PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2015-D5

PROVIDER –
Barberton Citizens Hospital
Barberton, OH

PROVIDER NO.: 36-0019

vs.

INTERMEDIARY –
CGS Administrators, LLC/
Blue Cross and Blue Shield Association

DATE OF HEARING -
November 20, 2014

Cost Reporting Periods Ended –
2004 and 2005

CASE NOs.: 07-0399 and 08-0748

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ISSUE STATEMENT

For fiscal years ("FYs") 2004 and 2005, does the Provider Reimbursement Review Board (the "Board") have jurisdiction over the Medicaid eligible days issue in the appeals?[1]

DECISION

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Board concludes that, pursuant to the concept of futility explained in the U.S. Supreme Court's decision in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*"),[2] it has jurisdiction under 42 U.S.C. § 1395oo(a) to hear this appeal for additional Medicaid eligible days for FYs 2004 and 2005. HCFA Ruling 97-2 requires hospitals to claim only State-verified Medicaid eligible days on the cost report and Barberton Citizen Hospital ("Barberton") has established that a practical impediment, through no fault of its own, prevented it from identifying and/or verifying with the relevant State the Medicaid eligible days at issue prior to filing of the cost reports at issue.

INTRODUCTION

Barberton filed timely requests for hearings for its cost reports for FYs 2004 and 2005 based on Notices of Program Reimbursement ("NPRs") issued for those years by CGS Administrators, LLC ("Medicare Contractor") which is the Medicare administrative contractor ("MAC")[3] assigned to Barberton. Barberton raised multiple issues in its appeal requests, and subsequently added additional issues to its appeals. For each of these fiscal years, all of the issues were either subsequently transferred to group appeals or withdrawn except the issue involving the number of Medicaid eligible days used to calculate the Disproportionate Share Hospital ("DSH") adjustment. The Medicare Contractor challenged the Board's jurisdiction over the Medicaid eligible days issue in both appeals by filing identical jurisdictional briefs on September 8, 2014. Barberton submitted responsive jurisdictional briefs on October 6, 2014.

The Board held a hearing to further develop the record as it relates to the Board's jurisdiction. Barberton was represented by Mark Polston, Esq., of King & Spalding, L.L.P. The Medicare Contractor was represented by Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield Association.

BACKGROUND ON THE MEDICIAD ELIGIBLE DAYS ISSUE

The Medicare program generally pays hospitals for inpatient services on a prospective basis under the inpatient prospective payment system ("IPPS"). The Medicare program adjusts the IPPS payment to certain hospitals that treat a large volume of low income patients. This adjustment is known as the "disproportionate share" ("DSH") adjustment.[4] This DSH adjustment

[1] Transcript, ("Tr") at 5-6.
[2] 485 U.S. 399, 404 (1988).
[3] Historically, the Medicare contractors charged with administering Medicare Part A were known as fiscal intermediaries ("FIs"). FIs and MACs will be referred to collectively as Medicare Contractors.
[4] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I) (low income patients).

is calculated based on a complex formula that requires a hospital to report on its Medicare cost report, the number of Medicaid eligible patient days. Specifically, the number of Medicaid eligible days is used in the numerator of the Medicaid fraction in calculating the DSH adjustment.

Prior to the addition of the DSH adjustment in 1986, hospitals had an obligation to report Medicaid *paid* days data on the cost report.[5] When the DSH adjustment was added, the Health Care Financing Administration ("HCFA") which is now known as the Centers for Medicare and Medicaid Services ("CMS")) did not substantively change the scope of hospitals' then-existing obligation to report Medicaid *paid* days on the cost report.[6] HCFA Ruling 97-2 expanded the days included in the numerator of the Medicaid fraction from Medicaid paid days to both Medicaid paid *and* unpaid days (collectively referred to as "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 hospital's obligation to claim on the cost report *only* those Medicaid eligible days that have been verified by State records.

