PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D26

PROVIDERS -
National DSH Dual Eligible Group Appeals

Provider Nos.: See Appendix II

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
National Government Services

DATE OF HEARING -
March 27, 2008

Cost Reporting Periods Ended -
See Appendix I

CASE NOs.: See Appendix I

INDEX

ISSUE:

Whether the Intermediary properly excluded dual eligible patient days from the Medicaid eligible days in determining the Medicaid percentages that were used for the disproportionate share hospital (DSH) adjustment payments.

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. §§405.1835-1837.

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 one of the hospital-specific adjustment, specifically the "disproportionate share hospital," or "DSH" adjustment. The Secretary is required to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income inpatients." 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 expressed as percentages: 1) the hospital's "SSI percentage," which relates to the hospital's level of low-income Medicare patients and 2) the hospital's "Medicaid percentage," which addresses the hospital's Medicaid patient level. 42 U.S.C. §1395ww(d)(5)(F)(vi). If a hospital's disproportionate patient percentage exceeds the

threshold specified in the statute, the hospital receives an additional payment for each Medicare inpatient discharge. 42 U.S.C. §1395ww(d)(5)(F)(i)(I).

The two components of a hospital's disproportionate patient percentage are precisely described in the statute. For the SSI percentage or fraction, the numerator is the number of hospitals patient days for patients entitled to both Medicare Part A and SSI benefits, excluding patients receiving state supplementation only, and the denominator is the number of patient days for patients entitled to benefits under Medicare Part A. 42 U.S.C. §1395ww(d)(5)(F)(vi). For the Medicaid percentage or fraction, the 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 who were 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Providers participating in each group appeal operated acute care hospital facilities subject to PPS. The case number for the group appeals are listed in Appendix I, attached to this decision. The schedules of providers in this appeal are in Appendix II.

The schedules of providers that were submitted in each appeal also identified the Providers' fiscal intermediaries. National Government Services served as the responsible intermediary under either its current name or former names for the largest number of Providers and cost reporting periods in the group appeals. Accordingly, its has been designated as the lead intermediary for the group appeals.

During audits of the Providers' cost reports for the periods involved in these appeals, the Intermediaries made calculations of the Providers' disproportionate patient percentages in order to determine whether each Provider qualified for DSH adjustment payments, and if so, the amount of such payments. With regard to the SSI percentage component of the Providers' disproportionate patient percentages, the Intermediaries simply used SSI percentage numbers from a report furnished by CMS. With regard to the Medicaid percentage component, the Intermediaries reviewed and made a determination regarding the number of Medicaid days to be included. As part of this review, the Intermediaries excluded Medicaid eligible days attributable to dual eligible patients from the number of Medicaid eligible days included in the Providers' Medicaid percentages.

The Providers furnished inpatient days of care to patients who were eligible for both Medicare Part A benefits and Medicaid, but who were not entitled to have payment made on their behalf under Medicare Part A for these days. According to CMS policy for the periods under appeal, patient days that were not covered under Medicare Part A were not to be included in the computation of the SSI percentage. Nevertheless, because these patients had been identified as being on the rolls of Medicare Part A, these non-covered days of care rendered to dual eligible patients were excluded by the Intermediaries in calculating the Providers' Medicaid percentages.

The Providers identified three main categories of days for which dual eligible patients were not entitled to have payment made under Medicare Part A, but which were excluded in the calculation of the Providers' Medicaid percentages. The first category of dual eligible days involved days of care furnished to patients after exhaustion of their Medicare Part A benefits (exhausted benefit days). Exhausted benefit days are not covered days under Medicare Part A.

The second category of days for which dual eligible patients were not entitled to have payment made under Medicare Part A are days for which another party was the primary payer, and for which the Medicare Program was secondary in order of payment, under the Medicare secondary payer (MSP) statutory provisions (MSP days). MSP days for which another party made payment and for which Medicare made no secondary payment are not covered days under Medicare Part A.

The third category of days for which dual eligible patients were not entitled to have payment made under Medicare Part A involved days for which coverage was denied, and no payment was made to the Providers under Medicare Part A. This category includes days denied as medically unnecessary or as custodial care. These days are also not covered days under Medicare Part A.

