PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2016-D17

PROVIDER –
HCA DSH-Colorado State Database Group Appeals

Provider Nos.: See Appendix A

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

DATE OF HEARING -
December 18, 2012

Cost Reporting Periods Ended -
See Appendix A

CASE NOs.: 07-0637GC, 08-1019GC, 08-0258GC, 10-0249GC, 13-1238GC, 14-0003GC, 14-2395GC, 14-3725GC, 15-0196GC

INDEX

ISSUE:

Whether patient days which the appealing Providers have identified as "inactive" in the Colorado Medicaid program should be included in the Medicaid proxy that is used in the calculation of the Medicare payment for disproportionate share hospitals ("DSH").[1]

DECISION

After considering the law and program instructions, the evidence presented, and the parties' contentions, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly excluded the "inactive" unpaid Medicaid patient days at issue from the Medicaid fraction of the Medicare DSH adjustment calculation for fiscal years ("FYs") included in Appendix A attached. Accordingly the Board directs the Medicare Contractor to include these days in the relevant Medicaid fraction for the Medicare DSH adjustment calculations.

INTRODUCTION

This consolidated group appeal involves five acute care hospitals which are located in the Denver Colorado metropolitan area and are owned and operated by HCA-Health One LLC, a subsidiary of HCA Holdings, Inc. ("HCA Hospitals" or "Providers"). The designated Medicare contractor[2] for HCA Hospitals is Novitas Solutions, Inc. ("Medicare Contractor").

The HCA Hospitals appealed the amount of their Medicare disproportionate share payment.[3] The HCA Hospitals complain that: (1) the Medicare Contractor failed to include in the Medicare DSH calculation patients who were eligible for the Colorado Medicaid program but were denoted as "inactive" in the Colorado Benefits Management System ("CBMS") for the relevant dates of service; and (2) this resulted in a shortfall in their Medicare DSH payment of over $40 million. The HCA Hospitals met the jurisdictional requirements for a hearing before the Board.

The HCA Hospitals were represented by Christopher L. Keough, Esq., of Akin Gump Strauss Hauer & Feld, LLP. The Medicare Contractor was represented by Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

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[1] *See* Transcript ("Tr.") at 5-6 (issue as agreed by the parties).

[2] Fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs") will be referred to as Medicare contractors.

[3] Appendix A contains list of the providers participating in this appeal by case number and fiscal year. Case Number 07-0637GC consists of only two hospitals as three hospitals withdrew their appeals. The remaining cases consist of five hospitals.

STATEMENT OF FACTS

A. THE DSH ADJUSTMENT AND DATA REQUIRED FOR ITS CALCULATION.

Since 1983, the Medicare program has paid most general acute care hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS"). IPPS pays a predetermined, standardized amount per discharge that is subject to certain payment adjustments.[4]

One of these payment adjustments increases the payment to hospitals that serve a disproportionate share of low-income patients and is commonly referred to as a Medicare DSH adjustment.[5] A hospital's disproportionate patient percentage ("DPP") determines whether it qualifies for a Medicare DSH adjustment and, if so, the amount of payment to that hospital.[6] The DPP is defined as the sum of 2 fractions expressed as percentages — the sum of the Medicare or SSI fraction and the Medicaid fraction.[7] It is the Medicaid fraction that is at issue in this case.

The Medicaid fraction is defined in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) as:

> [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 [*i.e., the Medicaid program*], but who were not entitled to benefits under part A of this subchapter [*i.e.,* Medicare Part A], and the denominator of which is the total number of the hospital's patient days for such period.[8]

The Medicare Contractor determines the numerator of the Medicaid fraction based on the Medicaid eligible days (paid and unpaid) that the hospital reports on the cost report for the relevant fiscal year which is filed five months from the close of that fiscal year.[9]

Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), "[t]he hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed . . ., and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day."[10] In 2003, Congress addressed a hospital's access to information needed to calculate the DSH Medicare and Medicaid fractions, as part of the Medicare

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[4] *See* 42 U.S.C. § 1395ww(d)(3); 42 CFR Part 412.
[5] 42 U.S.C. § 1395ww(d)(5)(F); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(1), 1395ww(d)(5)(F)(v)-(vi); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).
[9] 42 C.F.R. § 413.24(f)(2); Medicare Claims Processing Manual, Ch. 3, § 20.3.1.1 (Revised Oct. 1, 2003).
[10] *See* 63 Fed. Reg. 40954, 40984-85, 41004 (Jul. 31, 1998) (promulgating 42 C.F.R. § 412.106(b)(4)(iii)).

Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA").[11] 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."[12] CMS has stated: "[W]e 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."[13]

CMS maintains that it has satisfied its § 951 obligation under this interpretation because the current mechanisms in place allow hospitals to obtain access to this Medicaid days data and these mechanisms are sufficient.[14] Moreover, CMS stated that "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."[15] Accordingly, for purposes of reporting this data on the cost report, hospitals must verify Medicaid eligibility with the Medicaid eligibility system for the relevant Medicaid State agency.

In this case, the HCA Hospitals had to use the Colorado Medicaid electronic eligibility database, CBMS, in order to verify the days of patients who were eligible under the Colorado Medicaid program. The HCA Hospitals complain that a malfunction in the CBMS prevented them from timely and accurately obtaining this verification from the Colorado Medicaid program for dates of service in FYs under appeal prior to filing their cost reports and that CBMS malfunction continues to prevent them from getting the Medicaid eligibility information for FYs under appeal.

