PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D32

PROVIDER –
Exempla Lutheran Medical Center

Provider No.: 06-0009

vs.

INTERMEDIARY –
Wisconsin Physicians Service

DATE OF HEARING -
July 26, 2010

Cost Reporting Period Ended -
December 31, 2004

CASE NO.: 06-2319

INDEX

ISSUE:

Whether the Intermediary properly disallowed the Provider's entire Medicare disproportionate share hospital (DSH) payment.

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. *See* 42 U.S.C. §§ 1395 *et seq*. 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 (FI) or Medicare administrative contractors (MAC). FIs and MACs[1] 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.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. 42 C.F.R. § 413.20. The 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. *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

Medicare DSH Payment

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

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 payments to hospitals that serve a significantly disproportionate number of low-income patients. *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

[1] FIs and MACs are hereinafter referred to as intermediaries.

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (DPP). *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l). As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital. *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

The DPP is defined as the sum of two fractions expressed as percentages. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi). Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute defines the Medicare/SSI fraction as:

> 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/SSI 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 statute defines the Medicaid fraction 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, [the Medicaid program], 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).

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.l06(b)(4).

Medicare+Choice Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations (HMOs) and competitive medical plans (CMPs) is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization 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 …" Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days. Payments for medical services for Medicare beneficiaries enrolled in HMOs and CMPs were funded from Part A of the Medicare program.

In 1997, Congress amended the Medicare statute by adding a new part C for Medicare beneficiaries enrolled in managed care organizations after 1999. *See* Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, §4001, 111 Stat. 251, 270 (codified at 42 U.S.C. § 1395w-21). Part C governs the Medicare+Choice (M+C) program. This statute provides that a Medicare beneficiary may elect to receive Medicare benefits through one of two means:

> Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this subchapter –
>
> (A) through the original [M]edicare fee-for-service program under parts A and B of this subchapter, or
> (B) through enrollment in a Medicare+Choice plan under this part [Part C].

42 U.S.C. § 1395w-21(a)(1) (emphasis added); *see also* 42 C.F.R. § 422.50; 63 Fed. Reg. 34968 (June 26, 1998).

A "Medicare+Choice eligible individual" means an individual who is entitled to benefits under part A and enrolled under part B of the Medicare statute. 42 U.S.C. § 1395w-21(a)(3)(A).

Once a beneficiary elects to enroll in an M+C plan, however, the beneficiary receives Medicare benefits under part C and the Secretary makes payment to the contracted M+C plan. *See* 42 U.S.C. § 1395w-21(a)(1)(B)(i). Subject to certain exceptions that are not pertinent here, the statute requires the Secretary to make payments to the M+C plan under part C "instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B [of the Medicare statute] for items and services furnished to the individual" and provides that "only the Medicare+Choice organization shall be entitled to receive payments from the Secretary under this subchapter for services furnished to the individual." 42 U.S.C. § 1395w-21(i)(l)-(2) (emphasis added).

More recently, the Medicare Modernization Act of 2003 (MMA) (P.L. No. 108-173) established the Medicare Advantage (MA) program as part C of Title XVIII of the Act replacing the M+C program. This change is effective for cost reporting periods subsequent to September 30, 2004.

CMS Policy for Managed Care Days in DSH Calculation

In 1990, CMS published a statement in the Federal Register indicating that Medicare HMO days had been counted in the Medicare Fraction. 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990). It states in relevant part:

> *Comment:* One commenter believes that the disproportionate share adjustment calculation should be expanded to include days that Medicare patients utilize health maintenance organizations (HMOs) since these beneficiaries are entitled to Part A benefits.
>
> *Response:* Based on the language of section 1886(d)(5)(F)(vi) of the Act, which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A", we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs and, therefore, were unable to fold this number into the calculation. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time, we have been including HMO days in SSI/Medicare percentage.

Id.

CMS did not publish any further guidance regarding Medicare managed care days until it addressed the treatment of Part C M+C patient days in the DSH calculation in 2003 and 2004. In proposed regulations, 68 Fed. Reg. 27154, 27208 (May 19, 2003), CMS indicated that M+C days should not be counted in the Medicare fraction. CMS also proposed to permit hospitals to count these days in the numerator of the Medicaid fraction when an M+C enrollee is also eligible for Medicaid. It stated in relevant part:

> 8. Medicare+Choice (M+C) Days
>
> Under § 422.1, an M+C plan "means health benefits coverage offered under a policy or contract by an M+C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan." Generally, each M+C plan must provide coverage of all

> services that are covered by Medicare Part A and Part B (or just Part B if the M+C plan enrollee is only entitled to Part B).
>
> We have received questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation. The question stems from whether M+C plan enrollees are entitled to benefits under Medicare Part A since M+C plans are administered through Medicare Part C.
>
> We note that, under § 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.
>
> Therefore, we are proposing 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. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's [sic] days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.

Id. (Emphasis added).

