphis (Provider) operates a hospital-based, urban SNF in Memphis, Tennessee. The Provider is part of a chain of providers commonly owned and operated by Baptist Memorial Health Care Corporation (BMHCC), a home office, also located in Memphis, Tennessee.

Issue 1: Exception to the SNF RCL

Section 1819(a)(1) of the Social Security Act defines a SNF as an institution engaged in

providing skilled nursing and related services for residents who require medical and nursing care or rehabilitative services for injured, disabled or sick persons. Section 1861(v)(1)(A) established the method of cost reimbursement for SNFs as well as limitations on reimbursable costs. These limitations are called routine cost limits (RCLs) and are addressed in §§1861(v)(7)(B) and 1886(a) of the Social Security Act. 42 C.F.R. §413.30 implements the cost reimbursement limit for SNFs and also identifies the circumstances under which a provider may qualify for an exception to or an exemption from the limits. 42 C.F.R. §413.30(c) sets the procedural limits for requests regarding the applicability of the cost limits and states in pertinent part that a SNF's "… request must be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement."

One of the issues in dispute in this appeal involves the denial of a request for an exception to the routine cost limit.

Riverbend Government Benefits Administrator (Intermediary) used tentative[1] home office costs to finalize the Provider's 1995 cost report. After completing the 1995 home office cost audit, the Intermediary reopened the Provider's 1995 cost report to incorporate the audited home office costs and issued a revised NPR. The Intermediary made a number of adjustments to related party costs that impacted the SNF's costs. Based upon the impact of these adjustments, the Provider requested an atypical services exception to its RCL for the costs that were allowed in the revised NPR. The Intermediary denied the request for an exception as untimely filed (i.e., in excess of 180 days from the date of the original NPR), and the Provider appealed the denial. The two-fold issue under consideration is whether the Provider may file an exception pursuant to a revised NPR and, if so, whether the relief granted under the exception must be limited to the scope of the revised NPR.

PARTIES' CONTENTIONS:

The Provider contends that CMS' denial of its exception request is based upon an improper application of the 180-day rule. Neither the regulations at 42 C.F.R. §413.30(c) nor the instructions in PRM-1, §2531.1.A limit the window for filing an RCL exception request to 180 days from the date of the "initial" NPR. Indeed, the Board has previously determined that the regulation at §413.30(c) "makes no distinction between original and revised NPRs,"[2] and that an exception request to the routine cost limit could be filed by a SNF pursuant to the issuance of a revised NPR.[3] Further, the Provider contends that CMS never intended to limit the filing period for the exception request solely to the 180 days following the date of the "initial" NPR. The Provider argues that CMS included a specific provision for such a limitation at 42 C.F.R. §413.40(e)(1). That section details the procedure for hospitals requesting similar adjustments to

[1] Prior year ended 9/30/94 audited home office costs.
[2] Stanislaus Medical Center v. Blue Cross & Blue Shield Association/Blue Cross of Ca., PRRB Dec. No. 98-D79 (July 24,1998).
[3] Mercy General Hospital v. Blue Cross & Blue Shield Association/Blue Cross of California, PRRB Dec. No. 2000-D87 (September 22, 2000); see also, St. Anthony's Health Center - SNF v. Blue Cross and Blue Shield Association/ AdminaStar Federal Illinois, PRRB Dec. No. 2006-D55 (September 26, 2006).

their TEFRA rate-of-increase ceiling and requires that they submit their requests "no later than 180 days after the date on the intermediary's initial notice of program reimbursement (NPR) for the cost reporting period for which the hospital requests an adjustment." CMS did not use similarly restrictive language in 42 C.F.R. §413.30, and the Provider argues that had CMS intended such a limitation, it would have stated so in a regulation or manual provision. Accordingly, the Provider contends that its request for an exception from the SNF RCL may be based on a revised NPR.

The Provider also argues that it is entitled to the full amount of its exception request. The Provider contends that nothing in the regulation set forth at 42 C.F.R. §413.30 or manual provisions, PRM-I §2534 and §2531.1A, limit an exception filed from a revised NPR to the financial effect of specific adjustments; nor do they make a distinction between a decrease or an increase in costs. Rather, a provider's entitlement to an exception under the regulations hinges on the amount by which its costs exceed the RCL in total.

