PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2014-D3

PROVIDER –
Danbury Hospital

Provider No. 07-0033

Cost Reporting Period Ended -
September 30, 2005

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services, Inc.

CASE NO.: 08-2838

INDEX

ISSUE:

Whether the Provider Reimbursement Review Board ("Board") has jurisdiction over a claim for Medicaid eligible days for which there was no adjustment made by the Intermediary within the Notice of Program Reimbursement.

MEDICARE BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services. However, the Medicare reimbursement due is also affected by the Medicaid program. Therefore, a brief overview of both programs is in order.

The Medicare program was established under Title XVIII of the Social Security Act ("Act") to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the Department of Health and Human Services ("HHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to entities known as Medicare Administrative Contractors or Fiscal Intermediaries (collectively, intermediaries). Intermediaries determine payment amounts due the providers under Medicare law, regulation, and interpretative guidelines published by CMS.[1]

Medicaid was enacted as Title XIX of the Act which was codified at 42 U.S.C. Chapter 7, Subchapter XIX. The Medicaid statute authorizes the HHS Secretary to make federal funds available to assist States in providing medical assistance to certain groups, namely low income individuals with a high degree of medical need. Responsibility for administering the Medicaid program is shared by state and federal authorities.[2] For example, program regulations specify that, "[w]ithin broad federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures."[3] States that choose to participate in the Medicaid program must submit to the Secretary, and have approved, a State plan to provide medical assistance.[4]

Most providers are paid on a prospective basis for their inpatient operating and capital costs incurred in treating Medicare beneficiaries.[5] Specifically, the Medicare inpatient prospective payment system ("IPPS") pays providers a predetermined amount per inpatient discharge based on the beneficiary's diagnosis at the time of discharge. IPPS also provides for payment rate adjustments to certain types of providers, such as teaching hospitals or hospitals that treat a large volume of low income patients.[6] The IPPS payment rate adjustment that reflects treatment volume for low income patients is referred to as the Disproportionate Share Hospital ("DSH") adjustment.

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[1] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[2] *See* 42 U.S.C. § 1396a.
[3] 42 C.F.R. § 430.0.
[4] *See* 42 U.S.C. § 1396a.
[5] *See* Social Security Amendments of 1983, Pub. L. 98-21, Title VI, 97 Stat. 65, 149-172 (1984) (codifying the main IPPS statutory provisions at 42 U.S.C. § 1395ww(d)).
[6] *See, e.g.*, 42 U.S.C. § 1395ww(d)(5)(B) (indirect medical education); 42 U.S.C. § 1395ww(d)(5)(F)(i)(I) (low income patients).

Eligibility for a DSH adjustment payment is based on whether a provider meets certain criteria (*e.g.*, number of beds, geographic location) and whether it treats a threshold number of low income patients.[7] As a proxy for the number of low income patients, the Medicare statute uses the sum of two fractions – the Medicare and Medicaid fractions. The sum of these two fractions is known as the "disproportionate patient percentage" or "DPP."

The Medicare fraction (also known as the SSI fraction) utilizes the number of days of inpatient care for Medicare patients who are eligible for Supplemental Security Income ("SSI"). This fraction is statutorily established as follows:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which consists of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary 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.[8]

The Medicaid fraction is derived from inpatient hospital days for patients entitled to medical assistance under the Medicaid program. This calculation is also defined in the statute:

> [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 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.[9]

The greater the DPP exceeds the relevant threshold eligibility for a DSH adjustment, the greater the payment to the provider.

In addition to the statutory provisions governing DSH, there are a host of additional sources that govern the application of this payment adjustment. Most notably, CMS promulgated regulations to implement the DSH statute via an interim final rule published on May 6, 1986 ("May 1986 Interim Final Rule").[10] The primary DSH regulations are located at 42 C.F.R. § 412.106 which establishes the methodology for calculating the DSH adjustment. In particular, the May 1986 Interim Final Rule set forth the following formula in 42 C.F.R. § 412.106(a)(1) for determining the standard DPP (*i.e.*, the DPP based on the federal fiscal year as opposed to the provider's fiscal year):

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[7] 42 U.S.C. §§ 1395ww(d)(5)(F)(i).
[8] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[9] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).
[10] 51 Fed. Reg. 16772 (May 6, 1986).

> (a) *Basic rule.* (1) Unless a hospital elects the option concerning the period of time used for counting the number of patient days (that is, the hospital's cost reporting period rather than the Federal fiscal year), as described in (a)(2) of this section, a hospital's disproportionate patient percentage is the sum of the following, expressed as a percentage:
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> (i) Number of covered patient days during each month of the Federal fiscal year in which the hospital's cost reporting period begins of those patients who are entitled during that month to both Medicare Part A and Supplemental Security Income benefits under title XVI of the Act (excluding those patients receiving State supplementation only), summed for the months of the Federal fiscal year, and divided by the number of patient days during that same Federal fiscal year of those patients entitled to Medicare Part A.
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> (ii) Number of patient days during the hospital's cost reporting period of those patients who are entitled to Medicaid but not to Medicare Part A divided by the total number of patient days in that same period.[11]

Significantly, this regulation limited the numerator of the Medicaid fraction to Medicaid paid days (*i.e.*, days for which "patients are entitled to Medicaid").

CMS later finalized this regulation in the final rule published on September 3, 1986 ("September 1986 Final Rule").[12] In the preamble to the September 1986 Final Rule CMS states the following with respect to the process for obtaining a DSH adjustment:

> *Comment*: One commenter was concerned about the lack of a discussion in the interim final rule about how a hospital can apply for a disproportionate share adjustment. In particular, the commenter wants to know the means by which an adjustment is sought, the relative roles between HCFA and the fiscal intermediary, the time requirement for an application, and the criteria against which the application will be judged.
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> *Response*: It is not necessary for hospitals serving a disproportionate number of low income patients ... to formally apply for a disproportionate share adjustment. The Medicare fiscal intermediaries have been given instructions to make a determination concerning each hospital's eligibility for an adjustment under § 412.106(b)(1) based on Medicaid data from the

[11] 51 Fed. Reg. at 16788 (emphasis in original).

[12] *See* 51 Fed. Reg. 31454 (Sept. 3, 1986). The September 1986 Final Rule finalized 42 C.F.R. § 412.106 without any changes except that CMS made a clarification to subsection (a)(2) which is not at issue in this case. *See id.* at 31497.

> hospital's latest available cost report and the Supplemental Security Income (SSI)/Medicare percentages that have been supplied by HCFA central office. The intermediaries have reviewed the disproportionate share statistical data for each hospital they service and have begun making interim payments (subject to year-end settlement) for those hospitals that they have identified as disproportionate share hospitals.
>
> As we stated in the interim final rule (51 FR 16777), hospitals may submit additional Medicaid and total patient day data to their fiscal intermediaries if they believe that their latest cost report does not accurately reflect these data. However, additional data supplied are subject to intermediary review and verification.
>
> We are evaluating the need to publish regulations to outline procedures and requirements for hospitals to follow in applying for a disproportionate share adjustment based on the patient revenue criteria under section 1886(d)(5)(F)(i)(II) of the Act, as set forth in regulations at § 412.106(b)(2).[13]

Thus, at the outset of implementing the DSH adjustment, CMS stated that providers did not have to "formally apply" for a DSH adjustment and that the intermediary would base its decision to make a DSH adjustment on: (1) the relevant SSI information supplied by CMS; and (2) the Medicaid days information supplied by the provider as part of the cost reporting process.[14] Decisions on DSH adjustments are then included as part of the NPR for the relevant cost reporting period.[15]

Significantly, CMS also stated in the above quote that it was evaluating the need to publish regulations to outline DSH application procedures. However, to date, CMS has not promulgated regulations for any such DSH application procedures.

In the preamble to the May 1986 Interim Final Rule, CMS provides the following discussion on how a provider can resolve disagreements with DSH determinations:

> *The process* we will use for making payments to hospitals that serve a disproportionate share of low-income patients *will be similar to the process we use to make the additional payment for the indirect medical education costs*; that is, we will make interim payments based on the latest available data *subject to a year-end*

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[13] *Id.* at 31457 (italics in original and underline emphasis added).

[14] Similar to the preamble to the September 1986 Final Rule, CMS provides in the preamble to the May 1986 Interim Final Rule a description of the process for determining DSH adjustment payments and that process also did not specify or require any formal applications. *See* 51 Fed. Reg. at 16777 (quote include at text accompanying *infra* note 16).

