PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2004-D41

PROVIDER –
Empire 91-94 Medicaid Eligible Days Group
Spokane, Washington

Provider Nos.: Various

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING –
March 5, 2004

Cost Reporting Periods Ended - Various

CASE NO.: 98-3477G

INDEX

ISSUE:

Was the Intermediary's determination of the disproportionate share hospital (DSH) computation relating to state-only General Assistance Days proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The "Empire 91-94 Medicaid Eligible Days" Group (Providers) is composed of two acute-care hospitals which were reimbursed under the Prospective Payment System (PPS) for inpatient hospital services. The only issue in dispute centers around the state-only General Assistance Days related to discharges occurring between January 1, 1993 and June 30, 1994. Specifically, Mutual of Omaha, (Intermediary) determined that the days in question should be excluded from the numerator of the Medicaid fraction used to compute the Providers' DSH adjustment payment. The Providers appealed the Intermediary's determination to the Provider Reimbursement Review Board (Board) and have met the jurisdictional requirements of the regulations at 42 C.F.R. §§405.1835-405.1841. A hearing on the record was requested, and the parties submitted an extensive set of Stipulations.[1] The amount of Medicare funds in controversy is approximately $861,000.

The Providers were represented by Brian M.Werst, Esquire, of Stamper, Rubens, Stocker and Smith, P.S. The Intermediary was represented by Matt Pleggenkuhle, Appeals Consultant, Mutual of Omaha.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This case arises from a dispute over the amount of Medicare payments due the Provider, in particular its "disproportionate share" payment.

The Medicare Program's payment and audit functions are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by Centers for Medicare and Medicaid Services (CMS).

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 what proportion of those costs are to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a Notice of Program Reimbursement (NPR). 42 C.F.R.§405.1803. A provider dissatisfied with the intermediary's final determination may file an appeal with the Board within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

[1] Exhibit I-2

The Medicare statute specifies that the Secretary shall provide for an additional payment to hospitals that serve a significantly disproportionate number of low income or Medicare Part A patients. If a hospital has a DSH patient percentage that equals or exceeds 15%, is located in an urban area and has 100 or more beds, the hospital is eligible for DSH payment adjustment. 42 U.S.C. §1395ww(d)(5)(F)(v).[2] The determination of the "DSH patient percentage" is at issue in this case.

The formula used to calculate a provider's DSH adjustment is the sum of two fractions, often referred to as the Medicare Proxy and the Medicaid Proxy, expressed as percentages. SSA §1886(d)(5)(F)(vi). The Medicare Proxy's numerator is the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income, excluding patients receiving state supplementation only, and the denominator is the number of patient days for patients entitled to Medicare Part A. Id. The Medicaid Proxy'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 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. See 42 C.F.R. §412106(b)(4).

In the mid-1990s, a controversy arose over the Health Care Financing Administration's (HCFA), currently called CMS, interpretation of the DSH formula as set forth under the Act. Pursuant to the Act, the Medicaid component of the DSH formula:

> is the number of the hospital's patient days for such period which consists of patients who (for such days) were *eligible* for medical assistance under a State plan approved under Title XIX. . .

SSA §1886(d)(5)(F)(vi)(II) (emphasis added).

HCFA's regulation governing a provider's DSH percentage in effect at the time of the controversy referred to the "number of patient days furnished to patients *entitled* to Medicaid." 42 C.F.R. §412.106(b)(4) (1993) (emphasis added). In applying the statute and the regulation, HCFA's interpretation substituted the concept of payment by Medicaid for each day of care for the statutory standard of "eligibility" for Medicaid coverage. However, in HCFA Ruling No. 97-2 (February 27, 1997), HCFA changed its prior policy of including in the DSH calculation only inpatient days of service which were actually *paid* by a Medicaid State plan. HCFA's change in interpretation was in recognition of the holdings on this issue of the United States Courts of Appeals in the Fourth, Sixth, Eighth, and Ninth Circuits, which rejected HCFA's prior interpretation of including only patient days *paid* by Medicaid.

[2] Social Security Act ("SSA") Section 1886(d)(5)(F(i)(I).

Thus, in HCFA Ruling 97-2, HCFA conceded that it should include in the Medicaid fraction all days attributable to inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan, whether or not the hospital received payment for those inpatient hospital services.

The language in HCFA Ruling 97-2 and the implementing instructions regarding which individuals qualify as "eligible for medical assistance under a State plan approved under Title XIX" created a new controversy. HCFA Ruling 97-2 and the implementing instructions stated HCFA's policy that days attributed to individuals eligible for general assistance days (GADs) and other State-only funded programs (collectively, State-Only Program Days) should be excluded from the DSH calculation. Intermediaries in certain states historically had allowed providers to include State-Only Program Days applicable to health programs not contained in the relevant Medicaid State plans in their DSH calculations even though Section 1886(d)(5)(F)(vi)(II) of the Act states that only days attributable to individuals "eligible for medical assistance *under a State plan approved under Title XIX"* are to be included in the DSH calculation. (emphasis added). Based on the Ruling and the implementing instructions, several of the intermediaries that previously had allowed inclusion of State-Only Program Days in their providers' DSH calculations began amending their policies on this issue.

