PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D26

PROVIDER -
QRS Medicare Part A Title XIX Eligible Patient Days Group I

Provider Nos: Various

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ Noridian Administrative Services

DATE OF HEARING -
December 8, 2008

Cost Reporting Periods Ended - Various

CASE NO.: 05-1790G

INDEX

ISSUE:

Should patient days associated with Medicare Part A and Title XIX eligible patients that were not included in the Supplemental Security Income (SSI) percentage factor of the Medicare disproportionate share formula be included in the Medicaid days factor or the SSI percentage factor used in the determination of their Medicare Disproportionate Share Hospital (DSH) payment in accordance with the Medicare DSH statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?

MEDICARE STATUTORY AND PROCEDURAL HISTORY:

This is a dispute over the amount of Medicare reimbursement due providers 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 to organizations 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 allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviewed 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.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). 42 U.S.C. §1395ww(d). The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. 42 U.S.C. §1395ww(d)(5). This case involves one of the hospital-specific adjustments, 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 patients." 42 U.S.C. §1395ww(d)(5)(F)(i).

Whether a hospital qualifies for a disproportionate share hospital (DSH) adjustment, and how large an adjustment it receives, depends upon the hospital's disproportionate patient percentage. 42 U.S.C. §1395ww(d)(5)(F)(v). The "disproportionate patient percentage" is the sum of two fractions. The numerator for the first fraction, the Medicare fraction, is

the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income (SSI), (excluding state supplementation), and the denominator is the number patient days for patients entitled to Medicare Part A. 42 U.S.C. §1395ww(d)(5)(F)(vi). For the Medicaid fraction, the numerator consists of the number of hospital patient days for patients who were eligible for medical assistance under a State plan approved under Title XIX, but who are "not entitled to benefits under Medicare Part A." The denominator is the total number of the hospital's patient days. Id. A provider whose DSH percentage meets a certain threshold receives an increased payment for inpatient hospital services. 42 U.S.C. §1394ww(d)(5)(F)(ii).

The SSI program is administered by the Social Security Administration (SSA); therefore, identifying patients who were entitled to SSI during their hospitalization requires access to SSA's SSI data. To implement the DSH legislation, regulations provide that the number of patient days of those patients entitled to both Medicare Part A and SSI will be determined by matching data from the Medicare Provider Analysis and Review file (MEDPAR), which is Medicare's database of hospital inpatients, with a file created for CMS by SSA to identify SSI eligible individuals (SSA file). As noted above, the numerator of the Medicare fraction is the number of hospital inpatient days for an individual who is entitled to both Medicare Part A and to SSI benefits. The denominator is the total number of days of hospital inpatient care furnished to Medicare Part A beneficiaries. CMS calculates the Medicare fraction and notifies the Provider.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Providers in this group are four acute care hospitals located in the State of Washington. During the fiscal years at issue in this case (1998 through 2003), the Providers rendered inpatient hospital services to some patients that were eligible for Medicaid under the State of Washington's Title XIX program but who were later determined by the State to be entitled to Medicare Part A benefits. Nordian Administrative Services (Intermediary) excluded these patient days from the Medicaid fraction in calculating the Providers' DSH payment adjustment because the State classified them as entitled to Medicare Part A.

The Providers claim they were not aware these patients were entitled to Medicare Part A benefits and, therefore, did not submit timely bills to Medicare for these days. As a result, no Medicare Part A payments were made for the days and no data about these inpatient hospital days was included in CMS' MEDPAR database. Since CMS utilizes MEDPAR to match with SSI records to arrive at the SSI percentage, the SSI percentage in this case was determined without these patient days taken into consideration. Thus, the patient days at issue in this case have not been counted in either the Medicare or Medicaid fractions of the DSH adjustment calculation.

STIPULATIONS[1]:

The Providers and the Intermediary, through their respective counsel, stipulated to the following:

1. This group appeal involves 4 different Providers and cost reporting periods from 1998 through 2003, with multiple cost reporting periods for one of the Providers.

2. Each of the Providers in this group appeal is an acute care facility in the State of Washington that received payments under Medicare Part A for services provided to Medicare beneficiaries for the cost reporting periods at issue.

