PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D48

PROVIDERS –
Providence Health & Services 10/01/2004-12/31/2007 Dual Eligible Days CIRP Group

Provider Nos: See Appendix A

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions

HEARING DATE –
March 9, 2017

Cost Reporting Period Ended –
10/1/2004 - 2007

CASE NO.: 09-0937GC

INDEX

ISSUE:

Should patient days associated with Medicare Part A and Title XIX eligible patients that were not included in the SSI percentage factor of the Medicare Disproportionate Share formula be included in the Medicaid fraction of the Medicare DSH formula?[1]

DECISION:

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

INTRODUCTION:

These appeals involve numerous acute care hospitals (referred to collectively as "Providers") for cost reporting periods spanning from 10/1/2004 through 12/31/2007.[2] Noridian Healthcare Solutions, LLC ("Medicare Contractor") did not include patient days for certain patients that were eligible for Medicaid and also entitled to Medicare Part A services (known as "dual eligible" patients) in the Providers' DSH payments. The Medicare Contractor 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.[3] The Providers state that these days were not billed to Medicare[4] 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.

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 March 9, 2017, at the request of the parties. The Providers were represented by Teresa Sherman of Paukert & Troppmann, PLLC. The Medicare Contractors were represented by Joe Bauers 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.[5] The governing regulation at 42 C.F.R. §

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[1] Transcript ("Tr.") at 5-6.
[2] *See* Appendix A for Schedules of Providers.
[3] Medicare Contractor's Final Position Paper at 7-9.
[4] Providers' Post-Hearing Brief at 4-5; Providers' Final Position Paper, Exhibit P-3 at 9; *see also* Tr. at 13-14.
[5] 42 U.S.C. § 1395ww(d)(5)(F)(v).

412.106(b) (2004) states that only covered patient days are to be counted when computing the Medicare fraction. It provides:

> (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 covered 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.[6] The MedPAR records represent final action claims data in which all adjustments have been resolved.[7] In order to be included in the MedPAR data set, providers must submit claims to Medicare.[8]

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.[9] CMS regulations and manuals establish the claim submission requirements.[10] Specifically, 42 C.F.R. § 424.30 (2004) states:

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[6] *See Allina Health Servs. v. Burwell*, CMS Adm'r Dec. (Dec. 1, 2015), *on remand from*, *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014), available at Medicare Contractor's Final Position Paper, Exhibit I-11.
[7] *Id* at 17.
[8] https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/MEDPARLDSHospitalNational.html.
[9] Providers' Final Position Paper, Exhibit P-3 at 9; *see also* 42 C.F.R § 424.44(a) (2004).
[10] There are also numerous manual provisions that support the regulation and provide additional specificity as to when providers are required to submit bills to Medicare. *See, e.g.*, Internet Only Manual, CMS Pub.

> 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).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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.

The Providers claim: (1) at the time the services were rendered, they acted diligently to check for Medicare eligibility and found no Medicare coverage;[11] and (2) the days at issue were paid by Medicaid or paid in full by another payer.[12] Additionally, the Providers claim the days at issue are not Medicare Part C days or Exhausted days.[13] Finally, the Providers assert they were not aware of the Medicare status of the patient until long after the time for submitting Medicare claims had passed.[14]

The Providers state that sometimes 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.[15] 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.[16] 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.[17] The Providers believe the regulations require inclusion of these days in the Medicaid fraction.[18]

The Providers point to a CMS letter to the State Medicaid Directors[19] and argue that (with one exception) when Medicaid has made payment, a provider does not have any obligation to file a 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

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100-04 Medicare Claims Processing Manual, Chapter 1 and CMS Pub. 100-05 Medicare Secondary Payer Manual, Chapter 3.

[11] Providers' Post-Hearing Brief at 4.

[12] Tr. at 11. The record does not identify the days the Providers are requesting to have added to the various DSH calculations.

[13] *Id*.

[14] Providers' Post-Hearing Brief at 5.

