PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D20

PROVIDER –
QRS 1995-1998 DSH Medicare HMO Days Groups

Provider No.: Various

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/ Noridian Administrative Services; National Government Services; Trailblazer Health Enterprises

DATE OF HEARING -
February 26, 2009

Cost Reporting Periods Ended - Various

CASE NOs.: 08-2752GC, 04-2131G, 04-2132G, 04-2133G, 04-2134G, 08-2845GC and 08-2756GC

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ISSUE:

Whether for fiscal years 1995-1998 the Intermediary should include dual-eligible, Medicare health maintenance organization (HMO) patient days in the Medicaid proxy in determining Medicare reimbursement for disproportionate share hospital (DSH) payments in accordance with the Medicare statute at 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 providers of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. *See* 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 to organizations known as fiscal intermediaries (FI) or Medicare administrative contractors (MAC). FIs and MACs[1] 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.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. 42 C.F.R. § 413.20. The 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. *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 - 1837.

Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (PPS). *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412. Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. *Id.*

The PPS statute contains a number of provisions that adjust reimbursement 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. *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

[1] FIs and MACs are hereinafter referred to as intermediaries.

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (DPP). *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l). The DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital. *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

The DPP is defined as the sum of two fractions expressed as percentages. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi). Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions require consideration of whether a patient was "entitled to benefits under part A."

The statute defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter....

42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added). The Medicare/SSI fraction is computed annually by CMS, and the Medicare fiscal intermediaries use CMS' calculation to compute a hospital's DSH payment adjustment. 42 C.F.R. § 412.106(b)(2)-(3).

The statute defines the Medicaid fraction as:

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

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added). The fiscal intermediary determines 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. 42 C.F.R. § 412.l06(b)(4).

Medicare Managed Care

The Medicare program permits its beneficiaries to receive services from managed care organizations. The original managed care statute implementing payments to health

maintenance organizations (HMOs) and competitive medical plans (CMPs) is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. §1395mm(a)(5) provides for:

> payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 were referred to as Medicare HMO patient care days and were paid under Part A of Medicare. *See* 42 U.S.C. §§1395mm(a)(5) and 1395i(a) and (h). The fiscal periods in dispute in this appeal are prior to 1999 and are governed by this statute.

In 1997, Congress amended the Medicare statute by adding a new part C for Medicare beneficiaries enrolling in managed care organizations after 1999. *See* Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, §4001, 111 Stat. 251, 270 (codified at 42 U.S.C. § 1395w-21). Part C governs the Medicare+Choice (M+C) program. This statute provides that a Medicare beneficiary may elect to receive Medicare benefits through one of two means:

> Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits [] under this subchapter --
> (A) through the original [M]edicare fee-for-service program under parts A and B of this subchapter, or
> (B) through enrollment in a Medicare+Choice plan under this part [part C]…

The fiscal years at issue in this case are all prior to the effective date of the M+C provisions of BBA.

CMS Policy for Managed Care Days in DSH Calculation

In 1990, CMS published a statement in the Federal Register stating that Medicare HMO days had been counted in the Medicare fraction. 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990). It states in relevant part:

> *Comment:* One commenter believes that the disproportionate share adjustment calculation should be expanded to include days that Medicare patients utilize health maintenance organizations (HMOs) since these beneficiaries are entitled to Part A benefits.
>
> *Response:* Based on the language of section 1886(d)(5)(F)(vi) of the Act, which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A", we believe it

> is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs and, therefore, were unable to fold this number into the calculation. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time, we have been including HMO days in SSI/Medicare percentage.

CMS did not publish any further guidance regarding Medicare managed care days until it addressed the treatment of Part C M+C patient days in the DSH calculation in 2003 and 2004. Therefore, for the years at issue in this appeal, the statement from the Federal Register of September 4, 1990 applies.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case involves seven group appeals collectively referred to as QRS DSH-Medicare HMO Days Groups (the Providers), consolidated for hearing by agreement of the parties. All the Providers in each of the groups are acute care facilities that received payment under Medicare for services to Medicare beneficiaries for the cost reporting periods from 1995 through 1998. All the Providers in each group seek to require the Intermediaries to include in the numerator of the Medicaid fraction, the days attributable to patients who were eligible for Medicaid and enrolled in Medicare managed care plans (or HMOs) during their inpatient hospital stays.

The Providers were represented by Alan J. Sedley, Esq. of Alan J. Sedley Law Offices. The Intermediaries were represented by Bernard M. Talbert, Esq. of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Intermediaries contend that CMS policy has consistently dictated that Medicare managed care days are to be included in the Medicare fraction. *See* 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990). Even after the legislation was changed to create Part C, CMS considered including M+C days in the Medicaid fraction, but following re-evaluation of the question, CMS determined that such days should remain in the Medicare fraction. *See* 69 Fed Reg. 48916, 49099 (Aug. 11, 2004).