[15] *See* 51 Fed. Reg. at 31458-31459 (stating, among other things, that "[s]ince the disproportionate share adjustment is based on a hospital's cost reporting period, final determination of a hospital's eligibility for, and amount of, any disproportionate share adjustment will be made by the fiscal intermediary at the time of the year-end settlement of its cost report").

> *settlement on a cost reporting period basis*. For purposes of making these interim payments, the initial determination of a hospital's eligibility for this payment will be made by the hospital's Medicare fiscal intermediary based on the Medicaid statistical data as reported on the hospital's most recent cost report and the SSI and Medicare data to be supplied by HCFA central office. *If a hospital disagrees with the intermediary's determination of its Medicaid patient days, it will be the hospital's responsibility to demonstrate to the intermediary that the Medicaid statistics reported on its cost report are incorrect or were improperly applied. Medicaid data submitted by the hospital*, whether on the cost report or furnished subsequently *are subject to intermediary audit* to ensure their accuracy.[16]

Thus, if a provider is dissatisfied with the intermediary's "determination of its Medicaid days" (whether for purposes of an interim DSH adjustment determination or for the final DSH adjustment determination), the provider as part of "year-end settlement on a cost reporting period basis" has "the . . . responsibility to demonstrate to the intermediary that the Medicaid statistics reported on its cost report are incorrect or improperly applied." Shortly thereafter, CMS confirmed in the preamble to the September 1986 Final Rule that DSH adjustment determinations are handled as part of the cost reporting process and that providers can exercise their appeals rights to appeal such determinations in accordance with the regulations set forth in 42 C.F.R. Part 405, Subpart R.[17]

CMS did not amend 42 C.F.R. § 412.106 as it related to the Medicaid fraction until it issued the final rule published on September 1, 1989 ("September 1989 Final Rule") which was "merely designed to make the regulations easier to read and understand."[18] As part of this final rule, CMS relocated provisions governing the DPP calculation to 42 C.F.R. § 412.106(b) entitled "Determination of a hospital's disproportionate patient percentage." This subsection stated the following as it relates to the Medicaid fraction for the DPP calculation:

> (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. . . .
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> (4) *Second computation.* The fiscal intermediary determines, for the hospital's cost reporting period, the number of patient days furnished to patients entitled to Medicaid but not to Medicare part A, and divides that number by the total number of patient days in that same period.

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[16] 51 Fed. Reg. at 16777 (emphasis added).

[17] *See* 51 Fed. Reg. at 31458-31459 (stating, among other things, that "[u]pon receipt of the Notice of Program Reimbursement, all hospitals have the right to appeal the fiscal intermediary's [DSH] determination in accordance with regulations set forth in 42 CFR Part 405, Subpart R, Provider Reimbursement Determination and Appeals (§§ 405.1801 through 405.1890)").

[18] 54 Fed. Reg. 36452, 36489 (Sept. 1, 1989).

> (5) *Disproportionate patient percentage*. The intermediary adds the results of the first computation made under either paragraph (b)(2) or (b)(3) of this section and the second computation made under paragraph (b)(4) of this section and expresses that sum as a percentage. This is the hospital's disproportionate patient percentage, and is used in paragraph (c) of this section.[19]

More broadly speaking, the DSH regulations have undergone numerous changes since the creation of the adjustment. Certain of these revisions came in the wake of circuit court decisions that invalidated CMS's computation of DSH adjustment payments, specifically the practice of limiting the numerator of the Medicaid fraction to Medicaid paid days. In response to these circuit court decisions, CMS issued HCFA Ruling 97-2 which expanded the type of days that could be included in the numerator of the Medicaid fraction:

> In order to ensure national uniformity in calculation of DSH adjustments, HCFA has determined that, on a prospective basis [effective February 27, 1997], HCFA will count in the Medicaid fraction the number of days of inpatient hospital services for patients eligible for Medicaid on that day, whether or not the hospital received payment for those inpatient hospital services.[20]

Hereinafter, when the term "Medicaid eligible days" is used in connection with the numerator of the Medicaid fraction, it will be referring to Medicaid days whether paid or unpaid.

The Ruling reiterated[21] that the responsibility for collecting, verifying, and reporting Medicaid eligibility as part of the cost reporting process lies with providers:

> Pursuant to this Ruling, Medicare fiscal intermediaries will determine the [DSH] amounts due and make appropriate [DSH] payments through normal procedures. ***Claims*** [for Medicaid eligible days] *must*, of course, *meet all other applicable requirements*. This includes the requirement for data that are adequate to document the claimed [Medicaid eligible] days. *The hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid* (for some covered services) during each day of the patient's inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. *Days for patients that cannot be*

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[19] 54 Fed. Reg. at 36494-36495 (emphasis in original).
[20] HCFA Ruling 97-2 at 3 (Feb, 27, 1997).
[21] CMS originally discussed providers' responsibility to report Medicaid days in the May 1986 Interim Final Rule and the September 1986 Final Rule. *See, e.g.*, 51 Fed. Reg. at 16777 (stating that "[i]f a hospital disagrees with the intermediary's determination of its Medicaid patient days, it will be the hospital's *responsibility* to demonstrate to the intermediary that the Medicaid statistics reported on its cost report are incorrect or were improperly applied" (emphasis added)).

> *verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.*[22]

Thus, HCFA Ruling 97-2 specifies that the provider bears the burden of proof with respect to the Medicaid eligible days claimed on the cost report and that the provider cannot claim Medicaid eligible days that have not been "verified by State records."

In the final rule published on July 31, 1998, CMS conformed the DSH regulations located in 42 C.F.R. § 412.106 "to the new statutory construction issued in HCFA Ruling 97-2."[23] In particular, as part of this final rule, CMS incorporated the hospital's obligation to provide Medicaid eligible days data into regulation at § 412.106(b)(4)(iii).[24] As a result of this revision (as well as other subsequent revisions), § 412.106(b)(4) read as follows during the time at issue:

> (4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation [*i.e.*, the Medicare fraction], 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. For purposes of this second computation [*i.e.*, the Medicaid fraction], the following requirements apply:
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> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
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> (ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.
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> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this

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[22] (Emphasis added.)

[23] *See* 63 Fed. Reg. 40954, 40985 (July 31, 1998).

[24] *Id. See also* Program Memorandum, CMS Pub. No. 60A, Transmittal No. A-01-13 (Jan. 25, 2001) (reissuing Program Memorandum, CMS Pub. No. 60A, Transmittal No. A-99-62 (Dec. 1, 1999)). This memorandum specifies that: "Regardless of the type of allowable Medicaid day, *the hospital bears the burden of proof and must verify with the State* that the patient was eligible under one of the allowable categories during each day of the patient's stay. The Hospital is *responsible for* and must provide adequate *documentation to substantiate the number of Medicaid days* ***claimed***. *Days for patients that cannot be verified by State* records to have fallen within a period wherein the patient was eligible for Medicare as described in this memorandum *cannot be counted.*" *Id.* (emphasis added).

> paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[25]

In 2003, Congress addressed a provider's access to information needed to calculate the DSH Medicare and Medicaid fractions, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA").[26] Specifically, MMA § 951 requires CMS to "*arrange to furnish* to subsection (d) hospitals ... the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year."[27]

In the preamble to the final rule published on August 12, 2005,[28] CMS discussed its implementation of MMA § 951. CMS stated that "we interpret section 951 to require CMS to arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records ..., in the case of the Medicaid fraction, against the State-Medicaid agency's records."[29] CMS maintained that it has satisfied its § 951 obligation under this interpretation because the "established mechanisms" in place at the States allow providers to obtain access to this Medicaid days data and these mechanisms are sufficient.[30] Moreover, CMS reiterated the idea that providers bear ultimate responsibility for verifying the Medicaid eligibility of patients claimed on their cost reports since they furnished inpatient care to the patients underlying any claimed days and, thereby, should be in possession of much of the information needed to verify the days:

> In addition, we believe it is reasonable to continue to place the burden of furnishing the data adequate to prove eligibility for each Medicaid patient day claimed for DSH percentage calculation purposes on hospitals because, *since they have provided inpatient care to these patients for which they billed the relevant payers, including the State Medicaid plan, they will necessarily already be in possession of much of this information. We continue to believe hospitals are best situated to provide and verify Medicaid eligibility information.* Although we believe the mechanisms are currently in place to enable hospitals to obtain the data necessary to calculate their Medicaid fraction of the DSH patient percentage, there is currently no mandatory requirement imposed upon State Medicaid agencies to verify eligibility for hospitals. At this point, we continue to believe there is no need to modify the Medicaid State plan regulations to require that State plans verify Medicaid eligibility for hospitals. However, should we find that States are not voluntarily providing or verifying Medicaid eligibility information for hospitals, we will consider amending the State plan

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[25] 42 C.F.R. § 412.106(b)(4) (2005) (emphasis in original).
[26] Pub. L. No. 108-173, 117 Stat. 2066 (2003).
[27] *Id.* at 2427 (emphasis added.)
[28] 70 Fed. Reg. 47278 (Aug. 12, 2005).
[29] *Id.* at 47438.
[30] *Id.* at 47442.