In 2004, however, CMS reconsidered its position and decided to count M+C days in the Medicare fraction. 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004). It stated in relevant part:

> 4. Medicare+Choice (M+C) Days
>
> Under existing § 422.1, an M+C plan means "health benefits coverage offered under a policy or contract by an M+C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan." Generally, each M+C plan must provide coverage of all services that are covered by Medicare Part A and Part B (or just Part B if the M+C plan enrollee is only entitled to Part B).
>
> We have received questions whether the patient days associated with patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation. The question stems from whether M+C plan enrollees are entitled to benefits under Medicare Part A since M+C plans are administered through Medicare Part C.
>
> We note that, under existing regulations at § 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. In the proposed rule of May 19, 2003 (68 FR 27208), we proposed that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary would not be included in the Medicare fraction of the DSH patient percentage. Under our proposal, these patient days would be included in the Medicaid fraction. The patient days of dual-eligible M+C beneficiaries (that is, those also eligible for Medicaid) would be included in the count of total patient days in both the numerator and denominator of the Medicaid fraction.
>
> *Comment:* Several commenters indicated that they appreciated CMS's attention to this issue in the proposed rule. The commenters also indicated that there has been insufficient guidance on how to handle these days in the DSH calculation. However, several 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-service program.
>
> *Response:* Although there are differences between the status of these beneficiaries and those in the traditional fee-for-service 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. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare 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.

Id. (Emphasis added).

CMS Audit Standards Regarding Sampling

The Medicare procedures, with respect to audit standards, set forth in the Intermediary Manual (CMS Pub. 13-4) §4112.4(B), provide the following direction to intermediaries:

> Ensure that evidence obtained during the course of the audit is sufficient to enable the auditor to support conclusions, adjustments, and recommendations. Make sure that there is enough factual and convincing evidence so that a prudent person can arrive at the same conclusion of fact as the auditor. In addition, evidence must be

> competent and relevant. That is, evidence must be valid and reliable and have a logical relationship to the issue/subject under review.

Medicare procedures allow for the use of sampling as evidence in audits. CMS Pub. 13-4 §4112.4(B)(1)(e) states in relevant part:

> Sampling is the application of an audit procedure to less than 100 percent of the items within an account balance or class of transactions to evaluate some characteristic of the balance or class. On the basis of the facts known to the auditor, decide if all transactions or balances that make up a particular account are reviewed in order to obtain sufficient evidence. In most cases, however, the auditor will test at a level less than 100 percent.
>
> There are two general sampling approaches, nonstatistical and statistical. Either approach, when properly applied, can provide sufficient evidential data related to the design and size of an audit sample, among other factors. A nonstatistical sample may support acceptance of findings, but finding must be scientifically established to support adjustments.
>
> Some degree of uncertainty is inherent in applying audit procedures and is referred to as ultimate risk. Ultimate risk includes uncertainties due both to sampling and other factors. Sampling risk arises from the possibility that when a compliance or a substantive test is restricted to a sample, the auditor's conclusions may be different had the test been applied in the same way to all items in the account balance or class of transactions.

The rules provide further guidance for planning samples, selecting a sample and sampling risk. *Id*.

In the instant case, the Provider disputes both the application of the sampling results and where the M+C days should be counted in the DSH calculation.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Exempla Lutheran Medical Center (Provider) is a 256-bed acute care hospital with a hospital-based 74-bed Psychiatric Unit and a hospital-based 18-bed Skilled Nursing unit located in Wheat Ridge, Colorado. Wisconsin Physicians Service (Intermediary) disallowed the Provider's entire DSH payment after a review of a sample of the Provider's Medicaid patient days. The Provider appealed the determination and met the jurisdictional requirements of 42 U.S.C. § 1395oo(a).

The Provider and Intermediary have stipulated to the following pertinent facts of this case:

- In its final determination for FY 2004, the Intermediary calculated the Provider's SSI percentage to be 3.98 percent. Provider Exhibit 2, at Adjustment 21.

- The Intermediary also determined that the Provider had 71,038 total inpatient hospital days for FY 2004. Provider Exhibit 11 at 3.

- In order to establish a 15 percent disproportionate patient percentage, which is the sum of the Provider's SSI percentage and [] its Medicaid fraction, the Provider needs at least 7,829 Medicaid patient days included in the numerator of its Medicaid fraction.

- Prior to the issuance of the NPR for FY 2004, the Provider furnished the Intermediary with a log and supporting information for 8,535 patient days associated with 2,767 Medicaid patient stays claimed for FY 2004. Intermediary Exhibit 8 at 1-4.

- The Intermediary determined that the Provider had only 6,559 allowable Medicaid patient days for FY 2004. Intermediary Exhibit 8. The Intermediary denied the Provider any DSH payment for FY 2004 as a result of that determination in audit adjustment number 21 in the audit adjustment report that accompanied the NPR for FY 2004. Provider Exhibit 2.

- The Intermediary's determination of the Provider's allowable number of Medicaid patient days was based on the extrapolation of error rates derived from the Intermediary's review of a sample of the Medicaid patient days claimed by the Provider in each of four strata selected by the Intermediary. *See* Intermediary Exhibit 8.

