PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D43

PROVIDER -
Baptist Memorial Hospital
Memphis, TN

Provider No.: 44-0048

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Riverbend Government Benefits
Administrators

DATE OF HEARING -
April 26, 2006

Cost Reporting Period Ended -
September 30, 1994

CASE NO.: 98-1942

INDEX

ISSUE:

Whether the Provider is entitled under CMS Program Memorandum (PM) A-99-62 to include Social Security Act, Section 1115 waiver days for the expanded Medicaid populations (a/k/a TennCare) days in the Medicaid component of the disproportionate share hospital (DSH) calculation.

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. §§1395-1395cc. 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

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 the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The Secretary is directed to provide for appropriate adjustments to the limitation on payments that may be made under the Prospective Payment System (PPS) for the reasonable operating costs of inpatient hospital services, including those deemed necessary to take into account

> (B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter.

42 U.S.C. §1395ww(a)(2)(B).

The Secretary is also directed to provide for an additional payment to certain hospitals that serve a significantly disproportionate number of low-income or Medicare Part A patients. The formula used to calculate a provider's DSH adjustment is the sum of two fractions, which are expressed as percentages. 42 U.S.C. §1395ww(d)(5)(F)(vi).

The first fraction's numerator is the number of hospital patient days for patients entitled to benefits under both Medicare Part A and Supplemental Security Income, 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. 42 U.S.C. §1395(d)(5)(F)(vi)(I).

The second 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. 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) and 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. 42 U.S.C. §1395(d)(5)(F)(i).

Until 1999, some Medicare intermediaries permitted a hospital to include in the numerator of the Medicaid fraction general assistance days associated with patients who were not eligible for medical assistance under an approved Medicaid state plan. On December 1, 1999 CMS issued Program Memorandum No. A-99-62 clarifying CMS' position that general assistance days and certain other types of days may not be included in the numerator of the Medicaid Proxy.

The program memorandum also announced a hold-harmless provision that allowed some hospitals to include otherwise "ineligible" days in the numerator of the Medicaid Proxy for cost reporting periods beginning before January 1, 2000. Under the memorandum, a hospital was allowed to include general assistance days and other days CMS considered ineligible in the numerator of the Medicaid fraction if the hospital had received a DSH payment for that type of day in a prior cost reporting period or if the hospital had filed a jurisdictionally proper appeal on this issue before October 15, 1999.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Baptist Memorial Hospital (Provider) is a general, short-term acute care hospital located in Memphis, Tennessee. On August 18, 2004, the Provider's and the Intermediary's representatives entered into a stipulation of facts.[1] The following summarizes the pertinent part of those stipulations:

[1] See, Provider's supplemental position paper Exhibit P-1.

1. On March 19, 1998, the Provider submitted a Request for Hearing to the PRRB for its fiscal year ending September 30, 1994. Appeal Issue #1 – entitled "Disproportionate Share" – stated:

> The Intermediary incorrectly calculated the Disproportionate Share adjustment. The audit adjustment in question is #49 attached hereto. The reimbursement impact of this adjustment is approximately $75,000.

2. It is usual and customary for this Provider to include only a brief statement of the issues in its Request for Hearing and to leave the details for the Preliminary Position Paper. In 1998, Provider Reimbursement Manual, Part 1 (HCFA-Pub. 15-1), §2921 ("Request for Board Hearing") stated that an individual request for hearing must contain:

> An identification of the issues in dispute with a short explanation of the basis for the dispute, the audit adjustment numbers, and the amount in controversy for each issue. . . ."

3. On November 29, 1999, the Provider submitted its Preliminary Position Paper. Appeal Issue #1 was "[w]hether the Intermediary's adjustment of the disproportionate share calculation (adjustment #49) is correct." The Provider clearly included TennCare Waiver days in its discussion. Regarding the relevant facts, the Provider stated:

> The Provider initially reported a total of 14,097 Medicaid days in the 1994 cost report, which included 10,196 Medicaid days paid under TennCare. At audit, the Provider gave the Intermediary a revised listing of TennCare days reflecting only 9,163 Medicaid days. The Intermediary audited the list based on a 100% review of patients with [a] length of stay of 30 or more and used a statistical sample of the remaining patients. The result of the audit was to remove 1,358 days from the allowed Medicaid days. The original report from the state of Tennessee showed 2,020 "uninsured days." These days were removed from the Medicaid eligible day count based upon the instructions given by the Intermediary. . . . Effective January 1, 1994, HCFA issued a section 1115 waiver to the state of Tennessee establishing the TennCare program, which expanded the optional coverage to include the uninsured and uninsurable citizens of Tennessee. . . .

In its "Arguments" section, the Provider stated that:

> . . . the uninsured patient days should have been counted in the DSH calculation, since the 1115 waiver expanded the state's program of optional coverage. The state includes these days in its request for Federal matching dollars. In PRRB case 99-D[F] sic. Jersey Shore Medical Center, the PRRB . . . found "that any person qualifying for/and receiving medical assistance under an approved State plan is . . . entitled to Medicaid." Further, the PRRB stated "that once a State plan is approved, the Federal Government provides matching funds for all medical services costs provided for in that plan."

The Provider then requested "that the PRRB direct the Intermediary to include the 'uninsured' patient days in the total Medicaid days for the DSH computation.

