PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2022-D24

PROVIDER–
Raritan Bay Medical Center

Provider No.:
31-0039

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc. – (J-L)

RECORD HEARING DATE –
August 8, 2022

Fiscal Year Ending –
December 31, 2008

Case No. –
14-4177

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor's determination of the Provider's disproportionate share hospital ("DSH") payment [was accurate] and whether that calculation should be revised to include additional Medicaid 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 Fiscal Year ("FY") 2008 DSH calculation for Raritan Bay Medical Center ("Raritan Bay" or "Provider") should be revised to include an additional 363 Medicaid-eligible days in the numerator of the Medicaid fraction. Accordingly, the Board remands this appeal to the Medicare Contractor to revise the cost report for the Provider as follows:

1. Add an additional 363 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 10,618 to 10,981; and

2. Increase Provider's disproportionate share percentage on Worksheet E, Part A, Line 4.03 from 11.06 percent to 11.41 percent.

STATEMENT OF FACTS AND PROCEDURAL HISTORY

Raritan Bay is an acute care hospital paid under Medicare's inpatient prospective payment system ("IPPS"). The period at issue in this appeal is FY 2008. Raritan Bay's designated Medicare contractor[2] is Novitas Solutions ("Medicare Contractor").[3]

On March 14, 2014, the Medicare Contractor issued a notice of program reimbursement ("NPR") for this cost reporting period to the Provider.[4] On September 8, 2014, the Provider timely filed this appeal with the Board seeking to include the aforementioned additional Medicaid-eligible days in the numerator of the DSH Medicaid fraction.[5]

On July 15, 2022, the parties submitted Stipulations and a Consent Request for a Hearing on the Record.[6] The parties stipulated, in part:

> 4. The parties have now reached an agreement on the cost report adjustments necessary to resolve this appeal. Attached as Exhibit 1 to this Stipulation is a copy of the MAC's audit

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[1] Stipulations and Consent Request for a Hearing on the Record (hereinafter "Stip.") (July 15, 2022) at ¶ 1.
[2] 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.
[3] Medicare Contactor's Final Position Paper (June 14, 2022) (hereinafter "Contractor's FPP") at 2.
[4] Stip. at ¶ 2.
[5] *Id.* at ¶ 3. This appeal initially contained other issues, but all other issues have been either transferred or withdrawn.
[6] *Id.* at ¶ 1.

adjustment report reflecting the parties' agreement. The agreed upon adjustments would add another 363 Medicaid-eligible days to the Provider's number of Medicaid-eligible days on Worksheet S-3, Part I, Line 2.00, Column 5, and would increase the Provider's disproportionate share percentage from 11.06% to 11.41% on Worksheet E, Part A, Line 4.03. These adjustments are worth $198,579 in additional DSH payments to the Provider.[7]

5. 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.[8]

On August 8, 2022, 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 the Inpatient Prospective Payment System ("IPPS").[9] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[10]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[11] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[12]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[13] 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.[14] The DPP is defined as the sum of two fractions expressed as percentages.[15] 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."[16]

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

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:

> [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.[17]

The DSH regulation at 42 C.F.R. § 412.106(b)(4) (2009) requires the Medicare Contractor to 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

As noted above, the issue in this appeal is whether the Provider's DSH payment for the FY 2008 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 363 Medicaid-eligible days to the Provider's number of Medicaid-eligible days on Worksheet S-3, Part I, Line 2.00, Column 5, and would increase the Provider's disproportionate share percentage from 11.06% to 11.41% on Worksheet E, Part A, Line 4.03. These adjustments are worth $198,579 in additional DSH payments to the Provider.[18]

However, the parties further stipulated that "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."[19] These binding instructions require the Board to issue a decision to allow for the resolution of this appeal.

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 the data in Stipulation ¶ 4 and finds that the cost reporting period's DSH calculation for the Provider should be revised to include an additional 363 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 audit

[17] (Emphasis added.)
[18] Stip. at ¶ 4.
[19] *Id.* at ¶ 5.

adjustments reflected in and attached to the Stipulations agreed to by the parties, and to make the additional DSH payment calculated for the cost reporting period as a result of those adjustments. Specifically, the Board directs the Medicare Contractor to: (1) add an additional 363 Medicaid-eligible days to the number of Medicaid-eligible days on the Provider's settled cost report at Worksheet S-3, Part I, Line 2.00, Column 5, thereby increasing the figure reported from 10,618 days to 10,981 days; and, (2) increase the Provider's disproportionate share percentage on the Provider's settled cost report at Worksheet E, Part A, Line 4.03 from 11.06 percent to 11.41 percent. As represented by the parties, these adjustments are worth $198,579 in additional FY 2008 DSH payments to the Provider.[20]

DECISION AND ORDER

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the 2008 DSH calculation for the Provider should be revised to include an additional 363 Medicaid-eligible days in the numerator of the Medicaid fraction. Accordingly, the Board remands this appeal and directs the Medicare Contractor to revise the cost report for Raritan Bay Medical Center as follows:

1. Add an additional 363 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 10,618 days to 10,981 days; and

2. Increase the Provider's disproportionate share percentage on Worksheet E, Part A, Line 4.03 from 11.06 percent to 11.41 percent.