- Three of the four strata were established by the Intermediary based upon the length of stay for each patient that had been matched to a State of Colorado Medicaid eligibility file; the fourth stratum included the patient stays that the Provider identified as having been paid by Medicaid but were not matched to the State eligibility database. *See* Intermediary Exhibit 8. The Intermediary reviewed a sample of patient days in each stratum to determine whether the patient was eligible for Medicaid and not enrolled in Medicare Part A. *See* Provider Exhibit 8. The results of the Intermediary's review are summarized in the following table and discussed further below in paragraphs 11-15:

Stratum	Total Stays & Days in Stratum	Sample Size	Sampled % of Stratum	Sampled Days Allowed	% Sampled Days Allowed	Projected Allowable Number of Days
Matched (LOS < 10 days)	5,296 days 2,294 stays	44 days 25 stays	0.8% days 1.09% stays	35 days	79.55%	4,213 days
Matched (LOS 10-47 days)	2,141 days 116 stays	390 days 20 stays	18.2% days 17.2% stays	323 days	82.82%	1,773 days
Matched (LOS > 47 days)	242 days 4 stays	242 days 4 stays	100%	242 days	100%	242 days
No Match	856 days 353 stays	44 days 20 stays	5.1% days 5.6% stays	17 days	38.64%	331 days
Total						6,559 days
					Confidence Factor: 90% Precision: ± 20%	

- The Intermediary's first stratum included the Medicaid patients claimed by the Provider with lengths of stay in the hospital of less than 10 days. Intermediary Exhibit 8. This stratum included 2,294 patient stays consisting of 5,296 patient days, which made up 83 percent of the total number of Medicaid patient stays (2,767) and 62 percent of the total number of Medicaid patient days (8,535) that [the] Provider claimed as allowable Medicaid patient days. Intermediary Exhibit 8; Provider Exhibit 8. The Intermediary reviewed a sample of 25 (1.09%) of the 2,294 patient stays, representing 44 (0.8%) of the 5,296 patient days, in this stratum. Intermediary Exhibit 8; Provider Exhibit 8. The Intermediary determined that 35 of the 44 sampled patient days in this stratum were allowable. Provider Exhibit 8. The Intermediary projected the result of its sample review to 4,213 allowable Medicaid patient days for this stratum. Provider Exhibit 8.

- The second stratum included the Medicaid patients claimed by the Provider for patients with lengths of stay of at least 10 days and not more than 47 days. Intermediary Exhibit 8. This stratum included 116 patient stays consisting of

2,141 patient days, which made up 4 percent of the total number of Medicaid patient stays (2,767) and 25 percent of the total number of Medicaid patient days (8,535) that the Provider claimed as allowable Medicaid patient days. Intermediary Exhibit 8; Provider Exhibit 8. The Intermediary reviewed a sample of 20 (17.2%) of the 116 patient stays, representing 390 (18.2%) of the 2,141 patient days, in this stratum. Intermediary Exhibit 8; Provider Exhibit 8. The Intermediary determined that 323 of the 390 sampled patient days in this stratum were allowable. Provider Exhibit 8. The Intermediary projected the result of its sample review to 1,773 allowable Medicaid patient days for this stratum. Provider Exhibit 8.

- The third stratum included the Medicaid patients claimed by the Provider with lengths of stay greater than 47 days. Intermediary Exhibit 8. This stratum included 4 patient stays consisting of 242 patient days, which made up 0.1 percent of the total number of Medicaid patient stays (2,767) and 2.8 percent of the total number of Medicaid patient days (8,535) that the Provider claimed as Medicaid patient days. Intermediary Exhibit 8; Provider Exhibit 8. The Intermediary reviewed 100 percent of the patient stays in this stratum. Intermediary Exhibit 8; Provider Exhibit 8. The Intermediary determined that all of the patient days in this stratum were allowable. Provider Exhibit 8.

- The fourth stratum included the patient stays that the Provider claimed as having been paid for by Medicaid but which were not matched to Medicaid eligibility file from the State of Colorado. Intermediary Exhibit 8. This stratum included 353 patient stays consisting of 856 patient days, which made up 12.8 percent of the total number of Medicaid patient stays (2,767) and 10.0 percent of the total number of Medicaid patient days (8,535) that the Provider claimed as allowable Medicaid patient days. Intermediary Exhibit 8; Provider Exhibit 8. The Intermediary reviewed a sample of 20 (5.6%) of the 353 patient stays, representing 44 (5.1%) of the 856 patient days, in this stratum. Intermediary Exhibit 8; Provider Exhibit 8. The Intermediary determined that 17 of the 44 sampled patient days in this stratum were allowable. Provider Exhibit 8. The Intermediary projected the result of its sample review to 331 allowable Medicaid patient days for this stratum. Provider Exhibit 8.

- The Intermediary used a software program developed by the Office of the Inspector General to determine the size of the sample the Intermediary determined to review for each stratum it created. Intermediary Supplemental Position Paper at 6-7; Intermediary Exhibits 7 and 8. The Intermediary used that program to select sample sizes with a 90 percent confidence level and a precision percentage of plus or minus 20 percent. Intermediary Exhibit 8. This means that there is a 90 percent probability that actual number of allowable days is no more than 20 percent greater or less than the point estimate of the allowable number of days that the Intermediary projected from its sample review for each stratum. Intermediary Exhibit 7 (at page 22).

- On February 26, 2009, the Provider requested that the Intermediary reopen its DSH payment determination for the Provider's FY 2004 to correct its calculation of the Provider's allowable number of Medicaid patient days for that year. Provider Exhibit 5. In support of that request, the Provider furnished the Intermediary with the patient-level detail data compiled and reviewed by Ernst & Young to support Medicaid eligibility for 7,987 patient days for the Provider's FY 2004. *See* Provider Exhibits 5, 6 & 9. That number of Medicaid patient days excluded patient days attributable to individuals that Ernst & Young identified as having been enrolled in Medicare Part A or as having received labor and delivery services, and included 337 Medicaid patient days that were not included in the Medicaid patient days that were previously claimed by the Provider as allowable Medicaid patient days. *See* Provider Exhibits 5, 6 & 9.