[15] *Id.* at 4 -5.

[16] *Id.* at 5 and Tr. at 115.

[17] Tr. at 27.

[18] Providers' Post Hearing Brief at 8.

[19] Providers' Post Hearing Brief, Exhibit P-14. (Note: the Providers' resubmitted Exhibit P-14 with their Post Hearing Brief because the Providers' Final Position Paper, Exhibit P-14 incorrectly contained the Summary of Analysis of CMS Administrator's Decisions rather than the CMS Letter to the State Medicaid Director).

Medicare.[20] The Providers believe this means if Medicaid has paid, then a provider has no obligation to bill on behalf of a dual eligible beneficiary, unless and until the State makes a timely request.[21]

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.[22] 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.[23] 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 unaccounted for at this time, should be put in either the SSI or the Medicaid fractions of the Providers' DSH calculations.[24]

The Medicare Contractor disagrees and states the days at issue cannot be included in the SSI fractions because the Providers failed to submit claims to Medicare.[25] Further, the Medicare Contractor points out that, based on CMS regulations,[26] the days cannot be included in the Medicaid fractions because the patients were entitled to benefits under Part A.[27]

The Board agrees with the Medicare Contractor 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**."[28] 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.[29]

The Board finds the Providers were required to bill Medicare Part A even if Medicare was not responsible for payment. The regulation at 42 C.F.R. § 424.30 states that "[c]laims must be billed 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 the primary payer.[30]

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[20] Providers' Post Hearing Brief at 5-6.
[21] Tr. at 43-44.
[22] Providers' Post-Hearing Brief at 3.
[23] *Id.* at 10. *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.
[24] Providers' Post-Hearing Brief at 8.
[25] Medicare Contractor's Post Hearing Brief at 9.
[26] 42 C.F.R. § 412.106(b)(4).
[27] Medicare Contractor's Post Hearing Brief at 3.
[28] Emphasis added.
[29] *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 919-20 (D.C. Cir. 2013).
[30] Tr. at 11 - 12.

The Providers assert there is "no specific requirement to submit a claim to Medicare for no payment when it's a Medicare secondary payer ["MSP"] issue."[31] The Board disagrees with this statement and 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).[32] 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.[33] Although the record is not clear on when the Providers learned the patients were dual eligible or why Medicaid paid the claims,[34] 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.[35]

The Board finds the Medicare Contractor was correct in excluding these days from the Medicaid fractions of the Providers' DSH calculations because 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.

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, 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.

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[31] Tr. at 41-42. *See also* Providers' Post Hearing Brief at 5.

[32] The Providers' Post-Hearing Brief at 13 states "it does not appear that no-payment bills would be used in the Providers' PS&R [Provider Statistical &Reimbursement] Reports for DSH purposes." The Board points out that CMS uses the MedPAR file not the PS&R Reports when calculating the SSI fraction.

[33] 42 C.F.R. § 424.30.

[34] The Board asked the Providers to submit post-hearing additional information on the percentage or number of additional days by category including 1) Medicaid days where the Providers were not requested to bill Medicare; 2) Medicaid days where payment was recouped and the state requested the Providers bill Medicare; and 3) MSP days paid in full by the primary insurance. However the Providers declined to submit this information stating it was not available and that audit work would be needed to ensure the requested days were not already included in the SSI percentage. *See* Providers' Post Hearing Brief at 6.

[35] 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."

BOARD MEMBERS PARTICIPATING:

Charlotte Benson, CPA
Gregory Ziegler, CPA, CPC-A
Robert Evarts, Esq.

FOR THE BOARD:

/s/
Charlotte Benson
Board Member

DATE: September 7, 2018

Appendix A
Schedule of Providers

Model Form G: Schedule of Providers in Group

Case No.: 09-0937GC

Page 1 of 5

Group Name: Providence Health Systems 2005 Dual Eligible Days CIRP Group

Date Prepared: May 13, 2016

Group Representative: Blumberg Ribner, Inc.

