PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D35

PROVIDER -
Allina Health System 1995-2003 DSH Dual Eligible Days Group

Provider Nos.: See Attachment

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/ Noridian Administrative Services

DATE OF HEARING -
February 4, 2009

Cost Reporting Periods Ended - Various

CASE NO.: 04-2261G

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ISSUE:

Whether the Intermediary's calculation of the Providers' Medicare disproportionate share hospital (DSH) payments improperly omitted days attributable to patients who were dually eligible for Medicare Part A and Medicaid, but for which Medicare Part A did not make payment, from the numerator of the "Medicaid fraction" described in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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 to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and interpretive guidelines published by CMS. 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 receipt of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §§405.1835-405.1837

Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." 42 U.S.C. §1395d(a)(1). Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS"). 42 U.S.C. §§1395ww(d)(1)-(5); 42 C.F.R. Part 412. Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. *Id.*

One of the PPS payment adjustments is the DSH payment adjustment. The Secretary is required 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); 42 C.F.R. § 412.106. Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage." 42 U.S.C. §1395ww(d)(5)(F)(v).

The DSH patient percentage is defined as the sum of two fractions expressed as a percentage. 42 U.S.C. §1395ww(d)(5)(F)(vi). Both of these fractions look, in part, to

whether the hospital's patients during the particular cost reporting period were "entitled to benefits" under Medicare Part A.

The first fraction that is used to compute the DSH payment is commonly known as the "Medicare fraction."[1] The statute defines the Medicare fraction as:

> (I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this subchapter . . .

42 U.S.C. §1395ww(d)(5)(F)(vi)(I) (emphasis added).

The Medicare fraction is computed annually by CMS, and the Medicare fiscal intermediaries use CMS' calculation to compute a hospital's DSH payment adjustment. 42 C.F.R. §412.106(b)(2)-(3).

The second fraction that is used to compute the DSH payment is the "Medicaid fraction." The statute defines the Medicaid fraction as:

> (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) 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) (emphasis added).

According to CMS' regulation, the intermediary determines the Medicaid fraction for each provider: "The fiscal intermediary determines . . . the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period." 42 C.F.R. § 412.106(b)(4).

[1] This fraction is also sometimes referred to as the SSI fraction.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Providers are five hospitals owned and operated by the Allina Health System, a non-profit health system in Minnesota. The Providers participating and the cost reporting periods at issue in this case are: United Hospital, Provider No. 24-0038, FYEs 12/31/1992 through 12/31/2003; Abbott Northwestern Hospital, Provider No. 24-0057, FYEs 12/31/1997 through 12/31/2003; Buffalo Hospital, Provider No. 24-0076, FYE 12/31/2002; Mercy Hospital, Provider No. 24-0115, FYEs 12/31/1995 through 12/31/1998 and FYEs 12/31/2000 through 12/31/2003; and Unity Hospital, Provider No. 24-0132, FYEs 12/31/1995 through 12/31/2003. Noridian Administrative Services (Intermediary) audited each of the cost reports at issue and made final determinations as to the Providers' Medicare DSH payments. This group appeal is a consolidation of nine Allina Health System group appeals on the same issue: 04-2261G, 04-2309G, 04-2306G, 04-2258G, 04-2150G, 05-1376G, 05-1658G, 06-0738G, and 06-1374G. The Providers appealed to the Board the exclusion of the dual eligible days at issue from the Providers' Medicare DSH calculations and met the jurisdictional requirements of 42 U.S.C. §1395oo and 42 C.F.R. §§ 405.1835 - 405.1841.

The facts of this case have been agreed to by the parties.

The parties' stipulations include the following:

1. For each of the Providers the parties have agreed upon the number of days at issue for each of the cost reporting periods in this group appeal.
2. All of the patients whose days are at issue were eligible for medical assistance under a State plan approved under the Medicaid statute in Title XIX of the Social Security Act. All of the patients were also eligible for Medicare Part A.
3. For all the days at issue, Medicare did not make payment under Part A either because the patient had exhausted Medicare Part A benefits or because a payer other than Medicare made payment for the days.
4. The Providers have determined that none of the days at issue were included in the denominator of the "Medicare fraction" described in 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. §412.106(b), which includes days for which CMS has determined that the patients were entitled to benefits under Medicare Part A. The Providers reached this determination based on their review of the patient-level "routine use" data furnished to the Providers by CMS to show the days that CMS included in its calculation of the DSH Medicare fraction for each provider cost reporting period at issue. The Providers have furnished that CMS data to the Intermediary for each Provider cost reporting period at issue, and the Intermediary has not identified any days at issue that are included in that data.