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:

9/7/2022

X Clayton J. Nix

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

[20] *Id.* at ¶ 4.

ATTACHMENT A

R.1.1 page 1 of 1 LJS 4/1/2021

Audit Adjustment Report CMS-2552-96
Date Prepared: 4/1/2021 Page 1
Data File: \\fcsonas.fcso.net\Citrix$\FSLogix\FolderRedirects\e1bh\Desktop\F0_310039_12312008.mca
Fiscal Year: 01/01/2008 To 12/31/2008
Provider Name: RARITAN BAY MEDICAL CENTER Health Financial Systems
Provider No: 310039 MCRIF32

	Previous Value	Difference	New Value	Action

Adjustment No. 1 **Ref: 1**

WPR:
Completed cost reporting forms and pages in accordance with current regulations.
42 CFR section 412ff and 413ff CMS PUB. 15-II Section 3600

Adjustment No. 2 **Ref: 2**

WPR:
Corrected mathematical and flow through errors in cost reporting forms and pages as necessary.
42 CFR section 412ff and 413ff CMS PUB. 15-II Section 3600

Adjustment No. 3 **Ref: 3**

WPR:
To determine whether total Program reimbursement costs exceed total Program charges, and if so, to restrict the reimbursement to the lower of cost or charges.
42 CFR section 412ff and 413ff

Adjustment No. 4 **Ref: 5**

WPR: R.10
To allow additional Medicaid eligible days and adjust the DSH percentage accordingly.
42 CFR 412.106

S-3, Part I, Line 2.00 HMO				
5.00 I/P DAYS O/P VISITS/TRIPS TITLE XIX	10,618	363	10,981	Replace
E, Part A, Title XVIII, Hospital, Line 4.03 Allowable disproportionate share percentage. (see instructions)				
1.00	11.06	0.35	11.41	Replace

Adjustment No. 5 **Ref: 4**

WPR: R.8
To record last final settlement as tenative for proper appeal reimbursement,
42 CFR 413.64, PRM 15-I, Section 2408.

E-1, Title XVIII, Hospital, Line 5.50 TENTATIVE TO PROGRAM				
1.00 PART A MM/DD/YYYY	00/00/00		03/14/2014	Replace
2.00 PART A AMOUNT	0	2,130,141	2,130,141	Replace
3.00 PART B MM/DD/YYYY	00/00/00		03/14/2014	Replace
4.00 PART B AMOUNT	0	31,442	31,442	Replace

Issue 1: DSH Eligible Days R.10 LJS 3/17/2021

Provider Name: Raritan Bay MC
Provider No.: 31-0039
FYE: 12/31/2008
PRRB Case No. 14-4177

Purpose: To review and determine if additional Medicaid eligible days should be allowed in the DSH payment computation.

Source: Jamie Basco, McKay Consulting
Medicaid listing
Cost Report
Ubs, Medicaid Eligiblity docs
Randle Mix-State of NY

Reference: 42 CFR 412.106

Findings: The Provider is requesting 363 additional Medicaid eligible days .
See listing at R.10.1

R.10.1 Raritan0BRO-AdditionalEligible

Duplicate Review

A listing of previously claimed days can found on R.10.2. These were verified to the CR. The additional days listing and the last NPR'd listing were sorted by patient name and a detail review and comparion was done between the listings.
No duplicates were found.

R.10.2 Previously Claimed Days.xls

Testing Results

Stratified Days:

Per review at R.10.3 , all of the 84 Stratified days were found to be allowable.

Sample Review:

Per review at R.10.3 , all of the 81 tested sample days were found to be allowable. All 279 in universe will be allowed

Final Allowable Days Computation:

Allowable Stratified Days	84
Allowable Sampled Days	279
Total Allowed Additional Days	**363**

The last final DSH computation can be found at R.10.4
The revised DSH computation can be found at R.10.5

R.10.4 DSH Calculation .xls

R.10.5 Revised DSH Calculation.xls

The MAC will allow an addditonal 363 Medicaid eligible days and adjust the DSH percentage to 11.41.

Conclusion: Based on audit work performed above, the following adjustments are necessary:

Proposed Adjustments

To adjust to revised Medicaid eligible days and adjust the DSH percentage accordinly.

		Per C/R	Per Audit	Variance
S-3, line 2, col 5	HMO Medicaid Days-S-3	10618	363	10981
E-Part A line 4.03	DSH Percentage	11.06	11.41	0.35

Health Financial Systems MCRIF32 FOR RARITAN BAY MEDICAL CENTER IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 4/ 1/2021 9: 6

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: 31-0039	PERIOD FROM 1/ 1/2008 TO 12/31/2008	INTERMEDIARY USE ONLY --AUDITED X-DESK REVIEW --INITIAL --REOPENED --FINAL 2-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: 6/ 9/2009 INTERMEDIARY NO: 12001

ELECTRONICALLY FILED COST REPORT DATE: 4/ 1/2021 TIME 9:06

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 IMPRISIONMENT 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:
RARITAN BAY MEDICAL CENTER 31-0039
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2008 AND ENDING 12/31/2008 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	198,579		0	2,321,704
100	TOTAL	0	198,579		0	2,321,704

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