> regulations to add a requirement that State plans provide certain eligibility information to hospitals.[31]

All providers are required to file cost reports annually, with reporting periods based on the provider's fiscal or accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to Medicare.[32] Each 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").[33] As noted in HCFA Ruling 97-2, under the "normal procedures," intermediaries determine DSH adjustment payments under the IPPS for a cost reporting period based, in part, on the Medicaid eligible days that providers claim on the relevant cost report forms. An intermediary's determination of a provider's eligibility for a DSH adjustment during a cost reporting period and, if eligible, the amount of that adjustment, is issued as part of the relevant NPR.

A provider that is dissatisfied with the intermediary's final determination of total reimbursement (*i.e.*, the NPR) may file an appeal with the Board provided it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy must be $10,000 or more for an individual appeal (or $50,000 for group appeals); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[34]

All decisions of the Board are subject to review by the HHS Secretary, who may reverse, affirm or modify any determination.[35]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Danbury Hospital ("Provider") is a Medicare certified hospital located in Danbury, Connecticut. National Government Services, Inc. is the Provider's designated intermediary ("Intermediary").

On September 23, 2008 the Provider filed with the Board a timely request for hearing for its cost report for the fiscal year ending September 30, 2005 ("FY 2005") based on an NPR dated April 10, 2008. The Provider raised five issues in its appeal request. However, four issues were subsequently transferred to group appeals.[36] The remaining issue in this case concerns the DSH adjustment, namely the Medicaid eligible days data used in the Medicaid fraction. The Provider has described this issue as "[w]hether the numerator of the 'Medicaid fraction' properly includes all 'eligible' Medicaid days."[37]

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[31] *Id.* (emphasis added). *See also* 63 Fed. Reg. at 40985 (July 31, 1998) (stating that "[o]ur proposed revisions to §412.106(b)(4), like the Ruling [97-2], would continue to place on the hospital *the burdens of production, proof, and verification* as to each claimed Medicaid patient day" (emphasis added)).
[32] *See* 42 C.F.R. §§ 413.20, 413.24.
[33] *See* 42 C.F.R. § 405.1803.
[34] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.
[35] *See* 42 U.S.C. § 1395oo(f)(1).
[36] *See* Preliminary Joint Scheduling Order at Tab 2 (April 28, 2009)(filed by the Provider with Board on July 8, 2009); Model D Forms executed to request transfer of Issues 1, 3, 4, & 5 (each filed April 28, 2009).
[37] Provider's Final Position Paper at 3.

The Intermediary challenged the Board's jurisdiction over the DSH/Medicaid eligible days issue by filing a jurisdictional brief dated May 12, 2011 (the "Intermediary's Challenge"). The Provider submitted a responsive jurisdictional brief dated May 18, 2011 (the "Provider's Response").

In order to further develop the record as it relates to the Board's jurisdiction to hear this matter, the Board sent the Provider two separate requests for additional information. First, on February 22, 2012, the Board sent the Provider a letter requesting additional information concerning the Medicaid eligible days issue. The Provider replied via letter dated March 22, 2012. Then, on September 21, 2012, the Board sent the Provider a second letter requesting more detailed and specific information with regard to the same issue. The Provider replied via letter dated October 18, 2012.

The Provider was represented by J.C. Ravindran of Quality Reimbursement Services, Inc. ("Provider Representative"). The Intermediary was represented by the Blue Cross and Blue Shield Association.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that there was no adverse finding from which the Provider can claim dissatisfaction, as required for Board jurisdiction. The Intermediary claims that it did not adjust the number of Medicaid paid and unpaid days reported on the as-filed FY 2005 cost report; rather, it accepted and used the number of such days that the Provider reported on that cost report.[38]

Furthermore, the Intermediary believes that the Provider has had ample time since the issuance of HCFA Ruling 97-2 to either establish a method for accumulating its own Medicaid eligible days (paid and unpaid) or to timely make a request to its State agency for the data prior to submission of its cost report for FY 2005. In addition, the Intermediary cites to prior Board decisions in which the Board ruled that it lacked jurisdiction over issues of unclaimed costs where "[t]here was nothing in the statute, regulations, or manual provisions that prevented the Provider from making the cost report elections in the manner it requested through the reopening request."[39]

As the Intermediary understands the issue, Medicare program requirements dictate that providers have the responsibility of submitting complete and accurate data on their cost reports, including the number of Medicaid eligible days to be used in calculating the DSH payment at final settlement.[40] The Intermediary argues that intermediaries do not accumulate cost report data for providers, but rather are responsible for the review of the data submitted by providers and for verification that this data meets regulatory requirements.

Moreover, the Intermediary requests that the Board review its prior interpretation of DSH application procedures. The Intermediary argues that, in assessing jurisdiction over DSH

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[38] Intermediary's Challenge at 2-3.

[39] *Id.* at 3-4 (citing *Maple Crest Care Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2003-D4 (Nov. 7, 2002), *declined review*, Administrator (Jan. 8, 2003)).

[40] *Id.* at 5-6 (citing to 42 C.F.R. § 413.24).

concerns, the Board misapplies certain agency guidance in the September 1986 Final Rule that should be interpreted as applying only to certain interim payments made at that time.[41] Under this reasoning, the MAC believes that the oft-cited guidance does not apply to the final DSH payment calculation.

PROVIDER'S CONTENTIONS:

The Provider believes that Board jurisdiction can be found based on the holding of the Supreme Court in 1988 in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[42] The Provider believes that *Bethesda* stands for the idea that a provider may appeal costs which it excludes from its cost report, if the inclusion of such items would be futile.[43] This concept of jurisdiction over "self-disallowed" claims, the Provider argues, is also reflected in the Board's own rules.[44]

The Provider asserts that the Medicaid eligible days (including those at issue) are often not available from the State in time for the Provider to include them on the cost report prior to the filing deadline. In support of its position, the Provider asserts that prior Board jurisdiction decisions have suggested that "the practical difficulties in getting [State] information combined with the Secretary's statement it is not necessary for hospitals to formally apply for a DSH adjustment create circumstances in which a provider may demonstrate that it is dissatisfied with the Intermediary's determination of reimbursement despite not having made a claim on the cost report."[45] The Provider essentially asserts that the preambles to the May 1986 Interim Final Rule and the September 1986 Final Rule confirm that providers do not need to make a formal claim for a DSH adjustment and that providers can later submit additional Medicaid eligible days data if they believe their cost report is not accurate.[46]

In addition, the Provider points to the Medicare program regulations which set forth the DSH classification criteria and claims that these regulations "predetermined" that it would not have qualified for DSH.[47] As a result, the Provider asserts that it self-disallowed certain Medicaid eligible days in the cost report in accordance with Board Rule 7.2.A which reads:

> **A. Authority Requires Disallowance**
>
> If you claim that the item you are appealing was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed,
> - give a concise issue statement describing the self-disallowed item[*sic* ,]
> - the reimbursement or payment sought for the item, and

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[41] Intermediary's Challenge at 4 (citing 51 Fed. Reg. at 31457).
[42] 485 U.S. 399 (1988).
[43] Provider's Response at 1 (citing to *Bethesda*).
[44] *Id.* at 2 (citing to Board Rule 7.2A, titled "Authority Requires Disallowance," available at http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/ PRRBRules2009_070109.pdf (last visited December 28, 2012).
[45] *Id.* at 1 (no citations provided for the quote or in support of the assertion).
[46] *Id.* at 1-2 (citing to 51 Fed. Reg. at 16777; 51 Fed. Reg. at 31454, 31457).
[47] *Id.* at 3 (citing to 42 C.F.R. § 412.106(c)).

