

# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D29

**PROVIDER -**  
Memorial Hospital of Salem County  
Salem, New Jersey

Provider No.: 31-0091

**vs.**

**INTERMEDIARY -**  
BlueCross BlueShield Association/  
Highmark Medicare Services  
(formerly Riverbend Government Benefits  
Administrator)

**DATE OF HEARING -**  
May 6, 2010

Cost Reporting Period Ended -  
December 31, 2001

**CASE NO.:** 05-0148

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ISSUE:

Whether the Intermediary properly included all appropriate Medicaid eligible days in calculating the Provider's disproportionate patient percentage for purposes of the Medicare disproportionate share hospital (DSH) adjustment under the Prospective Payment System (PPS) for inpatient operating and capital costs for the fiscal year ended (FYE) December 31, 2001.<sup>1</sup>

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- et seq. 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 (FI) and Medicare administrative contractors (MAC). FIs and MACs<sup>2</sup> 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 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 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 receipt of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). *See* 42 U.S.C. § 1395ww(d)(1)-(5). The PPS statute contains a number of provisions that adjust payment based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves one of the hospital-specific adjustments, specifically the "disproportionate share hospital," or "DSH" adjustment. The Secretary is required to provide increased PPS payment to hospitals that serve a "significantly disproportionate number of low-income patients." *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).

Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage." *See* 42 U.S.C.

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<sup>1</sup> *See* Stipulation of Parties.

<sup>2</sup> FIs and MACs are hereinafter referred to as intermediaries.

§ 1395ww(d)(5)(F)(v). The “disproportionate patient percentage” is the sum of two fractions, the “Medicare and Medicaid fractions,” expressed as a percentage for a hospital’s cost reporting period. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi). A provider whose DSH percentage exceeds certain thresholds receives an adjustment which results in increased PPS payment for inpatient hospital services. *See* 42 U.S.C. § 1395ww(d)(5)(F)(i). The Medicare fraction’s numerator is the number of hospital patient days for patients entitled to both benefits under Medicare Part A and Supplemental Security Income (SSI) benefits, 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. *Id.*; *See also*, 42 C.F.R. § 412.106(b)(2). The Medicare fraction is also referred to as the Medicare proxy or the SSI fraction.

The Medicaid 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. *Id.*; *See also*, 42 C.F.R. § 412.106(b)(4). The Medicaid fraction is also referred to as the Medicaid proxy. The Medicaid fraction is the only fraction under the Title XVIII Medicare DSH statute at issue in this case.

#### STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Memorial Hospital of Salem County (the Provider) is a general acute care hospital located in Salem, New Jersey. The Intermediary is Highmark Medicare Services<sup>3</sup>. The cost reporting period at issue is the fiscal year ended December 31, 2001.

On October 1, 2002 the hospital was sold. However, the prior owner/seller remained responsible for wind-down of the operations, receivables and liabilities for periods prior to the sale, including the Provider’s fiscal year ending December 31, 2001.<sup>4</sup>

On July 13, 2004 the Intermediary issued an NPR in which it adjusted<sup>5</sup> the claimed Medicaid and HMO Medicaid days<sup>6</sup> eliminating the DSH operating adjustment payment and reducing the DSH inpatient capital payment. The Intermediary adjusted the Medicaid days claimed to agree with a report from the New Jersey Division of Medicaid Assistance and Health Services (NJDMAHS). The Provider appealed that determination on October 27, 2004 and met the jurisdictional requirements of 42 U.S.C. § 1395oo(a). *See also* 42 C.F.R. §§ 405.1835-405.1840.

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<sup>3</sup> Formerly Riverbend Government Benefits Administrator.

<sup>4</sup> *See* Provider Exhibit P-24.

<sup>5</sup> *See* Provider Exhibit P-1 adjustments 3 and 14.

