PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D43

PROVIDERS –
QRS 2004-2005 Medicare Part A Title XIX Eligible Patient Days Group III

QRS Empire 2000, 2003-2004, 2006-2007 Medicare Part A Title XIX Eligible Days – No Pay Part A CIRP Group

QRS 10/1/2004 – 2008 DSH No Pay Part A Group

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions, LLC/Wisconsin Physicians Service

HEARING DATE –
November 30, 2016

Cost Reporting Periods Ended –
2000 - 2009

CASE NOs.: 08-2598G, 08-2955GC;
13-0016G;

INDEX

ISSUE:

Should patient days associated with Medicare Part A, Title XIX eligible patients that were not included in the Supplemental Security Income ("SSI") percentage factor of the Medicare Disproportionate Share Hospital ("DSH") formula be included in the Medicaid days factor or the SSI percentage factor used in the Medicare DSH formula?[1]

DECISION:

After considering the Medicare law, regulations, program instructions, evidence admitted, and arguments presented, the Provider Reimbursement Review Board ("Board") finds that the hospital days for dual eligible patients (patients eligible for both Medicare Part A and Medicaid), but for whom Medicare claims were not submitted, were properly excluded from both the SSI fractions and the Medicaid fractions of the DSH calculations.

INTRODUCTION:

These appeals involve numerous acute care hospitals (referred to collectively as "Providers") for various cost reporting periods spanning 2000 through 2009.[2] Noridian Healthcare Solutions, LLC and Wisconsin Physicians Service ("Medicare Contractors") did not include patient days for certain dual eligible patients in the Providers' DSH payments. The Medicare Contractors did not include the days at issue in the Medicaid fractions of the DSH calculations because dual eligible patients are entitled to Medicare Part A and, therefore, the days belong in the SSI fractions. However, the Providers state that these days were not billed to Medicare so the Centers for Medicare & Medicaid Services ("CMS") was unaware of the days and, therefore, the days were not in the SSI fractions calculated by CMS.[3]

The Providers timely appealed the exclusion of these dual eligible patient days from their Notices of Program Reimbursement ("NPRs") and met the jurisdictional requirements for a hearing before the Board. The Board conducted a telephonic hearing on November 30, 2016, at the request of the parties. The Providers were represented by Teresa Sherman of Paukert & Troppmann, PLLC. The Medicare Contractors were represented by Scott Berends of Federal Specialized Services.

STATEMENT OF FACTS:

Whether a hospital qualifies for a DSH payment, and how large a payment it receives, depends upon the hospital's disproportionate patient percentage, which is the sum of two fractions: the SSI (or Medicare) fraction and the Medicaid fraction.[4] The governing regulation at 42 C.F.R. § 412.106(b) (2004) states:

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[1] Transcript ("Tr.") at 6.
[2] *See* Appendix A for Schedules of Providers.
[3] Providers' Consolidated Final Position Paper at 5.
[4] 42 U.S.C. § 1395ww(d)(5)(F)(v).

> (b) *Determination of a hospital's disproportionate patient percentage*.
> (1) *General Rule*. A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
> (2) *First computation*: *Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
> (i) Determines the number of patient days that –
> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;
> (ii) Adds the results for the whole period; and
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patients that—
> (A) Are associated with discharges that occur during that period; and
> (B) Are furnished to patients entitled to Medicare Part A.
>
> * * *
>
> (4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, 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.

The agency has used the Medicare Provider Analysis and Review ("MedPAR") file as the source for the Medicare DSH calculation since the implementation of DSH.[5] The MedPAR records represent final action claims data in which all adjustments have been resolved.[6] In order to be included in the MedPAR data set, providers must submit claims to Medicare:

> MedPAR consolidates Inpatient Hospital or Skilled Nursing Facility (SNF) claims data from the National Claims History (NCH) files into stay level records. The accumulation of claims submitted for the period commencing on a beneficiary's date of admission to an inpatient hospital or SNF and ending on the beneficiary's date of discharge from that hospital or SNF represents one stay.[7]

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[5] *See* Medicare Contractor's Consolidated Final Position Paper, Exhibit I-7 at 16.
[6] *Id.*
[7] https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/MEDPARLDSHospitalNational.html.