- Although the Intermediary issued a notice of reopening upon receipt of the Provider's request, *see* Provider Exhibit 10, the Intermediary did not review or accept all of the patient-level detail support that was furnished to the Intermediary for the 7,987 patient days identified by Ernst & Young's review of the Provider's Medicaid patient days for FY 2004. *See* Provider Exhibits 10 and 11; Intermediary Exhibit 9. The Intermediary reviewed only the patient-level detail support for the patient days that were included in the sampled days the Intermediary had previously reviewed and for the 337 patient days that were not included in the Medicaid patient days that the Provider originally claimed as allowable. *See* Provider Exhibits 10 and 11; Intermediary Exhibit 9. Based upon its review of that documentation, the Intermediary determined that 40 of the 44 patient days that were included in its sample review of the patient days in the fourth stratum of the Intermediary's original review were allowable Medicaid patient days. Intermediary Exhibit 9. As a result of that change, the Intermediary revised its sample review of the Medicaid patient days originally claimed by Provider as summarized in the following table:

Stratum	Total Stays & Days in Stratum	Sample Size	Sampled % of Stratum	Sampled Days Allowed	% Sampled Days Allowed	Projected Allowable Number of Days
Matched (LOS < 10 days)	5,296 days 2,294 stays	44 days 25 stays	0.8% days 11.9% stays	35 days	79.55%	4,213 days
Matched (LOS 10-47 days)	2,141 days 116 stays	390 days 20 stays	18.2% days 17.2% stays	323 days	82.82%	1,773 days
Matched (LOS > 47 days)	242 days 4 stays	242 days 4 stays	100%	242 days	100%	242 days
No Match	856 days 353 stays	44 days 20 stays	5.1% days 5.6% stays	40 days	89.19%	763 days
Total						6,991 days
					Confidence Factor: 90% Precision: ± 20%	

- By letter dated June 10, 2009, the Intermediary notified the Provider that it "closed" the reopening based on its determination that the Provider did not qualify for a DSH payment for FY 2004. Provider Exhibit 10. The Intermediary determined that the Provider did not qualify for a DSH payment because it had no more than 7,328 Medicaid patient days, including an additional 443 allowable Medicaid patient days projected from the Intermediary's revised sample review of the Medicaid days originally claimed as allowable by the Provider and 337 Medicaid patient days that were included in Ernst & Young's review but were not included in the Medicaid patient days originally claimed as allowable by the Provider. Provider Exhibits 10 and 11.

- Following the Intermediary's revisions to its sample findings, nearly all of sampled patient days that were determined to be not allowable were patient days attributable to individuals who were eligible for Medicaid and Medicare Part A (per the Common Working File). *See* Provider Exhibits 8, 9 and 12. The Provider's detailed patient account records reveal that each of those individuals was receiving Medicare benefits under Part C through enrollment in a M+C plan. *See* Provider Exhibits 13-20.

The Provider was represented by Christopher L. Keough, Esq. of King and Spalding, L.L.P. The Intermediary was represented by Stacey Hayes of Wisconsin Physicians Service.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's disallowance of the DSH payment for the Provider's cost year ended December 31, 2004 must be reversed for four principal reasons. First, the Intermediary's disallowance is derived from a judgmental sample, which is not a statistically valid random sample. The Intermediary could have used RATSTAT sampling program to a select a statistically valid random sample. The Intermediary did use a stratified sample, but the auditor used his/her judgment to select the sample sizes of each stratum – each of which departed from the number generated by the RATSTATS sampling program (Intermediary Exhibit 8 at 2-3).

Second, the Provider claims that the Intermediary's disallowance was the result of a judgmental sample that employed an irrational stratification criterion (length of stay) of the Provider's Medicaid days. The Intermediary's purpose in reviewing the sampled patient stays was to determine two variables: whether the patient was eligible for Medicaid and whether the patient was enrolled in Medicare Part A. The Intermediary's choice to stratify the sample based on length of stay bears no rational connection to variables being tested. Had the Intermediary not stratified its sample based on length of stay, the Provider would have qualified for DSH.

Third, the Provider states that since the judgmental sample was not statistically valid, the findings from the sample should not have been extrapolated to the entire population. The Provider notes that in Girling Health Care, inc. v. Blue Cross and Blue Shield Ass'n, Medicare and Medicaid Guide (CCH) ¶45,646 (Sept. 10, 1997), the Board held that based on errors found in a judgmental sample, the results should not have been extrapolated.

Finally, the Provider contends that even assuming that the Intermediary's sampling methods are consistent with Medicare law and CMS policy, the disallowance nonetheless must be overturned because nearly all of the sampled days disallowed by the Intermediary are attributable to patients who were eligible for Medicaid and were receiving Medicare benefits under Part C though enrollment in the M+C plan. The Provider contends that the Intermediary's decision to exclude days attributable to these patients from the numerator of the Provider's Medicaid fraction is unlawful and contrary to the DSH statute.