B. VERIFYING MEDICAID ELIGIBLE DAYS WITH THE COLORADO MEDICAID PROGRAM.

The Colorado Department of Health Care Policy and Financing ("Colorado DHCPF") administers the Colorado Medicaid program and the Colorado Department of Human Services ("Colorado DHS") is responsible for administering certain other Colorado public assistance programs.[16] The Colorado DHCPF and DHS developed a CBMS, in order to provide a single unified system for Colorado to determine eligibility for 92 different Colorado public benefit programs, including the Colorado Medicaid program.[17] The Colorado DHCPF and DHS developed CBMS in partnership with CMS and implemented it on September 1, 2004.[18]

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[11] Pub. L. No. 108-173, 117 Stat. 2066, 2427 (Dec. 8, 2003) (copy included at Provider Exhibit P- 21).
[12] (Emphasis added.)
[13] 70 Fed. Reg. 47278, 47438 (Aug. 12, 2005) (copy included at Medicare Contactor Exhibit I-2).
[14] *Id.* at 47442.
[15] *Id.*
[16] Provider Exhibits P-8 at 15, P- 9 at 12.
[17] Provider Exhibits P- 9 at 3, P-8 at 16.
[18] *See* Provider Exhibits P-9 at 3.

Following the implementation of CBMS, both the Colorado Office of the Auditor ("COA") and CMS conducted audits on CBMS. The federal and state reports for these audits found that CBMS has had many operational issues relating to Colorado Medicaid eligibility determinations:

1. *A COA performance audit on eligibility determinations for federal benefit programs for FY 2005 (i.e., September 1, 2004 to June 30, 2005)*. - In connection with the Colorado Medicaid program, this audit sampled 96 Medicaid payments from FY 2005 and found, among other things, that: (a) CBMS had no automated history to track changes made to a case file;[19] (b) there were irreconcilable differences between Medicaid data in CBMS and Medicaid data in Colorado's legacy systems;[20] and (c) there was incorrect Medicaid data input that could potentially affect the recipient's eligibility in the future.[21] Significantly, COA was unable to audit Medicaid denials because CBMS could not provide COA with a "user friendly" report of applicants who had been denied such eligibility.[22] Further, Colorado recognized that this audit period was "most volatile" for CBMS.[23]

2. *A **delayed***[24] *CMS post-implementation efficacy audit conducted in June 2006*. - The CMS efficacy audit sampled 103 Medicaid cases which were made up of the following categories: approved, denied, closed and redetermination.[25] CMS found significant deficiencies with CBMS including: (a) incorrect

[19] COA determined that "CBMS was not programmed to automatically provide an accessible case history for each benefit recipient that tracks the changes made to a recipient's file" (Provider Exhibit P-8 at 4) and that manual interventions were required to recreate historical eligibility determinations (*see id.* at 5, 9, 12).
[20] The audit revealed instances where COA was unable to determine whether the Medicaid recipient was in fact eligible because it was "unable to reconcile the clients' [Medicaid] data contained in the legacy systems to the [Medicaid] data in CBMS or to determine if [Medicaid] data contained in the legacy systems was converted appropriately to CBMS upon the system's implementation." *Id.* at 27-28.
[21] *See id.* at 53 (stating that there was "incorrect data input into CBMS for Medicaid applicants" where "these deficiencies could potentially affect the recipients' eligibility in the future or affect other programs").
[22] *See id.* at 43.
[23] *Id.* at 65.
[24] CMS stated that "CMS would typically conduct a post-implementation ["P-I"] review of a large integrated eligibility system 6 months after its implementation. However, as a result of difficulties experienced by the [Colorado] Departments and counties immediately upon implementation of CBMS, and for several months thereafter, the CMS Denver Regional Office made the decision to postpone its P-I review of the system. This decision was made in light of several factors affecting the use of the new system and concomitant problems experienced by the State in administration of the programs delivered by CBMS. An additional significant factor for the State at this time was its involvement as Defendant in a lawsuit brought by the Colorado Center for Law and Policy on behalf of various Colorado beneficiaries and with regard to alleged damages suffered by this group as a result of the CBMS implementation. . . . In April 2006, the Denver Regional office determined that the State had had a reasonable period of time to employ its mitigation strategies for CBMS stabilization." Provider Exhibit P-9 at 4.
[25] *See id.* at 4,6.

effective dates for eligibility;[26] (b) failure to screen Medicaid applicants for all eligibility groupings regardless of the eligibility selection made in the application;[27] and (c) inability to determine if 50 of the 103 Medicaid cases reviewed were handled correctly due to "incomplete" case file records or information in CBMS indicating "incorrect handling" of the case.[28] The 50 errors included the following types of situations:

> (a) 8 cases where it is unclear why the client's Medicaid effective date was much later than the date client became SSI eligible;
> (b) 7 cases where there was no reason for termination/break in coverage or the reason for retroactive termination directly contradicted the case file;
> (c) 4 cases where the client was an undocumented Medicaid recipient or there was conflicting information in file such that the medical spans or basis for eligibility were not clear; and
> (d) 7 cases where benefits were improperly terminated on a retrospective basis because there was no advance notice.