At the hearing, the Board requested from the Providers a breakdown of the dual eligible patient days by the three categories of days described above.[1] Pursuant to the Board's request, the Providers have furnished an estimated breakdown of the number of days and the reimbursement effect for each of these three categories of dual eligible days, for each Provider and fiscal year. As indicated in this breakdown of patient days, most of the dual eligible days at issue fall within the categories of exhausted benefit days and MSP days, and less than 10% of the dual eligible days are days denied by Medicare for lack of medical necessity or as custodial care.[2]

PARTIES' CONTENTIONS:

The Providers contend that the Medicaid and SSI percentages were designed by Congress to provide complementary and mutually exclusive measures of the low-income patient populations served by a hospital. The two percentage formulas have parallel but complementary structures. Given these structures, dual eligible patient days which are excluded from the calculation of one of the components of the disproportionate patient percentage should be included in the calculation of the other component of the disproportionate patient percentage. A CMS policy on dual eligible days that does no reflect this basic structure of the statute is by its very nature an unreasonable interpretation of the statute. Furthermore, to exclude a portion of dual eligible days from both formulas would mean that the disproportionate patient percentage would not accurately measure a hospital's low-income patients.

[1] Hearing Transcript (Tr.) at 133-136
[2] See Providers Exhibit 24.

The Providers maintain that any days of care rendered to dual eligible patients which were to excluded from the SSI percentage under CMS policy must be included in their Medicaid percentages. Whatever arguments may be advanced for including certain types of dual eligible patient days in the SSI percentage, it would clearly be improper not to include these days for dual eligible patients in either part of the DSH calculation. Exclusion of these days from the disproportionate patient percentage altogether would frustrate the Congressional intent to provide DSH adjustment payments to those hospitals serving a disproportionate share of low-income patients. Therefore, to the extent that CMS has excluded from the determination of the SSI percentage certain types of patient days for dual eligible patients, such as days not covered by Medicare due to exhausted Part A benefits, MSP days, or other noncovered days, those patient days should be treated as Medicaid eligible days for purposes of calculating the Medicaid percentage.

The Intermediary contends that Medicare exhausted Part A benefit days, Medicare secondary payor days, and denied Medicare Part A days (either for medical necessity or custodial care) are not includable in the DSH calculation and not entitled to payment based on the Medicare statute and regulations in effect during the years under appeal. First, the patients are not to be included in the Medicaid fraction unless they are "not in Medicare program at all."[3] Second, these patients would not be included in the "Medicare proxy because they would not be in the database from which the claims are matched from the SSI files to the Medicare claims files to produce the SSI percentage."[4] The Intermediary believes that regulatory changes to 42 C.F.R. §412.106 adopted on or after October 1, 2004, which allow exhausted benefit days to be included in the SSI percentage do not apply to the period under appeal. Finally, the Providers' method would increase reimbursement by $9 million for days related to denials for medical necessity or custodial care. The Intermediary considers this increase an inappropriate payment "for services that should not have been incurred or were incurred at the hospital's own expense."[5]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the parties' contentions and the evidence submitted, the Board finds and concludes that the dual eligible days for Medicare Part A exhausted benefit days, Medicare secondary payer days and denied days for lack of medical necessity or custodial care should be included in the Medicaid percentage that is used to calculate the DSH adjustment payment.

The controlling statute and precise language addressing entitlement is in 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) which states:

> [T]he 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) were eligible for medical assistance

[3] Tr. at 83
[4] Tr. at 80-81.
[5] Tr. at 90-91

> under a State plan approved under subchapter XIX of this chapter, 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)

The following language from the Sixth Circuit of the United States Court of Appeals in Jewish Hospital, Inc. v. Secretary of Health and Human Services, 19 F. 3d 270, 275 (6th/Cir. 1994) appropriately defines entitlement as follows:

> . . . Congress spoke of "eligibility" in the Medicaid proxy and "entitlement" in the Medicare proxy. See U.S.C. §1395ww(d)(5)(F). The Secretary would have this Court conflate eligibility with entitlement. Adjacent provisions utilizing different terms, however, must connote different meanings. To 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.