The Provider acknowledges that in cases decided in 1998 and 2000, the Board found the right to an exception request following a revised NPR to be limited by reference to the reopening rules at 42 C.F.R. §§ 405.1885-405.1889. However, the Provider contends that the regulatory scheme for SNF exceptions is separate and distinct from the appeal rules for NPRs issued following a reopening, and the Board should not apply the reopening rules here. The Provider also argues that appeals from revised NPRs are filed with the Board and must reflect the Board's statutory jurisdiction as interpreted by the courts. SNF exception requests are filed with the intermediary and ruled upon by the same. The Board's jurisdictional limits have no bearing on the right to a SNF exception as set forth in 42 C.F.R. §413.30(c) and (e). The Provider cites to the Board's decision in *St. Anthony's Health Center*[4] in support of its contentions. In St. Anthony's, the Board rejected arguments limiting the scope of an allowable exception request filed pursuant to a revised NPR. Rather, the Board found that the provider was "entitled to consideration of the full amount of the exception request based on the appeal of its revised NPR." The Board found further that "…[t]he regulation does not make a distinction between the types of NPRs; therefore, a provider should be allowed to make an exception request for the full amount from any NPR in which the RCL is at issue."

The Intermediary challenges the Provider's interpretation of the Board's determination in *Mercy General Hospital* and argues the holding in Mercy was that "the Board finds that the HCFA determination limiting RCL relief to the scope of the revised NPR was proper." The Intermediary acknowledges that, from a purely jurisdictional standpoint, an RCL exception request can be triggered from a revised NPR. However, the decision in Mercy limits the level of exception relief available to the impact of the revised NPR that triggered the request which is the amount of additional routine costs disallowed by application of the RCL to the final costs. Where there is financial detriment (i.e., either the routine cost limit is lowered or allowable costs allocated to the SNF are increased), there is potential for recovery of only the incremental

[4] St. Anthony's Health Center- SNF v. Blue Cross and Blue Shield Association/ AdminaStar Federal Illinois, PRRB Dec. No. 2006-D55 (September 26, 2006).

amount of loss caused by the revised NPR. There is no basis to recover any of the shortfall that could have been recovered from an appeal of the initial NPR. Where there is no financial detriment, (either the cost limit increases or allowable costs allocated to the SNF are lowered), there is no basis for relief. The revised NPR reflected a lower difference between the RCL and the Provider's actual costs. Contextually, the impact of the revised NPR was zero and relief must, therefore, be zero as well.

Issue 2: Section 1115 Waiver Days

The Secretary is directed to provide for appropriate adjustments to the limitation on payments that may be made under the Prospective Payment System (PPS) for the reasonable operating costs of inpatient hospital services, including those deemed necessary to take into account

> (B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter.

42 U.S.C. §1395ww(a)(2)(B).

The Secretary is also directed to provide for an additional payment to certain hospitals that serve a significantly disproportionate number of low-income or Medicare Part A patients. The formula used to calculate a provider's DSH adjustment is the sum of two fractions which are expressed as percentages. 42 U.S.C. §1395ww(d)(5)(F)(vi).

The first fraction's numerator is the number of hospital patient days for patients entitled to benefits under 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 benefits under Medicare Part A. 42 U.S.C. §1395(d)(5)(F)(vi)(I).

The second fraction's numerator is the number of hospital patient days for patients who were eligible for medical assistance under a State plan approved under Title XIX 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. 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. §412.106(b)(4). The second fraction is frequently referred to as the Medicaid Proxy.

Providers whose DSH percentages meet certain thresholds receive an adjustment which results in increased PPS payments for inpatient hospital services. 42 U.S.C. §1395(d)(5)(F)(i).

Until 1999, some Medicare intermediaries permitted a hospital to include in the numerator of the Medicaid fraction general assistance days associated with patients who were not eligible for medical assistance under an approved Medicaid state plan. In December 1999, CMS issued Program Memorandum No. A-99-62 clarifying CMS' position that general assistance days and certain other types of days may not be included in the numerator of the Medicaid Proxy.

