PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2006-D13

PROVIDER –
Community Hospital of the Monterey Peninsula

Provider No: 05-0145

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services, LLC--CA

DATE OF HEARING –
October 25, 2005

Cost Reporting Period Ended –
December 31, 1993

CASE No. : 01-2940

INDEX

ISSUE:

Whether for purposes of the Provider's disproportionate share (DSH) adjustment calculation, the Provider is entitled to an increased number of days of care rendered to eligible Medicaid beneficiaries.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement to a provider of medical services.

The Medicare program provides health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services (Secretary) is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payments for those services. 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 the program's administration. CMS has entered into contracts with insurance companies known as fiscal intermediaries to maintain the program's payment and audit functions. Intermediaries determine payment amounts due providers of health care services (e.g., hospitals, skilled nursing facilities, and home health agencies) under Medicare law and interpretative guidelines issued by CMS.

At the close of its fiscal year, each provider submits a cost report to its intermediary showing the costs it incurred during the period 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 notifies the Provider in a Notice of Program Reimbursement (NPR). 42 C.F.R §405.1803. A provider dissatisfied with the intermediary's determination may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days 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). The PPS contains a number of provisions that adjust reimbursement based on hospital-specific factors. See 42 U.S.C. §§1395ww(d)(5).

This case involves the hospital-specific disproportionate share adjustment. The "disproportionate share," or "DSH," adjustment requires the Secretary to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 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. §1395ww(d)(5)(F)(v). The "disproportionate patient percentage" is the sum of two fractions, the Medicare fraction and Medicaid fraction for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi).

The computation of the numerator of the "Medicaid" fraction is at the heart of this case. The

numerator of this fraction is calculated by determining the total number of a hospital's inpatient days attributable to patients who "were eligible for medical assistance under a State plan approved under subchapter XIX, but not entitled to benefits under Part A of this subchapter." 42 U.S.C. §1395ww(d)(5)(F)(vi)(II).

From 1986 through 1997, the Secretary construed the first portion of this numerator calculation to include only those patients who were both eligible for Medicaid payments under the relevant state Medicaid plan and actually received such payments from the state. See 42 C.F.R §412.106(b)(4). Providers challenged this interpretation, and every circuit court that subsequently considered the Secretary's interpretation rejected it. The courts of appeals uniformly concluded that the numerator calculation must include all patient days for which a patient was eligible for Medicaid regardless of whether a state Medicaid program actually paid the hospital for services provided to the patient. See Cabell Huntington Hospital, Inc. v. Shalala, 101 F.3d 984, 988 (4th Cir. 1996); Legacy Emanuel Hospital and Health Center v. Shalala, 97 F.3d 1261, 1266 (9th Cir. 1996); Deaconess Health Services Corp. v. Shalala, 83 F.3d 1041, 1041 (8th Cir. 1996); Jewish Hospital, Inc. v. Secretary of Health and Human Services, 19 F.3d 270, 276 (6th Cir. 1994).

In February, 1997 the Secretary of HHS issued a ruling that rescinded the original interpretation of the statutory provision and prospectively mandated that in calculating the disproportionate patient percentage, the Medicaid fraction's numerator must include all inpatient days for patients who were eligible for Medicaid "whether or not the hospital received payment for those inpatient hospital services."[1] In issuing the Ruling, the Secretary did not concede that the prior interpretation was incorrect. Instead, she stated that "although HCFA believes that its longstanding interpretation of the statutory language was a permissible reading of the statutory language, HCFA recognizes that, as a result of the adverse court rulings, this interpretation is contrary to the applicable law in four judicial circuits." Id. According to the Secretary, the changed interpretation would apply only prospectively, "in order to ensure national uniformity in calculation of DSH adjustments." Id. The Ruling also expressly announced that the Secretary would not reopen past NPRs on the basis of this changed statutory interpretation. See Id.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Community Hospital of the Monterey Peninsula (Provider) is a short-term acute care general hospital located in Monterey, California. On November 7, 2000 United Government Services, California (Intermediary) issued a revised Notice of Program Reimbursement (RNPR) to adjust the number of Medicaid patient days and to revise the disproportionate share (DSH) adjustment amount. On May 4, 2001 the Provider filed an appeal from this revised NPR, claiming that the Medicaid ratio (Medicaid Eligible Days) used in determining the DSH payment was incorrect. The Intermediary challenged the Board's jurisdiction, and both parties submitted jurisdictional briefs. On March 17, 2005, the majority of the Board found that the Board has jurisdiction over this issue.