3. *CMS follow-up efficacy audit of CBMS conducted in the second half of 2010*. - For this study, "CMS' review objective was to determine if [Colorado] adequately and effectively implemented corrective actions that were identified through various reports and audits conducted on the CBMS system since its inception in 2004."[29] The areas of CBMS remediation and Medicaid program delivery that CMS examined included "Timely determinations of Eligibility", "CBMS Re-Determinations of Medicaid Eligibility," "Client Notifications," and "Vanishing Medicaid Eligibility Spans."[30] In this regard, CMS found that Colorado was out of compliance with federal rules for terminating Medicaid eligibility, issuing client notices, and documenting and maintaining "an adequate and complete eligibility history of the Medicaid individuals."[31] In particular, with regard to the vanishing eligibility spans, CMS made the following findings:

> CMS found that, in an analysis performed by [Colorado], when a valid eligibility span in CBMS is retroactively removed, historical records of the span are also removed from the Medicaid Management Information Systems (MMIS) in a majority of the vanishing cases. Clients in

[26] *See id.* at 14 (stating that aged, blind and disabled cases incorrectly had date-specific eligibility as the effective date of Medicaid eligibility when it should have been full-month coverage consistent with the Colorado Medicaid State Plan).
[27] *See id.* at 21-22.
[28] *See id.* at 26. The fact that Colorado subsequently provided "sufficient information which verifies that the majority of the cases were corrected and appropriately acted upon" (*id.* at 26-27) reinforces that these potential errors were real.
[29] Provider Exhibit P-10 at 6. *See also id*. at 3-4.
[30] *Id*. at 6.
[31] *Id.* at 3.

> these cases are defined as having "uncertain eligibility history", because there is uncertainty around the past eligibility status of the clients.
>
> CBMS functionality currently permits county and medical assistance site workers to change data to an existing medical eligibility span within the system. This change may result in the medical eligibility span "vanishing" retroactively without an audit trail or a record of the original medical eligibility span.[32]

As part of its response to this finding, Colorado stated that it "maintains paper or electronic application files for all eligible individuals, which can be used to determine if the individual is eligible."[33]

Colorado also contracted with Deloitte and the Public Knowledge, LLC to conduct certain post-implementation audits for 2005 and 2008 respectively that resulted in similar findings.[34] The above audits/reviews confirm that CMS was aware that: (1) CBMS has had many operational issues including terminating an individual's eligibility during redetermination, and backlogs in processing applications;[35] and (2) Medicaid eligibility records suffered from "vanishing spans of eligibility"[36] that apparently was not resolved even as late as August 2012.[37]

These CBMS issues caused Colorado hospitals such as the HCA Hospitals to have difficulties in verifying Medicaid eligibility for many of its patients. In particular, during the time at issue (as described more fully below), the CBMS-generated data identified many of its Medicaid beneficiaries as "inactive." The "inactive" designation is a national standard response code indicating that an individual was located in the Medicaid eligibility system but was not confirmed to be eligible for Medicaid for the dates of service in question.[38]

As a result of these difficulties, the HCA Hospitals made multiple requests to Colorado, the Medicare Contractor, and CMS for assistance in matching the HCA Hospitals' records of their Medicaid-eligible patients with the CBMS eligibility database to determine the appropriate number of Medicaid eligible days to be included in the Medicaid fraction of the HCA Hospitals' Medicare DSH calculation.[39] State Medicaid

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[32] *Id*. at 30.
[33] *Id*. at 31.
[34] *See* Provider Exhibit P-15 (copy of the 2005 Deloitte report); Provider Exhibit P-14 (copy of the 2008 Public Knowledge LLC report).
[35] Provider Exhibit P-10 at 30-31. *See also* Provider Exhibit P-15 at 7, 19.
[36] Provider Exhibit P-10 at 30-31. *See also* Provider Exhibit P-15 at 7, 14-15, 17, 19. 21, 24, 27.
[37] *See* Provider Exhibit P-10 at 31. *See also* Provider Exhibits P-8 – P-10, P-12 – P-15, P-16 – P-18, P-22, P-24.
[38] In addition to the "inactive" designation, the state also returns a code of "Error – not found" if there is no data on the patient in the system.
[39] *See, e.g.*, Provider Exhibits P-5, P-6, P-7, P-31.

representatives determined that some of these inactive patients were, in fact, Medicaid eligible on the relevant dates of service and that the Medicaid program had properly made payments on their behalf. For Medicare DSH purposes, the Medicare Contractor counted these "inactive" paid days.

However, other patients still came back as "inactive" without identifying any record of Medicaid payments being made on their behalf. In these instances, the Medicare Contractor refused to count the "inactive" unpaid days as Medicaid-eligible days for the purpose of the Medicare DSH calculation for the HCA Hospitals. The HCA Hospitals argue that these "inactive" unpaid days should also have been included in their Medicare DSH calculation.

HCA Hospitals timely appealed the exclusion of the "inactive" unpaid days from the Medicare Contractor's DSH adjustment determination for their cost reports for FYs 2004 to 2012.[40]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor contends that 42 C.F.R. § 412.106(b)(4) places the burden on the HCA Hospitals to furnish Medicaid eligibility data and requires them to verify with the state that a patient was eligible for Medicaid for each day claimed.[41] The Medicare Contractor makes the following three arguments:

1. Colorado had CBMS in place as its system to verify Medicaid eligibility and this system satisfied the MMA § 951 obligation imposed on CMS to arrange to furnish Medicaid eligibility data for hospitals, including the HCA Hospitals.[42] Indeed, the system was not a total disaster as a number of "inactive" were ultimately included where it was established that the claims were paid.

2. The HCA Hospitals are improperly trying to shift the burden of proof to CMS by focusing on the difficulties with CBMS and arguing that the Colorado's CBMS' problems are somehow the responsibility of CMS.[43] The Medicare Contractor maintains that the real problem is the significant time lag between the date on which medical services were provided and the date on which the HCA Hospitals try to obtain confirmation of Medicaid eligibility from CBMS. This lag time made it impossible for the HCA Hospitals to include all of the eligible days at the time of filing their cost reports.

3. Section 951 of the Medicare Modernization Act of 2003 ("MMA") does not require CMS to "guarantee" a state system to respond to that time lag.[44] The Medicare Contractor maintains that CMS has discharged its obligation by requiring state

[40] *See* Provider Exhibit P-46 (summary of the data submitted to the MAC and the dates submitted).
[41] *See* Medicare Contractor's Consolidated Replacement Final Position Paper at 4. *See also* 63 Fed. Reg. 40954, 40984-85, 41004 (July 31, 1998).
[42] *See* Medicare Contractor's Consolidated Replacement Final Position Paper at 7.
[43] *Id.* at 4.
[44] *Id.* at 8.