During the cost years under appeal, providers had a maximum time limit for billing claims to the Medicare program of between 15 and 27 months.[8] CMS regulations and manuals establish the claim submission requirements.[9] Regulations at 42 C.F.R. § 424.30 (2004) state:

> This subpart sets forth the requirements, procedures, and time limits for claiming Medicare payments. Claims must be filed in all cases except when services are furnished on a prepaid capitation basis by a health maintenance organization (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP).

The dispute in this case centers on the issue of whether dual eligible days, paid in full by Medicaid or another payer and not billed to Medicare Part A, should be included by the Medicare Contactor in either fraction of the DSH calculation.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Providers claim 1.) at the time the services were rendered, they acted diligently to check for Medicare eligibility and found no Medicare coverage, 2.) the days at issue were paid in full by Medicaid or by another payer, and 3.) it is likely that for a number of these days the patient was also eligible for SSI.[10] Additionally, the Providers claim the Part A No Pay days at issue are not Medicare Part C days or Exhausted days.[11] Finally, the Providers assert the days at issue are not Medicare Secondary Payer ("MSP") days as Medicare Part A was not billed or notified of the services rendered, and someone or some entity other than Medicare Part A made payment for the days at issue.[12]

The Providers state that occasionally hospitals are not aware that patients are eligible for Part A benefits and, therefore, the hospitals do not bill the Medicare program and Medicare does not pay. Additionally, the Providers state that if they find out a patient has Medicare after the time limit to file Medicare claims has expired, they will not be able to bill Medicare.[13] When Medicare does not get billed, Medicare is not aware of a patient's hospitalization and the days are not included in the files CMS uses for calculating the SSI fraction. The Providers believe the regulations require inclusion of these days in the Medicaid fraction.[14]

The Providers point to a CMS letter to the State Medicaid Directors[15] and argue that (with one exception) when Medicaid has made payment, a provider does not have any obligation to file a

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[8] Providers' Consolidated Final Position Paper at 10; *see also* 42 C.F.R § 424.44(a) (2004).
[9] There are also numerous manual provisions that support the regulation and provide additional specificity as to when providers are required to submit bills for patients to Medicare. *See, e.g.*, Internet Only Manual, CMS Pub. 100-04 Medicare Claims Processing Manual, Chapter 1 and CMS Pub. 100-05 Medicare Secondary Payer Manual, Chapter 3.
[10] Providers' Post-Hearing Brief at 4.
[11] Providers' Consolidated Final Position Paper at 16.
[12] *Id. See also* comment section in Providers' Exhibit P-6a submitted with Providers' Post Hearing Brief.
[13] Providers' Consolidated Final Position Paper at 10.
[14] *Id.* at 11.
[15] Providers' Consolidated Final Position Paper, Exhibit P-14.

claim with Medicare. The exception to this rule is if the State makes a timely request to the provider within Medicare's prescribed claim filing period, a provider must file a claim with Medicare.[16] The Providers believe this means Medicare has no obligation to pay Part A benefits on behalf of a dual eligible beneficiary unless and until the State makes a timely request.[17] In this situation, the Providers conclude the "beneficiary's potential entitlement to Part A benefits is contingent upon the State Medicaid agency providing timely notification to the hospitals identifying Medicare as a liable third party."[18]

Finally, the Providers assert that it is undisputed the days at issue are legitimate Title XIX eligible patient days that must be counted somewhere in the DSH formula to properly reimburse the Providers for serving low-income patients. The Providers believe that the *Allina Health Services* decision made it clear that it is not acceptable to exclude dual eligible patient days from both fractions.[19] Simply put, the Providers' believe the patients at issue were either entitled to benefits under Part A or not entitled to benefits under Part A. Therefore, the Providers believe these days, which are uncounted for at this time, should be put in either the SSI or the Medicaid fractions of the Providers' DSH calculations.[20]

The Medicare Contractors disagree and state the days at issue cannot be included in the SSI fractions because the Providers did not exhaust their administrative remedies because they failed to submit claims to Medicare.[21] Further, the Medicare Contractors point out that, based on CMS regulations,[22] the days cannot be included in the Medicaid fractions because the patients were entitled to benefits under Part A.