The parties disagree solely on the question of whether these patients were "entitled" to benefits under Medicare Part A. If the patients were not entitled to Medicare Part A benefits for the days at issue, then the days at issue should be included in the numerator of the Medicaid fraction of the DSH calculation. Conversely, if the patients were entitled to Medicare Part A benefits for the days at issue, then the days should not be included in the numerator of the Medicaid fraction.

The Providers are represented by Stephanie A. Webster, Esq., of King & Spalding, L.L.P. The Intermediary is represented by Bernard Talbert, Esq., of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Providers argue that the Intermediary improperly excluded from the numerator of the Providers' Medicaid fractions days attributable to patients who were eligible for Medicaid, but not entitled to benefits under Medicare Part A, because Medicare Part A did not make payment for the days. Medicare Part A did not make payment either because the patients had exhausted Part A benefits or because a payer other than Medicare made payment; i.e., Medicare was the secondary payer (MSP) for those days.

The Medicare DSH statute defines the numerator of the Medicaid fraction as the number of days for patients who were eligible for Medicaid but "not entitled to benefits" under Part A of Medicare. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). 42 C.F.R. § 412.106(b)(4). The Providers assert that the Intermediary's exclusion of dual eligible exhausted and MSP days violates the plain language of the Medicare statute, which defines entitlement to benefits under Medicare Part A as the right to have payment made on the patient's behalf for covered services. 42 U.S.C. §1395d(a). The Providers contend that, under 42 U.S.C. §§ 1395d(a) and 1395y(b)(2)(A), the patients whose days are at issue were clearly not entitled to have payment made on their behalf for those days.

The Providers further contend that CMS has conceded in a Federal court case that it did not consider exhausted days or MSP days to be days for which the patient was "entitled to benefits" under Part A. See Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008). The Providers also argue that the Intermediary's determination is inconsistent with CMS' policy and practice, as explained in CMS' inpatient prospective payment system (IPPS) rule published in the Federal Register for Federal fiscal year 2005 (69 Fed. Reg. 48,916, 49,098 (Aug. 11, 2004)), of treating dual eligible exhausted days and MSP days as not "entitled to benefits" under Part A prior to October 1, 2004.

The Intermediary contends CMS addressed this issue in a letter dated April 19, 2001,[2] which stated: "When calculating the DSH percentage, a patient who has exhausted Part A coverage is still eligible for Medicare. Therefore, even if the remainder of the hospital stay is paid by Medicaid, that person is considered to be dual-eligible, and the days would not count in the calculation for Medicaid."

[2] Intermediary Exhibit I-3.

The Intermediary also contends that it is bound by CMS policy as stated in the Federal Register for Federal fiscal year 2005 (69 Fed. Reg. 49098 and 49099). That policy states that CMS' "current policy" is to exclude dual eligible days from the Medicaid fraction and include them in the Medicare fraction.

Finally, the Intermediary asserts that its position is supported by the Administrator's decision in Alhambra Hosp. v. Blue Cross Blue Shield Association/ United Government Services, LLC - CA, CMS Adm'r Dec. No. 2005-47 Medicare & Medicaid Guide (CCH ¶81,441) (Oct. 6, 2005). The Administrator found that a reasonable interpretation of the statutory phrase in the Medicaid fraction, "but who were not entitled to benefits under Part A of this title" required the exclusion of the dual eligible days from the numerator of the Medicaid fraction.

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 and Medicare secondary payer days at issue 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 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 Medicare statute provides that entitlement to benefits under Medicare Part A means the right to have payment made on the patient's behalf for covered services. 42 U.S.C. §1395d(a); 42 U.S.C. § 426(c)(1). The Sixth and Ninth Circuits have held that entitlement means the "absolute right" to payment. See Jewish Hosp. Inc., v. Sec'y of Health and Human Servs., 19 F.3d 270, 274-75 (6th Cir. 1994); Legacy Emanuel Hosp. and Health Ctr. v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996). The dual eligible days at issue here were not attributable to patients who were entitled to have payment made on their behalf for those days.

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 (6thCir. 1994) 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.

With respect to exhausted days, the Medicare statute provides that the Part A benefit for inpatient hospital services covers 90 days per spell of illness with a lifetime reserve of 60 days. 42 U.S.C. §1395d(a)(1). 42 C.F.R. §409.61(a). Therefore, a Medicare beneficiary is entitled "to have payment made on his behalf" only for those days. 42 U.S.C. §1395d(a)(1). Payment "may not be made" for inpatient days in excess of those limits. 42 U.S.C. §1395d(b)(1). MSP days are also not days for which Medicare makes payment. Under the Medicare MSP statute, a Medicare beneficiary is not entitled to have Medicare Part A payment made on his behalf to the extent that Medicare is secondary to a health plan, worker's compensation, or other liability insurance. 42 U.S.C. §1395y(b)(2)(A). See Medicare Intermediary Manual. (CMS Pub. 13-3), Ch. VII, §3685(B) ("If payment by the primary payer for Medicare covered services . . . equals or exceeds the hospital's full charges for those services or the Medicare payment rate . . . no payment is due from Medicare . . .").