> Medicaid programs to work with hospitals to verify Medicaid eligible days as Colorado has done in this case.

On the other hand, the HCA Hospitals argue that the MMA language does impose a statutory duty on CMS to ensure that State Medicaid programs can verify the patient days for Medicaid eligible individuals to allow the hospitals to file accurate cost reports. Having failed in that duty, HCA Hospitals request the Board to direct CMS to include all of the HCA Hospitals' inactive days in the DSH adjustment calculation.[45]

HCA Hospitals also assert that CMS Ruling 97-2[46] compels the Medicare Contractor to include both paid and unpaid "inactive" days in their DSH adjustment calculation. By issuing the Ruling, CMS has conceded that the Medicare Contractor should include both paid and unpaid Medicaid eligible days in the DSH adjustment calculation and that the Medicare Contractor is violating the express requirements of the Ruling in its refusal to do so.[47]

The Board acknowledges that CMS Ruling 97-2 requires a hospital to report both *paid* and *unpaid* days so that CMS can use this information to calculate its DSH adjustment. However, it does not appear that the Medicare Contractor has actually based its denial of unpaid days on the fact that CBMS lists these days as unpaid. Rather, it is apparent to the Board that the HCA Hospitals were unable to verify these days with Colorado because CBMS was not capable of accurately verifying the Medicaid eligible days necessary for the HCA Hospitals to correctly claim them on their cost reports.

The evidence documents not only that CBMS was unable to accurately verify Medicaid eligibility for the HCA Hospitals' patients for FYs in question but also that both CMS and Colorado State Auditors found that Colorado and CBMS (the electronic database used to track Medicaid eligibility) was out of compliance with a host of federal Medicaid requirements.[48] CMS itself confirmed as part of its 2010 audit issued in 2011 that Colorado's electronic Medicaid eligibility records that reflected "inactive" eligibility status for specific dates of service were "*unjustifiably uncertain*."[49] The earlier Colorado State Auditor's report documented a myriad of problems with the eligibility determination processes for Medicaid, Food Stamps and Temporary Assistance for Needy Families ("TANF").[50] The evidence reveals that these problems were fully documented in a federal lawsuit[51] and in the 2010 CMS audit, which declared that Colorado was out of compliance with federal law.[52]

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[45] Providers' Consolidated Position Paper at 4; Tr. at 14-15.
[46] Copy included at Provider Exhibit P-19.
[47] Providers' Post Hearing Brief at 10.
[48] Provider Exhibit P-10 at 3.
[49] *Id.* at 31.
[50] *See, e.g.*, Provider Exhibit P-8.
[51] *See* Provider Exhibit P-23 (information and documents on the lawsuit that was initiated on August 30, 2004).
[52] Provider Exhibit P-10 at 6.

Testimony at the hearing was even more compelling. Witnesses for the HCA Hospitals testified that, before CBMS was implemented, the HCA Hospitals' staff was limited in its ability to verify eligibility to the following two methods: telephone or fax communication with Colorado Medicaid staff on a patient-by-patient basis after the date of service. Unlike the online "batch" matching system used by other state Medicaid programs, Colorado's Medicaid program could not verify large numbers of Medicaid patients' eligibility before the submission of the cost reports.[53] Retroactive Medicaid eligibility for which approval could take up to a year also extended the time that eligibility data could be delayed.[54]

In 2006, after CBMS was implemented, the situation did not improve. After a batching process became available in late 2007, the HCA Hospitals hired a consultant to identify additional Medicaid-eligible individuals for cost reporting purposes.[55] Through its work with the new batching process, the consultant discovered the "vanishing Medicaid eligibility spans" issue in which individuals determined to be Medicaid-eligible at one point in time were later listed as not being eligible during that same time period.[56] The consultant also discovered that CBMS listed some individuals as Medicaid eligible but "inactive" and for whom payment may, or may not, have been made by the Colorado Medicaid program.[57]

In response to these identified problems, the HCA Hospitals' consultant began to do quarterly eligibility checks to try to mitigate the "vanishing eligibility spans" issue.[58] It submitted a listing of the "inactive" patient days that became the subject of these appeals and requested that the Colorado Medicaid office conduct a manual eligibility review to verify whether those patients were eligible for Medicaid for the time periods at issue.[59] Colorado's Medicaid program did not respond to this request so the HCA Hospitals asked both CMS and the Medicare Contractor to provide information to the HCA Hospitals to confirm that "these individuals were or were not eligible for Medicaid for these periods."[60] Neither CMS nor the Medicare Contractor responded to the HCA Hospitals' requests.