[1] See Defendant's Motion to Dismiss., Heath Care Financing Administrative Ruling 97-2 at 2 (Feb. 27, 1997) ("Ruling" or "Ruling 97-2").

INTERMEDIARY'S CONTENTIONS:

42 C.F.R. §405.1889 establishes the basis for an appeal when a RNPR has been issued:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in $405.1855, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

The Intermediary contends that the Board does not have jurisdiction over the Medicaid eligible days issue because there was no audit adjustment made to Medicaid eligible but unpaid days, and as a result, these days were not part of the Intermediary's revised determination of reimbursement. Rather, the revision addressed Medicaid paid days only, as specified by the Provider in its reopening request. The Intermediary states that the Provider could have included a claim for Medicaid eligible but unpaid days in its reopening request pursuant to HCFA Administrative Ruling 97-2, but failed to do so.

PROVIDER'S CONTENTIONS:

The Provider argues that the Board has jurisdiction over the Medicaid eligible days issue and contends that the term Medicaid eligible days includes all eligible days, both paid and unpaid. The Provider is seeking additional DSH reimbursement pursuant to 42 C.F.R. §412.106 and states that the regulations clearly refer to only one category of day, Medicaid eligible days, and do not differentiate between paid and unpaid days. The Provider contends that its appeal is about proper DSH reimbursement, and the Provider is entitled to have the PRRB make certain that the Intermediary determines the correct DSH amount by using all qualifying Medicaid days.

Prior to the issuance of the Board's jurisdictional decision, the Provider had submitted documentation to the Intermediary supporting the number of eligible but unpaid Medicaid days. The Intermediary audited the documentation and has identified a total of 6,058 Medicaid eligible days, resulting in an increase in the DSH payment from $925,191 to $1,138,378. On May 31, 2005, the parties executed a written stipulation agreeing to these amounts.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSIONS:

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

The Board majority finds that it does have jurisdiction over the Medicaid eligible days issue. Pursuant to 42 C.F.R. §405.1889, which defines a reopening as a "separate and distinct determination or decision," appeals of reopenings are limited in that they are "issue specific." Since the DSH settlement was the basis for the RNPR and Medicaid eligible days are a component of that settlement regardless of their paid status, the Board majority has determined that the Medicaid eligible days should be included in the Intermediary's determination on the RNPR.

The Parties stipulated that "With respect to the Medicaid eligible days issue the Intermediary agrees that Medicaid eligible days should be increased to a total of 6,058 days and that the DSH payment amount should be increased from $925,191 to $1,138,376 if the PRRB's jurisdictional decision dated March 17, 2005 was proper."

Having determined that it does have jurisdiction over the Medicaid eligible days issue, the Board majority finds that the correct number of Medicaid eligible days for purposes of calculating the Provider's DSH reimbursement is 6,058.

DECISION AND ORDER:

The Board majority finds that the correct number of Medicaid eligible days for purposes of the DSH calculation is 6,058.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A. (Dissenting as to jurisdiction)

FOR THE BOARD:

Suzanne Cochran
Chairperson

Dissenting Opinion of Elaine Crews Powell:

The majority accepted jurisdiction over the Provider's appeal, from a Revised Notice of Program Reimbursement (RNPR), of the inclusion of Medicaid eligible days in the DSH payment computation. I respectfully dissent.

A review of the facts in this case indicates that Community Hospital requested a reopening regarding the number of "paid days" it wished to have included in the DSH payment computation.[2] Following its review, the Intermediary included the paid days, recomputed the DSH payment amount, and issued a RNPR. The Provider then filed an appeal, from the RNPR, regarding the "Medicaid eligible days" issue.

I find that the RNPR did not address, nor did it adjust, the number of Medicaid eligible days. 42 C.F.R. 405.1835 entitled **Right to Board Hearing** addresses the circumstances under which a provider has a right to Board hearing, stating in relevant part:

> (a) *Criteria.* [t]he provider . . . has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if:
>
> (1) An intermediary determination has been made with respect to the provider. . .

Since the Intermediary made no determination regarding Medicaid eligible days in the RNPR, I believe that the Board does not have jurisdiction.

Elaine Crews Powell

[2] Under the provisions of CMS Ruling 97-2, the Provider could have amended its reopening request and asked that the issue of Medicaid eligible days be added; however, it never did so.