Lead Intermediary: Noridian Healthcare Solutions, LLC

Issue: Dual Eligible Days

#	Provider Number	Provider Name / Location (city, county, state)	FYE	Intermediary / MAC	A Date of Final Determination	B Date of Hearing Request / Add Issue Request	C No. of Days	D Audit Adj. No.	E Amount in Controversy	F Prior Case No(s).	G Date of Direct Add / Transfer(s) to Group
1	05-0078	San Pedro Peninsula Hospital (San Pedro, CA)	12/31/2004	Noridian Healthcare Solutions, Inc.	03/21/2008	07/21/2008	122	3, 41, 44 and 45	$184,000	08-2314	Transfer-09/23/2009
2	05-0078	San Pedro Peninsula Hospital (San Pedro, CA)	10/31/2005	Noridian Healthcare Solutions, LLC	07/31/2008	01/29/2009	182	41, 42 and 43	$14,000	09-0799	Initial Req for Group and Transfer 02/23/2009
3	05-0078	San Pedro Peninsula Hospital (San Pedro, CA)	12/31/2005	Noridian Healthcare Solutions, Inc.	08/07/2008	01/29/2009	175	32 and 33	$3,000	09-0800	Transfer-03/12/2009
4	05-0078	San Pedro Peninsula Hospital (San Pedro, CA)	12/31/2006	Noridian Healthcare Solutions, Inc.	09/25/2009	02/19/2010	147	5, 11, 12, 26, 27, 44, 45, 48 & 49	$225,000	10-0736	Transfer-09/01/2010
5	05-0235	Saint Joseph's Medical Center (Burbank, CA)	12/31/2005	Noridian Healthcare Solutions, Inc.	06/16/2008	11/19/2008	156	10, 11, 12, 15, 16, 51 and 52	$79,000	09-0419	Transfer-07/27/2009
6	05-0235	Saint Joseph's Medical Center (Burbank, CA)	12/31/2006	Noridian Healthcare Solutions, Inc.	12/10/2008	5/27/2010	533	5, 23, 24, 26, 53 & 54	$772,000	09-1816	Transfer-12/01/2009

Total Amount in Controversy for all Providers: $ 3,282,000

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Page 2 of 5

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7	05-0278	Providence Holy Cross Medical Center (Mission Hills, CA)	12/31/2006	Noridian Healthcare Solutions, Inc.	12/12/2008	05/21/2009	160	3 and 4	$77,000	09-1768	Transfer-12/01/2009
8	05-0353	Little Company of Mary Hospital (Torrance, CA)	12/31/2004	Noridian Healthcare Solutions, LLC	09/19/2007	01/22/2008	125	16	$324,000	08-0666	Transfer-10/23/2009
9	05-0353	Little Company of Mary Hospital (Torrance, CA)	10/31/2005	Noridian Healthcare Solutions, Inc.	09/20/2007	01/22/2008	126	3 and 4	$109,000	08-0670	Transfer-10/23/2009
10	05-0353	Little Company of Mary Hospital (Torrance, CA)	12/31/2005	Noridian Healthcare Solutions, Inc.	09/24/2007	01/22/2008	130	3, 26 and 28	$96,000	08-0671	Transfer-10/23/2009
11	05-0353	Little Company of Mary Hospital (Torrance, CA)	12/31/2006	Noridian Healthcare Solutions, Inc.	09/21/2009	02/19/2010	151	4, 9, 16, 17, 40 and 41	$530,000	10-0735	Transfer-09/01/2010
12	38-0004	Providence Saint Vincent Medical Center (Portland, OR)	12/31/2005	Noridian Healthcare Solutions, Inc.	10/15/2007	04/14/2008	182	14	117,000	08-1764	Transfer-12/16/2014

