PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D13

PROVIDER –
Covenant Health System 91, 93-97
DSH/Medicaid Proxy Group

Provider Nos.: Various

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING –
June 15, 2007

Cost Reporting Periods Ended –
June 30, 1991;
June 30, 1993 through June 30, 1997

CASE NO.: 00-1904G

INDEX

ISSUE:

Whether the Intermediary's calculation of the disproportionate share hospital (DSH) payment was proper.

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 the 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 operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The PPS statute 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 hospital," 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 and Medicaid fractions," expressed as a percentage for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi). The Medicare fraction'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 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 eligible for 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 Medicaid fraction is frequently referred to as the Medicaid Proxy and is the only fraction at issue in this case.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Mary's of the Plains and Methodist Hospital (the Providers), are acute care hospitals in the State of Texas that received payments under Medicare Part A for services to Medicare beneficiaries during the cost reporting periods ending in 1991, and 1993 through 1997. Both Providers were participants in the Texas State Medicaid program and rendered care to patients eligible for the charity care program established by the state Medicaid program. Neither Provider received Medicaid DSH payments for the services rendered to the charity care patients, but both Providers received DSH reimbursement in addition to their PPS reimbursement for services rendered to Medicare beneficiaries during most of the years at issue.[1]

At issue in this case is whether patient days attributable to the Texas Charity Care Plan should have been recognized in the Medicaid fraction of the DSH calculation for the Providers.

The Providers appealed the DSH reimbursement to the Board on February 25, 2000. The Providers were represented by Teresa A. Sherman, Esq. of Sherman Law Office, PLLC. The Intermediary was represented by Byron Lamprecht, Senior Appeals Consultant, of Mutual of Omaha Insurance Company.

JURISDICTIONAL CHALLENGE - PARTIES' CONTENTIONS:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 -1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group appeal), and the request for a hearing is filed within 180 days of the date of the final determination.

The Intermediary contends that the Providers have not met the "amount in controversy" prerequisite for a Board hearing. Although the Providers indicated in their jurisdictional documents that the amount in controversy was approximately $485,000, the Intermediary challenges the validity of this amount as simply a guess and that no confirmation or verification can be made without a listing of the patient days in dispute. Therefore, the Intermediary asserts that the Provider's contentions are undocumented and there is no amount in dispute.

[1] As the NPRs included with the Schedules of Providers in the record for fiscal years ended 1993 and 1997 for St. Mary of the Plains did not specifically identify that DSH payments were received, it is unclear if the Provider received a DSH payment for those years.

The Providers assert that an estimate of days was submitted in the jurisdictional documents which calculated an estimated reimbursement impact per cost reporting period based upon a projected increase in the total Medicaid days relative to this issue (.30% for each Provider and cost reporting year). The Providers acknowledged at the hearing that although a detailed listing of the days in dispute had been provided to the Intermediary prior to the start of the hearing, the listing was not included in the record and a reconciliation had not been completed between the days in dispute and the dollar amount included in the jurisdictional filing.

JURISDICTIONAL CHALLENGE – BOARD CONCLUSION

Once a provider meets a certain disproportionate share percentage threshold, the provider is entitled to a DSH add-on payment and any additional days would result in an incremental increase. The DSH calculation is a product of ratios. The Providers in this case used an incremental increase percentage to calculate what they believe would be the impact on their DSH percentage and payment.

The Board finds that the "amount in controversy" is the amount claimed by the Providers. Determining jurisdiction does not require proof that the exact amount claimed is adequately supported. The Providers used a percentage to estimate the amount in controversy. The nature of the DSH calculation is that it is a fraction which is the sum of two other fractions. Therefore, percentages are fundamental to the DSH calculation, and the Board does not find it unreasonable for the Providers to express the "amount in controversy" as a percentage instead of a specific number of days. The Board finds the evidence in the record sufficient to show that the amount in controversy exceeds the $50,000 group appeal jurisdictional threshold.

PARTIES' CONTENTIONS:

The Providers argue that the language of the Medicare DSH statute is clear and unambiguous. Under the statute, the Medicaid proxy of the DSH calculation includes all of a 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 Title XIX of this chapter, but who were not entitled to [Medicare Part A benefits]." 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). Therefore, it is the provisions of the State Plan that determine the eligibility of patients to be counted in the Medicaid proxy.