- the authority that predetermined that the claim would be disallowed.

In this regard, the Provider contends that it can now qualify for a DSH adjustment only as a result of the additional Medicaid days at issue.[48]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered Medicare law and guidelines, the parties' contentions and the evidence presented on record. Set forth below are the Board's findings and conclusions.

At the outset, the Board recognizes that CMS' computation of DSH payment has been shaped by decisions from the Supreme Court and administrative tribunals. In particular, the Board recognizes that the following decisions are relevant to this case in connection with whether the Board has jurisdiction to conduct a hearing on it: (1) the Supreme Court's decision in *Bethesda*; (2) the Board's recent decision in *Norwalk Hospital v. BlueCross BlueShield Ass'n* ("*Norwalk*");[49] and (3) the Administrator's decision in *Norwalk* overturning the Board's decision ("*Norwalk* Administrator Decision").[50] Accordingly, the Board's decision in this case will include a discussion of them.

Similar to its decision in *Norwalk*, the Board finds that: (1) a provider does have an obligation to submit Medicaid eligible days information as part of the cost reporting process; and (2) this obligation is separate and distinct from the DSH adjustment determination process handled by its intermediary.

In support of these findings, the Board notes that the preambles to the May 1986 Interim Final Rule and the September 1986 Final Rule confirm that providers have been required (both prior to and following 1986 when the DSH adjustment payment was added) to submit the Medicaid days data as part of the normal cost reporting process and that this information has been and continues to be subject to the normal cost report audit and settlement process.[51]

Second, the Board notes that the addition of the DSH adjustment in 1986 did not alter the scope of the providers' obligation to submit Medicaid days data. Specifically, in implementing the DSH adjustment in 1986, CMS did not substantively change the scope of providers' then-existing obligation to report Medicaid *paid* days on the cost report. In the preamble to the

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[48] *See* Provider letters to the Board dated March 22, 2012 and October 18, 2012.

[49] PRRB Dec. No. 2012-D14 (Mar. 19, 2012).

[50] Administrator Dec. (May 21, 2012), reversing, PRRB Dec. No. 2012-D14 (Mar. 19, 2012). The *Norwalk* provider appealed to federal district court and the case was later dismissed. The record suggests that the parties settled the case and that the provider requested dismissal of its appeal. *See* Joint Status Rep. at ¶ 1 (Sept. 16, 2013) and Stipulation of Dismissal (Nov. 5, 2013), *Norwalk Hosp. Ass'n v. Sebelius*, Case No. 3:12-cv-01065-JBA (D. CT. filed July 20, 2012 and dismissed Nov. 5, 2013) (stating in the Joint Status Report that "[o]n or about July 23, 2013, the parties reached an agreement in principle with respect to settlement of the ... appeal").

[51] *See supra* notes 13, 14, and 16 and accompanying text. The Board further notes that 42 C.F.R. § 413.24(f) describes a provider's cost report as a "report[] of its operations" which necessarily would include not only a report of costs but also certain occupancy and volume statistics such as Medicaid eligible days. *See also* Provider Reimbursement Manual, CMS Pub. No. 15-2 ("PRM 15-2"), § 3600.

September 1986 Final Rule, CMS stated that its interpretation of the Medicaid days as used in the Medicaid percentage of the DSH calculation was "consistent with the way we require Medicaid days to be reported on the Medicare cost report."[52] CMS explained that its initial interpretation was based, in part, on CMS' belief that Congress did not intend that "an additional reporting mechanism, possibly tied to State eligibility records, be developed to obtain Medicaid statistics on noncovered patient days."[53] As a result, the Board concludes that the then-existing obligation to report Medicaid *paid* days data was not subsumed into the DSH adjustment decision process (*i.e.*, that obligation remained separate and distinct from the DSH adjustment decision process).

Third, the preamble to the May 1986 Interim Final Rule confirms that, if a provider is dissatisfied with the intermediary's "determination of its Medicaid days" (whether for purposes of interim DSH adjustment determination or for the final DSH adjustment determination), the provider as part of the "year-end settlement on a cost reporting period basis" has "the . . . responsibility to demonstrate to the intermediary that the Medicaid statistics reported on its cost report are incorrect or were improperly applied."[54] This discussion confirms that CMS viewed decisions on Medicaid days as a separate and distinct from the DSH adjustment determination itself. The separate and distinct nature of Medicaid days is supported by the facts that it is reported on a separate line and in a separate worksheet from where the DSH adjustment is claimed. Specifically, a provider claims Medicaid eligible days in Worksheet S-3 and claims a DSH adjustment in Worksheet E, Part A.

Based on the above, the Board concludes that: (1) the provider has an obligation to submit Medicaid days information as part of the cost reporting process; and (2) this obligation is separate and distinct from the DSH adjustment determination process. If a provider is dissatisfied with the intermediary's determination of its Medicaid days, the provider can exercise appeal rights in accordance with the regulations set forth in 42 C.F.R. Part 405, Subpart R.[55]

As previously discussed, HCFA Ruling 97-2 expanded the days included in the numerator of the Medicaid fraction from Medicaid paid days to Medicaid paid and unpaid days (*i.e.*, Medicaid eligible days). Further, as part of HCFA Ruling 97-2 and the subsequent promulgation of 42 C.F.R. § 412.106(b)(4)(iii), CMS codified the provider's obligation to claim only those Medicaid eligible days that have been verified by State records. In this regard, that Ruling states that "[c]laims [for Medicaid eligible days] must, of course, meet other applicable requirements" such

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[52] 51 Fed. Reg. at 31460. *See also* 56 Fed. Reg. 43358, 43379 (Aug. 30, 1991) (cross-referencing the September 1986 Final Rule discussion of CMS' interpretation of Medicaid days being based, in part, on how Medicaid days was then-currently being reported as part of the normal cost reporting process).

[53] 51 Fed. Reg. at 31460.

[54] 51 Fed. Reg. at 16777 (emphasis added) (discussing the DSH adjustment process as being "similar to the process we use to make the additional payment for indirect medical education costs").

[55] *See* 51 Fed. Reg. at 31458-31459. *See also* Board Rule 8.2; *see generally* Board Rule 8. Board Rule 8.0 addresses how to frame issues for adjustments involving multiple components and Board Rule 8.2 describes a DSH adjustment as the type of adjustment that may involve multiple issue components. Board Rule 8.1 specifies that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in [Board] Rule 7." Similarly, the Board Rules in effect from March 1, 2002 to August 21, 2008 specified the following in Part I.B.II.a: "You must clearly and specifically identify your position in regard to the issue in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not define the issue as 'DSH.' You must precisely identify the component of the DSH issue that is in dispute."

as "the requirement for data adequate to document the claimed [Medicaid eligible] days" and that "[d]ays for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted." Similarly, the preamble to the July 1998 Final Rule that promulgated § 412.106(b)(4)(iii) states "[o]ur proposed revisions to § 412.106(b)(4), like the Ruling, would continue to place on the provider the burdens of production, proof, and verification *as to each **claimed** Medicaid patient day*."[56] Thus, CMS made clear that, following the expansion of Medicaid days to include paid and unpaid days, providers continued to have the responsibility of claiming the relevant Medicaid days on the cost report (*i.e.*, "production") and proving and verifying with the State each of those claimed days.

This expansion of the types of days included in the numerator of the Medicaid fraction to include State-verified Medicaid eligible days that were unpaid created challenges for providers. Historically, the data needed by providers from the State to verify Medicaid eligibility during a specific fiscal year often had not been available for months or even years after the cost report filing deadline for that fiscal year had tolled. This lack of availability and/or access to State data created a practical impediment to reporting all Medicaid eligible days (both paid and unpaid) for a given fiscal year at the time of the relevant cost report filing deadline. Specifically, it created situations where none (or only a portion) of the relevant Medicaid eligible days data for a fiscal year was available from the State prior to the cost report filing deadline for that fiscal year. In those situations, as required by HCFA Ruling 97-2, providers were to claim only those Medicaid eligible days that were verified by State records.