The Board agrees with the Medicare Contractors that days for dual eligible patients cannot be included in the Medicaid fraction. Specifically, 42 C.F.R. § 412.106(b)(4) states that the Medicaid fraction consists of "the number of the hospital's patient days of service for which patients were eligible for Medicaid **but not entitled to Medicare Part A**."[23] Although the Providers claim that these patients were not entitled to Part A benefits because someone else paid for the services in full, the Board disagrees. Specifically, the Board points to the decision in *Catholic Health Initiatives Iowa Corporation*, where the court stated that entitlement to the Medicare benefit is simply a matter of meeting statutory criteria, not a matter of payment.[24]

Additionally, the Board notes that the Providers' data shows if Medicare was billed for the services, the days would have been included in the MedPAR file used by CMS to calculate the SSI fractions.[25] The Board finds the Providers were required to bill Medicare Part A even if

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[16] *Id.* at 17.
[17] *Id.* at 17-18.
[18] *Id.* at 19.
[19] Providers' Post Hearing Brief at 16. *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1108 (D.C. Cir. 2014). The Board notes that the *Allina* case addressed the Secretary's position related to Part C days and the present cases do not challenge Part C days.
[20] Providers' Post Hearing Brief at 13.
[21] Medicare Contractors' Consolidated Final Position Paper at 8-9.
[22] 42 C.F.R. § 412.106(b)(4).
[23] Emphasis added.
[24] *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 919-20 (D.C. Cir. 2013).
[25] Providers' Post Hearing Brief at 8. *See also Id.* at Exhibit P-6a, Account No. D22934475, stating "Medicaid originally paid then we billed Medicare after it was identified . . . [and] Medicare paid this

Medicare was not responsible for payment. The regulation at 42 C.F.R. § 424.30 states that "[c]laims must be filed in all cases except when services are furnished on a prepaid capitation basis by a health maintenance organization (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP)." The Providers in these cases are not claiming these are HMO, CMP, HCPP, or Part C days of any type. Rather, the Providers state that the days at issue were not billed because they were paid in full by Medicaid, the county jail, another county program, or a commercial payer.[26]

Further, the Board disagrees with the Providers' claim that none of these days are MSP days because they were paid in full by another primary payer. The Providers' witness stated she was not aware of any requirement to submit no-pay bills except in situations involving Part C claims. However, the Board finds the MSP billing rules apply even when payment was made in full by the primary payer (e.g., commercial insurance or other payer primary to Medicare). Specifically, the Internet Only Manual CMS Pub. 100-05, MSP Manual, Chapter 3 § 30.3 states:

> For an inpatient hospital or SNF stay, if the GHP's [group health plan's] payment equals or exceeds the gross amount payable by Medicare, or equals or exceeds the provider's charges for Medicare covered services or the provider accepts or is obligated to accept the GHP payment as payment in full, a no payment bill is submitted in accordance with Chapter 5, §40.8.

The Board also finds the Providers were required to bill Medicare when they learned days paid by Medicaid were for dual eligible patients.[27] Although the record is not clear on when the Providers learned the patients were dual eligible or why Medicaid paid the claims, the Internet Only Manual CMS Pub.100-04, Medicare Claims Processing Manual, Chapter 1 §§ 70.6 – 70.7 allows for claims to be filed after Medicare's timely filing period in cases of administrative error, retroactive Medicare enrollment and other situations involving misinformation.[28]

The Board finds the Medicare Contractors were correct in excluding these days from the Medicaid fractions of the Providers' DSH calculations as dual eligible days can only be included in the SSI fraction. The Board also finds that the Providers were responsible for billing Medicare in situations involving MSP, retroactive Medicare enrollment, or misinformation, even if Medicare's timely filing period had expired. The Board concludes that the Providers DSH payments were correctly calculated based on the information submitted to CMS by the Providers.