The HCA Hospitals then asked the Board to issue a subpoena for Colorado to appear at the hearing and furnish the eligibility records, including the paper records if necessary. Colorado opposed the request confirming that "the electronic data does not exist for the years requested" and alleging that "[a] manual search of paper records would be unduly burdensome and unreasonable."[61] Notwithstanding, Colorado did subsequently offer to

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[53] Tr. at 122-124, 130, 139, 147.
[54] *Id*. at 131-132.
[55] *Id*. at 179-180.
[56] Provider Exhibits P-2 –P-4, P-6, P-7; Tr. at 155. *See also* Provider Exhibit 39.
[57] Provider Exhibits P-2 –P-4, P-6, P-7; Tr. at 155, 159-168, 276-282. *See also* Provider Exhibit 39.
[58] Provider Exhibit P-22; Tr. at 168-69, 276-82.
[59] Provider Exhibit P-5.
[60] Provider Exhibits P-6, P-7.
[61] Provider Exhibit P-30 (copy of Colorado's objection). Colorado estimated that that "[i]t would require a full time staff person an average of 1-day per requested client to locate the client file, travel to the

assist the HCA Hospitals by giving them access to certain electronic data on payments made to behavioral health organizations ("BHOs"). According to Colorado, this electronic data would be helpful because any Medicaid recipient would have had a BHO capitation payment made on his/her behalf for each month that he/she was eligible for Medicaid.[62] While the project did validate a small number of the inpatient stays at issue (specifically 260 inpatient stays), this project was ultimately unsuccessful because these data files were found to be plagued by the same vanishing records issue as CBMS.[63] Colorado could not explain the vanishing records and advised that they had exhausted its electronic data resources and had no further viable suggestions.[64]

The HCA Hospitals' consultant undertook its own effort to establish a correct number of eligible days by analyzing both the HCA Hospitals' historical Medicaid eligible data and by comparing its data to CMS' HCRIS data for hospitals in Colorado and nationally.[65] Further, the consultants verified the number of Medicaid-eligible patients by comparing the number of Medicaid-eligible patients in the appealing HCA Hospitals with those in other similar hospitals in the State. Specifically, the consultants found that, when the Medicaid fractions for the cost reporting periods that covered the FYs 2004-2006 are adjusted to include the inactive days at issue, the resulting fractions are in line with:

1. The Medicaid fractions for all urban hospitals nationally which received Medicare DSH during the same time periods and had more than 100 beds;[66]
2. The Medicaid fractions for other urban Colorado hospitals which received Medicare DSH during the same time periods and had more than 100 beds;[67] and
3. The Medicaid fractions for the HCA Hospitals for FYs 2010 and 2011 when they implemented processes to mitigate the problem of the vanishing Medicaid eligibility spans (*e.g.*, match every quarter, match at the cost report filing, and match one year later).[68]

The HCA Hospitals conclude that they have done everything in their power to resolve the uncertainties inherent in the Colorado's electronic records.

As explained below, the Board finds a condition precedent to establishing a hospital's burden under 42 C.F.R. § 412.106(b)(4)(iii) to verify Medicaid eligibility with the relevant state for purposes of the DSH Medicaid fraction is that, pursuant to MMA § 951, CMS must "arrange to furnish" (*i.e.*, make available) the necessary underlying Medicaid data needed for the hospital to do that verification. For this

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[relevant] county [where the paper file is located/stored], perform the necessary research, and then copy records to verify eligibility." *Id*. at 2.

[62] *See* Tr. at 295-296.

[63] *See* Tr. at 297-303; Provider Exhibit 31 at 3-6.

[64] *See* Tr. at 301-02.

[65] *See* Tr. at 290-95; Provider Exhibits P-36, P-37.

[66] *See* Provider Exhibit P-37; Tr. at 293-294. Provider Exhibit P-37 shows that the median Medicaid fraction for urban hospitals nationally was 20.24 percent and the average Medicaid fraction was 23.39 percent. This is in line with the summary Medicaid utilization rate for the HCA Hospitals of 23.32 percent.

[67] *See* Provider Exhibit P-37; Tr. at 294-95.

[68] *See* Provider Exhibit P-36; Tr. at 290-291. This Decision covers FY 2004-2012.

case, the Board finds that this condition precedent has not been met so as to trigger the regulatory burden because the unique facts of this case demonstrate that CMS has failed to "arrange to furnish" (*i.e.*, make available) the necessary underlying Colorado Medicaid data needed for the HCA Hospitals to do required verification. Further, the Board finds that the HCA Hospitals have provided sufficient evidence to demonstrate that, using the best available data, they are entitled to the additional Medicaid eligible days at issue. Accordingly, the Board finds that the HCA Hospitals are entitled to the additional Medicaid eligible days which they have claimed for FYs in dispute.

At the outset, the Board recognizes that, in 1998, CMS promulgated 42 C.F.R. § 412.106(b)(4)(iii) to specify that "[t]he hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed . . . and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital stay."[69] However, in 2003, subsequent to the creation of this regulatory burden, Congress enacted MMA § 951 to charge CMS with the following affirmative statutory obligation to make available the data necessary for calculating the Medicare DSH adjustment:

> [T]he Secretary shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) 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.

In the final rule published on August 12, 2005 ("August 2005 Final Rule"), CMS acknowledged that statutory obligation stating: "With respect to . . . the . . . Medicaid fraction[], 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."[70] In reconciling CMS' statutory obligation to "arrange to furnish" with the hospital's regulatory burden of proof under 42 C.F.R. § 412.106(b)(4)(iii), CMS recognized that the hospital's regulatory burden to verify with the State is predicated or conditioned on the State "provid[ing] hospitals the data needed to meet their obligation under § 412.106(b)(4)(iii) in the context of . . . an eligibility inquiry with the State plan"[71] and confirmed that "[w]e will continue to work with the individual State agencies to

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[69] *See* 63 Fed. Reg. 40954, 40985 (July 31, 1998).
[70] 70 Fed. Reg. at 47438 (emphasis added).
[71] *Id.*at 47441. Similarly, CMS stated: "We note that Center for Medicaid and State Operations in CMS has communicated CMS' expectation of compliance with hospitals' requests for Medicaid eligibility information to the State Medicaid agencies. If the State Medicaid agencies refuse to provide data to enable hospitals to calculate their DSH Medicaid fraction and meet their obligations under our regulations at § 412.106(b)(4)(iii), we will consider amending the Medicaid State plan requirements to require the State agency to release the information to the requesting hospitals." *Id.* at 47442.

ensure that hospitals have access to the information."[72] Accordingly, the Board concludes that a condition precedent to establishing a hospital's burden under 42 C.F.R. § 412.106(b)(4)(iii) to verify Medicaid eligibility with the relevant state for purposes of the DSH Medicaid fraction is that, pursuant to MMA § 951, CMS must "arrange to furnish" (*i.e.*, make available) the necessary underlying Medicaid data needed for the hospital to do that verification.