Notwithstanding the increased complexity associated with reporting Medicaid eligible days data, CMS did not identify and adjust for that complexity when it implemented HCFA Ruling 97-2 as well as CMS' obligation under MMA § 951 to "arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records, . . . in the case of the Medicaid fraction, against the State-Medicaid agency's records."[57] In particular, CMS has not addressed how the practical impediment described above (*i.e.*, the fact that only Medicaid eligible days verified by the State can be claimed and that the data needed to verify Medicaid eligibility may not be available through no fault of the provider) may affect a provider's appeal rights under 42 U.S.C. § 1395oo(a).[58] As described below, the Board concludes that this practical impediment is similar to the legal impediment in *Bethesda.*

In *Bethesda*, the Supreme Court was presented with a situation where regulations prohibited a provider from claiming certain items on its cost report. The provider filed its cost report in compliance with the applicable regulations, but later sought to use the Board appeals mechanism as a means to address the perceived reimbursement shortfall. The Supreme Court held that the Board's "dissatisfaction" requirement could be met absent an adverse adjustment from a fiscal intermediary, stating:

> We agree that under subsection (a)(1)(A)(i) [of 42 U.S.C. § 1395oo], a provider's dissatisfaction with the amount of its total

[56] 63 Fed. Reg. at 40985 (emphasis added).
[57] 70 Fed. Reg. at 47438.
[58] The Board is not aware of CMS ever revisiting its 1986 evaluation of "the need to publish regulations to outline procedures and requirements for hospitals to follow in applying for a disproportionate share adjustment based on the patient revenue criteria under section 1886(d)(5)(F)(i)(II) of the Act." 51 Fed. Reg. at 31457. *See supra note* 13 and accompanying test.

> reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the fiscal intermediary. *Providers know that*, under the statutory scheme, the fiscal intermediary is confined to the mere application of the Secretary's regulations, *that the intermediary is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the intermediary to do otherwise would be* ***futile***.[59]

Significantly, the Supreme Court stated that this futility concept applies to cost reporting situations where the intermediary has no discretion (*i.e.*, where "the intermediary is without power to award reimbursement except as the regulations provide"). In support of this finding, the Supreme Court footnoted the following regulatory citations:

> See 42 CFR § 421.100 (1987) (stating that the provider can only pay claims that are "covered under Medicare Part A or Part B"); § 421.120 (directing that the Secretary shall periodically review an intermediary's audit procedures to ensure it is making "[c]orrect coverage and payment determinations" and is guarding the "proper management of administrative funds"); 42 CFR § 405.460(a)(2) (1985) ("Reimbursable provider costs may not exceed the costs estimated by HCFA [Health Care Financing Administration] to be necessary for the efficient delivery of needed health services. HCFA may establish estimated cost limits for direct or indirect overall costs or for costs of specific items or services or groups of items or services").[60]

The Supreme Court concluded that "petitioners could claim dissatisfaction, within the meaning of the statute, without incorporating their challenge in the cost report filed with their fiscal intermediaries."[61]

As the regulations cited to support the *Bethesda* futility concept continued to be substantively the same during the time at issue,[62] the Board concludes that the *Bethesda* futility concept also

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[59] *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 404 (1988) (emphasis added and footnote omitted).
[60] *Id.* at 404 n2 (brackets in original).
[61] 485 U.S. at 405.
[62] *Compare* citations in quote with 2006 edition of 42 C.F.R. (note that CMS relocated 42. C.F.R. § 405.460(a)(2) (1985) to 42. C.F.R. § 413.30(a)(2)). Further, the manual provisions governing the intermediary audit and reimbursement process specifies that: "In carrying out your audit responsibilities, your primary goal is to arrive at a correct settlement of the cost report. In so doing, preserve the provider's interest and rights but at the same time apply program policies to specific situations to assure compliance with these policies. *Your authority does not extend to determining whether program policies and procedures are appropriate* or should be applied in a given

remains applicable to this case. In applying this concept, the Board concludes that, if a provider did not claim certain Medicaid eligible days on a cost report because the relevant information to verify such Medicaid eligible days with the State was not available (through no fault of the provider) prior to the relevant cost report filing deadline, then the provider could claim dissatisfaction with regard to those Medicaid eligible days. The Board notes that HCFA Ruling 97-2 and 42 C.F.R. § 412.106(b)(4)(iii) recognize that any Medicaid days claimed by the provider on the cost report must be adequately documented with verification from the State of Medicaid eligibility and they necessarily prohibit intermediaries from counting any such days that have not been verified by the State. As a result, the intermediary has no discretion in counting any unverified days.

The Board recognizes that CMS promulgated regulatory provisions to address *Bethesda* situations in the final rule published on May 23, 2008 (May 2008 Final Rule).[63] Specifically CMS promulgated new regulatory provisions at 42 C.F.R. § 405.1835(a)(1) describing how a provider can preserve its right to claim dissatisfaction and to pursue a Board hearing:

> (a) *Criteria.* A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if—
>
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either—
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy: or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).[64]

Significantly, CMS describes the new § 405.1835(a)(1)(ii) as "more akin simply to a presentment requirement" than "an exhaustion requirement."[65]

Section 405.1835(a)(1)(ii) states that the "presentment requirement" is not applicable to FYs that end prior to December 31, 2008 and, thereby, is not applicable to this case. Nevertheless, the

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circumstance. Rather, *your responsibility is to enforce such policies and procedures.* Take corrective action where noncompliance exists." Medicare Financial Management Manual, Pub. No. 100-06, Ch. 8, § 30.2 (emphasis added).

[63] 73 Fed. Reg. 30190 (May 23, 2008).

[64] *Id.* at 30249 (italics in original).

[65] *Id.* at 30196-30197.

regulatory history indicates that CMS anticipated that a provider may protest self-disallowed claims in compliance with § 405.1835(a)(1)(ii) where the cost is unknown and still have appeal rights. In the preamble to the May 2008 Final Rule, CMS recognized that providers can appeal certain situations where the provider is uncertain about the cost of a protested item and does not have access to the underlying data to verify such costs. Specifically, in connection with "Provider Hearing Rights," CMS states the following in the preamble:

> In § 405.1811(b)(2)(i) and § 405.1835(b)(2)(i), we proposed that a provider would be required to explain its dissatisfaction with the amount of Medicare payment for the specific item(s) at issue by stating why Medicare payment is incorrect for each disputed item. *We acknowledge that there may be instances in which a provider may be uncertain as to whether Medicare payment is incorrect because it does not have access to the underlying data (**for example, data from a State agency**).* Accordingly, we have revised § 405.1811(b)(2)(i) and § 405.1835(b)(2)(i) to allow a provider to explain why it is unable to determine whether payment is correct as a result of not having access to underlying information.[66]

This preamble supports the Board's application of *Bethesda* to this case, namely that, prior to the "presentment requirement" specified in § 405.1835(a)(1)(ii) going into effect, a provider was not required to "present" or "claim" Medicaid eligible days which (through no fault of the provider) could not be identified and/or verified with the State because the provider did not have access to the data from the State necessary to identify and/or verify those days.

The Board's application of *Bethesda* is also consistent with Board Rule 7, entitled "Issue Statement and Claim of Dissatisfaction." The portions of Board Rule 7 which apply to this case are only those portions which do not involve the § 405.1835(a)(1)(ii) "presentment requirement" governing self-disallowed items.[67] Specifically, Board Rule 7.1 describes what is required for issue statements that are included in appeal requests and address "NPR or Revised NPR Adjustment." It recognizes in Paragraph B that there may situations where a provider may not have access to data:

> **B. No Access to Data**: If the Provider, *through no fault of its own*, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.[68]

Similarly, Board Rule 7.2 describes what is required for issue statements addressing "Self-Disallowed Items" and recognizes in Paragraph B that there may be situations where a provider may not have access to data:

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[66] *Id* at 30194 (emphasis added) (quoting from Section II.D entitled "Provider Hearing Rights (§ 405.1803(d), § 405.1811, and § 405.1835)").

[67] Subsection C of Board Rule 7.2 addressing the protest of self-disallowed items applies to cost reporting periods ending on or after December 31, 2008. As the cost reporting year in this case ended September 30, 2005, subsection C is not applicable.

[68] (Bold emphasis in original and italics added.)