The inclusion of State-verified Medicaid eligible days that were unpaid in the numerator of the Medicaid fraction created challenges for providers. Hospitals generally have complained that they cannot obtain accurate Medicaid eligibility verification for all days from the State Medicaid programs, within the five-month deadline for filing the Medicare cost report with their Medicare Contractor. As a result, hospitals often have obtained additional information on Medicaid eligible days subsequent to the cost report filing and have either submitted requests to their Medicare Contractor (*e.g*., request to supplement a cost report, request to file an amended cost report, request to reopen an NPR) to have these days included as part of the DSH calculation or the hospitals have filed requests for a hearing with the Board.

Medicare Contractors have challenged the Board's jurisdiction to hear many of these appeals and the basis for the Medicare Contractor's challenge generally has been that the hospitals cannot be dissatisfied with the Medicare Contractor's determination as required by 42 U.S.C. § 1395oo(a) because the hospitals did not claim the additional Medicaid eligible days on the as-filed cost report.

In its decisions in *Norwalk Hosp. v. Blue Cross and Blue Shield Ass'n* ("*Norwalk*")[7] and *Danbury Hosp. v. Blue Cross and Blue Shield Ass'n* ("*Danbury*"),[8] the Board determined that: (1) hospitals have an obligation to submit Medicaid eligible days information as part of the cost reporting process; (2) this obligation is separate and distinct from the DSH adjustment determination process; and (3) the hospitals have the burden of proof and can only report and claim on their cost report those Medicaid eligible days that have been verified with the relevant

[5] *See* 51 Fed. Reg. 16772, 16777, 16788 (May 6, 1986) ("May 1986 Interim Final Rule"); 51 Fed. Reg. 31454, 31457, 31458-31459 (Sept. 3, 1986) ("September 1986 Final Rule"). 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 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.
[6] *See* 51 Fed. Reg. at 31460; 56 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).
[7] PRRB Dec. No. 2012-D14, (Mar. 19, 2012), *vacated*, CMS Adm'r Dec. (May 21, 2012).
[8] PRRB Dec. No.2014-D03 (Feb. 11, 2014), *declined review*, CMS Adm'r (Mar. 26, 2014).

State.[9] The Board further determined that, pursuant to the concept of futility in *Bethesda*, it had jurisdiction over a hospital's appeal of the number of Medicaid eligible days for the DSH adjustment if that hospital can establish a "practical impediment" as to why it (through no fault of its own) could not claim these days at the time that it filed its cost report. In granting jurisdiction, the Board concluded that a "practical impediment" (*i.e.*, the fact that only Medicaid eligible days verified by the State can be claimed on the cost report and that the hospital, through no fault of its own, was unable to verify the Medicaid eligible days at issue from States' records prior to filing its cost report due to lack of availability or access to the relevant State records) was analogous to the "legal impediment" which the Supreme Court found sufficient for Board jurisdiction under 42 U.S.C. § 1395oo in *Bethesda* because both are grounded in the following *Bethesda* concept of the futility – "[p]roviders know that . . . the intermediary is without power to award reimbursement except as the regulations provide, and any attempt to persuade the intermediary to otherwise would be futile."[10]

On May 23, 2014, the Board issued Alert 10 to give hospitals with an appeal currently pending before the Board that included the Medicaid eligible days issue an opportunity to supplement the record based on the Board's decision in *Danbury*.[11] Specifically, these hospitals were given 60 days from the date of the issuance of Alert 10 to supplement the record with additional arguments and/or documentation that would help the Board understand the practical impediment which prevented them from verifying the Medicaid eligible days with the State prior to filing their cost report. The Board issued Alert 10 in order to provide an opportunity to hospitals to explain the process that they used to obtain the Medicaid eligible days reported on their as-filed cost report and explain what barrier(s) that they faced, which were outside of their control, in obtaining State verification of the Medicaid eligible days at issue in advance of their cost report filing deadline.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