The Providers contend that the Texas State Medicaid Plan (the plan) was amended September 1, 1993 to provide reimbursement for charity care provided by the hospitals.[2] The Providers included in the record, the portion of the plan that allowed for payment to qualified hospitals for inpatient services provided to indigent or "charity care" patients at Exhibit P-1. The effective date of the plan included in the record is September 1, 1995. Mr. Richard Peters, a previous employee of the Texas Department of Health that administers the Texas Medicaid program, testified that the same basic provisions in the

[2] Tr. Page 67.

plan dated September 1, 1995 were in effect as of September 1, 1993 through 1997.[3] The Providers contend that because the Texas charity care program is part of the Texas State Medicaid Plan approved under Title XIX that provides Federal Financial Participation (FFP) for medical services provided to this defined group of low-income patients, the days associated with that program are required to be included in the Medicaid proxy for the Medicare DSH calculation.

The Providers assert that minimum charity care requirements are imposed on Texas hospitals to qualify for participation in the State Medicaid program. Hospitals file an annual survey report with the State to document the level of charity care they provide. Pursuant to the terms of the Title XIX State plan, the State identifies and reimburses those hospitals that provide a disproportionate share of inpatient care to indigent patients. Therefore, not all hospitals that render charity care services qualify to receive payment for those services. The Providers in this case did not provide charity care at a level sufficient to meet the mathematical test in place for the years in issue to qualify for Medicaid DSH payments. The Providers argue that regardless of whether they were paid for the services, they did provide the services to eligible patients and, therefore, the days associated with those services should be included in the Medicaid proxy.

The Intermediary asserts that the terms "medical assistance" in §1886(d)(5)(F)(vi)(II) of the Social Security Act (as codified at 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) and "Medicaid" in 42 C.F.R. §412.106(b)(4) are interchangeable, and both mean that Medicaid eligibility is required in order for a patient's days to be included in the Medicaid proxy.

> 42 U.S.C. §1395ww(d)(5)(F)(vi)(II): the 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) <u>were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter</u>, 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. (emphasis added)
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> 42 C.F.R. § 412.106(b)(4): *Second computation.* The fiscal intermediary determines, for the hospital's cost reporting period, the number of patient days furnished to patients <u>entitled to Medicaid</u> but not to Medicare part A, and divides that number by the total number of patient days in the same period.[4] (emphasis added)

The Intermediary asserts that the term "medical assistance" is not defined in the statute and that nothing in the statutory language indicates congressional intent to prohibit the

[3] Tr. Page 94.
[4] 42 C.F.R. §412.106(b)(4) did not change during the FY's covered in this appeal.

Secretary from interpreting the term "medical assistance". The Secretary has interpreted "eligible for medical assistance under a State plan approved under Title XIX" as meaning eligible for Medicaid. The Secretary has reasonably excluded the non-Medicaid days because the statute does not unambiguously require their inclusion. The Secretary's interpretation is reasonable and is entitled to deference.

Additionally, the Intermediary argues that the Providers were unable to substantiate at the hearing that the hospitals actually participated in the charity care program, and if so, how many days of charity care were provided by the hospitals. The Intermediary asserts that neither the Providers' witness testimony nor the record identifies how many charity care days, if any, are in dispute. Therefore, the Providers have failed to show proof that they rendered charity care to indigent patients under an approved plan.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

It is undisputed that 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) governs the issue in this case. Under the Medicare statute, the Medicaid proxy of the DSH calculation includes all "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 of this chapter, but who were not entitled to [Medicare Part A benefits]." The Providers submitted excerpts from the Texas State plan effective September 1, 1995[5] which documented that the charity care program at issue was, in fact, included in the Texas State plan and the evidence established that it remained in effect through September 1, 2001.