> **B. No Access to Data**
> If the Provider elects to not claim an item on the cost report because, *through no fault of its own*, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon filing the cost report.[69]

Finally, the Board believes that the basis for above preamble discussion and for Board Rules 7.1.B and 7.2.B continues to exist. In particular, the Board believes that, despite recent improvements in the availability of data, some providers may still experience delays in obtaining access to this State data (*e.g.*, some States will not accept requests relating to a fiscal year until the cost report filing deadline for that fiscal year has tolled).

The Board recognizes that the CMS Administrator, acting on authority delegated by the HHS Secretary, overturned the Board's decision in *Norwalk*. In overturning that decision, the Administrator noted that the burden for verifying Medicaid eligibility for cost reporting purposes has consistently fallen on providers. In support, the Administrator cited regulations, agency rulings, and published agency notices that clearly demonstrate that providers bear ultimate responsibility for fully and accurately reporting Medicaid patient day information.[70] Further, the Administrator asserted that the provider could not be dissatisfied within the meaning of 42 U.S.C. § 1395oo(a) because there was no adjustment of eligible days on the NPR and the provider was simply dissatisfied with its own reporting of Medicaid days.[71] Here, the Administrator would not allow a practical difficulty in meeting that reporting obligation to absolve the provider from fulfilling its responsibilities and seeking reimbursement via the appeals channel. Furthermore, the Administrator was unwilling to concede that such a practical impediment could give rise to jurisdiction under *Bethesda*.[72] Finally, the Administrator suggests that the Provider could have reported non-verified days on the cost report based on its own internal records:

> Technically, CMS did not state in HCFAR 97-2 that the State data is required to file a claim for these days, but stated that such "claimed" days must be verified to be "counted" by the Intermediary in the DSH calculation. As noted, HCFAR 97-2 stated: "*As the intermediaries may require*, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted." In addition, CMS Program Memorandum Transmittal A-01-141 (December 14, 2011) was issued to clarify CMS expectations on the audit and settlement of cost reports. The Transmittal sets out the timeframes for providers to submit

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[69] (Bold emphasis in original and italics added.)
[70] *Norwalk* Administrator Decision at 6-12 (citing to such rules and regulations as HCFA Ruling 97-2, 42 C.F.R. § 412.106(b)(4)(iii), CMS Transmittal A-01-1 (Jan. 25, 2001)).
[71] *Id.* at 19-20.
[72] *Id.* at 21.

> documentation for auditing after submission of the cost report and the Medicare cost report submission requirements and the requirements for a complete cost report.[73]

In reviewing the Administrator's decision in *Norwalk*, the Board disagrees with the Administrator's finding that a practical impediment in reporting on the as-filed cost report certain Medicaid eligible days that could not be verified with the State, through no fault of the provider, prior to the filing of the cost report could not give rise to jurisdiction under *Bethesda*. Similar to its holding in *Norwalk*, the Board maintains that a *Bethesda* situation exists in this scenario because first and foremost the *Bethesda* ruling is based on the principle that it would be "futile" for the provider to claim an item on the cost report (such as then-unverified eligible days) because the intermediary must enforce Medicare program statutes, regulations, rulings and manuals, including HCFA Ruling 97-2 which specifies that any claimed eligible days that have not been verified with the State cannot be counted as allowable Medicaid eligible days for DSH purposes. The fact that a provider's records suggest that additional days *potentially* may be later identified and/or verified with the State, notwithstanding the fact that such State verification could not be obtained from the State prior to the cost report filing, through no fault of the provider, does not in any way lessen that provider's right to assert *Bethesda* futility. This is because the provider's right to assert *Bethesda* futility is based on the facts existing at the time of the cost report filing.

If a provider has information at the time of the cost report filing that suggests that, *subsequent to that filing and through no fault of the provider*, the provider may *potentially* obtain confirmation/verification from a third party of the additional relevant facts, one could argue that this information would counteract some or all of the *Bethesda* futility. However, that argument necessarily hinges on whether that information will in fact later be confirmed/verified (*i.e.*, later proved to be true/accurate). As a result, under the Administrator's rationale, in connection with any Medicaid eligible days, if it was not able to identify and/or verify with the State, through no fault of its own, prior to filing its cost report, the provider would be required to estimate at the time of the cost report filing how many additional Medicaid eligible days it should claim on the cost report. This estimate would necessarily be based on how many additional Medicaid eligible days the provider believes that it subsequently could identify and verify with the State. Requiring the provider to claim those estimated days on the as-filed cost report in order to protect its ability to later claim dissatisfaction would raise significant thorny issues. When each provider signs the cost report form, it certifies that the cost report "is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted" and that "the services identified in this cost report were provided in compliance with such laws and regulations."[74] Similarly, the cost report form includes the following warning regarding misrepresentation and false claims:

> MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE,

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[73] *Id.* at 20-21 n.31 (emphasis in original).
[74] Worksheet S of the CMS Form-2552-96.

IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.[75]

The following list provides examples of the types of issues that would be raised if a provider were required to include on the cost report estimates of any Medicaid eligible days that the provider, through no fault of its own, could not identify and/or verify with the State prior to the cost report filing deadline:

1. Claiming of any estimated Medicaid eligible days on the cost report, regardless of their accuracy, may raise potential issues under the False Claims Act[76] because "§ 412.106(b)(4), like the Ruling [97-2], would continue to place on the hospital the burdens of production, proof, and verification *as to each claimed Medicaid patient day*."[77] How would a provider ensure that any estimated Medicaid eligible days claimed on the as-filed cost report do not raise any of the misrepresentation or false claim issues covered by the warning included on the cost report form? This issue is highlighted by the fact that, as suggested by the Administrator's decision in *Norwalk*, these estimated days would need to be verified with the State prior to the issuance of the NPR so that the additional verified days could be included as part of the audit process or as part of an amended cost report filed prior to the issuance of the NPR. As a result, any estimated days included on the as-filed cost report would need to be based only on the subset of Medicaid eligible days which the provider believes exist *and* which could actually be verified by the State prior to the issuance of the NPR.[78] How would a provider estimate this subset and include it on the cost report without raising any of the misrepresentation or false claim issues covered by the warning included on the cost report?[79]

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[75] *Id.*

[76] In this regard, the Board notes that the CMS Administrator's decision fails to address whether claiming eligible days on the as-filed cost report that have not been verified with the State could raise any potential false claims issues. *See, e.g., U.S. ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 20 F. Supp. 2d 1017 (S.D.Texas 1998); *U.S. ex rel. Augustine v. Century Health Servs., Inc.*, 136 F. Supp. 2d 876 (M.D. Tenn. 2000), *aff'd*, 289 F.3d 409 (6 th Cir. 2002). However, in raising this potential issue and making this observation, the Board makes no finding on whether this scenario in fact raises any actual issues under the False Claims Act as this is outside of the Board's scope of review under 42 U.S.C. § 1395oo and the regulations governing the Board at 42 C.F.R. Part 405, Subpart R.

[77] 63 Fed. Reg. at 40985 (emphasis added) (excerpt from July 1998 Final Rule which conformed 42 C.F.R. § 412.106 "to the new statutory construction issued in HCFA Ruling 97-2").

[78] Further, the provider has only a limited time in which to file an amended cost report (*i.e.*, prior to the issuance of the NPR) and the provider's estimate would have to be based on the subset of Medicaid eligible days that it believes potentially exist *and* could be identified and/or verified by the State prior to the issuance of the NPR. An amended cost report submitted after the issuance of the NPR would be treated differently; specifically, it would be treated as a request for reopening of the NPR. *See infra* note 80 and accompanying text.

[79] Calculating this estimate would be further complicated by the fact that intermediaries are not required to issue NPRs within a specified time frame. In this regard, the Board notes that, even though 42 C.F.R. § 405.1835(c) (2005) as well as § 405.1835(a)(3)(ii) as promulgated under the May 2008 Final Rule each suggest that an NPR should be issued within 12 months of the cost report, the actual issuance can vary significantly from year to year and may be many months beyond that 12 month mark.

2. How would a provider accurately estimate how many additional Medicaid eligible days during a cost reporting period are attributable to patients who were retroactively approved for Medicaid but for whom identification and/or verification from the State was not available prior to the cost report filing through no fault of the provider (*e.g.*, the retroactive approval by the State Medicaid program occurred subsequent to the cost report filing)? Are provider records sufficient to accurately identify the potential universe of these retroactively-approved Medicaid beneficiaries prior to the cost report filing?