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 cannot be counted in the Medicare fraction but would be included in Medicaid fraction.

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, and services being covered by a secondary payer (not Medicare). Such days should be included in the calculation of the Medicaid fraction in the determination of the DSH adjustment in accordance with the plain language of 42 U.S.C. §1395ww(d)(5)(F).

The Board finds that the Intermediary's exclusion of the days at issue from the Medicaid fraction is also inconsistent with the position of the Secretary of Health and Human Services (Secretary) in Baystate, 545 F. Supp. 2d 20 (D.D.C. 2008).[3] In that case the Secretary conceded that exhausted and MSP days are not Medicare "covered" days for which patients are "entitled to benefits under Part A" for purposes of the Medicare fraction of the DSH calculation.[4] The Board agrees with the Providers' position that if

[3] In that case, the hospital challenged the Secretary's calculation of its Medicare fractions for its fiscal years ending 1993, 1994, 1995, and 1996.

[4] See Defendants' Memorandum of Points and Authorities in Support of Defendant Leavitt's Motion for Summary Judgment and in Opposition to Plaintiff's Motion for Summary Judgment at 221, 24; see also Plaintiff's Reply Memorandum in Support of Its Motion for Summary Judgment and Memorandum in

the days are not considered "entitled" under Part A for purposes of the Medicare fraction, then they cannot be entitled for purposes of the Medicaid fraction. See, e.g., Adena Reg'l Med. Ctr. v. Leavitt, 527 F.3d 176, 180 (D.C. Cir. 2008) ("as the Supreme Court has instructed on countless occasions, we are to presume that identical words used in . . . the same act are intended to have the same meaning").

By excluding the dual eligible exhausted and MSP days from the Medicaid fraction, the Intermediary is effectively equating the terms "eligible" and "entitled" in the DSH statute. Four consecutive circuit courts rejected CMS' prior attempts to equate these two terms. See Jewish Hosp., 19 F.3d at 270, 274-75 (6th Cir. 1994; Cabell Huntington Hosp. v. Shalala, 101 F.3d 984, 988 (4th Cir. 1996); Legacy Emanuel, 97 F.3d at 1261, 1265; Deaconess Health Servs. Corp. v. Shalala, 83 F.3d 1041 (8th Cir. 1996) (per curium). Under these cases, the statute's reference to an individual who is "entitled" to Medicare Part A must mean something more than a beneficiary who has met Medicare eligibility criteria for some covered Medicare services but who is not entitled to have Medicare payment made for particular days of inpatient hospital services. HCFA Ruling 97-2 acquiesced to these court decisions.

As days not included in the denominator of the Medicare fraction, those days cannot be "entitled to benefits under Part A." Therefore, those days should be included in the numerator of the Medicaid fraction.

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. The Intermediary improperly excluded dual eligible exhausted and MSP days from the number of Medicaid eligible days used for purposes of calculating the Medicaid fraction of the Providers' DSH payments for the periods at issue.

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.

Opposition to Defendant Leavitt's Motion for Summary Judgment at 35, Baystate, 545 F. Supp. 2d 20 (D.D.C. 2008) .

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: July 30, 2009

Allina Health System 1995-2003 DSH Dual Eligible Days Group,

PRRB Case No 04-2261G

Provider	FYE	No. of Days
Abbott Northwestern Provider No. 24-0057	12/31/97 12/31/98 12/31/99 12/31/00 12/31/01 12/31/02 12/31/03	18 462 278 169 305 128 149
United Hospital Provider No. 24-0038	12/31/92 12/31/93 12/31/94 12/31/95 12/31/96 12/31/97 12/31/98 12/31/99 12/31/00 12/31/01 12/31/02 12/31/03	290 58 98 78 26 76 35 31 200 146 149 134
Buffalo Hospital Provider No. 24-0076	12/31/02	33
Mercy Hospital Provider No. 24-0115	12/31/95 12/31/96 12/31/97 12/31/98 12/31/00 12/31/01 12/31/02 12/31/03	64 127 13 21 11 19 38 33
Unity Hospital Provider No. 24-0132	12/31/95 12/31/96 12/31/97 12/31/98 12/31/99 12/31/00 12/31/01 12/31/02 12/31/03	11 30 5 75 19 29 42 40 64