At the outset, consistent with its decision in *Danbury*, the Board concludes that, pursuant to the concept of futility in *Bethesda*, the Board has jurisdiction over a hospital's appeal of additional Medicaid eligible days for the DSH adjustment calculation if that hospital can establish a "practical impediment" as to why it could not claim these days at the time that it filed its cost report (*i.e.*, the fact that only Medicaid eligible days verified by the State can be claimed on the cost report and that the hospital, through no fault of its own, was unable to verify the Medicaid eligible days at issue from States' records prior to filing its cost report due to lack of availability or access to the relevant State records).[12] Accordingly, the issue in the case turns on whether

[9] 42 CFR § 412.106(b)(4)(iii). *See also* Danbury PRRB Decision, at 15.
[10] *Bethesda*, 485 U.S. at 404. *See also Danbury* PRRB Dec. No. 2014-D03 at 15-18.
[11] Available at http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Alerts.html (copy included at Medicare Contractor Exhibit I-7 (Case No. 07-0399)). Similar to this appeal the "presentment requirement" in 42 C.F.R. § 405.1835(a)(1)(ii) was not applicable in *Danbury* and, thus, was not addressed by the Board.
[12] *See generally Danbury*, PRRB Dec. No. 2014-D03. The Board recognizes that the Provider has alleged that there was an established agency practice and/or policy to grant jurisdiction in cases similar to this case and argues that the practical impediment standard (as discussed by the Board in *Danbury*, *Norwalk*, and Alert 10) unlawfully attempts to retroactively change this alleged practice. *See* Provider's Post-Hearing Brief at 29-37. Unlike the situation in *Northeast Hospital Corp. v. Sebelius*, 657 F.3d 1, 15 (D.C. Cir. 2011) ("*Northeast*"), the Medicare Contractor disputes that CMS had such a practice or policy. The Board is not persuaded that CMS had such a policy or

Barberton has established that it had a practical impediment that prevented it from reporting the Medicaid eligible days at issue on its as-filed cost reports for FYs 2004 and 2005.

In this appeal, the Medicare Contractor argues that Barberton has not carried its burden to establish that a practical impediment prevented it from claiming the additional Medicaid eligible days at the time it filed its cost report.[13] The Medicare Contractor contends that Barberton must (1) explain why the additional Medicaid eligible days could not have been verified at the time that it filed its cost report (*i.e.*, identify and explain the impediments) and (2) establish it was without fault, namely that it had a process for determining all the Medicaid eligible days that could be identified based on the data available to it at the time that it filed its cost report. The Medicare Contractor maintains that Barberton has failed to satisfy both of these requirements.[14]

ARGUMENTS RELATING TO THE IMPEDIMENTS

The Medicare Contractor asserts that Barberton has failed to establish a reason why additional Medicaid eligible days could not have been verified at the time it filed its cost report. In particular, the Medicare Contractor asserts that Barberton must be able to assign a specific impediment to each of these additional Medicaid days.[15]

Based on the evidence in the record and testimony presented at the hearing, the Board finds that Barberton has met its burden of proof and has established that there were practical impediments that prevented it from claiming the additional Medicaid eligible days on its cost report. In this regard, Barberton identified multiple impediments that made it impossible for it to verify and/or obtain reliable Medicaid eligibility data from the Ohio State Medicaid program on the Medicaid eligible days at issue in advance of its cost report filing deadline. Further, based on the nature of the practical impediments, the limitations of the State's verification system, and Barberton's process to identify Medicaid eligible days and verify them with the State (as discussed in the next subsection), the Board is satisfied and finds that these practical impediments prevented Barberton, through no fault of its own, from identifying and reporting the Medicaid eligible days at issue on the cost reports at issue.

