PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D3

PROVIDER -
QRS 1994 DSH Medicare Managed Care and Medicaid Eligible Days Group

Provider No.: 50-0024

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ Noridian Administrative Services

DATE OF HEARING -
February 26, 2008

Cost Reporting Period Ended -
December 31, 1994

CASE NO.: 04-2130G

INDEX

ISSUE:

Whether the Intermediary should include dual-eligible, managed care days in the Medicaid proxy in determining Medicare reimbursement for disproportionate share hospital (DSH) payments in accordance with the Medicare statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)(II).

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 and 413.24.

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). See, 42 U.S.C. §1395ww(d). 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 DSH adjustment, which 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 (DPP)." See, 42 U.S.C. § 1395ww(d)(5)(F)(v). The DPP is the sum of two fractions, the "Medicare and Medicaid fractions," for a hospital's fiscal period. 42 U.S.C. §1395ww(d)(5)(F)(vi). The Medicare fraction's numerator is the number of a hospital patient days for such period which were made up of patients who (for such days) were entitled to both Medicare Part A and SSI, excluding patients receiving state supplementation only, and the denominator is the number of patient days for patients entitled to Medicare Part A. See also, 42 C.F.R. §412.106(b)(2). The Medicaid fraction's numerator is the number of hospital patient days for patients who (for such days) 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. See also, 42 C.F.R. §412.106(b)(4). A provider whose DSH percentage meets certain thresholds receives an adjustment which results in increased PPS payment for inpatient hospital services. 42 U.S.C. §1395ww(d)(5)(F)(ii).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The lone provider which remains in this group appeal is Providence St. Peter Hospital, located in Olympia, Washington for FYE 12/31/1994.[1] The Intermediary is Noridian Administrative Services.

The Intermediary did not include in the numerator of the Medicaid fraction the days[2] attributable to patients who were eligible for Medicaid and enrolled in a Medicare managed care plan (or HMO) during their inpatient hospital stays. Those dual eligible days were likely to have been included by the Intermediary in the SSI fraction.[3] The Provider has appealed the Intermediary's treatment of the 49 dual eligible days at issue.

The Provider was represented by Mr. Alan J. Sedley, Esq. of Alan J. Sedley Law Offices. The Intermediary was represented by Bernard Talbert, Esq. of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Intermediary contends that CMS policy has consistently dictated that Medicare managed care days be included in the Medicare fraction. Although CMS had considered including these days in the Medicaid fraction, following debate, CMS determined that the Medicare fraction should remain the proper placement for such days. In the August 11, 2004 Final Rule CMS commented on how dual eligible Medicare Managed Care days should be counted:

> Comment: . . . (S)everal commenters disagreed with excluding these days from the Medicare fraction and pointed out that these patients are just as much Medicare beneficiaries as those beneficiaries in the traditional fee-for-services program.
>
> Response: Although there are differences between the status of these beneficiaries and those in the traditional fee-for-service

[1] Prior to the hearing, the Provider either withdrew or the Board denied jurisdiction over all other providers/FYEs which had been included in this appeal. The Provider was notified that the Board was aware that the remaining Provider, Providence St. Peters Hospital was part of a chain organization and the Provider was given an opportunity to identify if other chain components had the same issue pending in other individual or group appeals. The Provider verified that no other related entities had this issue outstanding in an individual or group appeal.

[2] Provider Exhibit 9 identifies 49 dual eligible days.

[3] Tr. Pgs. 80-81.

> program, we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. As noted previously, if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.

63 FR 49099[4]

The Intermediary contends that the PRRB found in its favor on the issue of M+C days and the Administrator confirmed its decision in St. Joseph's Hospital and St. John's Northeast Hospital v. Blue Cross BlueShield Association/Noridian Government Services , PRRB Decision No. 2007-D68, Affirmed CMS Administrator Decision, November 13, 2007. In that case that Administrator ruled:

> In this case, while the Provider agreed with the Board's determination that M+C days must be included in the Provider's DSH calculation, the provider argued that the M+C days belong in the numerator of the Medicaid fraction instead of the Medicare fraction. The Administrator agrees with the Board's finding that the dual eligible M+C days should be included in the Medicare DSH calculation.

The Provider contends that the plain language and a proper interpretation of the relevant statute and regulations require the inclusion of Dual Eligible Medicare managed care days in the Medicaid fraction of the DSH formula. The Provider argues that CMS has erred including the days in the Medicare proxy as Congress did not intend to include those days in the Medicare SSI proxy. The Provider argues Medicare is precluded from making payments to a hospital for services furnished to HMO enrollees by 42 U.S.C. §1395mm(a)(6). As it is clear that no Medicare Part A payment may be made for HMO inpatients, it cannot be argued that an HMO enrollee is "entitled to benefits under Part A". Therefore, the proper treatment for the days would be in the Medicaid fraction.