A number of states raised concerns with the need to repay the portion of the DSH payments attributable to the State-Only Program Days. In response to these concerns, HCFA decided to "hold harmless" hospitals that had received certain additional Medicare DSH payments, because guidance on how to claim these funds was not sufficiently clear.

HCFA issued its guidance to fiscal intermediaries, Program Memorandum A-99-62, on December 1, 1999 (Program Memo). The Program Memo addressed the treatment of the State-Only Program Days issue on both a prospective and retrospective basis. The first portion of the Program Memo addressed HCFA's clarification of the issue for cost reporting periods beginning on or after January 1, 2000. It is this provision that is at issue in this case. For such future periods, HCFA clarified that "the term 'Medicaid days' refers to days on which a patient is eligible for medical assistance benefits under an approved Title XIX State plan."[3] The Program Memo provides an example of what days were not included in the term "Medicaid days." Specifically, it provided that the term "Medicaid days" does not refer to days such as those utilized by beneficiaries in state programs that were not Medicaid programs, but that provided medical assistance to beneficiaries of state-funded income support programs.[4] Those beneficiaries were generally not eligible for health benefits under a State plan approved under Title XIX; therefore, according to the Program Memo, days utilized by those beneficiaries did not count in the Medicare disproportionate share calculation. Furthermore, the Program Memo declared that no State-Only Program Days would be counted as Medicaid days for

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[3] Program Memo at 2.

[4] The Program Memo contained an exhibit that outlines other types of days that also do not qualify as Medicaid days for purposes of the DSH calculation.

purposes of the DSH calculation for cost reporting periods beginning on or after January 1, 2000 for any provider.

The second portion of the Program Memo contained what amounted to a change in HCFA's policy regarding State-Only Program Days applicable to cost reporting periods beginning prior to January 1, 2000 (the New Policy). HCFA split the hospitals that could retain or receive payments under the New Policy into two groups. The first group included those hospitals that already had received payments reflecting the inclusion of the State-Only Program Days. For cost reporting periods beginning prior to January 1, 2000, HCFA directed intermediaries not to disallow the portion of Medicare DSH payments previously made to hospitals attributable to the inclusion of the State-Only Program Days in the Medicaid Proxy component of the Medicare DSH formula. In addition, the Program Memo stated that for open cost reports, intermediaries were to allow only those State-Only Program Days that the hospital *received* payment for in previous cost reporting periods settled before October 15, 1999.

The second group of hospitals addressed by the New Policy focused on those hospitals that did *not* receive a Medicare DSH payment based on the inclusion of the State-Only Program Days. For cost reports that were settled before October 15, 1999, if a hospital never received any DSH payment based on the erroneous inclusion of State-Only Program Days and the hospital did not file a jurisdictionally proper appeal to the Board on this issue prior to October 15, 1999, then intermediaries were not to pay the hospital DSH funds based on the inclusion of these types of days for any open cost reports for periods beginning prior to January 1, 2000. The Program Memo further stated that on or after October 15, 1999, intermediaries were not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of State-Only Program Days in the Medicare DSH formula. However, if for cost reporting periods beginning prior to January 1, 2000, a hospital that had not received payments reflecting the inclusion of State-Only Program Days and had filed a jurisdictionally proper appeal to the Board for any single fiscal year on this issue before October 15, 1999, the intermediary was to reopen any such cost report and revise the Medicare DSH payment to reflect the inclusion of these State-Only Program Days in the Medicaid Proxy.

PARTIES' CONTENTIONS

The Provider contends that pursuant to CMS Program Memorandum A-99-62, intermediaries were instructed to do the following with regard to "state-only program days:"

> If, for cost reporting periods beginning before January 1, 2000, a hospital did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, reopen the cost report at issue and revise the Medicare DSH Payment to reflect the inclusion of these days as Medicaid days.

Therefore, CMS Program Memorandum A-99-62 mandated that Intermediaries reopen the cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days if the hospital had filed a jurisdictionally proper appeal to the PRRB before October 15, 1999. This mandate also applies to hospitals that appealed after October 15, 1999, if the hospital appealed the denial of payment for the days in question in previous cost reporting periods.

