PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD

99-D14

PROVIDER -

University of Chicago Hospital
Chicago, Illinois

Provider No. 14-0088

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Administration
Blue Cross and Blue Shield of Illinois

DATE OF HEARING-
November 10, 1998

Cost Reporting Period Ended -
June 30, 1992 and June 30, 1993

CASE NO. 94-3074 & 95-2199

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ISSUES:

1. Was the Intermediary's calculation of the Provider's number of beds for purposes of determining the Provider's IME adjustment proper?

2. Were the Intermediary's payments for outlier cases proper pursuant to 42 U.S.C. § 1395ww(d)(5)(A)(iv), insofar as total outlier payments by the Secretary in the fiscal years in question were less than five percent of the total payments made based on DRG prospective payments for the years in question?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

University of Chicago Hospital ("Provider") is a voluntary non-profit, general short term, hospital located in Chicago, Illinois.[1] For the fiscal years ended June 30, 1992 and June 30, 1993 the Provider included its 45 neonatal intensive care unit ("NICU") beds in the total bed count used to calculate the Indirect Medical Education ("IME") payments.[2] This action was taken to be consistent with the Intermediary's adjustment to the June 30, 1988 cost report, wherein NICU beds were included in the bed count.[3] Since the Provider is not in agreement with the Intermediary position, the Provider views its subsequent years inclusion of the NICU beds as a self disallowance.[4]

Notices of Program Reimbursement ("NPRs") were issued on April 20, 1994 and January 18, 1995 for the June 30, 1992 and June 30, 1993 Medicare cost report years, respectively. Contained therein were calculations including the NICU beds. In addition, the NPRs reflected the results of revised "per resident" amounts which served to reduce allowable graduate medical education costs. On July 7, 1994 and July 13, 1995 the Provider filed timely appeals to the Provider Reimbursement Review Board ("Board") relative to the NICU issue noted above.[5] On February 10, 1997, the Provider designated the per resident/graduate medical education issue as an additional issue for appeal. However, that issue has been subsequently withdrawn. The Provider has met the jurisdictional requirements of 42 C.F.R. § 405.1835-

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1 Intermediary Position Paper at p. 1.

2 Id at p. 4.

3 Id

4 Intermediary Position Paper at p. 2.

5 Intermediary Position Paper at p. 1.

.1841. The reimbursement effect of the Intermediary's inclusion of NICU beds in the IME calculation is approximately $ 4,300,000.[6]

By letter[7] dated July 31, 1998 the Provider added a new issue related to outlier payments which is now the second issue listed above. In the interest of facilitating the presentation of these issues to the Board, a Joint Stipulation of the Parties[8] was submitted to the Board on September 1, 1998. The facts are summarized as follows:

1. With respect to Issue number 1, the parties stipulate to the factual background relating to this issue as per section I. B. of the Provider's position paper.

2. With respect to issue number 1, the parties agree to submit the issue for an on-the-record resolution by the Board.

3. The Provider has previously withdrawn the issue relating to the per resident amount, graduate medical education calculations.

4. With respect to the current issue number 2, the parties stipulate to the following:

   a. in each of the years in question, the Provider received payments for outlier cases pursuant to 42 C.F.R. § 412.80 et seq.

   b. as reflected in Provider Exhibits 3, 4, & 5, in each of the years in question, the outlier payments to the Provider were made using payment rates established by the Secretary which resulted in aggregate outlier payments of less than five percent of the total DRG payments for the years in question.

5. The parties submit the outlier issue for an on-the-record resolution by the Board. (The parties note that the Board has ruled in previous cases that it lacks jurisdiction to address this issue).

The Provider was represented by Joseph W. Metro, Esquire, of Reed Smith Shaw and McClay, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

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6 Provider Position at p. 8.

7 See letter to Board from Provider dated July 31, 1998.

8 See Joint Stipulation of the Parties submitted to Board September 1, 1998.

Issue No. 1- Inclusion of NICU Beds

Medicare Regulatory Background

On September 3, 1985, the Health Care Financing Administration ("HCFA") published a final rule specifying how the number of beds is to be determined for purposes of the IME adjustment. That regulation provided:

> Determination of number of beds. For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

42. C.F.R. § 412.118(b) (1985). In adopting the regulation, HCFA stated that "available beds" are generally defined as adult or pediatric beds (exclusive of newborn bassinets, beds in excluded units, and custodial beds that are clearly identifiable) maintained for lodging inpatients. The language of the regulation remained in effect throughout the periods at issue, although it was reclassified to 42 C.F.R. § 412.105(b) in August of 1991.

Until 1988, there was nothing in the Provider Reimbursement Manual, (HCFA Pub. 15-1) which indicated that the term 'newborn beds" in 42 C.F.R. § 412.118 (b) should be interpreted to exclude newborn intensive care beds in the IME calculation. In 1988, HCFA imposed a qualification on the regulation, by defining beds as follows:

> [A] bed is defined [for purposes of the IME calculation] as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units.