The program memorandum also announced a hold-harmless provision that allowed some hospitals to include otherwise "ineligible" days in the numerator of the Medicaid Proxy for cost reporting periods beginning before January 1, 2000. Under the memorandum, a hospital was allowed to include general assistance days and other days CMS considered ineligible in the numerator of the Medicaid fraction if the hospital had received a DSH payment for that type of day in a prior cost reporting period or if the hospital had filed a jurisdictionally proper appeal on this issue before October 15, 1999.

On October 20, 2006, the Provider's and the Intermediary's representatives entered into a stipulation of facts. The following summarizes the pertinent part of those stipulations:

1. On February 24, 2005, the Provider's Fiscal Intermediary issued a revised NPR for FYE 9/30/95 that adjusted the number of Medicaid days used to calculate the Medicaid proxy portion of the Provider's Medicare DSH qualification and payment. The adjustment excluded Section 1115 Expanded Waiver Days from the DSH Medicaid eligible days count.

2. By letter dated August 19, 2005, the Provider requested a hearing before the PRRB with respect to the Intermediary's determination of the Provider's DSH payment, including the Section 1115 Waiver Days - Hold Harmless issue.

3. On September 27, 2005, the Provider submitted a Supplemental Position Paper arguing that the Provider filed its FYE 9/30/94 appeal[5] of the DSH Waiver Day issue before October 15, 1999 and met the requirements for hold harmless treatment in the FYE 9/30/00, as well as in all other fiscal years subsequent to the FYE 9/30/94.

4. On October 18, 2006, the Intermediary submitted a Supplemental Position Paper that challenged the Provider's entitlement to hold harmless treatment for FYE 9/30/95.

5. In December 1999, CMS issued Program Memorandum A-99-62 to "clarify" the Medicaid days to be included in the Medicaid fraction portion of the Medicare DSH calculation. The PM instructed intermediaries to make DSH payments to hospitals under certain circumstances for days such as expanded waiver days, not normally included in the DSH calculation. CMS Instructed intermediaries to make payment for such days to any hospital for any fiscal year that had a valid appeal filed after October 15, 1999 if the hospital appealed the "inclusion of these types of days" before October 15, 1999 in any previous cost reporting period.

6. The Intermediary acknowledged the PM's instructions in its own bulletin to Tennessee hospitals in Flash No. 00-4, March, 2000.

[5] PRRB Case No. 98-1942

7. The Provider contends that it met the requirements of the hold harmless policy because it appealed the waiver day issue for FYE 9/30/94 by the deadline of October 15, 1999 as required by Program Memorandum A-99-62.

8. The PRRB held a hearing on April 26, 2006, on the hold harmless issue raised in the Provider's FYE 9/30/94 appeal.

9. The Parties agree that under the hold harmless policy, the Provider's right to hold harmless treatment in FYE 9/30/95 depends upon the Board's decision regarding the Provider's entitlement to hold harmless treatment in its FYE 9/30/94 appeal.

10. The Parties agree that the Board's decision for FYE 9/30/95 should reflect the decision reached for FYE 9/30/94.

11. The Parties agree that, if the Board finds in favor of the Provider in Case No. 98-1942, the hold harmless policy would apply to FYE 9/30/95.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law, program instructions, the parties' contentions, and the evidence presented, the Board finds and concludes as follows:

Issue 1: Exception to the SNF RCL

The questions presented for the Board's consideration are whether the Provider may file an exception pursuant to a revised NPR and, if so, whether the relief granted under the exception must be limited to the scope of the revised NPR.

The Board has examined the propriety of filing an exception request pursuant to a revised NPR in prior decisions and has found that nothing in the regulation at 42 C.F.R. §413.30(c) nor the instructions in PRM-1, §2531.1.A limits the window in which to request an RCL exception to 180 days from the date of the "initial" NPR. In contrast, CMS included a specific provision for such a limitation at 42 C.F.R. §413.40(e)(1), which details the procedure for hospitals requesting similar adjustments to their TEFRA rate-of-increase ceiling. It requires that providers submit their requests "no later than 180 days after the date on the intermediary's initial notice of program reimbursement (NPR) for the cost reporting period for which the hospital requests an adjustment." We find significant that CMS used particular limiting language in one section but omitted limiting language in another very similar section. Accordingly, the Board concludes that absence of a clause limiting the filing of an RCL exception request to an initial NPR was a cognitive omission by the Secretary. Because section 413.30(c) makes no distinction between original and revised NPRs, an exception request to the routine cost limit could be filed by a SNF pursuant to the issuance of a revised NPR. The Board affirms those conclusions and finds that CMS' determination disallowing the Provider's request as having been untimely because it was not filed within 180 days of the date of the Intermediary's original NPR was

improper.[6]