3. Even though a provider may, subsequent to the issuance of the NPR, through no fault of its own, obtain the requisite identification and/or verification of additional Medicaid eligible days from the State, the provider does not have an absolute right to have the intermediary reopen that NPR because, regardless of the equities involved, the intermediary has discretion whether to grant a reopening and the intermediary's denial of a reopening is not reviewable.[80] If a practical impediment could not rise to the level of a *Bethesda*-type self-disallowance, how would a provider protect its right to claim any Medicaid eligible days that, through no fault of its own, it was not able to identify and/or verify prior to the issuance of the NPR?

Based on the above, the Board concludes the provider's ability to correct the as-filed cost report through certain administrative procedures (*e.g.*, file an amended cost report prior to the issuance of an NPR or request a reopening subsequent to the NPR) has no bearing on whether the *Bethesda* futility exists at the time of filing. This is supported by the fact that in promulgating 42 C.F.R. § 405.1835(a)(1)(ii), CMS has characterized the requirement to protest any self-disallowed items as "more akin simply to a presentment requirement" than "an exhaustion requirement."[81]

Notwithstanding, the Board agrees with the Administrator in *Norwalk* that a provider does have an obligation to establish that a practical impediment did exist preventing it from obtaining required verification from the State. In this regard, the Administrator noted that, if the practical impediment theory were allowed to proceed, the provider would have a high burden of proof to establish the existence of such a practical difficulty. Under this alternative theory, the Administrator ruled that the *Norwalk* provider had failed to meet that high burden of proof:

> Moreover, even assuming *arguendo* that there could be a practical impediment to claiming all the costs for which one is entitled to receive payment that could rise to the level of a Bethesda-type self-disallowance, the facts in this case do not demonstrate such practical impediment existed here. As noted, the Provider did not

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[80] In this regard, the Board notes that the criteria specified in the first sentence of the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2931.2 that intermediaries should apply in deciding whether to grant a reopening (*e.g.*, "new and material evidence") is not enforceable by providers when a reopening is not granted. *See Your Home Visiting Nurse Servs., Inc. v. Shalala*, 525 U.S. 449 (1999) (holding that "the right of a provider to seek reopening exists only by the grace of the Secretary" and the Board does not have jurisdiction to review an intermediary's refusal to reopen an NPR determination). In such instances where a reopening is not granted in contravention to the criteria, the only recourse a provider might have would be to file a complaint with CMS for purposes of the performance review of the contractor.

[81] 73 Fed. Reg. at 30196-30197.

> submit any evidence as to the internal methods it used to accurately capture all Medicaid days, nor the actions it took to acquire the State day listing and thus did not demonstrate that there existed in fact a practical impediment to claiming these days.[82]

In this case, the Board recognizes that CMS did not promulgate, and continues not to promulgate any regulations to establish a formal DSH application process. The cost report forms relevant to the years at issue did not allow a provider that was not currently receiving DSH adjustments (such as the Provider) to claim a DSH adjustment on the cost report. In this regard, the cost report instructions in effect during the period at issue specified that a provider could claim a DSH adjustment in the DSH section of Worksheet E, Part A (Lines 4 to 4.04) only if it answered "yes" to Line 21.01 of Worksheet S-2.[83] The following is asked on Line 21.01:

> Does your facility qualify and is it currently receiving payment for disproportionate share hospital adjustment, in accordance with 42 CFR 412.106?[84]

As the Provider was not receiving DSH adjustment payments when it completed the cost report at issue, the cost report instructions for Worksheet E, Part A, prohibited the Provider from claiming a DSH adjustment on the cost report at issue.[85] As a result, the Provider has essentially argued that, even though it did not qualify for a DSH adjustment at the time it filed its cost report, it had no ability to apply for a DSH adjustment on the cost report or to subsequently submit additional Medicaid eligible days data to the intermediary if it believed its cost report did not accurately reflect this data and these additional days would allow it to qualify for a DSH adjustment. The Provider asserts that the additional Medicaid eligible days at issue, if allowed, would enable it to qualify for a DSH adjustment for the cost reporting period at issue.

The Board rejects the Provider's argument because the Provider was responsible for accurately reporting Medicaid eligible days on its cost report and, as previously noted, this reporting obligation is separate and distinct from the DSH adjustment determination process without regard to whether there is or is not a formal DSH application process.[86] In this regard, the Board

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[82] *Norwalk* Administrator Decision at 21 (italics in original).

[83] *See* PRM 15-2 § 3630.1 (specifying the following in the instructions for the DSH section of Worksheet E, Part A (Lines 4 to 4.04): "Complete this portion only if you answered yes to line 21.01 of Worksheet S-2").

[84] Worksheet S-2, Line 21.01.

[85] The Board notes that the DSH section of Worksheet E, Part A and Question 21.01 of Worksheet S-2 were both originally added in August 1997. *See* PRM 15-2, Ch. 36, Transmittal No. 3 (Aug. 1997). The original instructions for the Worksheet E, Part A are the same as those in effect during the time at issue, namely that a provider could complete the DSH section only if it answered "yes" to Line 21.01 of Worksheet S-2. As it was originally posed in August 1997, Question 21.01 simply asked: "Are you eligible for disproportionate share adjustment payments in accordance with 42 CFR 412.106? (see instructions)." *Id.* In May 1999, CMS revised Question 21.01 to limit its application to those currently receiving DSH. *See* PRM 15-2, Ch. 36, Transmittal No. 5 (May 1999). As a result, for cost reporting periods ending on or after September 30, 1997 but prior to September 30, 1998, a provider that qualified for a DSH adjustment was able to claim that on the cost report regardless of whether they were then-receiving DSH adjustment payments. *See* PRM 15-2, Ch. 36, Transmittal Nos. 3 and 5. Transmittal 5 does not include any discussion of why CMS revised Question 21.01 in May 1999 to effectively preclude a provider which is not then-receiving DSH adjustment payments from claiming a DSH adjustment on a cost report even though that provider may so qualify for a DSH adjustment for the cost reporting period covered by that cost report.

[86] The Board notes that the Provider cites to the preambles to the May 1986 Interim Final Rule and September 1986 Final Rule in support of its position. *See* Provider Response at at 1-2 (citing to 51 Fed. Reg. at 16777 and 51 Fed. Reg. at 31454, 31457) . However, the Provider misconstrues the discussion in these preambles. This discussion

agrees with the Intermediary that intermediaries do not accumulate Medicaid eligible days data for providers, but rather they are responsible for reviewing any such data submitted by providers and verifying that it meets regulatory requirements (*e.g.*, each claimed day is State-verified).

As discussed above, the Board has interpreted and applied *Bethesda* such that, prior to the "presentment requirement" specified in § 405.1835(a)(1)(ii) going into effect, a provider was not required to "present" or "claim" Medicaid eligible days that (through no fault of the provider) could not be identified and/or verified with the State because the provider did not have access to the data from the State necessary for such identification and/or verification. As a consequence, the Board asked the Provider to bolster the record on two separate occasions. However, despite these Board requests, as explained more fully below, the Provider failed to demonstrate the existence of a practical impediment that prevented it from claiming the days in question on the as-filed cost report. This evidentiary shortcoming is especially glaring in light of the Board's multiple attempts to obtain additional information from the Provider on the issue.

In February, 2012, the Board wrote the Provider seeking further information. In particular, the Board stated that:

> In order to make its determination, the Board needs to know the number of additional Medicaid eligible and paid days that you are requesting to be included in the DSH calculation and an explanation as to why these days were not included in the as filed cost report.[87]

The Provider responded on March 22, 2012. While the response indicated that an additional 474 days were sought, the Provider's explanation as to why these days were not claimed was phrased broadly:

> As to this remaining issue, DSH/Medicaid Eligible Days, the Provider is seeking an additional 474 paid and eligible days. These days were not included in the as filed cost report because late paid claims are not included and state eligibility systems across the country are constantly being updated so that subsequent reviews are necessary to capture all Medicaid Eligible days. In addition, this Provider did not qualify for DSH when the cost report was filed, *so special attention was not given to obtaining all possible Medicaid paid and eligible days.*[88]

The Board found that this response did not provide sufficient detail to justify a practical impediment. In particular, the Board notes that the Provider's response suggests that the

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simply confirms that, similar to other cost reporting issues (*e.g.* indirect medical education costs), a provider may submit additional Medicaid days data (which at that time was limited to Medicaid paid days) for the intermediary's review during the cost report audit and settlement process. As a result, the Board concludes that the discussion in these preambles cannot be construed as granting any data submission rights or privileges above and beyond those granted for other cost reporting issues.