The Providers' witness testified that the Texas State Medicaid plan was totally revamped as of 1993[6] and that the effective date was September 1, 1993. The Providers did not furnish the State plan in effect prior to September 1, 1995; however, the Providers' witness testified that he was involved with writing the State plan and was familiar with the requirements of the plan, and knew that the charity care program was substantially the same in the September 1, 1995 plan as in the 1993 plan. The Board finds the Providers' witness testimony to be credible that substantially the same plan was in effect starting September 1, 1993 through September 1, 2001. There is no evidence in the record that the charity care program was in effect prior to that date, however. Therefore, the Board finds that the Providers have failed to meet their burden of proof that the charity care program was part of the State Plan for FY 1991.

The purpose of the DSH statute is to compensate hospitals for the additional costs associated with treating low-income patients. The plain language of the statute requires all days relating to patients eligible for medical assistance under a State plan approved under Title XIX to be included in the Medicaid proxy. The Board finds no authority or overriding rationale to limit the term "eligible for medical assistance under a State plan

[5] Provider Exhibit P-1. The plan included in the record covered the years in issue of 1996 and 1997.
[6] Tr. pgs 64-66, 95 and 110.

approved under Title XIX" to the Intermediary's Medicaid-eligible definition. Although the patients in the charity care program did not qualify for Medicaid under Section 1901 of the Social Security Act, the patients do qualify for medical assistance under a State approved plan as these programs are included in the State approved plan. See previous Board decisions: Ashtabula County Medical Center et al. v. BlueCross BlueShield Association/AdminiStar Federal, Inc., PRRB Case No. 2005-D49 (August 10, 2005) and Washington State Medicare DSH Group II v. BlueCross BlueShield Association, PRRB Case no. 2007 D-5 (November 22, 2006) and the recent decision from the Unites States District Court for the District of Columbia, Adena Regional Medical Center v. Michael A. Leavitt, United States District Court for the District of Columbia, Civil Action No. 05-2422 (LFO), (June 21, 2007) .

Although Providers did not receive payment for the days in question, the paid versus eligible days issue was resolved with cases such as Jewish Hospital, Inc. v. Secretary of Health and Human Services, 19 F.3d 270, 272 (6th Cir. 1994), Deaconess Health Services. Corp. v. Shalala, 83 F.3d 1041 (8th Cir. 1996), and Legacy Emanuel Hospital and Health Center v. Shalala, 97 F.3d 1261, 1266 (9th Cir. 1996) and the CMS issuance of Program Memorandum A-99-62. There is no evidence in the record of why the hospitals did not qualify to receive payment for the charity care services rendered, i.e., whether it was a qualifying threshold issue, or that they did not meet other conditions of participation, although the Providers assert in their Post Hearing Brief that the Providers "did not provide the charity care at a level sufficient to meet the mathematical test in place for those years".[7] The Board, therefore, finds consistent with the above referenced cases, that the Providers' failure to be paid for the services rendered to charity care patients is irrelevant, as the basis for their inclusion in the Medicaid proxy is based on their "eligibility" status.

Although the Providers established that charity care days for the period beginning September 1, 1993 and ending June 30, 1997 should be counted, the Providers failed to meet their burden of proof in an essential element of their case. The Providers presented absolutely no evidence of the charity care days they are claiming; nor was there any evidence in the record of the Providers' attempt to resolve the specific days prior to the hearing. This was the basis of the Intermediary's motion to dismiss the case, or alternatively to exclude any evidence that was not submitted until shortly before the hearing. However, the Board denied that motion and allowed the Providers to submit any evidence in support of their case during the hearing.. The Providers essentially want the Board to bifurcate the case, i.e., to decide the legal issue of whether the program falls within the State plan and then to later allow the Providers to prove up the number of days for which they are requesting payment. The Board historically does not bifurcate cases, and the Providers did not request, and the Board did not grant, a bifurcation of the case. A hearing date is set for a provider to prove all elements of its case, and in this case the Providers did not address the days at issue.[8] Therefore, the Board finds that the Providers have failed to adequately support their claim to include the Texas charity care days in the DSH computation.

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[7] Providers' Post Hearing Brief, page 5 and Tr. page 89.
[8] 42 C.F.R. §405.1851.

DECISION AND ORDER:

The Intermediary's adjustments properly excluded Texas charity care days from the Providers' DSH calculations. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: January 11, 2008