In this case, it is clear that CMS approved federal Medicaid matching funds to partially fund the development and implementation of CBMS and that CMS conducted post-implementation audits of CBMS in 2006 and 2010. These facts along with the Congressional mandate in MMA § 951 confirm that CMS had some amount of federal oversight responsibilities in Colorado's development and implementation of CBMS in 2004. While the Board agrees that CMS generally does not have a statutory obligation to "guarantee" the availability of state Medicaid data, the facts of this case are unique and demonstrate that CMS failed to meet its statutory obligation to "arrange to furnish" the necessary underlying Colorado Medicaid data for the time period at issue. In that regard, the record demonstrates the following facts:

1. When CBMS was implemented in September 2004, CMS was aware that CBMS had many operational issues including terminating an individual's eligibility during redetermination and backlogs in processing applications. Indeed, as a result of the CBMS operational issues, CMS delayed its post-implementation audit of CBMS from the usual 6 months post-implementation to 18 months post-implementation (*i.e.*, April 2006) apparently in order to give the State "a reasonable period of time to employ its mitigation strategies for CBMS stabilization."[73]

2. CMS was aware that Medicaid eligibility records in CBMS suffered from "vanishing spans of eligibility"[74] and that this issue would remain unresolved even as late as August 2012 because, in response to the 2010 CMS audit findings, Colorado represented that it planned to implement certain changes to the CBMS system by August 2012 that were designed to minimize the "vanishing spans eligibility" issue.[75] As an interim measure, Colorado represented to CMS that it could mitigate the effect of the "vanishing eligibility spans" issue by using paper or electronic application files

[72] *Id.* at 47443. *See also* Provider Exhibit P-40 (CMS memorandum dated September 9, 2003 to the Association Regional Administrators for the Division of Medicaid for Regions I through X "request[ing] the full cooperation of State Medicaid agencies and/or the States' contractors in responding to hospital requests for Medicaid eligibility information").
[73] Provider Exhibit P-9 at 4. *See also* Provider Exhibit P-10 at 30-31; Provider Exhibit P-15 at 7, 19, 21.
[74] Provider Exhibit P-10 at 30-31. *See also* Provider Exhibit P-15 at 7, 19, 21, 67 (finding in 2005 "missing or incorrect [eligibility] spans on the [] system"; raising "significant concern[s] over inquiry capabilities [] in CBMS . . . to get an [accurate] picture of case circumstances at a given point in time"; and stating "[o]f main concern is that eligibility technicians are entering or changing information in CBMS that adversely affect other program's areas EDBC [eligibility determination and benefit calculation] results").
[75] *See, e.g.*, Provider Exhibits P-8 – P-10, P-12 – P-15, P-16 – P-18, P-22, P- 24.

maintained for all Medicaid eligible individuals as back up to confirm whether an individual was eligible during a particular time period.[76] However, as previously discussed, Colorado has refused to make these paper records available because it would be unduly burdensome. The Board agrees with Colorado that it would be unduly burdensome as there are more than 10,000 patient stays at issue and Colorado has estimated that it would take 8 hours per patient stay to identify, pull and analyze any relevant paper records if they are indeed available.[77]

3. It is clear that the HCA Hospitals, through no fault of their own, were unable to obtain accurate and complete Medicaid eligibility data from Colorado (a sovereign State over which they had no control) and, accordingly, their responsibility under 42 C.F.R. § 412.106(b)(4)(iii) was not triggered. The evidence (as previously discussed and summarized in Provider Exhibit P-31) confirms that:
   a. The HCA Hospitals were both diligent *and* timely in their efforts to identify the nature and scope of the "vanishing eligibility spans" issue and to involve Colorado, the Medicare Contractor and CMS to resolve the issue so that the HCA Hospitals could obtain the needed Medicaid eligibility verification.
   b. Colorado admits that "the electronic [CBMS eligibility] does not exist for the years requested."[78]
   c. CMS failed to assist the Colorado hospitals such as HCA Hospitals in developing an alternate process to verify Medicaid eligibility when CMS became aware that Colorado's CBMS system was out of compliance with federal Medicaid requirements and that Colorado hospitals would be unable to obtain appropriate verification through CBMS. Further, CMS did not respond to the HCA Hospitals specific request for assistance from CMS.
   d. The HCA Hospitals have exhausted all reasonable means to obtain state verification of the Medicaid eligible days at issue from Colorado.

Accordingly, based on the unique facts of this case, the Board concludes that, pursuant to MMA § 951, CMS had an affirmative legal obligation to assist the HCA Hospitals in obtaining Colorado Medicaid eligibility data relevant to the Medicaid eligible days at issue in order to calculate the Medicare DSH payment due to the HCA Hospitals for the FYs in dispute. As CMS did not satisfy its legal obligation under MMA § 951 and that legal obligation is a condition precedent to the HCA Hospitals' verification burden under 42 C.F.R. § 412.106(b)(4)(iii), the Board finds that the HCA Hospitals' burden under 42 C.F.R. § 412.106(b)(4)(iii) has not been triggered.

[76] Provider Exhibit P-10 at 31.
[77] *See* Provider Exhibit P-30 at 2; Provider Exhibits P-2, P-3, P4. Even a statistically valid sample involve hundreds of patient stays and, accordingly, would not be feasible based on Colorado's estimate.
[78] Provider Exhibit P-30 at 2.