[87] Board Letter to Provider Representative (Feb. 22, 2012).

[88] Provider Representative Letter to Board (Mar. 22, 2012) (emphasis added).

Provider was not diligent and may have been at fault for not identifying some of the days at issue on the as-filed FY 2005 cost report.

As a result, the Board made a second request for additional information from the Provider in September 2012. In this letter, the Board was more explicit in its demands and requested the following three distinct items for development:

- A detailed description of the process that the Provider used to identify and accumulate the actual Medicaid paid and eligible days that were reported and filed on the Medicare cost report at issue.
- The number of additional eligible and paid days that the Provider requests be included in the DSH calculation.
- A detailed explanation why these additional days could not be verified by the state at the time the cost report was filed. (*Please identify how many days are included in each category*).[89]

The Provider responded via a letter dated October 18, 2012 that contained a brief response to each demand.[90] In response to the first Board request, the Provider described its identification and accumulation process as follows:

> At the time the cost report was filed the Provider asked for a Paid Claims Listing from the State of Connecticut, then reviewed internal reports to identify additional Medicaid eligible days not on that Paid Claims Listing, and then compiled a list of Medicaid eligible days to be included on the cost report.[91]

With regard to the two remaining Board development items, the Provider first reiterated that it was seeking the inclusion of 474 additional Medicaid eligible and paid days, and then offered an explanation of the difficulties it faced in breaking out and categorizing the requested days:

> *The ability to identify how many eligible days are included in each category is not readily available*, but the days are eligible pursuant to HCFA 97-2. However, [the Provider Representative] believes that some of the 474 additional days that the Provider is seeking to include in the Medicaid fraction of the DSH calculation are days that could not be verified by the State of Connecticut at the time the cost report was filed because these were late filed claims. In addition, some of the patients qualified for Medicaid retroactively so at the time of the cost report filing such patients did not qualify for Medicaid. As a result, some of the 474 additional days could

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[89] Board Letter to Provider Representative (Sept. 21, 2012) (emphasis added).
[90] Provider Representative Letter to Board (Oct. 18, 2012).
[91] *Id.*

> not be claimed as Medicaid eligible days until they received retroactive coverage. Additional days were also identified through a review performed by [the Provider Representative] to ensure all possible Medicaid paid and eligible days were properly claimed once it was determined that the Provider might qualify for DSH with the inclusion of additional Medicaid eligible days.[92]

The Board finds this explanation lacking and not responsive to the Board's request. Despite the Board's repeated efforts to develop the record as to this issue, the Provider has not offered any specific or detailed information about the Medicaid eligible days at issue. The Provider has not shown that, in connection with the Medicaid eligible days at issue, it faced a practical impediment to which the *Bethesda* self-disallowance rationale might attach.

First, the Provider has not adequately described its internal process for gathering State information, particularly as it relates to identifying and verifying Medicaid eligible days that were unpaid. For example, despite being asked to address the specific difficulties that it encountered in obtaining information from the State of Connecticut for the cost report year in question, the Provider's first response letter instead invoked broad flaws with "state eligibility systems across the country" as a basis for the shortcomings of its as-filed FY 2005 cost report.[93]

When the Board extended a second chance to develop the record concerning the same issue, the Provider Representative did provide some additional information; however, the Provider again failed to provide sufficient detail. For example, the Provider simply states that it based its reported Medicaid eligible days data on a "Paid Claims Listing" from the State of Connecticut and certain internal reports concerning Medicaid eligible days that were unpaid, without giving either a description of that process or an explanation of how that process satisfied the Provider's responsibility to report these days on the cost report. Similarly, the Provider Representative stated that it became aware of some of these purported additional days following its own "review." However, the record does not reflect the date at which the Provider became aware of these additional days. The Board has only been told that such days were discovered following the finalization of the Provider's cost report and have been presented on appeal as a self-disallowance.

Second, the Provider has not adequately identified the nature of the days that it seeks to include on appeal.[94] While the Provider has stated that it seeks 474 additional days, it has offered very little information regarding the composition of these days. Despite being specifically asked to "identify how many days are included in each category" of Medicaid days, the Provider claims that this information is "not readily available." This suggests that information is available but that there may be some difficulty in obtaining it. Furthermore, the Provider does not elaborate as to the reason this information is "not readily available" or why the Provider should be excused

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[92] *Id.* (emphasis added).

[93] For example, the Provider could have articulated specific issues regarding timely generation of reports from the State of Connecticut that contributed to a delay in obtaining further data about unpaid days prior to the filing of the cost report.

[94] The record indicates that the Provider filed the FY 2005 cost report on April 13, 2006 which was finalized on April 1, 2008. The FI issued the NPR on April 10, 2008 with no adjustment in the number of Medicaid eligible days from which the Provider appealed on September 22, 2008. The actual number of additional Medicaid eligible days (474)which it was seeking was not stated until the Final Position Paper filed on June 20, 2011.

from providing it. Similarly, the Provider offers few, if any, specifics as to the processes that it employed in attempting to refine this number.

Finally, similar to the Provider's first response letter, the information that was provided in the Provider's second response letter also suggests that the Provider may have been at fault for not identifying at least some of the days at issue on the as-filed FY 2005 cost report. Specifically, the Provider states that a portion of these days were attributable to certain unexplained "late-filed claims" and to a review conducted "to ensure all possible Medicaid paid and eligible days were properly claimed once it was determined that the Provider may qualify for DSH with the inclusion of additional Medicaid eligible days."

Based on the above, the Board concludes that it does not have jurisdiction under 42 U.S.C. § 1395oo(a) to hear the claim for 474 additional Medicaid eligible days pursuant to *Bethesda* because the Provider failed to establish that there was a practical impediment, through no fault of the Provider, preventing the Provider from identifying and/or verifying these days with the State prior to the filing of the cost report.

Notwithstanding the Board's denial of jurisdiction under 42 U.S.C. § 1395oo(a) to hear the Medicaid eligible days claim, the Board recognizes that the Provider did include in its original appeal other issues which establish the Board's jurisdiction under 42 U.S.C. § 1395oo(a) to hold a hearing (*e.g.*, whether the Intermediary used the correct SSI percentage in the DSH calculation) and that the Board could exercise discretion under 42 U.S.C. § 1395oo(d) to hear the Medicaid eligible days claim.[95] However, the Board declines to exercise its discretion under subsection (d). In this regard, the Board notes that it decides whether to exercise discretion on a case-by-case basis and that the record for this case contains little if anything for the Board to consider as the Provider has neither presented any evidence supporting its claim that a practical impediment existed nor asked and explained why the Board should exercise jurisdiction under subsection (d).[96]

DECISION OF THE BOARD:

The Board finds that it lacks jurisdiction under 42 U.S.C. § 1395oo(a) over the Provider's Medicaid eligible days claim for FY 2005. Further, the Board declines to exercise its discretion under 42 U.S.C. § 1395oo(d) to hear this claim. Since this claim is the final issue in the appeal, the case is hereby dismissed.

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[95] *See St. Vincent Hosp. & Health Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2013-D39 at 13, 15 (Sept. 13, 2013) (stating that "the Board has generally interpreted [42 U.S.C.] § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) . . . requiring that dissatisfaction be expressed with respect to total reimbursement for 'each claim' . . . because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report" (citations omitted) and "only when the provider has established jurisdiction under § 1395oo(a) with respect to one or more of such claims/issues can the Board then exercise discretion to hear other claims not considered by the intermediary (*e.g.*, unclaimed costs)"). *See also MaineGeneral Med. Ctr. v. Shalala*, 205 F.3d 493 (1st Cir. 2000).

[96] Further, the Board notes that the Provider is located in Danbury, Connecticut which is in the Second Circuit and, should the Provider pursue an appeal in the federal court system, it could pursue such an appeal in either the Second Circuit or the Circuit for the District of Columbia ("D.C. Circuit"). However, neither the Second Circuit nor the D.C. Circuit has addressed a provider's right to appeal under subsections (a) or (d) of 42 U.S.C. § 1395oo. Accordingly, the Board is following its interpretation of those rights as discussed in *supra* note 95.

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Michael W. Harty
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DATE: FEB 11 2014