<sup>6</sup> The Intermediary based the adjustment to days on a one page report received from the New Jersey Division of Medical Assistance and Health Services (NJDMAHS). NJDMAHS created this report through matching patient day data submitted from providers to state records as outlined in the Provider’s Exhibit P-23. Providers were allowed three data submissions for FYE 12/31/2001, the first by 08/21/2002, the second by 09/20/2002 and the third by 11/29/2002.

The Provider was represented by Christopher Crosswhite, Esquire, of Duane Morris LLP. The Intermediary was represented by L. Sue Anderson, Esquire, of Blue Cross Blue Shield Association.

THE PARTIES' CONTENTIONS:

The Provider contends that it is entitled to DSH adjustment payments under inpatient operating PPS and increased DSH adjustment payments under inpatient capital PPS. The Provider believes it is obvious that a substantial number of Medicaid eligible days were excluded from the NJDMAHS report used by the Intermediary as the basis for the audit adjustments in controversy. That report showed Medicaid paid days but no Medicaid eligible days. Also, the Medicaid days on the report for FYE 2001 was substantially lower than the Medicaid days indicated on the reports for FYEs 12/31/2000 and 9/30/2002. The Provider asserts the failure to include all days for Medicaid eligible patients in calculating DSH adjustment payments is in conflict with Medicare law and program policy citing 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), 42 C.F.R. § 412.106(b)(4), HCFA Ruling 97-2 and Program Memorandum A-99-62 reissued as Program Memorandum A-01-13.

The Provider points out it did not resubmit the claims data to NJDMAHS due to circumstances surrounding the change in ownership; and that it did not directly receive notices from the State and Intermediary after the change in ownership.<sup>7</sup> After discovering the results of the NJDMAHS report the Provider contacted the state and was told the NJDMAHS report would not be changed.<sup>8</sup> The Provider then asked the Intermediary if it could send information on Medicaid eligible days in the format used for earlier years prior to the electronic submission process. The Provider submitted this alternative hard-copy submission in support of a substantial increase in the number of Medicaid eligible days over the number shown on the state report. The Intermediary has asserted that the Provider has not sufficiently documented Medicaid eligibility for the days in question. The Provider argues that under Medicare program guidance and relevant case law, the adequacy of documentation must be evaluated in light of the best available data at the time of the Intermediary's DSH adjustment determination. The Provider specifically references *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) (Baystate) which states,

*Here, ignoring the existence of more reliable data that is available before the DSH adjustment is finally determined—that is, within the cost report settlement period—simply cannot be reconciled with the standard of reasoned decisionmaking. . . . [U]se of the best available data is firmly recognized by the case law and, indeed, by the Administrator to be essential to the standard of reasoned*

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<sup>7</sup> See Provider's Post Hearing Brief at p. 16, Tr. at pp. 265-266.

<sup>8</sup> Tr. at p. 61.

decisionmaking in Medicare reimbursement decisions. It is, as a practical matter, well within that which can “reasonably be delivered” by the agency.

*Id.* at 49-50 (emphasis added).

The Provider believes the Intermediary’s reliance on the incomplete state report and its rejection of the Provider’s documentation was not in accordance with this standard. The Provider objects to the Intermediary now asserting, years after the relevant period, that the documentation is not sufficient because it does not contain certain information, such as program codes, that was not available at the time of the Intermediary’s determination and that remain unavailable to this day for the period under appeal. The Provider believes this position is arbitrary and capricious and must be rejected as inconsistent with the best available data at the time.

The Intermediary believes it properly used the NJDMAHS report as a basis for the audit adjustments in controversy. Shortly after the issuance of HCFA Ruling 97-2, the Intermediary began working with the State Medicaid office to develop a single, reliable source for Medicaid eligible days.<sup>9</sup> Reports based on that source would be used by the New Jersey hospitals in the calculation of the DSH payment. *Id.* The Intermediary points out the Provider was aware of the process that was used to obtain relief under HCFA 97-2 but was unable to comply with the established procedures due to a change of ownership. The Intermediary believes the Provider has the burden to verify Medicaid eligibility with the State. *See* 42 C.F.R. § 412.106(b)(4)(iii) and HCFA Ruling 97-2.