INTERMEDIARY'S CONTENTIONS:

The Intermediary believes it properly followed the RATSTATS program when stratifying and sampling the patient day population. The Intermediary contends the auditor's judgment (including stratification) was both necessary and acceptable in the selection of a statistical sample. It believes evidence shows the sample was randomly generated using the RATSTATS program and was sufficient in size to meet a confidence level of 90%

with a precision level of 20%. After testing the sample selected, the Intermediary believes it was required to extrapolate its finding to a point estimate and make the adjustment to patient days based upon audit instructions at CMS Pub. 100-6, Chapter 8, specifically Section 60.6 which states: "If the results of testing your sample that was selected using a statistical method indicate probable errors in the universe, document your decision to project the error to the universe/population."[2] The Intermediary interprets CMS Pub. 13-3, Transmittal No. 1770, March 1, 1999, which would not allow the use of point estimates for adjustments, to apply only to Comprehensive Medical Review (CMR) procedures for overpayment estimation. Thus its limitation would not apply to this case.

The Intermediary points out that subsequent to the initial audit adjustments being made the Provider supplied additional data. The Intermediary accepted all of the "new" days[3] identified on the new list submitted during the appeal process. The Intermediary also evaluated additional information that was submitted on previously disallowed patient days in the sample and made adjustments to its previous findings.[4] However, the Intermediary contends that starting an entirely new review when providers supply new listings would waste intermediary resources. The Intermediary is also concerned that allowing this data replacement could lead to "incorrect acceptance" of faulty data.[5]

The Intermediary implies the Provider did not follow the proper procedure for challenging the sample. The Intermediary states the Provider could have submitted rebuttal evidence demonstrating that the sample conducted on the original list represented an inaccurate point estimate, or it could have selected a different random sample from the "original" list of stays as allowed in *Hospital of San Francisco, Inc. v. Cooperativa de Seguros de Vida de Puerto Rico*, CMS Administrator Decision, case number 2003-D57, Nov. 10, 2003 (*San Francisco*).[6]

The Intermediary agrees that the majority of the auditor's adverse findings were associated with M+C patients. However it believes M+C patient days are included in the DSH Medicare fraction not the Medicaid fraction based upon several arguments. First, the Intermediary points to CMS Ruling 1498-R[7] as stating that dual eligible days do not belong in the Medicaid fraction.[8] Next, the Intermediary argues that there is nothing in the statute or regulation to suggest that whether Medicare directly pays for a day instead of purchasing coverage from an HMO affects entitlement to Medicare part A. It believes an individual who is enrolled in a Medicare HMO for a particular period who is over 65 and entitled to monthly Social Security benefits, would still be "entitled to" Medicare part A benefits under the statute. Further, the statute speaks solely in terms of entitlement of the beneficiary to Medicare part A, not whether payment to the provider is from

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[2] Intermediary Exhibit I-5.
[3] "New days" are days not included in the audited data population.
[4] *See* Stipulation 17.
[5] For discussion of this audit risk see Intermediary Supplemental Paper at p. 6.
[6] *See*, Intermediary Exhibit I-6.
[7] *See*, Intermediary Exhibit I-10.
[8] *See*, Intermediary Supplemental Position Paper, p. 8.

Medicare part A or part C.[9] The Intermediary believes M+C patient bills are submitted as no-pay bills to Medicare and these patients ultimately end up in the Medicare SSI ratio. The Intermediary concludes that since these days are in the SSI ratio they cannot be in the Medicaid ratio.[10] Finally, the Intermediary points to the Board's previous decision in *Baystate Medical Center v. Mutual of Omaha*, PRRB Decision 2006-D20, March 17, 2006 as requiring HMO days to be counted 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 the sampling methodology used by the Intermediary was improper and prior to October 1, 2004 M+C days should be included in the Medicaid fraction used to calculate the DSH adjustment.

Intermediary's Sampling Methodology

Based upon the CMS guidelines for performing provider audits set forth in CMS Pub. 13-4 § 4112.4(B), the Board finds that the Intermediary may utilize a sampling methodology to determine the accuracy of the Medicaid days claimed by the Provider, but must use competent evidence sufficient to support its adjustments. The evidence must be relevant, reliable and logically related to the issue under review. Also, the evidence obtained and procedures used to support the audit results should be appropriately documented and should support the auditor's opinions, judgments, conclusions and recommendations. *Id.*

Audits based on statistical analysis are appropriate when time and resources do not permit auditing the full universe and the results of tests on a sufficiently representative sample can reasonably be extrapolated to the entire universe. The Intermediary used a statistical sampling software program developed by the OIG, known as RAT-STATS, which was designed to assist users in selecting representative samples and evaluating audit results.[11] The Board finds the use of the RAT-STATS program is acceptable if the program is appropriately applied. In this case the Board finds several errors in its application. First, the Board finds the sample size too small. The Intermediary decided to split the Medicaid day population to be tested into four strata. It separated the data into two populations, patient stays which were matched to the State eligibility database and patient stays that were not matched to the State eligibility database.[12] It then divided the patient stays that were matched to the State eligibility database into 3 strata based on length of stays less than ten days, stays 10-47 days and stays over 47 days.[13] While the 4 patients in the length of stays over 47 days stratum were not sampled but tested 100%[14] the other three strata were sampled. Two of the sampled strata had 20 stays sampled and

[9] *Id*., pp. 9-15.
[10] *Id*., p. 15.
[11] *See* OIG website regarding the Office of Audit Services (OAS) RAT-STATS program at http://oig.hhs.gov/organization/oas/ratstats.asp.