HCFA Pub. 15-1 § 2405.3G. This manual provision was effective August 25, 1988.

On September 1, 1994, HCFA amended the text of 42 C.F.R. § 412.105(b) to provide:

> [f]or purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including nursery beds assigned to newborns that are not in intensive care areas, custodial care beds, and beds in excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

Id.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's failure to exclude NICU beds from the Provider's IME calculation was inconsistent with the plain language of the regulation at 42 C.F.R. § 412.105. The regulation governing the calculation of the teaching adjustment factor used to compute the IME adjustment clearly stated that the number of beds in a hospital was not to include "beds assigned to newborns." 42 U.S.C. § 412.105(b). NICU beds clearly are assigned to newborns, making the Intermediary's inclusion of them improper and depriving the Provider of substantial reimbursement to which it is entitled. The Provider points out that the language of the regulation applicable during the periods at issue stands in stark contrast to HCFA's revised rule, which provides that "nursing beds assigned to newborns that are not in intensive care areas" are excluded from the bed count. See 42 C.F.R. § 412.105(b). The Provider notes that the Board has repeatedly recognized that the plain language of this regulation requires the exclusion of NICU beds. See Baystate Medical Ctr. v. Aetna Life Ins. Company, PRRB Dec. No. 96-D60, September 6, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,646, rev'd HCFA Adm. November 1, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,979. The Provider also points to Pacific Presbyterian Medical Center v. Blue Cross and Blue Shield of California, PRRB Dec. No. 94-D55, June 13, 1994, rev'd HCFA Admin., September 9, 1994, reprinted in Medicare & Medicaid Guide (CCH) ¶ 42,718. In Pacific Presbyterian, the Board noted that the governing regulatory rule was to "exclude all beds assigned to newborns, regardless of whether the newborn beds are located in a routine or intensive care unit." Id. Accordingly, the Provider asserts that, in the instant case, the Intermediary's inclusion of those beds ignores the governing regulatory rule.

The Provider further contends that, although intermediaries in other PRRB appeals have sought to rely on Section 2405.3(G) of HCFA Pub. 15-1 to support the inclusion of NICU beds, such reliance is incorrect. HCFA's interpretive guidelines must be consistent with, and cannot contradict, the provisions of a Medicare regulation. The Provider cites several cases where the Board determined that 42 C.F.R. § 412.105 clearly defined the method of determining the number of beds, and that HCFA Pub. 15-1 § 2405.3(G) conflicted with the language of the governing regulation. See Sioux Valley Hospital v. Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 92-D53, July 27, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,747, rev'd HCFA Admin., October 28, 1992, Medicare & Medicaid Guide (CCH) ¶ 41,044. Grant Medical Center v. Community Mutual Insurance Co., PRRB Dec. No. 94-D14, December 14, 1993, Medicare & Medicaid Guide (CCH) ¶ 42,168, rev'd HCFA Admin., May 15, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,421; and St. Joseph Hospital v. Mutual of Omaha, PRRB Dec. No. 94-D29, December 14, 1993, Medicare & Medicaid Guide (CCH) ¶ 42,253, rev'd HCFA Admin., June 20, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,559.

The Provider believes that the HCFA Administrator wrongly reversed the Board's decisions in these cases.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly counted the NICU beds for IME purposes in accordance with PRM-1, Section 2405.3(G), that states as follows:

> G. Bed size.--A bed is defined ... as an adult or pediatric bed (exclusive of beds assigned to newborns **which are not** in **intensive care areas,** custodial beds, and beds in the excluded units) maintained for lodging inpatients, including beds in intensive care units, **neonatal intensive care units,** and other special care inpatient hospital units ...

Id (emphasis added).

Counting the NICU beds to arrive at the correct bed size or count is not a new policy, since HCFA transmitted that instruction in August, 1988. Also, related policies have been in effect since early 1976 in HCFA Pub. 15-1, Section 2202.7 regarding the special care and intensive care type units, and Section 2510.5 regarding the determination of hospital bed size. HCFA merely clarified those policies through PRM-1, Section 2405.3(G).

The Intermediary contends that HCFA made the policy clarification because of the following provisions of 42 CFR § 412.118(b):

> (b) Determination of number of beds. For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, **not including beds assigned to newborns,** custodial care, and excluded distinct part hospital units ....

Id. (emphasis added.)

As shown, HCFA has addressed the methodology for determining the number of beds under PPS through 42 CFR § 412.118(b), but did not clearly incorporate the long-standing policy for counting the number of beds. To enforce and ensure a consistent application of that policy, HCFA revised the referenced Program regulation in August, 1991. The revised regulation, as redesignated in 42 CFR § 412.105(b), states as follows:

> (b) determination of number of beds. For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, **not including nursery beds assigned to newborns that are not** in **intensive care areas,** custodial care beds, and beds in the excluded units ....