3. Each of the Providers in this group appeal provided inpatient hospital care to patients who were certified by the Department of Social and Health Services of the State of Washington as eligible for Title XIX programs for the dates of service at issue.

4. There are no jurisdictional issues. Each of the Providers, for the cost reporting periods included in the appeal, have properly established appeal rights applicable to the following stated issue:

   > Should patient days associated with Medicare Part A and Title XIX eligible patients that were not included in the SSI percentage factor of the Medicare disproportionate share formula be included in the Medicaid days factor or the SSI percentage factor used in the determination of their Medicare disproportionate share hospital (DSH) payment in accordance with the Medicare DSH statute at 42 U.S.C. §1395ww(d)(5)(F)(vi).

5. Each of the Providers in this group appeal qualified for the Medicare DSH payment adjustment for each of the cost reporting periods included in the group appeal.

6. The electronic verification system used by the Department of Social and Health Services for the State of Washington (the "State") to verify the number of Title XIX eligible patient days to be used in the Medicare DSH payment calculation has been programmed to verify Title XIX eligible patient days, including Title XIX eligible patient days for those also identified as Medicare.

7. The patient days detailed in the excerpt from the State's Title XIX eligibility report, included as Provider Exhibit P-11, represent patient days that were verified to be eligible for medical assistance under the Washington State Title XIX Plan approved by the Secretary of the United States Department of Health and Human Services.

[1] See Stipulations, December 1, 2008.

8. The patient days, as detailed in Provider Exhibit P-11, were classified as being Medicare by the electronic verification system used by the State and were excluded by the Intermediary from the Medicaid days factor when determining each Providers [sic] Medicare DSH payment adjustment.

9. The Medicare common working file indicates Medicare Part A entitlement for each of the patients or mothers of the patients included in Provider Exhibit P-11 for the dates of service indicated.

10. Medicare Part A benefits were not paid for services rendered to the patients identified in Provider Exhibit P-11. The absence of Medicare payment or coverage may be ascertained by cross matching patient specific information with (i) the provider specific data obtained from the CMS MEDPAR file by Medicare HIC number and by dates of service which shows Medicare covered days; or (ii) the Provider Statistical & Reimbursement System Payment Reconciliation Report provided by the Intermediary showing paid Medicare Part A claims activity; or (iii) the Washington State Medical Assistance Administration Medicaid Paid Claims Report showing Medicaid payment; or (iv) the Provider's [sic] Accounts Receivable Records. The patient days identified in Provider Exhibit P-11 were NOT paid by Medicare Part A, as demonstrated by one of the above listed means.

11. The patient days listed in Exhibit P-11, that were not paid by Medicare Part A, were not included in the Providers' SSI percentage factor.

12. An adjustment to the Providers' SSI percentage factor, to take into account additional SSI and Medicare Part A patient days, would require an adjustment to both the numerator and denominator if CMS determines any of the days at issue to be SSI entitlement days.

The Providers were represented by Teresa A. Sherman, Esquire, of the Sherman Law Office PLLC. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Providers contend that the Intermediary improperly excluded some low-income patient days in calculating the Providers' DSH payment adjustment, and that they must be included in either the Medicaid fraction or the Medicare fraction, provided the records regarding entitlement to SSI benefits are cross-matched to this patient population. Simply stated, the patients at issue are either entitled to Medicare Part A benefits or not entitled to Medicare Part A benefits. They cannot be considered entitled to Part A

benefits for purposes of the Medicaid fraction and at the same time considered not entitled to Part A benefits for purposes of the Medicare fraction. If the patients are entitled to Medicare Part A benefits, then they must be crossed-matched with the records of individuals entitled to SSI benefits for purposes of calculating the Medicare fraction. If these patients are not entitled to Medicare Part A benefits, the record already reflects that they are eligible for medical assistance under a State plan, and therefore must be included in the numerator of the Medicaid fraction. In this case, the patients have been excluded from both the Medicaid fraction and the Medicare fraction. The Providers are asking the Board to direct the Intermediary to include these low-income patient days in either the Medicare fraction or the Medicaid fraction, without necessarily advocating either.