The Provider points out that the DSH and GME statutes have similar language regarding "entitled to benefits under part A" and "with respect to whom payment may be made under Part A". See 42 U.S.C. §1395 ww(d)(vi)(F)(6)(I) and §1395 ww(h)(3)(C). CMS, through its preamble to the 1989 implementing rule, specifically construes the GME statute to

[4] It is noted that the fiscal year in question in this appeal is FY 1994 which is ten years prior to the quoted final rule and the final rule references the M+C program which was established by the Balanced Budget Act of 1997.

exclude Medicare HMO days from the calculation of the Medicare patient load category because Medicare HMO days "are recorded as *non-Medicare* days" for all Medicare payment purposes. [emphasis added] At the same time CMS interprets the similar phrase to mean Medicare HMO days should be included in the Medicare fraction for DSH. The Provider asserts this inconsistency is arbitrary and capricious.

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines the parties' contentions and evidence presented, the Board finds and concludes that dual-eligible Medicare managed care days should be counted in the Medicare fraction. Although the Medicare statute does not expressly address the treatment of Medicare managed care days, in reading the statute along with the DSH and Medicare managed care regulations, it is clear that the managed care days can only be counted in the Medicare fraction as they are specifically precluded from being included in the Medicaid fraction.

Pursuant to 42 U.S.C. §1395ww(d)(5)(F)(vi), a hospital's DPP is the sum of the Medicare and Medicaid fraction. The Medicare fraction's numerator is the number of a hospital patient days for such period which were made up of patients who (for such days) were entitled to both Medicare Part A and SSI, excluding patients receiving state supplementation only, and the denominator is the number of patient days for patients entitled to Medicare Part A. See also, 42 C.F.R. §412.106(b)(2). The Medicaid fraction's numerator is the number of hospital patient days for patients who (for such days) 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. See also, 42 C.F.R. §412.106(b)(4). (emphasis added)

The term "entitled" as it is used in the definition of the Medicare fraction found in 42 U.S.C. §1395ww(d)(5)(F), has been interpreted through case law. In *Jewish Hospital, Inc. v. Secretary of Health and Human Services*, 19 F.3d 270, 274-75 (6th Cir. 1994), the term "entitled" was defined as, "[t]o be *entitled* to some benefit means that one possesses the *right* or *title* to that benefit. Thus the Medicare proxy *fixes* the calculation upon the absolute right to receive an independent and readily defined payment." In support of the definition utilized by the court in *Jewish Hospital*, the U.S. District Court, Southern District of West Virginia[5] further defines "entitled":

> Looking at the dictionary definitions of the root words "eligible" and "entitle," it is seen that "eligible" and "entitle" are both defined as being synonymous with "qualified" The American Heritage Dictionary of the English Language 423 (eligible), 437 (entitle) (new college ed. 1976). However, "entitle" has the additional meaning of "[t]o give (one) a right to do or have something; allow." Id. at 437. "Qualified" means, in turn, simply "having met the requirements,"

[5] Cabell Huntington Hospital, et al. v. Shalala, et al., U.S. District Court, Southern District of West Virginia, C.A. No. 2:94-0345.

> id. at 1067, while "allow" includes the concepts of letting happen, permitting one to have, granting, or providing, id. at 35. The word "entitled" thus encompasses more than being eligible or qualified by meeting certain requirements. In the context of the Medicare proxy, it means, in addition, that one has a right to have Medicare benefits provided.

The managed care statute implementing payments to HMOs and CMPs is found at 42 U.S.C. §1395mm. The statute strictly requires at 42 U.S.C. §1395mm(a)(5) that payments will be made to eligible organizations under this section for ". . . individuals enrolled under this section with the organization and **entitled to benefits under Part A** of this subchapter and enrolled under part B of this subchapter. . ." (emphasis added). Therefore, pursuant to the statute, a beneficiary must first be entitled to benefits under Medicare Part A to enroll in a Medicare managed care program.

Based on the clear language of the DSH statute and implementing regulations along with the managed care statute, the Board therefore concludes that a beneficiary can only be eligible for managed care benefits if "entitled to benefits" under part A. Once so entitled, under the DSH statute, the individual would be excluded from being counted in the Medicaid percentage by the explicit language of DSH statute which limits inclusion in the Medicaid fraction to those "eligible for medical assistance under state plan approved under XIX" and "not entitled to benefits under part A." 42 C.F.R. §412.106(b)(4) (emphasis added)

The Board recognizes that the language regarding the treatment of Medicare managed care days for GME purposes is confusing and appears to conflict with more recent CMS policy to include Medicare managed care days as a Medicare day in the DSH calculation. The Board also recognizes that CMS' own policy on this issue has wavered over time and has at times reversed completely. However, the clear language of the statute cannot be overcome by commentary made by CMS in the preamble to a GME final rule[6] or in its policy shifts.

DECISION AND ORDER:

The Board finds that the Medicare managed care days are properly included in the Medicare fraction.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith Braganza, C.P.A. (inactive)

[6] See, 53 Fed. Reg. 36589, 36600 "As in the case with other apportionment issues, hospital inpatient days of Medicare beneficiaries whose hospital stays are paid by risk basis health maintenance organizations are recorded as non-Medicare days." See also, 42 U.S.C. 1395ww(h)(3)(D).

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: December 17, 2008