Although the Intermediary did not accept<sup>10</sup> the additional Medicaid patient day information found in Provider Exhibit P-6 through P-16 when it was submitted on April 30, 2004,<sup>11</sup> it did review the information in preparation for this hearing. At the time of the hearing the Intermediary had concluded the Provider failed to meet its burden of proof to show that the additional Medicaid days claimed were title XIX eligible.<sup>12</sup> In particular the Intermediary believes the Provider’s Medicaid days claimed include non-allowable general assistance (GA) and Title XXI days.<sup>13</sup> The Intermediary asserts the Provider supplied data just prior to and after the hearing that was adequate to support Medicaid eligibility of an additional 1,001 HMO Medicaid days.<sup>14</sup>

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<sup>9</sup> *See* Intermediary Final Position Paper at p. 6.

<sup>10</sup> *See* Provider Exhibit P-19, Tr. at p. 62.

<sup>11</sup> *See* Provider Exhibit P-20.

<sup>12</sup> Tr. at p. 46.

<sup>13</sup> Tr. at p. 434.

<sup>14</sup> *See* Intermediary Post Hearing Brief pp. 3 and 4. The 1,001 days include 400 Horizon Mercy HMO days and 601 Americhoice HMO days.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the evidence, the Medicare law and guidelines, and the parties' contentions, the Board finds an additional 1,001 days should be added to the numerator of the DSH Medicaid fraction.

The question for the Board to decide is what standard is to be used to determine Medicaid eligible patient days to be included in the DSH Medicaid fraction. The Board finds guidance in the regulation that states:

(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 service 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. For purposes of this second computation, the following requirements apply:

\* \* \* \* \*

(iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

42 C.F.R § 412.106(b)(4)

Similarly the HCFA Ruling 97-2 states, in part:

The hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patient's inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

HCFA Ruling 97-2, Intermediary Exhibit I-3 p. 6.

Based upon these authorities, the Board finds the Intermediary is responsible to insure Medicaid eligible patients were not entitled to Medicare part A, set requirements for providers' documentation of Medicaid eligible days and compute the fraction. Whereas the Provider is

responsible to furnish “data adequate to prove eligibility for each Medicaid patient day claimed for Medicare DSH and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.” *Id.*

The record shows the Intermediary has modified its Medicaid eligible day documentation requirements over time. In the past<sup>15</sup> the Intermediary accepted documentation such as what has been received in the record to verify Medicaid eligibility.<sup>16</sup> However, shortly after the issuance of HCFA Ruling 97-2, the Intermediary began working with the State Medicaid office to develop a single, reliable source for Medicaid eligible days.<sup>17</sup> Their efforts resulted in a report that would be used by the New Jersey hospitals in the calculation of the DSH payment. The Board finds the process<sup>18</sup> set up by the Intermediary and the State, which requires providers to submit their patient day information to the State to be matched with Medicaid eligibility data, to be consistent with the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and HCFA Ruling 97-2. The Board finds the Provider was aware of the process since it used it to qualify for DSH for FYE 12/31/2000 on the same timetable as was required for FYE 12/31/2001.<sup>19</sup> The Board finds the Ruling clearly states “[a]s the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed.” *Id.* The Board finds the Intermediary set the documentation requirement through the State matching process in this case. The Board finds the change in ownership/lack of receipt of notices argument proffered by the Provider inadequate to avoid this requirement.<sup>20</sup> Furthermore, since the Intermediary has now tested the information submitted by the Provider, the lack of receipt of notices argument is moot.

The Board also finds it obvious from evidence comparing data from previous and future years that the State report is missing HMO days in the FYE 12/31/2001.<sup>21</sup> The Provider does not believe Medicaid paid days are at issue but argues managed care (HMO) Medicaid days should be added.<sup>22</sup> Subsequent to the hearing the Intermediary reviewed additional HMO Medicaid days documentation and eligibility records supplied by the Provider.<sup>23</sup> Of the 1,617 HMO Medicaid

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<sup>15</sup> See Provider Exhibit P-21 and P-23 stating the State of New Jersey began Medicaid eligible days process in 1999 and the “time table for processing year one (2000 and 2001 discharges).” Note Tr. at p. 54 states “starting with fiscal year 1997, the State started doing an electronic match process so at that point in time it was no longer necessary to do a manual submission.”

<sup>16</sup> Tr. at pp. 54, 61-62 and 126.

<sup>17</sup> See Intermediary Final Position Paper at p. 6.

<sup>18</sup> See Provider Exhibit P-23.

<sup>19</sup> *Id.*

<sup>20</sup> The Board notes the first two data submission dates were prior to the 10/1/2002 change in ownership. *Id.*

<sup>21</sup> See Intermediary Exhibit I-5 pp. 2-5. Tr. at p. 19.

<sup>22</sup> Tr. at pp. 22-23.

<sup>23</sup> The HMO Medicaid eligibility documentation relied on by the Intermediary in its post hearing analysis is not contained in the record.

days claimed<sup>24</sup> by the Provider the Intermediary found 1,001 Medicaid days<sup>25</sup> eligible and allowable, 141 non-allowable GA and Title XXI days<sup>26</sup>, and 475 days where the Medicaid eligibility documentation was not received.<sup>27</sup> The Board finds that 1,001 HMO Medicaid days would be allowable per the Intermediary's findings. The Board finds no portion of the 475 days where Medicaid eligibility was not verified with the State can be allowed under 42 C.F.R. § 412.106(b)(4)(iii) and HCFA Ruling 97-2. The Ruling specifically states, "days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted." *Id.* Intermediary Exhibit I-3 p. 6.

Finally, the Board finds the *Baystate* standard on "best data available" does not support the Provider. First, the Board finds the Provider did not follow the required process by properly submitting its patient day records to the State for matching to the Medicaid eligibility files. Neither the Intermediary nor the State contributed to the Provider not following the Intermediary's required process. Second, the "best data available" standard includes a "reasonably accurate" assumption.<sup>28</sup> The Provider's data was not accurate. Twelve percent of the days submitted by the Provider were not allowed when the Provider's data was reviewed by the Intermediary post-hearing.<sup>29</sup> Moreover, the Board finds the "best data available" standard is not appropriate in the case of Medicaid eligible days. The Board finds the regulation and Ruling apply the standard that the Provider must verify the Medicaid eligibility with State records for each day claimed in order to count the day. *See* 42 C.F.R. § 412.106(b)(4)(iii) and HCFA Ruling 97-2.

#### DECISION AND ORDER:

The Provider is allowed an increase of 1,001 Medicaid eligible days for a total of 2,254 in the calculation of its DSH Medicaid fraction. The Intermediary's adjustment is modified.

#### Board Members Participating:

Yvette C. Hayes  
Keith E. Braganza, CPA  
John Gary Bowers, CPA  
Michael W. Harty

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<sup>24</sup> *See* Intermediary Post Hearing Position Paper at pp. 3-4. Total of 738 Horizon Mercy days, 667 Americhoice days and 212 PHS days.

<sup>25</sup> *Id.* Total of 400 Horizon Mercy days and 601 Americhoice days.

<sup>26</sup> *Id.* Total of 75 Horizon Mercy days and 66 Americhoice days.

<sup>27</sup> *Id.* Total of 263 Horizon Mercy days and 212 PHS days.

<sup>28</sup> *Baystate Medical Center v. Mutual of Omaha Insurance Co.*, CMS Administrator Dec. 2006-D20, (May 11, 2006), Medicare & Medicaid Guide (CCH) ¶81,506 p. 13 and fn 35; Provider Exhibit P-26.

<sup>29</sup> Days where HMO Medicaid eligibility not allowed divided by total days where HMO Medicaid eligibility documentation available. (12%=141/(141+1,001))

FOR THE BOARD

Yvette C. Hayes  
Acting Chairperson

DATE: May 26, 2011