First, Barberton established that there was an impediment associated with retroactive eligibility determinations. Barberton's witness testified that a patient may apply for Medicaid during an inpatient stay but may not be determined eligible for Medicaid up to a year after hospital discharge making it impossible for the State to identify these eligible days prior to the cost report filing deadline.[16] Notwithstanding, Barberton's witnesses further testified that, for both the FY

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practice. Administrative resolutions ("ARs) to which CMS is not a party generally do not, by themselves, establish that *CMS* had such a practice or policy and the Provider has not produced (nor has the Board identified) any evidence to establish or suggest that CMS had such a practice or policy with either the MAC or the Board (*e.g.*, there is no evidence that CMS gave guidance to MACs on how and when to enter into ARs involving DSH issues involving Medicaid eligible days). *See* Tr. at 137-139; 150-154, 313-315; *Danbury*, PRRB Dec. No. 2014-D03 at 5-10, 23; *Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 230 (D.C. Cir. 2009). Further, unlike *Northeast*, the issue involved in this case is one of jurisdiction that that the MAC has no authority to decide; rather, this is an issue that the Board must decide.

[13] Medicare Contractor's Jurisdictional Challenge at 2-3.

[14] Medicare Contractor's Post-Hearing Briefs at 10.

[15] *See* Tr. at 88-89; Medicare Contractor's Post-Hearing Brief at 12 -13.

[16] Tr.at 334-335. *See also* Provider's Post-Hearing Brief Exhibit 2 at 2 (Decl. of Michael Newell).

2004 and FY 2005 cost reports, Barberton included, on the cost reports, a certain number of inpatient days attributable to individuals with "pending" Medicaid applications based on historical estimates of the number of patients who were determined eligible retroactively.[17]

Second, Barberton established that there was an impediment created by gaps in the Ohio State Medicaid program eligibility database. Following the submission of the FY 2004 and 2005 cost reports, Barberton discovered that, between 2004 and 2007 – a time period that encompasses these appeals, the Ohio State Medicaid program had a "gap" in its current and historical eligibility verification databases.[18] By way of background, a provider had the following three methods by which if could verify Medicaid eligibility through the Ohio State Medicaid program: (1) a provider could telephone the State directly and obtain verbal confirmation over the telephone ("Telephone Verification"); (2) a provider could request current real-time database verification (Current Database Verification), or (3) a provider could submit a request to Emdeon, the State's CMS-certified Medicaid eligibility contractor, to make a batch run against a historical eligibility database (Historical Database Tape Verification).[19] Barberton's witness testified that Barberton used all of these methods to identify their Medicaid eligible days and that each method had its limitations and potential for error.

With regard to Telephone Verification and Current Database Verification, the database underlying these verifications was limited to 12 months of data.[20]

With regard to the Historical Database Tape Verification, the witness testified that Barberton could only access this historical database through Emdeon and that inquiries to Emdeon were made judiciously because they were expensive.[21] If Barberton requested a patient eligibility match in which the date of service was more than 12 months old, Emdeon would check the Historical Database which was only updated periodically. If the search was being done before the next file update, there was a data gap which prevented verification of eligibility for anyone whose eligibility start dates fell within the gap.[22] One of Barberton's witnesses testified that the gap in the historical database was large because, based on his experience with Emdeon requests and conversations with Emdeon, the historical database maintained by Emdeon was not updated between 2004 and 2007.[23]

In addition to retroactive eligibility and the database gap issues, there were limitations in accessing the Ohio State database. Barberton's witnesses testified that data elements such as names and Social Security numbers are continuously being updated to correct errors, add missing elements (*e.g.*, middle name), and update information (*e.g.*, name change). These changes delay Medicaid eligibility verification. Barberton's witness further testified that "after a year you probably have 95 to 98 percent of the eligibles determined" and that new data can be found up to three years after the end of the fiscal year.[24]

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[17] Tr.at 110-111.
[18] *See* Tr. at 62-64, 235-236, 331-332.
[19] *Id.* at 110-111, 142-143.
[20] *See* Provider's Post-Hearing Brief Exhibit 3 at 2 (Decl. of Gavin Johnson).
[21] *Id.*. at 109.
[22] *Id.* at 32-33, 141-144 .
[23] *See id.* at 331-332. *See also id.* at 235-236.
[24] *Id.* at 32, 161-162, 334-335.