[12] *See* Stipulation 10.
[13] *Id*., 10-13.
[14] *Id*., 13.

one had 25 stays sampled.[15] The Board finds that sampling less than 30 patients in a stratum is contrary to CMS policy related to comprehensive medical reviews (CMR) and triggers a cautionary note in the RAT-STATS program. Specifically the Medicare Intermediary Manual, Part 3 (CMS-Pub. 13-3) Transmittal No. 1770 states[16]:

> "For stratified random sampling, the recommended minimum sample size is 100 sampling units with a minimum of 30 sampling units per stratum. If fewer than 30 are present, then all units are used."[17]

Similarly the RAT-STATS 2007 program automatically alerts:

> Whenever one or more of the sample sizes are under 30, the program output will conclude with the note immediately following the calculated total sample sizes.
>
> . . . . .
>
> NOTE (*): One or more sample sizes were under 30. The generated sample sizes were the result of mathematical formulas and did not incorporate management decisions concerning the purpose of the sample or current organizational sampling policies. You may need to increase the sample sizes in order to be in compliance with organizational objectives.
>
> *See*, Intermediary Exhibit I-7, p. 23-24.

The Board finds results based upon sample sizes under 30 per stratum inadequate for eliminating the entire DSH payment.

Second, the Board does not find any rational justification for all the stratifications of the sample. The Board finds the stratifications of patients who did not match to the State eligibility database and the 100% review of the patients with length of stays over 47 days reasonable. However, the Board does not see a relationship between allowable DSH days and length of stay. Therefore the Board finds the breakdown of two strata based on length of stays less than ten days and stays 10-47 days unnecessary.

Finally, the Board finds the results of the sample do not support the Medicaid days eliminated in the audit adjustment. CMS Pub. 13-4 §4112.4(B)(1)(e) states "[s]ampling risk arises from the possibility that when a compliance or a substantive test is restricted to

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[15] *Id*., 10-12 and 14.

[16] The Board is aware that this manual section has procedures limited to the circumstances outlined in this manual section and is only relying on the language as an indication of the inadequacy of the sample size.

[17] Medicare Intermediary Manual, Part 3 (CMS-Pub. 13-3) Transmittal No. 1770, March 1, 1999. Provider Exhibit P-33, p. 5.

a sample, the auditor's conclusions may be different had the test been applied in the same way to all items in the account balance or class of transactions." Sampling variability refers to the different values which a given function of the data takes when it is computed for two or more samples drawn from the same population. To address this uncertainty in sampling, the precision parameters defined as part of the sample selection process must be used to calculate the upper and lower limits of the confidence interval.

The Intermediary used a stratified sampling plan in which the universe was divided into multiple, non-overlapping categories (strata) and selected patient files (i.e., entire stays), not individual patient days, as the sampling unit. The Intermediary used the RAT-STATS variable appraisal module to determine the sample size sufficient to obtain 20 percent precision at a 90 percent confidence level, and to generate the random numbers for selecting the specific sample.[18] Precision is a measure of how close an estimator is expected to be to the corresponding unknown universe value, while confidence level refers to the likelihood of the corresponding interval containing the true universe total. The Intermediary's stated sample parameters allow for a 90 percent probability that the Provider's true number of allowable Medicaid eligible days falls somewhere within a confidence interval that is 20 percent higher or lower than the point estimate[19] derived from the sample results; there is a 10 percent risk that the true number may fall outside this range.

Based upon this sampling method used, the Board finds the Intermediary was limited to two options. First, it could have adjusted to the upper confidence level and had a 90% assurance that the adjustment was justified. Alternatively it could have reduced the claimed Medicaid eligible days for those days actually audited and determined[20] to be non-allowable. Under both of these methods the Provider would have qualified for DSH payments.

The Board notes that although the Intermediary argued that it was its policy to use the point estimate (midpoint of the confidence interval) there is no documentation in the record to indicate that the use of the point estimate is a sanctioned Medicare policy. The Intermediary cited CMS Pub. 100-06, § 60.6 which states, "If the results of testing your sample that was selected using a statistical method indicate probable errors in the universe, document your decision to project the error to the universe/population." [21] The Board finds no mention of the use of point estimates in this manual section. The Board notes CMS Pub. 100-08, § 3.10.5.1 discusses point estimates stating, "the [contractor] is not precluded from demanding the point estimate where high precision has been

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[18] *See* Intermediary Ex. I-8.

[19] Point estimate is defined as a single estimate for the universe total based on the sample mean multiplied by the universe size. *See* Variable-Stratified Program Output definitions from RAT-STATS 2007 User Guide, pages 4-31 and 4-32 at http://oig.hhs.gov/organization/oas/ratstats/UserGuide2007.pdf.

[20] The Board's finding that Intermediary inappropriately disallowed M+C days from the DSH Medicaid fraction would have to be taken into account in determining Medicaid allowable day reductions.

[21] Intermediary Exhibit I-5; Intermediary Post-Hearing Brief at 7-8.

achieved." The Board does not consider a 20% precision to be a "high" precision. The Intermediary had the discretion to increase the sample size, thereby yielding estimates with better precision and a smaller confidence interval, but it chose not to do so.