The Medicare DSH statute uses only the term "entitled" with respect to Medicare Part A benefits. It is the Providers' contention that the term must be applied consistently as it is used in the statute in connection with both the Medicaid fraction and Medicare fraction. The Providers characterize the Intermediary's position as suggesting the term "entitled" should be interpreted for purposes of the Medicaid fraction to mean something akin to "eligible" (whether or not Medicare Part A paid for the benefits the patient was entitled to or enrolled in at the time services were provided). For purposes of the Medicare fraction, the Intermediary claims "entitled" should mean something more, requiring payment or billing or some form of "coverage." The Provider argues this interpretation is contrary to the rules of statutory construction that require similar language contained within the same section of a statute be accorded a consistent meaning, citing Nat'l Credit Union Admin. v. First Nat'l Bank & Trust Co., 522 U.S. 479, 501 (1998).

The Providers also direct the Board to case law that discusses the interpretation of the terms "entitled" and "eligible" as they are used in the Medicare DSH statute. The case law makes it clear that "eligible" and "entitled" are not interchangeable terms. The courts have held that "entitled" means possession of the right or title to a benefit; "eligible," means qualified for but does not require actual payment of benefits. Jewish Hospital, Inc. vs. Secretary of Health and Human Services, 19 F.3d 270, 275 (6th Cir. 1994); Legacy Emanuel Hosp. and Health Ctr. vs. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).

In the current case, Providers believe the Intermediary interpreted Medicare Part A entitlement for purposes of the Medicaid fraction to equate to being eligible for Medicare Part A benefits, whether or not there is actual Medicare payment. The Providers argue that this is contrary to the case law that clearly distinguished the terms "eligible" and "entitled." It is also inconsistent with the actual application of the definition of the term "entitled" as it is used for purposes of the Medicare fraction. As noted in the stipulations, these patients were not considered for the Medicare fraction because they would not be included in the Medicare inpatient discharges files, for patient services paid or covered by Medicare, that are then cross matched by CMS with the SSA's SSI records.

It is the Providers' position that the weight of the authorities, case law and the actual application of the definition of entitled in the context of the calculation of the Medicare

fraction, lead to a determination that "entitled" requires Medicare payment or some form of coverage which is considered utilization of Medicare benefits. In that case, the patient days at issue must be included in the Medicaid fraction as they were not entitled to Medicare Part A (or not paid by Medicare under Part A). However, should the Board determine these patients were entitled to Medicare Part A, whether or not they were paid by Medicare, then they must be considered entitled for purposes of inclusion in the Medicare fraction and cross-matched with the SSI files. The term "entitled" must be applied consistently within the Medicare DSH statute, which means these "dual eligible" patients must be included in either the Medicaid fraction or the Medicare fraction.

The Intermediary contends that under the Medicare DSH statute, patients are either counted in the Medicaid portion of the DSH calculation (if they are eligible for Medicaid but were not entitled to Medicare Part A) or they are counted in the Medicare portion of the DSH calculation (if they are entitled to Medicare Part A and entitled to SSI). In this case the Providers acknowledged that they were unaware that patients were entitled to Medicare Part A benefits and therefore did not bill the Medicare program. [2] As a result, the Medicare program did not make payment on the claims and no record of the patient's hospital utilization was captured or included in the data base used to calculate the Providers' SSI percentages. The Intermediary asserts that the days at issue were for patients that were entitled to Medicare Part A and should have gone into the Medicare portion of the DSH fraction. The Providers failure to bill for these patients therefore forfeited their opportunity to have these patients included in the count.

The Intermediary indicates that the issues addressed in Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008) (Baystate), are not applicable to this case. In Baystate, CMS was charged with developing the mechanism by which Medicare patients would have their Medicare discharges matched against the SSI data and when there was a match, put those days into the Medicare proxy. The finding in that case was that the system did not work well enough to count all Medicare patient days. In this case, the fault was not in CMS' system but the Providers' failure to bill for patients that resulted in the patient days not being counted in the database. The Intermediary states that there is no process to add patients (for whom no claim has been submitted) into the system, match them with the SSI database and then include them in the Medicare fraction.