Finally, Barberton produced a declaration from a Medicaid eligibility verification consultant, employed by Emdeon, who worked on Ohio Medicaid verification and data conversion issues during 2004-2005. This declaration enumerated several other errors with the Historical Database that were not reconciled until 2007 or afterwards, including: the Ohio Department of Human Services ("ODHS") policy on data purges (where ODHS periodically purged data due to patient deaths or due to the data segment limitations in the ODHS systems); the ODHS policy on multiple record sets (*e.g.*, frequent transactions in foster care) where conflicting records were set aside; and other corrupted or clearly incorrect records that as a matter of policy were eliminated from the Historical Database Tapes because their accuracy could not be verified.[25]

Based on the facts of this case, the Board disagrees with the Medicare Contractor's assertion that Barberton must be able to assign a specific impediment to each additional Medicaid eligible day that it seeks to include. Based on the evidence and testimony provided, the Board finds that the State of Ohio does not provide public access to the type of information that is necessary to attribute specific impediments to specific Medicaid eligible days.[26] The Board further finds that, as discussed in the next subsection, Barberton has submitted sufficient information and evidence to demonstrate why, through no fault of its own, Barberton was unable to verify Medicaid eligibility of all inpatient days before cost report filing. The Board's finding is supported by the fact that, for each of the years at issue, the percentage of net additional Medicaid eligible days identified is relatively low for each year and consistent between them – 6.0 percent for FY 2004 and 9.8 percent for FY 2005.[27]

ARGUMENTS RELATING TO THE PROVIDER'S PROCESSES

The Medicare Contractor essentially asserts that Barberton's process to gather and report its Medicaid eligible days on its cost report was fatally flawed because it was not set up in a way that it allowed Barberton to identify all of those days. To support why the process to report days on the FY 2004 cost report was inadequate, the Medicare Contractor cites to the fact that there was a seven percent difference in the number of eligible days between the FY 2004 and 2005 cost reports.[28] The Medicare Contractor also argues that Barberton's process estimated the number of Medicaid eligible days based on a historical conversion rate for patients who were placed in a "Medicaid pending" category.[29] The Medicare Contractor highlights testimony at the hearing which establishes that Barberton may have made errors in the data-entry process that caused it to not capture all Medicaid eligible days.[30] Finally, the Medicare Contractor notes that Barberton's witness admitted that it was possible that some portion of the additional Medicaid

[25] *See* Provider's Post-Hearing Brief Exhibit 3 at 4 (Decl. of Gavin Johnson).
[26] *See* Provider's Post-Hearing Brief Exhibit 2 at 5 (Decl. of Michael Newell); Tr. at 158-160.
[27] *See* Provider's Final Position Paper at Exhibit P-14.B (Case No. 07-0399) (showing 284 net Medicaid days being claimed to be added to the as-filed 4741 Medicaid eligible days for FY 2005); Provider's Final Position Paper at Exhibit P-14.B (showing 489 net Medicaid days being claimed to be added to the as-filed 4996 Medicaid eligible days for FY 2005).
[28] Medicare Contractor's Post-Hearing Brief at 10.
[29] *Id* at 11.
[30] *See* Tr. at 163-164. The Medicare Contractor also argues it was possible that some of Barberton's patients could have been eligible for Medicaid in States other than Ohio, which Barberton would not have identified because its process only checked Ohio Medicaid records. *Id.* at 254-256. However, this is a red herring as all of the Medicaid eligible days at issue involve only the Ohio Medicaid program. *See id.* at 205.

eligible days were patients who had private insurance whom Barberton did not examine to determine whether they were Medicaid eligible.[31]

The Board finds that, for the fiscal years at issue, Barberton had in place a process that used all available and practical means to identify, accumulate, and verify with the State the actual Medicaid eligible days that were reported on its Medicare cost reports, and was diligent in following that process. Barberton presented evidence which described the process by which it gathered patient information from the admissions department and business office and entered that information into its patient account system ("PAS"). Upon admission of a patient, the admissions department would collect demographic information from the patient, including details relating to the patient's payer information. Patients who self-reported as having Medicaid coverage would be noted in the PAS as Medicaid primary, secondary, or tertiary depending upon whether the patient provided evidence of other insurance that would be primary to Medicaid.[32]