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claim." These days are in the MedPAR file (Providers' Consolidated Final Position Paper, Exhibit P-8 at 8.51).

[26] Providers' Post Hearing Brief, Exhibit P-6a.

[27] 42 C.F.R. § 424.30.

[28] Prior to the Internet Only Manual Pub. 100-04, this information was included in HCFA Pub. 10, Hospital Manual § 270.1 stating "Where the hospital believes SSA or its agents are responsible for the late filing, it should file a regular payment bill and attach a statement explaining its view of the circumstances which led to the late filing, and if practical, the written explanation of the beneficiary as to such circumstances."

DECISION:

After considering the Medicare law, regulations, program instructions, evidence submitted, and arguments presented, the Board finds that the hospital days for dual eligible patients, for whom Medicare claims were not submitted, were properly excluded from both the SSI fractions and the Medicaid fractions of the DSH calculations.

BOARD MEMBERS PARTICIPATING:

Charlotte Benson, CPA
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FOR THE BOARD:

/s/
Charlotte F. Benson
Board Member

DATE: July 5, 2018

APPENDIX A

CASE NO. 08-2598G

	Provider No.	Provider Name	FYE
1		Dismissed	
2		Dismissed	
3	24-0036	St. Cloud Hospital	6/30/2004
4	50-0129	Tacoma General Hospital	12/31/2004
5	10-0001	Shands Jacksonville Medical Center	6/30/2005
6	24-00369	St. Cloud Hospital	6/30/2005

CASE NO. 08-2955GC

	Provider No.	Provider Name	FYE
1	50-0044	Deaconess Medical Center	12/31/2000
2	50-0044	Deaconess Medical Center	12/31/2004
3	50-0044	Deaconess Medical Center	12/31/2006
4	50-0044	Deaconess Medical Center	12/31/2007
5	50-0044	Deaconess Medical Center	9/30/2008
6	50-0119	Valley Hospital Medical Center	12/31/2004
7	50-0119	Valley Hospital Medical Center	12/31/2005
8	50-0119	Valley Hospital Medical Center	12/31/2006
9	50-0119	Valley Hospital Medical Center	12/31/2007
10	50-0119	Valley Hospital Medical Center	9/30/2008

CASE NO. 13-0016G

	Provider No.	Provider Name	FYE
1	50-0129	Tacoma General Hospital	12/31/2004
2	10-0001	Shands Jacksonville Medical Center	6/30/2005
3	10-0002	Bethesda Memorial Hospital	9/30/2005
4	24-0036	St. Cloud Hospital	6/30/2005
5	50-0079	Good Samaritan Hospital	9/30/2005
6	50-0129	Tacoma General Hospital	12/31/2005
7	07-0002	St. Francis Hospital & Medical Center	9/30/2006
8	10-0001	Shands Jacksonville Medical Center	6/30/2006
9	24-0036	St. Cloud Hospital	6/30/2006
10	50-0016	Central Washington Hospital	12/31/2006
11	50-0058	Kadlec Medical Center	12/31/2006
12	11-0034	Medical Center of Georgia	6/30/2007
13	24-0036	St. Cloud Hospital	6/30/2007
14	50-0003	Skagit Valley Hospital	12/31/2007
15	50-0026	Stevens Healthcare	12/31/2007
16	50-0058	Kadlec Medical Center	12/31/2007

17	10-0084	Leesburg Regional Medical Center	6/30/2008
18	10-0092	Wuesthoff Medical Center	9/30/2008
19	24-0036	St. Cloud Hospital	6/30/2008
20	50-0039	Harrison Medical Center	4/30/2008
21	50-0039	Harrison Medical Center	4/30/2009