4. In December of 1999, CMS issued Transmittal No. A-99-62, a Program Memorandum for Intermediaries. Its subject was the "Clarification of Allowable Medicaid Days in the Medicare DSH Adjustment Calculation." The PM stated:

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

5. On February 8, 2000, the Fiscal Intermediary submitted its Preliminary Position Paper. The Position Paper recognized that waiver days were an issue.

The Provider appealed the Intermediary's calculation of its DSH reimbursement to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Edward D. Kalman, Esquire, of Behar and Kalman. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

<u>FINDINGS OF FACT,CONCLUSIONS OF LAW AND DISCUSSION</u>:

After considering the Medicare law, program instructions, the evidence submitted and the parties' contentions, the Board finds and concludes that the Provider is entitled to include its Section 1115 Waiver expanded Medicaid population (TennCare) days in the Medicaid component of the Medicare disproportionate share hospital (DSH) calculation.

The Interemdiary does not dispute the Provider's assertion that, effective January 1, 1994, CMS issued a section 1115 waiver to the State of Tennessee establishing the TennCare program which expanded the optional coverage to include the uninsured and uninsurable citizens of Tennessee.[2] The dispute results from the Intermediary's interpretation and application of Program Memorandum (PM) A-99-62 in denying the inclusion of TennCare days in the DSH calculation. That PM, issued in December 1999, provided a review of practices and policies regarding Medicare DSH payments, and among other things, clarified its definition of eligible Medicaid days. Even though the type of days in issue here, "waiver" days, were considered ineligible, the PM nevertheless offered instructions for inclusion as "hold harmless" days if they were claimed for cost reporting periods beginning before January 1, 2000, the effective date of the PM. The part of the PM relevant to this case is stated below.

> Hospitals That Did Not Receive Payments Reflecting the Erroneous Inclusion of Days at Issue
>
> [I]f a hospital did not receive any payment based on the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for cost reports that were settled before October 15, 1999, and the hospital never filed a jurisdictionally proper appeal to the Provider Reimbursement Review Board (PRRB) on this issue, you are not to pay the hospital based on the inclusion of these types of days for any open cost reports for cost reporting periods beginning before January 1, 2000. Furthermore, on or after October 15, 1999, you are not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.

The critical issue presented by the parties in this case is whether the Provider met the filing requirement of a jurisdictionally proper appeal to the Provider Reimbursement Review Board in accordance with the PM instructions.[3] The Intermediary contends that the filing requirement was not met; therefore, payment of the TennCare days is not allowable. It contends that the Provider's appeal request, made on March 19, 1998, only included a vague reference to the DSH claim. The Intermediary argues that the Provider offered no discussion or reason for including the TennCare days in the appeal request, and thus concludes that the "hold harmless" provision of the PM does not apply to the Provider's TennCare days. The Provider counters that PM-A-99-62 does not require the use of specific language such as "TennCare days" in the appeal request and points out that two federal district courts agree. In St. Joseph Hospital v. Leavitt,[4] the court held that there was no need for specific language to claim expanded days. In United Hospital

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[2] See, Joint Stipulation #3 at Provider Exhibit 1.

[3] The Provider did not challenge CMS' position that the TennCare days were, in fact, ineligible for inclusion in the Medicaid proxy.

[4] No. 04-2147 (D.D.C. March 30, 2006). Slip opinion at Provider's exhibit P-31.

v. Thompson,[5] the Court held that expanded days could be added to the DSH calculation if claimed in an existing appeal before the PM was issued.

The Board finds that the Provider met the PM's requirement for a jurisdictionally proper appeal to the Board. The Provider clearly addressed the TennCare days issue in its preliminary position paper on November 29, 1999,[6] prior to the issuance of the PM in December 1999.[7] The Intermediary stated on page 9 of its position paper that it notified the Tennessee provider community of the application of the "hold harmless" provisions of PM A-99-62 to the Tennessee expansion waiver days in a bulletin dated March 2000.[8] Thus, the Provider's first actual notice of the PM in March 2000 was significantly after the Provider had filed not only its appeal but also its preliminary position paper. Furthermore, the Board finds that there was no evidence or argument from the Intermediary that the Provider either attempted to circumvent the intent of the PM or had actual knowledge of its content. The Board agrees with the Intermediary that the Provider's appeal began as a general DSH case. However, the issue was clarified and expanded in its preliminary position paper. Thus, after reviewing all of the evidence and the parties' arguments, the Board concludes that the Provider filed a jurisdictionally proper appeal to the Board before the October 15, 1999 deadline established by the PM. The Provider incurred and claimed TennCare days eligible for payment under the "hold harmless" provision of PM A-99-62. Thus, the Provider is entitled to include TennCare days in the Medicaid component of its DSH calculation.

DECISION AND ORDER:

The case is remanded to the Intermediary for inclusion of the Provider's TennCare days in the Medicaid component of its DSH calculation.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: June 29, 2007

Suzanne Cochran
Chairperson

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[5] No. 02-3479 (D. Minn. June 9, 2003), CCH Medicare and Medicaid Guide ¶301,323. See Provider's Exhibit P-26.
[6] See, Joint Stipulation #3 at Provider Exhibit P-1.
[7] See Provider Exhibit P-4.
[8] See, Intermediary Exhibit I-6.