The Board agrees with the findings of various U.S. courts that the term entitlement denotes a right to have payment made under part A of title 18. Because there is no right to payment from Medicare once a patient has exhausted its benefits or services are covered/paid by a primary payor other than Medicare or are non-covered, these days can not be counted in the Medicare proxy but would be included in Medicaid proxy.

The Board finds that the Intermediary improperly eliminated from the DSH calculation patient days for patients who were eligible for Medicaid benefits, but not entitled to Medicare benefits due to Medicare benefits being exhausted, services being covered by a secondary payer (not Medicare), services not medically necessary under the Medicare program, and custodial care services not covered under Medicare. Such days should be included in the calculation of the Medicaid proxy in the determination of the DSH adjustment in accordance with the plain language of 42 U.S.C. §1395ww(d)(5)(F).

Finally, the Board rejects the Intermediary's assertion that counting days related to denials for medical necessity or custodial care in the Medicaid proxy would inappropriately pay for patient services specific to these patients. The Board agrees with Jewish Hospital decision that "Congress sought to adjust the Medicare PPS system to recognize the higher costs incurred by hospitals that serve a large number of low-income patients."[6] Therefore, DSH payments are not specific payments for specific patient services but an additional lump sum reimbursement augmenting Medicare's normal PPS payments.[7]

---

[6] Jewish Hospital, Inc. v. Secretary of Health and Human Services, 19 F.3d 270, 272 (6th Cir. 1994).

[7] The lump sum adjustment payment for DSH is not triggered until a threshold number of low income days are treated making the assignment of DSH payments to a specific patient impossible.

DECISION AND ORDER:

The Providers' dual eligible patient days not entitled to benefits under part A should be included in the Provider Medicaid percentage used to calculate the DSH adjustment payment. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A
Keith E. Braganza, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: June 23, 2009

Appendix I

NATIONAL DSH DUAL ELIGIBLE GROUP APPEALS

PRRB Case No. 04-0620G: Fiscal Years Ending 1993

PRRB Case No. 05-1462G: Fiscal Years Ending 1994

PRRB Case No. 05-0538G: Fiscal Years Ending 1995

PRRB Case No. 05-0539G: Fiscal Years Ending 1996

PRRB Case No. 04-0622G: Fiscal Years Ending 1997

PRRB Case No. 05-1476G: Fiscal Years Ending 1997(II)

PRRB Case No. 04-0621G: Fiscal Years Ending 1998

PRRB Case No. 05-2116G: Fiscal Years Ending 1998(II)

APPENDIX II

Case No.	Provider No.	Provider	Cost Reporting Period
04-0620G	33-0285	Strong Memorial Hospital	12/31/1993
05-1462G	23-0053	Henry Ford Hospital	12/31/1994
05-0538G	23-0053	Henry Ford Hospital	12/31/1995
05-0539G	33-0235	Auburn Memorial Hospital	12/31/1996
	33-0005	Buffalo General Hospital	12/31/1996
	23-0053	Henry Ford Hospital	12/31/1996
	33-0164	Highland Hospital of Rochester	12/31/1996
	33-0118	Millard Fillmore Hospital	12/31/1996
	33-0285	Strong Memorial Hospital	12/31/1996
	34-0141	New Hanover Regional Medical Center	9/30/1996
04-0622G	33-0005	Buffalo General Hospital	12/31/1997
	23-0053	Henry Ford Memorial Hospital	12/31/1997
	33-0147	Mercy Hospital-Detroit	6/30/1997
	33-0195	Long Island Jewish Medical Center	12/31/1997
05-1476G	23-0041	Bay Medical Center	6/30/1997
	33-0285	Strong Memorial Hospital	12/31/1997
04-0621G	23-0053	Henry Ford Hospital	12/31/1998
	23-0021	Lakeland Regional	9/30/1998
	23-0147	Mercy Hospital-Detroit	6/30/1998
	33-0226	Park Ridge Hospital	12/31/1998
	39-0223	Presbyterian Hospital	6/30/1998
	33-0215	Rome Memorial Hospital	12/31/1998
	33-0044	St. Luke's	12/31/1998
	33-0230	St. Clare's	12/31/1998
05-2116G	33-0285	Strong Memorial Hospital	12/31/1998
	34-0030	Duke University	6/30/1998