The Board has also addressed the scope of an exception request that was filed pursuant to a revised NPR in its decision in *St. Anthony's Health Center, supra.* There, the Board carefully considered the requirements of both 42 C.F.R. §413.30 and 42 C.F.R. §405.1889 and found no basis for limiting the relief from a revised NPR to the incremental increase only. 42 C.F.R. §405.1889 states:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination to which the provisions of §§405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

This section deals exclusively with the appeal rights of providers pursuant to a revised NPR but clearly imposes no threshold limits on the scope of the provider's exception request. 42 C.F.R. §413.30(c) sets the procedural limits for requests regarding the applicability of the cost limits and states in pertinent part that a SNF's "… request must be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement." The regulation makes no distinction between types of NPRs and provides no basis upon which to limit relief under a request. Accordingly, the Board concluded that the regulations make no distinction between types of NPRs and a provider should be allowed to make an exception request for the full amount from any NPR in which the RCL is at issue. The Board affirms its earlier findings and concludes that there is no basis to limit a provider's exception request from a revised NPR. The Provider may properly file its exception request for the full amount from the revised NPR.

Issue 2: Section 1115 Waiver Days

The Board issued its decision on the Provider's entitlement to hold harmless treatment in FYE 9/30/94 in PRRB Decision No. 2007-D43 dated June 29, 2007. In that decision the Board found that the Provider was entitled to include its Section 1115 Waiver expanded Medicaid population (TennCare) days in the Medicaid component of the Medicare disproportionate share hospital (DSH) calculation.

In stipulations numbered 8, 9, 10 and 11, the Parties agreed to the following:

1. The Board held a hearing for Provider's FYE 9/30/94 appeal involving the same Parties and the same Section 1115 Waiver Days issue on April 26, 2006.
2. The Provider's right to hold harmless treatment in FYE 9/30/95 depends upon the Board's decision regarding the Provider's entitlement to hold harmless treatment in its

[6] These findings and conclusions are consistent with our prior decisions in Stanislaus Medical Center v. Blue Cross, supra; Mercy General Hospital v. Blue Cross, supra; see also St. Anthony's Health Center-SNF v. Blue Cross, supra.

FYE 9/30/94 appeal.

3. The Parties agree that the Board's decision for FYE 9/30/95 should reflect the decision reached for FYE 9/30/94.
4. The Parties agree that the hold harmless policy would apply to FYE 9/30/95 if the Board finds in favor of the Provider in Case No. 98-1942.

The Board finds that the Provider filed a jurisdictionally proper appeal to the Board before the October 15, 1999 deadline established by PM A-99-62, and the Provider incurred and claimed TennCare days eligible for payment under the "hold harmless" provision of the PM.

In keeping with the above agreed to stipulations, the Board finds that the Provider is entitled to hold harmless treatment for FYE 9/30/95 in accordance with the decision reached for FYE 9/30/94, and the Intermediary is instructed to recalculate and make Medicare DSH payments based upon the inclusion of all of the excluded §1115 Waiver Days.

DECISION AND ORDER:

Issue 1: Exception to the SNF RCL

CMS's disallowance of the Provider's request for an exception pursuant to the revised NPR was improper. The Provider may properly make an exception request for the full amount of any NPR in which the RCL is at issue. The Board remands the request to CMS for a determination on its merits

Issue 2: Section 1115 Waiver Days

The Provider is entitled to hold harmless treatment for FYE 9/30/95. The Intermediary is instructed to recalculate and make Medicare DSH payments based upon the inclusion of all excluded §1115 waiver days.

BOARD MEMBERS PARTICIPATING:

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DATE: August 30, 2007

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