While the verification burden under 42 C.F.R. § 412.106(b)(4)(iii) has not been triggered, the HCA Hospitals' do still have a burden to establish by the preponderance of the evidence that the "inactive" days at issue are days where the patient was eligible for Colorado Medicaid. As explained below, the Board finds that the HCA Hospitals have met this burden and that all of the inactive days at issue should be included in the relevant Medicaid fractions for the FYs in dispute.

Again, at the outset, it is clear that the HCA Hospitals, through no fault of their own, were unable to obtain accurate and complete Medicaid eligibility data from Colorado (a sovereign State over which they had no control) and, accordingly, their responsibility under 42 C.F.R. § 412.106(b)(4)(iii) was not triggered. Further, it is clear from the nature of the "vanishing eligibility spans" issue that: (1) all of the individuals identified by CBMS as "inactive" had been eligible for Medicaid at some point based on what the term "inactive" means; and (2) some, if not all, of the "inactive" days at issue are days on which the individual was in fact Medicaid eligible. Indeed, although Colorado's latest proposal to use the BHO payment records as an alternative method for verification was rejected because it was afflicted with the same issue of vanishing records, the exploration of that proposal did confirm that some of the inactive days at issue (those relating to 260 patient stays) were for individuals who were Medicaid eligible on the relevant days.

Further, when the Medicaid fractions for the FYs 2004-2006 years are adjusted to include the inactive days at issue, it demonstrates that they are in line with the Medicaid fractions for the respective HCA Hospital's Medicaid fraction during FYs 2010 and 2011 when the HCA Hospitals took steps to mitigate the effects of the vanishing eligibility spans notwithstanding the fact that a myriad of problems with CBMS, including the "vanishing eligibility spans" issue continued to exist.[79] The reasonableness of including the "inactive" days at issue in the relevant Medicaid fractions is further supported by the fact that it is clear from the myriad of problems afflicting CBMS (*e.g.*, improper denials or terminations of eligibility) that there are some additional Medicaid eligible days that cannot be accounted for outside of the ones at issue. For example, the HCA Hospitals have concrete examples of where the "vanishing eligibility spans" issue resulted in the complete Medicaid eligibility record for an individual being wiped off the CBMS system and, as a result, these individuals will not appear as "inactive."[80]

Finally, the Board notes that Medicare Contractor has put forward no evidence that the HCA Hospitals' DSH adjustment calculations with the additional days which the HCA Hospitals have proffered is either inaccurate or unreliable. Based on the above

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[79] The Board further notes that the Medicaid fractions for FYs 2010 and 2011 at Provider Exhibit P-36 are themselves under-inclusive of all Medicaid eligible days because the "vanishing eligibility spans" issue existed at least until August 2012. As a result, the HCA Hospital's mitigation efforts may not have captured all Medicaid eligible days for FYs 2010 and 2011.

[80] *See* Provider Exhibit P-39. This phenomenon of whole records disappearing is further highlighted by the fact that approximately 20 percent of the patients that the State had identified as "inactive" could not be found at all within the BHO payment records for any period notwithstanding the facts that the "inactive" code means that the individual had Medicaid at some point and the State's representation that every Medicaid eligible individual would have a corresponding BHO payment reflected in the CBMS records for each month of eligibility. *See* Provider Exhibit P-31 at 6.

findings and analysis, the Board finds that the HCA Hospitals have presented the best available data and that this data is sufficient evidence to order the Medicare Contractor to include all of the "inactive" Medicaid eligible days at issue in the relevant HCA Hospitals' Medicare DSH adjustment calculations for the FYs in dispute.

DECISION AND ORDER:

After considering the law and program instructions, the evidence presented, and the parties' contentions, the Board finds that the Medicare Contractor improperly excluded the "inactive" unpaid Medicaid patient days at issue from the Medicaid fraction of the Medicare DSH adjustment calculation for fiscal years ("FYs") included in Appendix A attached. Accordingly the Board directs the Medicare Contractor to include these days in the relevant Medicaid fraction of the Medicare DSH adjustment calculations.

BOARD MEMBERS PARTICIPATING:

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Charlotte F. Benson, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Jack Ahern, M.B.A

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: September 12, 2016

APPENDIX A

APPENDIX A

Model Form G: Schedule of Providers in Group
Group Name: HCA 2004 DSH - Colorado State Database
Representative: HCA, Inc.
Case Number: 07-0637GC

	PROVIDER NUMBER	PROVIDER NAME CITY, COUNTY, STATE	COST REPORTING PERIOD
3.	06-0034	Swedish Medical Center Englewood, Arapahoe, Colorado	09/30/2004
4.	06-0065	North Suburban Medical Center Thornton, Adams, Colorado	12/31/2004

Model Form G: Schedule of Providers in Group
Group Name: HCA 2005 DSH - Colorado State Database
Representative: HCA, Inc.
Case Number: 08-1019GC

PROVIDER NUMBER	PROVIDER NAME CITY, COUNTY, STATE	COST REPORTING PERIOD
1. 06-0014	Presbyterian/St. Luke's Medical Center Denver, Arapahoe, Colorado	08/31/2005
2. 06-0032	Rose Medical Center Denver, Arapahoe, Colorado	12/31/2005
3. 06-0034	Swedish Medical Center Englewood, Arapahoe, Colorado	09/30/2005
4. 06-0065	North Suburban Medical Center Thornton, Adams, Colorado	12/31/2005
5. 06-0100	Medical Center of Aurora Aurora, Arapahoe, Colorado	12/31/2005