Based on these findings, the Board concludes that the Intermediary did not properly sample the population nor properly apply the results in adjusting Medicaid eligible days. The Intermediary failed to apply the estimation method that was consistent with its own sampling plan and did not use generally accepted statistical procedures to evaluate the audit findings. Rather, the Board finds that the Intermediary should have utilized the RAT-STATS variable appraisal results, and further, that it was necessary to consider the confidence interval from these results in order to account for the variability inherent in the sampling process. Based on the sample results, there is no basis to disallow any patient days beyond the lesser of the upper confidence interval or the total population less those actually audited and determined to be non-allowable.

Medicaid Eligible M+C days

The Board also finds that Medicaid patients enrolled in a Medicare Managed Care Plan should be included in the numerator of the DSH Medicaid fraction for those patient days occurring prior to the regulatory change effective October 1, 2004. The regulatory change required that M+C days be included in the DSH Medicare fraction. Under the managed care statute 42 U.S.C. § 1395mm, as well as the Balanced Budget Act of 1997, 42 U.S.C. § 1395w-21, a beneficiary must first be entitled to benefits under Medicare part A to enroll in a Medicare managed care plan.[22] However, once enrolled in the plan, that beneficiary would no longer be entitled to benefits under parts A or B. The statute provides that an M+C eligible beneficiary can elect to receive benefits through the traditional fee-for-service program under parts A and B, or enroll in an M+C plan under part C. *See* 42 U.S.C. § 1395w-21(a)(1). Significantly, the Medicare statute uses the disjunctive "or," stating that once that election is made, the beneficiary is entitled to receive benefits under one or the other, but not both. Hence, if a beneficiary is enrolled in an M+C plan, that beneficiary is not entitled to benefits under Medicare part A.[23]

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[22] In prior decisions, the Board found the statutory language dispositive of the question because to enroll in a Medicare+Choice plan under part C, a beneficiary was first required to be "entitled" to Part A benefits. *See e.g. QRS 1994 DSH Managed Care and Medicaid Eligible Days Group v. Blue Cross Blue Shield Association/Noridian Administrative Services*, PRRB Dec. No 2009-D3, Dec. 17, 2008, *declined rev.* CMS Administrator, Feb. 6, 2009. The Board is now convinced it stopped too short in its analysis of the statute. As the District Court in *Northeast Hospital* pointed out, the statute also expressly links "entitlement" to the right to receive payment and further provides that once a beneficiary elects a Medicare+Choice plan, payment is no longer made under part A, but is made under part C. 699 F.Supp.2d. at 81.

[23] In the August 2004 Final Rule, which was published after most of the fiscal year at issue in this case, CMS indicated that though Medicare beneficiaries may elect Medicare part C coverage, they are still, "in some sense" entitled to benefits under Medicare part A and should be included in the Medicare fraction. *See* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004). CMS did not articulate how, or in what sense beneficiaries might be covered by both parts A and C. However, the clear language of the statute cannot be overcome by commentary made by CMS in the preamble to a final rule or in its policy shifts.

The intent of Congress is also clear when one reviews the statute at 42 U.S.C. § 1395w-21(i)(1) which states that payments under a contract with an M+C organization with respect to an individual electing an M+C plan shall be instead of the amounts which would otherwise be payable under parts A and B for services furnished to the individual. Similar to the election of benefits, the payments made under the M+C plan replace payments under parts A and B. Therefore, once enrolled in the M+C program, the beneficiary is not entitled to payments under Medicare part A.

The Board finds that the plain language of the Medicare DSH statute requires the inclusion of M+C days in the numerator of the Medicaid fraction. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Board agrees with the holdings of the two district courts that have recently addressed this precise issue, the meaning of the phrase, "entitled to benefits under part A," as used in the DSH statute. The courts in *Northeast Hospital* and *Metropolitan Hospital* have both held that, as used in the context of the Medicare DSH statute, the term "entitled to benefits under part A" means the right to have payment made under part A for the inpatient hospital days in question. *See, Northeast Hosp.,* 699 F.Supp.2d at 93; *Metropolitan Hosp.*, 702 F.Supp.2d at 823. The Board agrees with the Provider's argument and the district court's holding in *Northeast Hospital* that once an individual has enrolled in a Medicare+Choice plan under part C, he or she is no longer "entitled to benefits under part A," because he or she is no longer entitled to have payment made under part A for the days at issue. *See Northeast Hosp.*, 699 F.Supp.2d at 93 (finding that Congress has "explicitly concluded that M+C patients are not 'entitled to benefits under [Medicare] part A' as that phrase is defined in the Medicaid [sic] statute").

The Board can discern no rational explanation for CMS' inconsistent interpretation of the term "entitled" as used in the same sentence within the DSH statute. On one hand, CMS states that SSI beneficiaries are "entitled to supplemental security income benefits" only when entitled to payment for the specific days at issue, while at the same time finding that any individual who is eligible for benefits under Medicare part A is also "entitled to benefits under part A," regardless of whether or not Medicare actually makes payment for the days at issue.

This same unexplained distinction is also evident in CMS' treatment of part A days for determining a hospital's payment for graduate medical education (GME). The M+C days that CMS insists are part A days for purposes of the DSH payment, are treated as *not* being part A days for purposes of the GME payment. The Board agrees with the Provider that Congress clearly manifested its intent in the GME statute that M+C patients should not be regarded as patients who are "entitled to benefits under part A." Otherwise, there would have been no need for Congress to establish additional GME and IME payments for patients enrolled in M+C plans.