The PAS also included information that identified patients with "pending" Medicaid coverage. This category included patients who were not Medicaid beneficiaries at the time of admission and whom the hospital determined might meet eligibility criteria based on certain demographic information collected during the admission process. Barberton would classify these patients as Medicaid-pending in the PAS, in order to identify patients who might become retroactively eligible after discharge. The hospital generally sought the assistance of an outside vendor to facilitate the patient's Medicaid application.[33] Barberton's patient accounting office continued to attempt to verify Medicaid eligibility throughout the year by placing phone calls through the State of Ohio's Medicaid telephone verification system. The business office would also, in some cases, submit through the State of Ohio's eligibility vendor, Emdeon, a request to match the eligibility of individual patients. In either case, any information returned by the State of Ohio that confirmed Medicaid eligibility would be entered into the PAS.[34]

For both FY 2004 and FY 2005, Barberton used a software module to pull information from the PAS in such a manner as to identify all inpatients who might possibly have been eligible for Medicaid to prepare the cost report. For patients who were identified as Medicaid-pending in the PAS, Barberton included an additional number of inpatient days that estimated the number of Medicaid-pending patients that would be likely later become Medicaid-eligible based on its historical experience. Finally, Barberton had a year-end reconciliation process that validated the accuracy of these reports by reconciling them with a report of paid Medicaid claims that it received from the State. All inpatient days identified by this process as either being paid by the State or otherwise attributable to eligible individuals but unpaid were included on the cost report.[35]

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[31] *See id.* at 240-242.
[32] *See id.* at 108-110; Provider's Post Hearing Brief at 13-15; Provider's Post-Hearing Brief Exhibit 4 at 3-4 (Decl. of Patrick McGreevy).
[33] *See* Tr. at 107-111.
[34] *See id.*at 109.
[35] *See id* at 280-281; Provider's Post-Hearing Brief Exhibit P-2 at 6-7 (Decl. of Michael Newell); Provider's Post-Hearing Brief Exhibit 4 at 3-4 (Decl. of Patrick McGreevy).

For FY 2005, Barberton added a step to its process to see if it could add even more Medicaid-eligible days. Specifically, Triad Hospital, Inc., Barberton's then parent company,[36] formatted Barberton's entire inpatient population for the year, excluded patients who were known to be entitled to Medicare, and submitted that file to Emdeon for a "batch match" against the State's verification system. The report returned by Emdeon was then reconciled with the hospital's internal Medicaid-eligible day reports and was used to prepare the FY 2005 cost report. [37]

Barberton maintains that the seven-percent difference in Medicaid days identified between the FY 2004 and 2005 cost reports can be attributed to the increase in its total patient load by more than 11 percent from FYs 2004 to 2005 and that the seven percent increase in Medicaid days between the FY 2004 and 2005 cost reports is likely a result of increased patient utilization rather than by any improvement in the process brought about by the batch match. [38] The Board finds that the seven-percent difference between FYs 2004 and 2005 is not significant, particularly in light of the increased patient load between these fiscal years. Rather, the relatively small difference provides a comfort level that Barberton was prudent and did all that it could have reasonably done with respect to identifying, accumulating, and verifying its Medicaid eligible days.