Id. (emphasis added.)

This argument is consistent with various HCFA Administrator's decisions that reversed the PRRB's decisions. See Sioux Valley Hospital, Grant Medical Center, and St. Joseph Hospital. The Intermediary notes that the HCFA Administrator affirmed the fiscal intermediaries' inclusion of intensive care nursery beds in the bed count to arrive at the correct resident-to-bed ratio needed to calculate the IME adjustment. Accordingly, the Intermediary contends it properly made its determinations and adjustments regarding the IME payments, pursuant to 42 C.F.R § 412.105, as well as the applicable HCFA Administrator's decisions.

Issue No. 2- Outlier Payments

PROVIDER'S CONTENTIONS:

The Provider contends that Intermediary payments for outlier payments pursuant to 42 U.S.C. 1395ww(d)(5)(A)(iv) were improper, insofar as total outlier payments made to the Provider were less than 5 percent of the total payments made based on DRG prospective payment rates for the years in question. The Provider offered as evidence proposed changes to HCFA's payment methodology for outlier payments.[9] As noted in the stipulation agreement referenced above, the Board has ruled in a previous case that it lacks jurisdiction to address this issue. See County of Los Angeles v. Shalala 992 F. Supp. 26 (D.D.C. 1990), app. pending D.C. Cir.

INTERMEDIARY'S CONTENTIONS:

The Intermediary offered no comments on this issue.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

I .	Law - Title XVIII of the Social Security Act: § 1866 (d)	-	Outlier Payments
2.	Law - 42 U.S.C: 1395oo(f)(1)	-	Provider Reimbursement Review Board
	1395ww(d)(5)(A)(iv) Period; DRG Classification System; Exceptions and Adjustments to PPS.	-	PPS Transition

[9] Provider Exhibits P-3, P-4, and P-5.

Regulations - 42 C.F.R.:

§ 405.1804	-	Matters not subject to administrative and judicial review under prospective payment.
§ 405.1835-1841	-	Board Jurisdiction
§ 405.1835 (b)	-	Prospective payment exceptions
§ 405.1867	-	Sources of Board's Authority
§ 412.2(f)	-	Additional payments to hospitals
§ 412.8(b)	-	Annual publication of schedule for determining prospective payment rates
§ 412.80 et seq	-	General Provisions
§ 412.105	-	Special treatment: Hospitals that incur indirect costs for graduate medical education programs.
§ 412.105(b)	-	Determination of number of beds
§ 412.118(b) (Redesignated 412.105)(b)	-	Determination of Indirect Medical Education Costs

4. Program Instructions-Provider Reimbursement Manual (HCFA Pub. 15-1):

§ 2202.7	-	Special Care Units/Intensive Care Type Units
§ 2405.3G	-	Bed Size

§ 2510.5 - Determining Hospital Bed Size

5. Case Law:

Bay State Medical Center v. Aetna Life Insur. Company, PRRB Dec. No. 96-D60, September 6, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,646, rev'd HCFA Adm. November 1, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,979.

Pacific Presbyterian Medical Center v. Blue Cross and Blue Shield of California, PRRB Dec. No. 94-D55, June 13, 1994, rev'd HCFA Adm. September 9, 1994, reprinted in Medicare & Medicaid Guide (CCH) ¶ 42,718.

Sioux Valley Hospital v. Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 92-D53, July 27, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,747, rev'd HCFA Adm. October 28, 1992, Medicare & Medicaid Guide (CCH) ¶ 41,044.

Grant Medical Center v. Community Mutual Insurance Co. , PRRB Dec. No. 94-D14, December 14, 1993, Medicare & Medicaid Guide (CCH) ¶ 42,168, rev'd HCFA Adm. May 15, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,421.

St. Joseph Hospital v. Mutual of Omaha, PRRB Dec. No. 94-D29, December 14, 1993, Medicare & Medicaid Guide (CCH) ¶ 42,253, rev'd HCFA Adm. June 20, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,559.

County of Los Angeles v. Shalala, 992 F. Supp. 26 (D.D.C. 1990), App. pending D.C. Cir.

Grant Medical Center v. Community Mutual Insurance Company/BCBSA, PRRB Dec. No. 97D67, (June 18, 1997) Medicare & Medicaid Guide (CCH) § 45.453. HCFA Adm, declined rev. July 30, 1997.

Sioux Valley Hospital v. Shalala, 29 F. 3d 628 (8th Cir. July 20, 1994.)

Hahnemann University Hospital v. Shalala, No. 96-5191, 1997 WL 362672 @ *I (D.C. Cir. May 5) (per curiam).