Model Form G: Schedule of Providers in Group
Group Name: HCA 2006 DSH - Colorado State Database
Representative: HCA, Inc.
Case Number: 08-0258GC

PROVIDER NUMBER	PROVIDER NAME CITY, COUNTY, STATE	COST REPORTING PERIOD
1. 06-0014	Presbyterian/St. Luke's Medical Center Denver, Arapahoe, Colorado	08/31/2006
2. 06-0032	Rose Medical Center Denver, Arapahoe, Colorado	12/31/2006
3. 06-0034	Swedish Medical Center Englewood, Arapahoe, Colorado	09/30/2006
4. 06-0065	North Suburban Medical Center Thornton, Adams, Colorado	12/31/2006
5. 06-0100	Medical Center of Aurora Aurora, Arapahoe, Colorado	12/31/2006

Model Form G: Schedule of Providers in Group

Group Name: HCA 2007 DSH - Colorado State Database
Representative: HCA, Inc.
Case Number: 10-0249GC

PROVIDER NUMBER	PROVIDER NAME CITY, COUNTY, STATE	REPORTING PERIOD
1. 06-0014	Presbyterian/St. Luke's Medical Center Denver, Arapahoe, Colorado	08/31/2007
2. 06-0032	Rose Medical Center Denver, Arapahoe, Colorado	12/31/2007
3. 06-0034	Swedish Medical Center Englewood, Arapahoe, Colorado	09/30/2007
4. 06-0065	North Suburban Medical Center Thornton, Adams, Colorado	12/31/2007
5. 06-0100	Medical Center of Aurora Aurora, Arapahoe, Colorado	12/31/2007

Model Form G: Schedule of Providers in Group
Group Name: HCA 2008 DSH - Colorado State Database
Representative: HCA, Inc. - Anne Browne
Case Number: 13-1238GC

	PROVIDER NUMBER	PROVIDER NAME CITY, COUNTY, STATE	COST REPORTING PERIOD
1.	06-0014	Presbyterian/St. Luke's Medical Center Denver, Arapahoe, Colorado	08/31/2008
2.	06-0032	Rose Medical Center Denver, Arapahoe, Colorado	12/31/2008
3.	06-0034	Swedish Medical Center Englewood, Arapahoe, Colorado	09/30/2008
4.	06-0065	North Suburban Medical Center Thornton, Adams, Colorado	12/31/2008
5.	06-0100	Medical Center of Aurora Aurora, Arapahoe, Colorado	12/31/2008

Model Form G: Schedule of Providers in Group

Group Name: HCA 2009 DSH - Colorado State Database
Representative: HCA, Inc.
Case Number: 14-0003GC

PROVIDER NUMBER	PROVIDER NAME CITY, COUNTY, STATE	COST REPORTING PERIOD
1. 06-0014	Presbyterian St. Luke's Medical Center Denver, Arapahoe, Colorado	08/31/2009
2. 06-0032	Rose Medical Center Denver, Arapahoe, Colorado	12/31/2009
3. 06-0034	Swedish Medical Center Englewood, Arapahoe, Colorado	09/30/2009
4. 06-0065	North Suburban Medical Center Thornton, Adams, Colorado	12/31/2009
5. 06-0100	Medical Center of Aurora Aurora, Arapahoe, Colorado	12/31/2009

Model Form G: Schedule of Providers in Group
Group Name: HCA 2010 DSH - Colorado State Database
Representative: HCA, Inc.,
Case Number: 14-2395GC

PROVIDER NUMBER	PROVIDER NAME CITY, COUNTY, STATE	COST REPORTING PERIOD
1.06-0014	Presbyterian/St. Luke's Medical Center Denver, Arapahoe, Colorado	08/31/2010
2.06-0032	Rose Medical Center Denver, Arapahoe, Colorado	12/31/2010
3.06-0034	Swedish Medical Center Englewood, Arapahoe, Colorado	09/30/2010
4.06-0065	North Suburban Medical Center Thornton, Adams, Colorado	12/31/2010
5.06-0100	Medical Center of Aurora Aurora, Arapahoe, Colorado	12/31/2010

Model Form G: Schedule of Providers in Group
Group Name: HCA 2011 DSH - Colorado State Database
Representative: HCA, Inc. -
Case Number: 14-3725GC

	PROVIDER NUMBER	PROVIDER NAME CITY, COUNTY, STATE	COST REPORTING PERIOD
1.	06-0014	Presbyterian St. Luke's Medical Center Denver, Arapahoe, Colorado	08/31/2011
2.	06-0032	Rose Medical Center Denver, Arapahoe, Colorado	12/31/2011
3.	06-0034	Swedish Medical Center Englewood, Arapahoe, Colorado	09/30/2011
4.	06-0065	North Suburban Medical Center Thornton, Adams, Colorado	12/31/2011
5.	06-0100	Medical Center of Aurora Aurora, Arapahoe, Colorado	12/31/2011

Model Form G: Schedule of Providers in Group
Group Name: HCA 2012 DSH - Colorado State Database
Representative: HCA, Inc.
Case Number: 15-0196GC

PROVIDER NUMBER	PROVIDER NAME CITY, COUNTY, STATE	COST REPORTING PERIOD
1. 06-0014	Presbyterian/St. Luke's Medical Center Denver, Arapahoe, Colorado	08/31/2012
2. 06-0032	Rose Medical Center Denver, Arapahoe, Colorado	12/31/2012
3. 06-0034	Swedish Medical Center Englewood, Arapahoe, Colorado	09/30/2012
4. 06-0065	North Suburban Medical Center Thornton, Adams, Colorado	12/31/2012
5. 06-0100	Medical Center of Aurora Aurora, Arapahoe, Colorado	12/31/2012