The Medicare Contractor asserts that Barberton is unable to explain why it could not, or did not, identify the additional eligible days that its consultant, Southwest Consulting, did. The Medicare Contractor argues some or all of the additional days were missed because of deficiencies in Barberton's process or because it did not utilize sufficient resources to identify the additional Medicaid eligible days.[39]

Barberton justifies its retainer of Southwest Consulting as part of its attempt to timely and adequately identify all Medicaid paid and unpaid eligible days for FYs 2004 and 2005. As a result of working with the consultant, Barberton was able to identify 685 and 627 additional Medicaid paid or unpaid eligible days that were not initially identified on the original cost reports for FYs 2004 and 2005 respectively. In addition, Southwest Consulting found Barberton included 401 and 288 days as Medicaid eligible, that should not have been included on the FY 2004 and 2005 cost reports respectively.[40]

The Board finds that Barberton has provided substantial evidence that it used all available practical means to identify, accumulate, and verify Medicaid-eligible days when it filed its cost reports. That process included numerous attempts throughout the fiscal year to verify eligibility with the State of Ohio's verification systems. The Board's decision in *Danbury* requires only that Barberton show a "practical" impediment not that it has exhausted all possible verification methods to ascertain Medicaid eligibility, including hiring a consultant.[41] The Board's finding

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[36] Barberton was later acquired by Community Health Systems, Inc.
[37] *See* Tr. at 112; Provider's Post-Hearing Brief Exhibit 4 at 3-4 (Decl. of Patrick McGreevy).
[38] *See* Tr. at 133-134, 278-280.
[39] *See* Medicare Contractor Post-Hearing Brief at 11-12.
[40] *See* Provider's Post-Hearing Brief Exhibit 2 at 6 (Decl. of Michael Newell); Provider's Post-Hearing Brief Exhibit 4 at 4 (Decl. of Patrick McGreevy).
[41] There is no exhaustion requirement. The Board notes that, in vacating the Board's decision in *Norwalk*, the Administrator suggests that the a provider need only use "due diligence in establishing methods of accurately capturing these days; and requesting and following up to obtain the State listings." *Norwalk*, CMS Adm'r Dec. at

is further supported by the fact that it is clear that the large data gaps in the Ohio State Medicaid eligibility verification system meant that Barberton was going to have to conduct another process to identify missing Medicaid eligible days subsequent to filing the cost reports at issue.

ARGUMENTS RELATED TO A PRESUMPTION OF A PRACTICAL IMPEDIMENT

Barberton argues that, because it diligently followed a reasonable process to identify Medicaid eligible days and the State of Ohio does not provide the type of information necessary to explain why a particular day could not have been verified at an earlier date, it is entitled to a presumption that none of the Medicaid eligible days at issue could have been verified prior to the filing of the FY 2004 and 2005 cost reports and that the days it seeks to add are the result of errors and/or data gaps by the Ohio State Medicaid program. As the presumption would then shift the burden of proof from Barberton to the Medicare Contractor, Barberton maintains that the Board should dismiss the Medicare Contractor's jurisdictional challenge because the Medicare Contractor has provided no evidence to rebut that presumption.[42] The Board declines to find that Barberton is entitled to such a presumption that would shift the burden to the Medicare Contractor merely because Barberton adhered to its process to identify and verify Medicaid eligible days and/or that the lack of information from the Ohio State Medicaid program on why previously unavailable information is now available. In Board appeals, a hospital has the burden of proof regarding its access to Medicaid data and to explain why the additional days could not have been verified prior to filing its cost reports. This burden does not shift and the Boards uses the full record (which includes but is not limited to the evidence upon which the Provider bases its presumption arguments) to make its findings.

DECISION

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Board concludes that, pursuant to the concept of futility explained in the U.S. Supreme Court's decision in *Bethesda*, it has jurisdiction under 42 U.S.C. § 1395oo(a) to hear this appeal for additional Medicaid eligible days for FYs 2004 and 2005. HCFA Ruling 97-2 requires hospitals to claim only State-verified Medicaid eligible days on the cost report and Barberton has established that a practical impediment, through no fault of its own, prevented it from identifying and/or verifying with the relevant State the Medicaid eligible days at issue prior to the filing of the cost reports at issue.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A.

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21. As explained in the next subsection, the Board finds that Barberton did use due diligence in establishing a method to accurately capture these days and that it diligently followed that method.

[42] *See* Provider's Post-Hearing Brief at 24-28; Provider's Supplemental Jurisdictional Response at 17; Tr. at 67.

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: March 19, 2015