Similarly, CMS' current interpretation of "entitled to benefits under part A," as used in the DSH statute under subparagraph (F) of section 1395ww(d)(5), conflicts with the agency's interpretation of the same phrase as used in the very next subparagraph (G) of the statute. Under subsection G, CMS interprets entitlement to cease once payment

cannot be made on the beneficiary's behalf. *See* 55 Fed. Reg. 35990, 35996 (Sept. 4, 1990).

The district court in *Northeast Hospital* found CMS' failure to acknowledge or explain its departure from established agency precedent to be arbitrary and capricious. *See* 699 F.Supp.2d at 94-95; *see also FCC v. Fox TV Stations, Inc.,* 129 S.Ct. 1800, 1811 (2009) (agencies "may not ... depart from a prior policy *sub silentio* or simply disregard rules that are still on the books"); *accord Dillmon v. Nat'l Trans. Safety Bd.,* 588 F.3d 1085, 1089 (D.C. Cir. 2009) ("Reasoned decision making, therefore, necessarily requires the agency to acknowledge and provide an adequate explanation for its departure from established precedent.").

The Board further finds that CMS' current interpretation of the DSH statute applied in this case improperly conflates the statutory terms "entitled" and "eligible" as used in a single sentence within the DSH statute. CMS' current interpretation construes these terms to have the same meaning, violating the elementary principle of statutory construction that Congress does not intend the same meaning when it uses different terms in different parts of the same statute. *See, e.g., Russello* v. *United States,* 464 U.S. 16, 23 (1983). The Board agrees with the *Metropolitan Hospital* court's holding that the statutory terms "entitled" and "eligible" are "conceptually and practically distinct and not to be used interchangeably." 702 F.Supp.2d at 825. The distinctions between these two terms and the impropriety of conflating them as having the same meaning has been established for over a decade. *See Jewish Hosp. Inc*., 19 F.3d at 274-75; *Cabell Huntington Hosp.,* 101 F.3d at 988 (4th Cir. 1996); *Legacy Emanuel Hosp. and Health Ctr.,* 97 F.3d at 1265-66 (9th Cir. 1996).

The Board finds that the exclusion of the M+C days at issue is contrary to the DSH regulation that was in effect during most of the period at issue. The regulation in effect interpreted the statutory phrase "entitled to benefits under part A" to mean "covered" by Medicare part A, *see, e.g.*, 42 C.F.R. § 412.106(b)(2)(i) (1997), and the part A coverage regulations define "covered" to mean "services for which the law and regulations authorize Medicare payment." 42 C.F.R. § 409.3 (1997). As the Provider correctly points out, this interpretation of the regulation is consistent with the Secretary's statements of intent at the time she adopted the DSH regulation in 1986, 51 Fed. Reg. 31460-61, in subsequent litigation before multiple federal courts of appeals, *see* Provider Ex. 29-31, and in the Administrator's 1996 decision in *Presbyterian Med. Ctr. of Philadelphia v. Aetna Life Ins. Co.*, CMS Administrator, November 29, 1996, Medicare and Medicaid Guide (CCH) ¶45,032, at 4. This is also consistent with CMS's calculation of the Medicare/SSI fraction for periods before the 2004 change in policy. 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004).

The Board does not find the Intermediary's argument with regard to CMS Ruling 1498-R convincing. The Board notes that the regulation quoted in the Ruling, 42 C.F.R. §412.106(b)(2), is quoted as "background" for the Ruling. This regulation does indicate dual eligible days (including M+C days) should be in the Medicare fraction. However, the application of this regulation is exactly what is in controversy in the *Northeast*

Hospital case. The M+C day language did not apply to this regulation until after October 1, 2004.

The Board also overrules the Intermediary's objection that the Provider's M+C issue was a new issue that was untimely added by the Provider.[24] The Board finds that the Provider has not added any issue but instead has simply offered new arguments regarding the same issue: Whether the Intermediary properly adjusted the Provider's number of DSH days.

Finally, the Board finds that Medicaid patients that had Medicare Managed Care days should be included in the numerator of the DSH Medicaid fraction prior to the regulatory change effective October 1, 2004. The Board finds it is bound by the regulatory change to 42 C.F.R. §412.106(b)(2)(i) effective October 1, 2004 which required the Medicare Managed Care days be included in the numerator of the DSH Medicare fraction not the DSH Medicaid fraction after October 1, 2004.[25]

DECISION AND ORDER:

Both the Intermediary's sampling methodology and the exclusion of Medicare+Choice days (prior to October 1, 2004) from the numerator of the Medicaid fraction used to calculate the DSH payment were improper. Based on the sample results, there is no basis to disallow any patient days beyond the lesser of the upper confidence interval or the total population less those actually audited and determined to be non-allowable. The Intermediary is directed to revise the Provider's DSH calculation for the cost reporting period under appeal allowing Medicaid eligible M+C patients (prior to October 1, 2004) in the Medicaid DSH patient count consistent with the Board's findings.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: June 3, 2011

[24] *See* Tr. 52.
[25] *See* 69 FR 48916, 49099 (August 11, 2004).