Total Amount in Controversy for all Providers: $ 3,282,000

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Page 3 of 5

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13	38-0061	Providence Medical Center (Portland, OR)	12/31/2005	Noridian Healthcare Solutions, Inc.	12/14/2007	06/03/2008	172	3 and 25	65,000	08-2066	Transfer-12/16/2014
14	50-0002	Saint Mary Medical Center (Walla Walla, WA)	12/31/2005	Noridian Healthcare Solutions, Inc.	11/08/2007	04/28/2008	172	none	$8,000		Transfer-08/16/2010
15	50-0014	Providence General Medical Center (Everett, WA)	12/31/2005	Noridian Healthcare Solutions, Inc.	04/04/2008	09/30/2008	179	8 and 17	$40,000	09-0104	Transfer-05/15/2009
16	50-0024	Providence Saint Peter Hospital (Olympia, WA)	12/31/2005	Noridian Healthcare Solutions, Inc.	07/30/2007	01/11/2008	165	10 and 11	$23,000		Transfer-08/16/2010
17	50-0024	Providence Saint Peter Hospital (Olympia, WA)	12/31/2006	Noridian Healthcare Solutions, Inc.	02/11/2008	08/01/2008	172	7 and 8	$62,000	08-2416	Transfer-08/01/2008
18	50-0024	Providence Saint Peter Hospital (Olympia, WA)	12/31/2006	Noridian Healthcare Solutions, Inc.	11/26/2008	03/20/2009	114	42	$50,000	09-1225	Transfer-11/12/2009

Total Amount in Controversy for all Providers: $ 3,282,000

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Page [illegible] of [illegible]

Date Prepared: [illegible]

#	Provider Number	Provider Name / Location (city, county, state)	FYE	Intermediary / MAC	A Date of Final Determination	B Date of Hearing Request / Add Issue Request	C No. of Days	D Audit Adj. No.	E Amount in Controversy	F Prior Case No(s).	G Date of Direct Add / Transfer(s) to Group
19	50-0025	Swedish Medical Center- Cherry Hill (Seattle, WA)	12/31/2007	Noridian Healthcare Solutions, Inc.	08/31/2012	02/25/2013	178	30,33	$112,000	13-0914	Appeal Direct- 02/22/2013
20	50-0027	Swedish Medical Center (Seattle, WA)	12/31/2007	Noridian Healthcare Solutions, Inc.	07/06/2012	12/26/2012	173	42 and 43	$24,000	13-1483	Appeal Direct- 12/26/2012
21	50-0054	Sacred Heart Medical Center (Spokane, WA)	12/31/2005	Noridian Healthcare Solutions, Inc.	11/25/2008	04/15/2009	141	9, 21, 24 and 43	$96,000	09-1533	Transfer- 06/12/2009
22	50-0054	Sacred Heart Medical Center (Spokane, WA)	12/31/2006	Noridian Healthcare Solutions, Inc.	03/26/2009	09/10/2009	168	35 and 36	$57,000	09-2222	Transfer- 09/03/2009
23	50-0054	Sacred Heart Medical Center (Spokane, WA)	12/31/2007	Noridian Healthcare Solutions, Inc.	03/07/2013	04/24/2013	48	5, 22, 23 and 24	$86,000		Appeal Direct- 04/24/2013
24	50-0077	Holy Family Hospital (Spokane, WA)	12/31/2005	Noridian Healthcare Solutions, Inc.	04/13/2007	10/04/2007	174	19	56,000	08-0026	Transfer- 08/16/2010

Total Amount in Controversy for all Providers: $ 3,282,000

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25	50-0077	Holy Family Hospital (Spokane, WA)	12/31/2006	Noridian Healthcare Solutions, Inc.	04/03/2008	09/02/2008	152	13 and 22	$55,000	08-2883	Transfer-06/05/2009
26	50-0077	Holy Family Hospital (Renton, WA)	12/31/2007	Noridian Healthcare Solutions, Inc.	02/26/2013	04/19/2013	52	4, 12, 14 and 15	$18,000		Appeal Direct-04/19/2013

Total Amount in Controversy for all Providers: $ 3,282,000