PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D30

PROVIDER -
SRI 1998 DSH Medicare Part C Days Group

Provider Nos.: See Appendix I

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ Noridian Administrative Services

DATE OF HEARING -
May 9, 2008

Cost Reporting Periods Ended -
Various – See Appendix I

CASE NO.: 04-2128G

INDEX

ISSUE:

Whether the exclusion of patient days attributable to Medicare + Choice (M+C) enrollees from the Medicaid fraction in calculating the Providers' disproportionate patient percentages contravenes the statute and regulations.

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 – 405.1837.

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 disproportionate share (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," expressed as percentages for a hospital's fiscal period, 42 U.S.C. §1395ww(d)(5)(F)(vi). The Medicare fraction's numerator is the number of hospital patient days for patients who (for such days) were entitled to both Medicare Part A and Supplemental Security Income (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 that results in increased PPS payment for inpatient hospital services. 42 U.S.C. §1395ww(d)(5)(F)(ii).

In 1997, Congress enacted the Balanced Budget Act of 1997 (BBA). Pub. L. No. 10533. Section 4001 of the BBA established a new Part C of the Act, known as the M+C program. 42 U.S.C. §§1395w-21 to 1395w-28. With the inception of the M+C program, a "Medicare +Choice eligible individual" is entitled to elect to receive benefits "…through the original Medicare fee-for-service program under Parts A and B or through enrollment in a Medicare +Choice plan under this part." 42 U.S.C. §§1395w-21(a)(1)(A), 1395w-21(a)(1)(B).

On May 19, 2003, the Secretary published a proposed rule in the *Federal Register* that proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage." 68 Fed. Reg. 27182, 27208 (May 19, 2003). Instead, the Secretary proposed that the "patient days…be included in the count of total patient days for the M+C beneficiary who is also eligible for Medicaid…be included in the numerator of the Medicaid fraction." Id. The Secretary noted that "under [42 C.F.R.] §422.50, an individual is eligible to elect an M+C plan if he or she is entitled to Medicare Part A and enrolled in Part B, however, "once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A." Id.

On August 11, 2004, the Secretary published a final rule in the *Federal Register* ("August 11, 2004 Final Rule") and indicated that the Department of Health and Human Services (HHS) would not adopt the proposal set forth in the May 19, 2003 proposed rule. 69 Fed. Reg. 49099 (2004). Instead, the Secretary advised that HHS would adopt a policy to include the patient days for M+C enrollees in the Medicare fraction." Id. The Secretary reasoned that "once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A." Id. Thus, in the August 11, 2004 Final Rule, the Secretary announced that HHS was "revising our regulations at 42 C.F.R. §412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation." Id.

In the Secretary's final hospital inpatient prospective payment rule for fiscal year 2008 (August 22, 2007 Final Rule), the Secretary revealed that HHS intended to make the above revisions in the August 11, 2004 Final Rule, but inadvertently failed to do so. Consequently, the Secretary made a "technical correction" to the regulatory text of the Medicare Fraction in the August 22, 2007 Final Rule. 72 Fed Reg. 47130, 47383-47409, 47411 (Aug. 22, 2007). Specifically, in the August 22, 2007 Final Rule, the Secretary revised 42 C.F.R. §412.106(b)(2)(i) and (iii) to read, in part, as follows:

(i) Determines the number of patient days that-
(A) Are associated with discharges occurring during each month; and
(B) Are furnished to patients who during that month were entitled to both Medicare
Part A (or Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;

* * *

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that-
(A) Are associated with discharges that occur during that period; and
(A) Are furnished to patients entitled to Medicare Part A or (Medicare Advantage (Part C)).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

During their 1998 fiscal years, the Providers[1] participated in the Medicare and Medicaid programs and were located in the State of Arizona. During those fiscal years, the Intermediary excluded Providers' patient days attributable to M+C enrollees from the Providers' Medicaid fractions in calculating the Providers' disproportionate patient percentages.

The Providers filed timely appeals in which they asserted that patient days attributable to M+C enrollees should be included in the count of total patient days in the denominator of the Providers' Medicaid fractions. The Provider further asserted that if the M+C enrollees were also eligible for medical assistance under a state plan approved under Title XIX, these patient days should be included in the numerator of the Providers' Medicaid fractions. The exclusion of the patient days at issue from the numerator of the Providers' Medicaid fractions has an aggregated Medicare reimbursement effect of approximately $736,838.[2]

The Providers' filings meet the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Providers were represented by Charles F. MacKelvie, Esquire, of MacKelvie & Associates, P.C. The Intermediary was represented by Bernard M. Talbert, Esquire, Senior Medicare Counsel, Blue Cross Blue Shield Association.

PARTIES CONTENTIONS:

The Providers contend that the exclusion of patient days attributable to M+C enrollees from the numerator of the Providers' Medicaid fractions in calculating the Providers' disproportionate patient percentages contravenes the Act, as well as the Secretary's regulations. A Medicare beneficiary who elects and/or is enrolled in an M+C plan becomes a M+C enrollee who is entitled to benefits only under Part C, and not under Part

[1] See Appendix I for the listing of Provider's
[2] Transcript (tr.) at page 18.

A, of the Act. Thus, the Providers' patient days attributable to M+C enrollees should be included in the count of total patient days in the denominator of the Providers' Medicaid fractions, and if the M+C enrollees were also eligible for medical assistance under a state plan approved under Title XIX, they should be included in the numerator of the Providers' Medicaid fractions.

