PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2009-D27

PROVIDER -
St. Mary's Hospital – Milwaukee
Milwaukee, Wisconsin

Provider No.: 52-0051

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services, LLC - WI

DATE OF HEARING -
March 2, 2009

Cost Reporting Period Ended -
June 30, 1999

CASE NO.: 05-1370

INDEX

ISSUE:

Whether the Medicare statute requires the Provider's Long Term Respiratory Unit (LTRU) days to be excluded from the Medicaid Proxy of the Medicare DSH calculation under 42 U.S.C. §1395ww(d)(5)(F)(vi)(II).

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). See, 42 U.S.C. §1395ww(d). The PPS statute contains a number of provisions that adjust payments based on hospital-specific factors. See 42 U.S.C. §1395ww(d)(5). This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. §1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage" (DPP). See, 42 U.S.C. §1395ww(d)(5)(F)(v).

The DPP is the sum of two fractions, the "Medicare and Medicaid fractions," for a hospital's fiscal period. 42 U.S.C. §1395ww(d)(5)(F)(vi). The Medicare fraction's numerator is the number of a hospital patient days for patients who for such period and for such days were entitled to both Medicare Part A and Supplemental Security Income (SSI), excluding patients receiving State supplementation only, and the denominator is the number of patient days for patients entitled to Medicare Part A. Id. The Medicaid fraction's numerator is the number of hospital patient days for patients who (for such days) were eligible for medical assistance under a

State Plan approved under Title XIX for such period but not entitled to benefits under Medicare Part A, and the denominator is the total number of the hospital's patient days for such period. Id.; See also, 42 C.F.R. §412.106(b)(4). The second fraction is frequently referred to as the Medicaid Proxy. The underlying legal issue in this case is whether patients who exhaust their Medicare Part A benefits are still "entitled" to Medicare benefits and, if so, should be excluded from the Medicaid proxy.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Mary's Hospital- Milwaukee (Provider) is a not-for-profit, acute care hospital located in Milwaukee, Wisconsin. The facts in this case are stipulated and undisputed. For the period under appeal, the Provider included in its DSH calculations 365 patient days (for one patient) in the facility's long term respiratory unit (LTRU).[1] The patient was eligible for Medicare but had exhausted his/her Medicare Part A inpatient benefits.[2] The same patient was eligible for Medicaid for each of the 365 patient days.[3] On November 5, 2004, the United Government Services, LLC (Intermediary) issued the Provider's NPR for the fiscal year ended (FYE) June 30, 1999. The Intermediary did not include the patient's LTRU days in the Medicaid fraction of the Provider's DSH calculation. The Provider filed a timely appeal with the Board. The Provider was represented by Steven B. Roosa, Esq. of Reed Smith, LLP. The Intermediary was represented by Bernard M. Talbert, Esq. of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider argues that the 365 LTRU days should be included in the Medicaid proxy calculation. The Provider contends that the patient was not "entitled" to payments for such days because the patient exhausted his/her coverage for such days. The Provider explains that "eligible" means qualifying for coverage or potential coverage because a patient is a participant in the program whereas "entitled" means "paid." As support, the Provider cites the Sixth Circuit's decision in Jewish Hospital, Inc. v. Secretary of Health and Human Services[4] :

> . . . Congress spoke of "eligibility" in the Medicaid proxy and "entitlement" in the Medicare proxy. See 42 U.S.C. §1395ww(d)(5)(F). The Secretary would have this Court conflate eligibility with entitlement. Adjacent provisions utilizing different terms, however, must connote different meanings. To be *entitled* to some benefit means that one possesses the *right* or *title* to that benefit. Thus, the Medicare proxy *fixes* the calculation upon the absolute right to receive an independent and readily defined payment.

[1] Stipulations of the Parties, ¶4.
[2] Id.
[3] Stipulations of the Parties, ¶5.
4 Jewish Hospital, Inc. v. Secretary of Health and Human Services, (hereinafter Jewish Hospital), 19 F.3d 270, 275 (6th Cir. 1994).

> By way of contrast, the Medicaid proxy speaks solely of *eligibility*. While Congress intended to refer to the qualification for Medicaid benefits in the calculation of this proxy, Congress could not have intended to fix its calculation on the actual payment of benefits in the state administered program. Had Congress intended that result, it would have also defined the Medicaid proxy in terms of entitlement to state Medicaid payments. Rather, Congress defined the Medicaid proxy with respect to eligibility for and not actual payment of benefits.

It is undisputed that the LTRU patient was otherwise *eligible* for Medicare Part A, but had exhausted his/her Part A benefits.[5] Accordingly, the patient had no right to Medicare payment on his behalf to the Provider. Applying the Court's reasoning, the Provider contends that as there was no "absolute right to receive an independent and readily defined payment" the patient was not *entitled* to Medicare payment. Nevertheless, the patient remained eligible for Medicaid[6] and should therefore have been included in the Medicaid Proxy.

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that the 365 days at issue should not be counted in the Medicaid proxy calculation and cites the CMS Administrator's reversal of the Board's decision[7] in St. Mary's Hospital-Milwaukee case for fiscal year ended June 30, 2000:

> The Administrator finds that the statutory phrase in the Medicaid proxy "but who were not entitled to benefits under Medicare Part A of this title" forecloses the inclusion of the days at issue in this case in the numerator of the Medicaid proxy. A review of the plain language of the statute reflects that the Medicare low-income proxy is intended to capture distinct patient populations. The Medicare low-income proxy, because it uses SSI as the low-income indicator, includes Medicare/Medicaid dual eligible patients. The Medicaid low-income proxy specifically excludes from its calculations patients entitled to Medicare Part A and limits its proxy to Medicaid-only eligible patients. The relevant language of the Medicaid proxy indicates that it is the status of the patient, as opposed to the payment of the day, which determines whether a patient day is included in the numerator of the Medicaid proxy.

The Intermediary argues that the same issue and arguments exist in this case.

---

[5] Stipulations of the Parties, ¶4.
[6] Id. ¶5
[7] St. Mary's Hospital – Milwaukee, 2008-D7 (November 16, 2007), rev'd CMS Adm. (January 15, 2008).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence the Board finds and concludes as follows:

The underlying legal issue in this case is whether a patient eligible for Medicare Part A, but who exhausts his/her Medicare Part A benefits, is still "entitled" to Medicare benefits and days should be excluded from the Medicaid proxy. The issue is not new and the Board has consistently applied the holdings of the Court in Jewish Hospital to its resolution. The Court defined "entitled" as follows: "To be entitled to some benefit means that one possesses the right or title to that benefit. Thus, the Medicare proxy fixes the calculation upon the absolute right to receive an independent and readily defined payment."[8] The Board considers the Court's definition consistent with the requirements of the statute and the plain language of the Act. Accordingly the Board concludes that exhausted days are not "entitled" to Medicare Part A benefits.

The Board finds that the Intermediary improperly eliminated from the DSH calculation patient days for patients who otherwise were entitled to both Medicare and Medicaid benefits, but who had exhausted their benefits. Such days should be included in the calculation of the Medicaid proxy in the determination of the DSH adjustment in accordance with both the plain language of 42 U.S.C. §1395ww(d)(5)(F) and Congressional intent. Accordingly, the DSH Medicaid fraction should be revised to permit the Provider to include the 365 LTRU days.

DECISION AND ORDER:

The Intermediary's determination of the Medicare DSH percentage is reversed and this case is remanded to the Intermediary to recalculate the DSH Medicare percentage consistent with this decision.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.
J. Gary Bowers, C.P.A.

[8] Jewish Hospital, Supra, 275.

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: June 24, 2009