The Intermediary contends that the cases referred to by the Providers concerning the difference between "eligible" and "entitled" do not apply to the facts in this case. The patients in question were entitled to Medicare Part A and belonged in the Medicare proxy, except for the fact that the Providers did not timely bill. With respect to whether the days belong in the Medicaid proxy, the Intermediary states that the statute excludes patients entitled to Medicare Part A and therefore they cannot be included there either. The Providers did not follow the proper billing procedures and therefore cannot claim the days in either DSH fraction.

[2] Provider position paper at 7.

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 as follows:

The facts in this case are not in dispute. The days that the Providers seek to include in the DSH calculation are for patients who were eligible for Medicaid and entitled to Medicare Part A benefits. The Providers were not aware that patients were entitled to Medicare and hence did not bill the Medicare program for those days. This resulted in these days being omitted from the database used for calculating the SSI percentage.

The governing regulation at 42 C.F.R. §412.106(b) (2002) states that only covered patient days are to be counted when computing the Medicare fraction. It provides:

> (b) *Determination of a hospital's disproportionate patient percentage*. (1) *General Rule*. A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
>
> (2) *First computation*: *Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of covered 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 and SSI, excluding those patient who received only State supplementation;
> (ii) Adds the results for the whole period; and
> (iii) Divides the number determined under paragraph (b)(2) (ii) of this section by the total number of patients that--
> (A) Are associated with discharges that occur during that period; and
> (B) Are furnished to patients entitled to Medicare Part A.

The Providers did not bill for those days; consequently, none of those days would be charged to the beneficiaries as utilized days and hence they could not be considered "covered patient days" as required by the regulation. Accordingly, those patient days would have been excluded when computing the Medicare fraction.

The Providers suggest that even though it is too late to bill Medicare for those patient days, they can document that the patients were entitled to Part A utilizing other information sources and so the days could be counted in the Medicare fraction. The Board finds that even if other information sources proved the patients were entitled to

payment by Medicare for those days, they would still not be "covered" days, because they would never have been billed and never attributed to a beneficiaries' covered days.

With respect to payment for Medicare services, the Providers cannot, after the deadline for billing, present evidence that the patients were entitled to payment under Medicare Part A and request payment for the services. The Board finds the timely billing restriction for payment for services analogous to the inclusion of the days in the Medicare portion of the DSH calculation. The Providers' mistake in not billing the Medicare program resulted in no payment for services and likewise resulted in exclusion of the days from the Medicare portion of the DSH calculation.

Medicare has established a national billing process and procedures and this process is utilized to generate the data used to determine the patient days in the Medicare fraction. Unlike the situation in Baystate, supra, in which problems with CMS' system resulted in some patient days not being counted, in this case, it is the Providers' inaction that caused the days not to be included in the Medicare fraction. The Boards finds that the process to collect the data is reasonable and that the Providers alone had control of the accuracy of the data being included. The Providers lost their opportunity to have this data included in the calculation when they failed to timely submit bills into the system. The Board is not aware of any requirement that it order the Intermediary to correct the Providers' mistake.[3] While the Board recognizes that its interpretation of the statute and regulations results in a harsh outcome because these days could possibly have been included in the Providers' Medicare DSH payment, it is not unreasonable merely because the Providers are disadvantaged due to their own mistake in not properly billing. See Ashland Regional Medical Center v. Shalala, 2 F. Supp. 2d 675 (April 3, 1998).

With respect to the Medicaid fraction, the Board finds that the patient days in question were for patients who, although eligible for Title XIX, were entitled to Medicare Part A. These patients' remained entitled to payment from Medicare even though the Providers' failure to timely bill affected Providers' right to claim those payments. Because those patients were entitled to Medicare, the statute prohibits those days being included in the Medicaid fraction.

DECISION AND ORDER:

The Board finds that the Intermediary's determination not to include the days at issue in either the Medicare or Medicaid fraction of the DSH adjustment calculation was proper. The Intermediary's determination is affirmed.

[3] The Board notes that the problem could be corrected if the Intermediary permitted the Providers to submit late "no-pay" bills so the data could go into the Medicare files and be matched for SSI entitlement. Once sufficient time had passed for the Medicare data files to be updated, the Providers could then request that the SSI calculation be determined using data from their fiscal year (as opposed to the Federal fiscal year), and it would contain the updated data.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: April 14, 2010