The Medicaid fraction is statutorily described as "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) were eligible for medical assistance 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." 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). The Providers also point out that an M+C eligible individual is "entitled to elect to receive benefits…through the original Medicare fee-for-service program under parts A and B" or "through enrollment in a Medicare + Choice plan under this part." 42 U.S.C. §§1395w21(a)(1)(A), 1395w21(a)(1)(B). The reference to "this part" is a reference to Part C, and not a reference to Part A, of the Act. Further, the Providers argue that Congress has explicitly directed that payments made to an M+C organization for items and services furnished to M+C enrollees be in lieu of amounts that would other wise be payable under Parts A and B of the Act. 42 U.S.C. §1395w-21(i)(1).

The Providers claim that there is evidence that Congress did not intend for M+C enrollees to be regarded as individuals who are entitled to benefits under Part A of the Act. The Providers reveal that, prior to the enactment of the Balance Budget Act of 1997 (BBA), the Act provided for graduate medical education (GME) payments based upon a hospital's percentage of total patient days "attributable to patients with respect to whom payment may be made under Part A" of the Act. 42 U.S.C. §1395ww(h)(3)(C). However, with the enactment of the BBA, Congress amended the GME provisions of the Act to provide for a separate GME payment with respect to M+C patient days. 42 U.S.C. §1395ww(h)(3)(D). By enacting a separate GME payment provision for M+C enrollees, the Providers reason that Congress expressed a clear intent that M+C enrollees should not be regarded as "patients with respect to whom payment may be made under Part A" of the Act.

On August 11, 2004, the Final Rule on the treatment of M+C patient days in the DSH patient percentage was published. This rule includes patient days for M+C enrollees in Medicare fraction. The August 22, 2007 Final Rule included a technical correction of the August 11, 2004 notice. 72 Fed. Reg. 47130, 47383-47409, 47411 (Aug. 22, 2007). The Providers maintain that the August 11, 2004 Final Rule and August 22, 2007 Final Rule may not be retroactively applied to the Providers' respective fiscal years ending June 30, 1998 and August 31, 1998. The Providers claim that the August 11, 2004 Final Rule was not effective until October 1, 2004, and that the August 22, 2007 Final Rule applies to discharges occurring on or after October 1, 2007. Furthermore, the Providers point out that the Secretary acknowledged in the August 22, 2007 Final Rule that CMS failed to make the requisite regulatory changes to the Medicare fraction in the August 11, 2004 Final Rule.

The Providers also contend that, under the Administrative Procedure Act, "a rule" is defined as "the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy . . ." 5 U.S.C. §551(4). Further, in *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 208 (1988), the U.S. Supreme Court ruled that, absent an express grant of authority from Congress, agencies are not authorized to adopt retroactive rules. Finally, prior to the Secretary's pronouncements in May 19, 2003 Proposed Rule and August 11, 2004 Final Rule, the Providers are not aware of any formal agency pronouncements regarding the disproportionate patient percentage and the treatment of patient days attributable to M+C enrollees. In fact, the Providers are not aware of any such formal pronouncements applicable to the Providers' respective fiscal years ending June 30, 1998 and August 31, 1998.

The Intermediary contends that the Proposed Rule[3] that the Providers used to support their position that the Medicare M+C days be included in the Medicaid portion of the DSH calculation was never finalized and cannot support their position. The Final Rule dated August 11, 2004 indicated that M+C days are to be included in the Medicare fraction of the DSH calculation, not the Medicaid fraction. The CMS Administrator in its review of Alhambra Hospital v. Blue Cross Blue Shield Association, United Government Services, L.L.C., PRRB Dec. No. 2005-D47, July 29, 2005, Medicare & Medicaid Guide (CCH) ¶81,371. rev'd by CMS Admin. Dec., October 6, 2005, CCH ¶81,441 interpreted the statement "not entitled to Medicare Part A" to mean the Medicaid proxy is limited to Medicaid patients only. Based on the above, M+C days cannot be included in the Medicaid proxy. Finally, there is no regulatory authority to allow M+C days in the Medicare fraction of DSH prior to October 1, 2004. It was CMS policy that only covered patient days were included in the Medicare fraction.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes that M+C patient days should be counted in the Medicare fraction. The Medicare fraction's numerator consists of patient days for patients who were **entitled** to both Medicare Part A and SSI, and the denominator is the number of patient days for patients **entitled** to Medicare Part A. The Medicare + Choice statute provides that payments will be made to eligible organizations under this section for ". . . individuals . . . **entitled to benefits under Part A** . . ." (emphasis added). 42 U.S.C. §1395mm(a)(5). Based on the clear language of the Medicare + Choice statute, the Board therefore concludes that a beneficiary can only receive benefits under Part C if "entitled to benefits" under part A.

It is also clear that the M+C enrollee would be **excluded** from being counted in the Medicaid percentage by the explicit language of the 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 U.S.C. §1395ww(d)(5)(F)(vi). The Board recognizes that the language regarding the treatment

[3] 68 Fed. Reg. 27182, 27208 (May 19, 2003).

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 Medicare days in the DSH calculation. Although CMS' own policy on this issue has wavered over time and has at times reversed completely, the Board finds that the clear language of the statute cannot be overcome by commentary made by CMS in the preamble to a GME final rule[4] or in its policy shifts. The Board does not reach the Providers' challenge to CMS' regulation under the APA as our decision is dictated solely by the statutory language.

DECISION AND ORDER:

The Board finds that the M+C patient days are properly excluded from the Medicaid fraction, but should be included in the Medicare fraction.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: July 9, 2009

[4] 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).

APPENDIX I

SCHEDULE OF PROVIDERS IN GROUP

PROVIDER NAME	PROVIDER NO.	FYE
Phoenix Baptist Hospital	03-0030	8/31/98
St. Mary's Hospital	03-0010	6/30/98
St. Joseph's Hospital	03-0011	6/30/98