The Providers in this appeal have a history of PRRB appeals challenging the Medicaid eligible patient day count, the SSI percentage, and the DSH payment amount. Specifically, the Providers filed the following appeals regarding the Intermediary's DSH calculation:

> On November 1, 1996, Empire Health Services files a notice of appeal to the PRRB on behalf of Deaconess Medical Center for the 1993 NPR.
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> On December 24, 1996, Empire Health Services filed a notice of appeal to the PRRB on behalf of Valley Hospital Medical Center for the 1993 NPR.
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> On October 1, 1997, Empire Health Services filed a notice of appeal to the PRRB on behalf of Deaconess Medical Center for the 1994 NPR.
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> On October 16, 1997, Empire Health services filed a notice of appeal to the PRRB on behalf of Valley Hospital Medical Center for the 1994 NPR.

Therefore the Provider asserts that it falls under the hold-harmless provision of CMS Program Memorandum A-99-62 in that it had a properly pending appeal before the October 15, 1999 deadline.

The Intermediary determined that 42 C.F.R of §412.106 (b)(4), the implementing regulation in effect during the appealed years, refers only patients entitled to Medicaid. However, Stipulation 3 indicated that prior to July 1, 1994, patients days occurring in two categories, Medically Indigent (MI) and General Assistance Unemployable (GAU) were reimbursed entirely through State funding. Thus, the Intermediary excluded those days from the Medicaid fraction. Further, the Intermediary contends that the Provider does not qualify for hold-harmless relief under CMS Program Memorandum A-99-62. First, the Providers never included the days at issue in their claim for DSH reimbursement, therefore, they never received any payment for them. They did appeal the "eligible days" issue for this period, but they did not in any way identify that they were asking that general assistance days be included in the Medicaid fraction. Second, the first time the Providers addressed the issue of general assistance days was when they filed their supplemental position paper on February 20, 2003. Thus, the Providers did not specifically appeal the days in question before October 15, 1999, as required by CMS Program Memorandum A-99-62.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and program instructions, parties' contentions and evidence submitted, finds and concludes as follows:

The Board finds that the Providers are not entitled to include State-Only Program Days in their DSH calculation for the period January 1, 1993 through June 30, 1994. The Board notes that the policy contained in Program Memorandum A-99-62 provides relief in certain situations for providers to receive reimbursement for State-Only days. Since the Providers did not fit into any of the groups noted in the Program Memorandum, the Board finds that the statute, which outlines the intent of DSH, is the controlling law in this case, not the Program Memorandum. Pursuant to the SSA §1886(d)(5)(F)(vi)(II), codifed at 42 U.S.C. §1395ww, the Medicaid component of the DSH formula:

> is the number of the hospital's patient days for such period which consists of patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX . . .

Id.

The corresponding regulation that discusses the calculation of the DSH adjustment states, in part, that the computation shall include the "number of patient days furnished to patients entitled to Medicaid." 42 C.F.R. §412.106(b)(4)

Based on the above statute and regulation, the Board finds that the days used to compute the DSH adjustment must be days under a State plan approved for Title XIX, i.e., Medicaid days. The Board finds that the MI and GAU days at issue in this case were State-Only days and not part of a plan approved under Title XIX. The Board also finds that the Providers did not fall under the Program Memorandum's two primary hold harmless categories, namely, 1) the Providers had never claimed or been paid for the State-Only days, and, 2) the Providers did not file an appeal of the specific issue of State-Only days by October 15, 1999.

The Board notes that the Providers never included the days at issue in their original claim for DSH reimbursement and never received any payment for them. The first mention of general assistance days was in the supplemental position paper dated February 20, 2003

The Board also considered the Providers' argument that HCFA violated the provisions of the Administrative Procedures Act (APA) § U.S.C. §501 et seq in that Program Memorandum A-99-62 was a substantive change in policy. The Board notes that much of the Providers' argument in their position paper centers around an inconsistent application of the policy. Accordingly, the fairness issue can be more appropriately addressed by a court with equitable powers.

The Board also points to the district court decision in United Hospital v. Thompson , 2003 WL 21356086, Medicare and Medicaid Guide (CCH) ¶ 301,323 (D. Minn. 2003).

In that case, the court ruled that a hospital was not entitled to "hold-harmless" protection under CMS Program Memorandum A-99-62, which would allow otherwise ineligible general assistance days to be included in the numerator of the Medicaid fraction for DSH, because the hospital did not have a jurisdictionally proper appeal on that precise issue prior to October 15, 1999. In addition, the court ruled that the program memorandum was not arbitrary and capricious in its differential treatment of hospitals. This ruling affirmed the Board's prior decision in: United Hospital v. Blue Cross Blue Shield Association/Noridian Government Services, PRRB Dec. No. 2002-D23, June 27, 2002, Medicare and Medicaid Guide (CCH) ¶ 80,882, decl'd. rev. HCFA Admin. August 12, 2002.

DECISION AND ORDER:

The Board concludes that the Providers are not entitled to include the State-Only days in their DSH calculation for the period January 1, 1993 through June 30, 1994. The Intermediary's position is affirmed.

BOARD MEMBERS PARTICIPATING:

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Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

DATE: September 17, 2004

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