> Little Company of Mary Hospital and HealthCare Centers v. BC/BS of Illinois, PRRB Dec. No. 98-D1, (October 21, 1997), Medicare & Medicaid Guide (CCH) § 45.739, rev'd in part, HCFA Admin. Dec. (December 22, 1997), Medicare & Medicaid Guide (CCH) § 46.053.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Issue 1 - Inclusion of NICU Beds:

The Board notes that the issue in this case has been brought before it many times in the past. The Board finds that its original position opposing the inclusion of NICU beds in the IME adjustment calculation was predicated on the Board's literal interpretation of 42 C.F.R. § 412.118(b).
This subsection, states in part:

> [d]etermination of number of beds. For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

42 C.F.R. § 412.118(b). (emphasis added).

The Board further notes that the Board majority modified the above position for cases with fiscal years beginning after the manual revision to HCFA Pub. 15-1, § 2405.3G on August 25, 1988, See Grant Medical Center v. Community Mutual Insurance Company/BCBSA, PRRB Dec. No. 97-D67, (June 18, 1997), Medicare & Medicaid Guide (CCH) ¶ 45,453, HCFA Adm. declined rev July 30, 1997. HCFA Pub. 15-1, § 2405.3G defines beds as follows:

> [a] bed is defined [for purposes of the IME calculation] as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units.

HCFA Pub. 15-1 § 2405.3.G (emphasis added).

The Board takes judicial notice of two United States Court of Appeals decisions on the same issue as presented in the instant case. See Sioux Valley Hospital v. Shalala, 29 F.3d 628

(8th Cir. July 20, 1994) and Hahnemann University Hospital v. Shalala, No. 96-5191, 1997 WL 362672, at *I (D.C. Cir. May 5) (per curiam). These two circuit court decisions put forth an interpretation of the issue in this case different from earlier Board decisions. The Board also recognizes the HCFA Administrator's position requiring inclusion of the NICU beds for purposes of the IME calculation. See Little Company of Mary Hospital and Health Care Centers v. BC/BS of Illinois, PRRB Dec. No. 98-DI, (October 21, 1997), Medicare & Medicaid Guide (CCH) ¶ 45,739, rev'd in part, HCFA Adm. Dec. (December 22, 1997), Medicare & Medicaid Guide (CCH) ¶ 46,053.

The Board finds the circuit courts' decisions and the HCFA Administrator decision in Little Company of Mary persuasive, and therefore gives deference to those decisions in their interpretation of the regulations regarding the inclusion of NICU beds in the IME calculation.

Issue 2 - Outlier Payments:

The Board notes that the Provider entered into an agreement entitled Joint Stipulation of the Parties. In that document, the parties agreed that the Provider received payments for outlier cases in accordance with 42 C.F.R. § 412.80 et seq. The parties also cited County of Los Angeles v. Shalala, 992 F. Supp. 26 (D.D.C. 1998), app. pending (D.C. Cir.), a case with this same issue, wherein the Board granted expedited judicial review. The Board finds that, in the instant case, the Provider's reference to the County of Los Angeles case should be treated as a request for expedited judicial review.

The Board further finds that:

I . An active appeal existed and the Provider sought to add an additional issue (correctness of outlier payments). The outlier payments were reflected on the Medicare cost report. Outlier payments do not fall under those matters not subject to administrative or judicial review under prospective payment as set forth in 42 C.F.R. §§ 405.1804 and 405.1835 b). This was further confirmed in the regulation at 42 C.F.R. § 412.2 (f), wherein outlier payments are reflected in a listing of situations/circumstances whereby hospitals receive payments in addition to those received under the prospective payment system. Accordingly, the Board has jurisdiction over this matter for the subject years and the Provider is entitled to a hearing before the Board.

2. Based upon the information in the Joint Stipulation of the Parties, there are no findings of fact for resolution before the Board.

3. The Board is bound by the applicable existing Medicare law and regulations (42 C.F.R. § 405.1867).

4. The statutory requirement under section 1866(d)(5)(A)(iv) of the Social Security Act requires that outlier payments be between 5 and 6 percent of the total outlier payments "projected or estimated to be made" based on DRG prospective payment rates for discharges in that year. There is no provision in the Act for retroactive adjustments. The Board is without authority to decide the legal question as to the validity of the above referenced section of the Act, or the Medicare regulations governing the outlier payment methodology at 42 C.F.R. §§ 412.8(b) and 412.80(b).

DECISION AND ORDER:

Issue 1. - Inclusion of NICU Beds:

The inclusion of the NICU beds in the IME calculation is proper. No additional Intermediary action is required.

Issue 2 - Outlier Payments:

The Board finds that the outlier issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider expedited judicial review for the outlier issue for the subject years.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: December 04, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman