PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2022-D07

PROVIDER–
Pitt County Memorial Hospital, dba Vidant Medical Center

Provider No.: 34-0040

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc.

RECORD HEARING DATE –
August 18, 2021

Fiscal Year Ending –
September 30, 2009

Case No. – 20-1892

INDEX

ISSUE STATEMENT

Whether the Provider's disproportionate share hospital ("DSH") payment for fiscal year ending September 30, 2009 ("FY 2009") should be revised to include additional patient days that were excluded from the numerator of the Medicaid fraction?[1]

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the FY 2009 DSH calculation for Pitt County Memorial Hospital, d/b/a Vidant Medical Center ("Vidant" or "Provider") should be revised to include an additional 564 Medicaid-eligible days in the numerator of the Medicaid fraction. Accordingly, the Board remands this appeal to the Medicare Contractor to revise the FY 2009 amended cost report[2] for Vidant as follows:

1. Add an additional 564 Medicaid-eligible days to the number of Medicaid-eligible days on Worksheet S-3, Part I, Line 2.00, Column 5, thereby increasing the total from 5,779 to 6,343; and

2. Increase Vidant's disproportionate share percentage on Worksheet E, Part A, Line 4.03 from 22.88 percent to 23.10 percent.

STATEMENT OF FACTS AND PROCEDURAL HISTORY

Vidant is an acute care hospital paid under Medicare's inpatient prospective payment system ("IPPS"). The period at issue in this appeal is FY 2009. Vidant's designated Medicare contractor[3] is Palmetto GBA, with review also performed by National Government Services (collectively the "Medicare Contractor").[4]

On August 1, 2013, the Medicare Contractor issued the initial notice of program reimbursement ("NPR") for FY 2009 to Vidant. By letter dated September 18, 2013, Vidant requested that the Medicare Contractor reopen the FY 2009 cost report to add Medicaid-eligible days, not included in the settled cost report, that had been identified by Vidant's consultant, Southwest Consulting Associates. Vidant had engaged Southwest Consulting to perform certain DSH analyses and the results of that engagement were summarized in letter attached to Vidant's reopening request. Specifically, Southwest Consulting's letter reflected a revised total of 62,591 Medicaid-eligible days compared to the 60,037 Medicaid-eligible days included in the settled cost report, for an increase of 2,554 net additional Medicaid-eligible days.[5]

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[1] Stipulations at ¶ 1 (Aug. 9, 2021).
[2] *See* Attachment A to this decision; Provider's Appeal Request at 11 (copy of the Revised NPR dated Mar. 27, 2019).
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Provider's Final Position Paper (hereinafter "Provider's FPP") at 6 (Feb. 12, 2021).
[5] *Id*. at 6-7.

Shortly thereafter, on January 27, 2014, Vidant filed a timely appeal with the Board seeking to include the aforementioned additional Medicaid-eligible days in the numerator of the DSH Medicaid fraction. The calculation of estimated impact for the DSH Medicaid-eligible days appeal issue reflected the addition of the same 2,554 net additional days and was the same as the impact for adding those days through the Reopening Request. The Board assigned Case No. 14-2001 to that appeal.[6]

On June 17, 2016, the Medicare Contactor granted Vidant's reopening request and issued a Notice of Reopening agreeing to "review additional Medicaid-eligible days for inclusion on Worksheet S-3 [of the Medicare cost report] and to adjust the applicable components of the DSH calculation based on the results of the review." On August 23, 2016, Vidant requested withdrawal of Case No. 14-2001 based on this agreement to reopen the cost report and the Medicare Contractor's statement that the reopening would entail review of Vidant's documentation to resolve the Medicaid-eligible days appeal. On August, 29, 2016, the Board granted the withdrawal request.[7]

During the reopening review process, the Medicare Contractor extrapolated six sampled days to exclude a total of 799 of the 2,554 Medicaid days that Vidant sought to have included in the Medicaid fraction through the appeal and the reopening.[8]

The Medicare Contractor concluded its reopening review and issued a Revised NPR ("RNPR") on March 27, 2019, which only included 1,550 of the total net additional Medicaid-eligible days. In Audit Adjustment Nos. 1 and 2 of the RNPR, the Medicare Contractor adjusted Vidant's count of Medicaid-eligible days to include only the 1,550 additional days.[9]

On September 20, 2019, Vidant timely filed the subject appeal from the RNPR seeking the inclusion of additional days (*i.e.*, the omitted days). The appeal requested the addition of the 799 Medicaid-eligible days that were excluded by the Medicare Contractor in the RNPR with an estimated impact of $392,437.[10]

On August 9, 2021, the parties submitted Stipulations and a Consent Request for a Hearing on the Record. The parties stipulated, in part:

> 5. The parties have now reached an agreement on the further cost report adjustments necessary to resolve this appeal. Attached as Exhibit 1 to this stipulation are copies of the MAC's audit adjustment report reflecting the parties' agreement. The agreed upon adjustments would add another 564 Medicaid-eligible days to the Provider's number of Medicaid-eligible days on Worksheet S-3, Part I, Line 2.00, Column 5 from 5,779 to

[6] *Id*. at 7.
[7] *Id*.; Stipulations at ¶ 2.
[8] Provider's FPP at 7; Stip. at ¶ 3.
[9] Provider's FPP at 9; Stip. at ¶¶ 2-3 (The revised NPR reflected a total of 5,779 Medicaid days on Worksheet S-3, Part I, Line 2.00, Column 5, and a disproportionate share percentage of 22.88 percent on Worksheet E, Part A, Line 4.03.).
[10] Provider's Appeal Request, Calculation Support.

6,343, and would increase the Provider's disproportionate share percentage from 22.88% to 23.10% on Worksheet E, Part A, Line 4.03. These adjustments are worth $283,712 in additional DSH payments to the Provider.

6. Notwithstanding the agreement on the necessary adjustments, the MAC contends that it is unable to enter into an administrative resolution at this time due to binding instructions from CMS precluding any MAC adjustment to the Provider's Disproportionate Patient Percentage or DSH payment calculations for periods prior to October 1, 2013.[11]

On August 18, 2021, the Board granted the Record Hearing Request and issued the Notice of Hearing on the Record.

STATUTORY AND REGULATORY BACKGROUND: MEDICARE DSH PAYMENT

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under IPPS.[12] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[13]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[14] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[15]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[16] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment that should be paid to a qualifying hospital.[17] The DPP is defined as the sum of two fractions expressed as percentages.[18] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both fractions consider whether a patient was "entitled to benefits under part A."[19]

The fraction at issue in this case is the Medicaid fraction which the statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines as:

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[11] Stipulations at ¶¶ 5 and 6.
[12] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[13] *Id*.
[14] *See e.g*. 42 U.S.C. § 1395ww(d)(5).
[15] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[16] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[17] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[18] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[19] *See e.g*. 42 C.F.R. § 412.106(b)(3), (4).

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[20]

The DSH regulation at 42 C.F.R. § 412.106(b)(4) (2009) specifies that the Medicare contractor calculate the Medicaid fraction for a hospital's cost reporting period by "determin[ing] . . . 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."

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

On March 18, 2021, the Medicare Contractor filed a Jurisdictional Challenge regarding the DSH Medicaid-Eligible Days issue in this RNPR appeal. On April 19, 2021, Vidant filed a Response to the Jurisdictional Challenge. The Board found that it has jurisdiction over the DSH Medicaid-Eligible Days issue in this appeal.[21] On May 28, 2021, the Board issued its jurisdictional determination finding jurisdiction "because the adjustment at issue was based on a sample of the requested days where the results of the sampling were projected on the universe of days requested" and "you cannot separate the extrapolated days denied from the extrapolated days granted (particularly since the extrapolation itself is also being challenged)."[22] Accordingly, the Board found jurisdiction over the extrapolated 799 additional Medicaid-Eligible Days that Vidant sought because that specific issue was revised by the RNPR, and the Medicare Contractor reviewed and considered these extrapolated days as a part of the cost report reopening and issuance of the RNPR.[23] This jurisdictional determination is now final and subject to Administrator and judicial review.[24]

As noted above, the issue in this appeal is whether Vidant's DSH payment for FY 2009 should be revised to included additional patient days that were excluded from the numerator of the Medicaid fraction. The parties have agreed to the following stipulation to resolve this issue:

> The agreed upon adjustments would add another 564 Medicaid-eligible days to the Provider's number of Medicaid-eligible days on Worksheet S-3, Part I, Line 2.00, Column 5 from 5,779 to 6,343, and would increase the Provider's disproportionate share percentage from 22.88% to 23.10% on Worksheet E, Part A, Line

[20] (Emphasis added.)
[21] Board's Jurisdictional Decision at 4 (May 28, 2021).
[22] *Id*.
[23] *Id*.
[24] *See* 42 C.F.R. § 405.1840(a)(5) (stating "Final jurisdictional findings and dismissal decisions by the Board under paragraphs (c)(1) and (c)(2) of this section are subject to Administrator and judicial review in accordance with paragraph (d) of this section.").

> 4.03. These adjustments are worth $283,712 in additional DSH payments to the Provider.[25]

However, "the [Medicare Contractor] contends that it is unable to enter into an administrative resolution at this time due to binding instructions from CMS precluding any [Medicare Contractor] adjustment to the Provider's Disproportionate Patient Percentage or DSH payment calculations for periods prior to October 1, 2013."[26]

Consistent with 42 C.F.R. § 412.106(b)(4) *and* based on the Board's finding of jurisdiction, the parties' stipulations, the parties' agreement to conduct a hearing on the record, and the record before the Board, the Board accepts Stipulation ¶ 5 and finds that the FY 2009 DSH calculation for Vidant should be revised to include an additional 564 Medicaid-eligible days in the numerator of the Medicaid fraction. Accordingly, the Board remands this appeal to the Medicare Contractor with direction to apply the proposed FY 2009 audit adjustments reflected in and attached to the stipulations agreed to by the parties, and to make the additional DSH payment for FY 2009 as a result of those adjustments. Specifically, the Board directs the Medicare Contractor to: (1) add another 564 Medicaid-eligible days to the number of Medicaid-eligible days on Vidant's FY 2009 settled cost report at Worksheet S-3, Part I, Line 2.00, Column 5, thereby increasing the figure there from 5,779 days to 6,343 days; and (2) increase Vidant's disproportionate share percentage on Vidant's FY 2009 settled cost report at Worksheet E, Part A, Line 4.03 from 22.88 percent to 23.10 percent. As represented by the parties, these adjustments are worth $283,712 in additional FY 2009 DSH payments to Vidant.[27]

DECISION AND ORDER

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the FY 2009 DSH calculation for Vidant should be revised to include an additional 564 Medicaid-eligible days in the numerator of the Medicaid fraction. Accordingly, the Board remands this appeal and directs the Medicare Contractor to revise the FY 2009 first amended cost report[28] for Vidant as follows:

1. Add an additional 564 Medicaid-eligible days to the number of Medicaid-eligible days on Worksheet S-3, Part I, Line 2.00, Column 5, thereby increasing the total from 5,779 days to 6,343 days; and

2. Increase Vidant's disproportionate share percentage on Worksheet E, Part A, Line 4.03 from 22.88 percent to 23.10 percent.

[25] Stipulations at ¶ 5
[26] *Id.* at ¶ 6.
[27] *Id.* at ¶ 5.
[28] *See supra* note 2.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Gregory H. Ziegler, C.P.A.
Robert A. Evarts, Esq.
Kevin D. Smith, C.P.A.
Ratina Kelly, C.P.A.

FOR THE BOARD:

1/31/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

Attachment A

Audit Adjustment Report CMS-2552-96
Date Prepared: 6/8/2021 Page 1
Data File: C:\Users\703I\Desktop\R1B340040_0909.mca
Fiscal Year: 10/01/2008 To 09/30/2009
Provider Name: PITT COUNTY MEMORIAL HOSPITAL Health Financial Systems
Provider No: 340040 MCRIF32

	Previous Value	Difference	New Value	Action
Adjustment No. 1 **Ref: 1**				
WPR: 602-7				
To adjust Title XIX days to reflect detailed review performed by MAC of additional days per provider appeal.				
S-3, Part I, Line 2.00 HMO				
5.00 I/P DAYS O/P VISITS/TRIPS TITLE XIX	5,779	564	6,343	Add
E, Part A, Title XVIII, Hospital, Line 4.03 Allowable disproportionate share percentage. (see instructions)				
1.00	22.88	0.22	23.10	Replace
Adjustment No. 2 **Ref: 2**				
WPR:				
tentative settlement				
E-1, Title XVIII, Hospital, Line 5.02 TENTATIVE TO PROVIDER				
1.00 PART A MM/DD/YYYY	00/00/00		03/27/2019	Replace
2.00 PART A AMOUNT	0	1,314,480	1,314,480	Replace
3.00 PART B MM/DD/YYYY	00/00/00		03/27/2019	Replace
4.00 PART B AMOUNT	0	9,657	9,657	Replace

Audit Adjustment Detail Report CMS-2552-96
Date Prepared: 6/8/2021 Page 1
Data File: C:\Users\703I\Desktop\R1B340040_0909.mca
Fiscal Year: 10/01/2008 To 09/30/2009
Provider Name: PITT COUNTY MEMORIAL HOSPITAL Health Financial Systems
Provider No: 340040 MCRIF32

	Previous Value	Difference	New Value	Action

Adjustment No. 1 Ref: 1

WPR: 602-7
To adjust Title XIX days to reflect detailed review performed by MAC of additional days per provider appeal.

S-3, Part I, Line 2.00 HMO
☐ Tagged Created: 6/8/2021 Modified: 6/8/2021 09:03:41 AM Identifier: Auditor:
☐ Reviewed Date: By:

5.00 I/P DAYS O/P VISITS/TRIPS TITLE XIX	5,779	564	6,343	Add

E, Part A, Title XVIII, Hospital, Line 4.03 Allowable disproportionate share percentage. (see instructions)
☐ Tagged Created: 6/8/2021 Modified: 6/8/2021 09:26:12 AM Identifier: Auditor:
☐ Reviewed Date: By:

1.00	22.88	0.22	23.10	Replace

Adjustment No. 2 Ref: 2

WPR:
tentative settlement

E-1, Title XVIII, Hospital, Line 5.02 TENTATIVE TO PROVIDER
☐ Tagged Created: 6/8/2021 Modified: 6/8/2021 09:14:54 AM Identifier: Auditor:
☐ Reviewed Date: By:

1.00 PART A MM/DD/YYYY	00/00/00		03/27/2019	Replace

☐ Tagged Created: 6/8/2021 Modified: 6/8/2021 09:15:11 AM Identifier: Auditor:
☐ Reviewed Date: By:

2.00 PART A AMOUNT	0	1,314,480	1,314,480	Replace

☐ Tagged Created: 6/8/2021 Modified: 6/8/2021 09:15:32 AM Identifier: Auditor:
☐ Reviewed Date: By:

3.00 PART B MM/DD/YYYY	00/00/00		03/27/2019	Replace

☐ Tagged Created: 6/8/2021 Modified: 6/8/2021 09:15:42 AM Identifier: Auditor:
☐ Reviewed Date: By:

4.00 PART B AMOUNT	0	9,657	9,657	Replace

Audit Adjustment Error Report CMS-2552-96
Date Prepared: 6/8/2021 Page 2
Data File: C:\Users\703I\Desktop\R1B340040_0909.mca
Fiscal Year: 10/01/2008 To 09/30/2009
Provider Name: PITT COUNTY MEMORIAL HOSPITAL Health Financial Systems
Provider No: 340040 MCRIF32

	Value	Error

No Errors.

Health Financial Systems MCRIF32 FOR PITT COUNTY MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 6/ 8/2021 9:26

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FORM APPROVED
FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE OMB NO. 0938-0050
THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
(42 USC 1395g).

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 34-0040	PERIOD FROM 10/ 1/2008 TO 9/30/2009	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL X-REOPENED --FINAL 4-MCR CODE 1 - # OF REOPENINGS	DATE RECEIVED: 2/26/2010 INTERMEDIARY NO: 11501

ELECTRONICALLY FILED COST REPORT DATE: 6/ 8/2021 TIME 9:26

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
PITT COUNTY MEMORIAL HOSPITAL 34-0040
FOR THE COST REPORTING PERIOD BEGINNING 10/ 1/2008 AND ENDING 9/30/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

_____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX
		1	A 2	B 3	4
1	HOSPITAL	0	283,712	0	11,614,090
2	SUBPROVIDER	0	0	0	2,321,355
2 .01	SUBPROVIDER II	0	0	0	1,213,619
100	TOTAL	0	283,712	0	15,149,064

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

FREEDOM OF INFORMATION ACT
PRINT DATA

6/08/2021

Number of printed pages: 2 (including this page)