The Intermediaries note that the Board ruled that HMO managed care days should be included in the Medicare fraction because a beneficiary must first be entitled to benefits under Medicare part A to enroll in a Medicare managed care plan. *See QRS 1994 DSH Managed Care and Medicaid Eligible Days Group v. Blue Cross Blue Shield Association/Noridian Administrative Services*, PRRB Dec. No. 2009-D3, December 17, 2008, *declined rev.* CMS Administrator, February 6, 2009.

The Providers contend that all days associated with dual-eligible, Medicare managed care days should be included in the numerator of the Medicaid fraction in the DSH formula.

The Providers contend that during the fiscal years at issue, 1995 to 1998, Congress manifested its clear intent that Medicare HMO enrollees not be regarded as patients for whom payments may be made under part A. 42 U.S.C §1395ww(h)(3)(C). Under that statute, CMS did not count Medicare HMO days in calculating Medicare payments to teaching hospitals for graduate medical education (GME). The Medicare HMO days were treated as non-Medicare days. The Providers point out that the DSH and GME statutes have similar language regarding "entitled to benefits under part A" and "with respect to whom payment may be made under part A". *See* 42 U.S.C. §1395ww(d)(5)(F)(vi)(I) and §1395ww(h)(3)(C). CMS, in the preamble to the 1989 implementing rule, specifically construes the GME statute to exclude Medicare HMO days from the calculation of the Medicare patient load category because Medicare HMO days "are recorded as *non-Medicare* days" for all Medicare payment purposes. 54 Fed. Reg. 40,286, 40,294-5 (September 29, 1989) (emphasis added).[2]

In 1997, Congress, presumably aware of CMS' existing policy of recording Medicare HMO days as non-Medicare days, enacted legislation providing for a separate, additional medical education payment specifically for hospitals that treat Medicare managed care patients. *See* Section 4624 of the BBA of 1997, 42 U.S.C. §1395ww(h)(3)(D)(i). Providers reason that if, under the pre-existing law, Congress had intended Medicare HMO patients to be counted as patients who were "entitled to benefits under Medicare Part A," then Medicare HMO patients would have already been included in the calculation of the standard GME payment. And it follows, that if that were the intent, Congress would simply have directed the Secretary to count Medicare HMO days in the GME payment calculation specified under the pre-existing law. There would have been no need for a separate additional payment for Medicare managed care enrollees.

Instead, Congress' enactment of a separate GME payment for Medicare HMO patient days manifests an intent that Medicare HMO enrollees not be regarded as patients "with respect to whom payment may be made under part A." 42 U.S.C. §1395ww(h)(3)(C). Like the GME statute, which fixes the GME payment on a hospital's number of patient days attributable to patients who are entitled to payment under Medicare Part A, the DSH statute also defines the numerator of the Medicare fraction as consisting of a hospital's number of days attributable to patients who are "entitled to benefits" under part A. The Providers argue that the Secretary's position that Medicare HMO days should be included in the Medicare fraction for DSH therefore conflicts with the intent of Congress. This, coupled with the unexplained inconsistent treatment of HMO days for all other payment purposes, indicates CMS' position is arbitrary and capricious.[3]

The Providers also claim that CMS' decision to include Medicare HMO days in the Medicare fraction is arbitrary and capricious because it never implemented a genuine policy to include these days. While the preamble to the 1990 rule said that CMS had been

[2] *See* Tr. at 21-22
[3] *See* Tr. at 24-26.

counting Medicare HMO days in the Medicare fraction since 1987, the Providers indicate that evidence in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C 2008, March 31, 2008) revealed that few HMO days were counted in the Medicare fraction because hospitals and HMOs had little incentive and no contractual obligation to submit data to CMS for Medicare HMO patient days.

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and the evidence presented, the Board finds and concludes that dual-eligible Medicare managed care days should be included in the Medicare fraction used to calculate the DSH adjustment.

This case pertains to inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 and to fiscal years prior to enactment of the BBA in 1997 which created Part C. The managed care statute implementing payments to HMOs and CMPs during this time period is at 42 U.S.C. § 1395mm which provides the following:

> The payment to the eligible [HMO] organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter *shall be made from the Federal Hospital Insurance Trust Fund* and the Federal Supplementary Medical Insurance Trust Fund.

42 U.S.C. § 1395mm(a)(5) (emphasis added). The Federal Hospital Insurance Trust Fund was established under Part A of the Medicare Act to fund the services provided under Part A. 42 U.S.C. §§1395i(a) and (h). Consequently, prior to the change in the Medicare Act which created Part C, HMO inpatient hospital services were paid pursuant to Part A of Medicare.

In *Jewish Hospital, Inc. v. Secretary of Health and Human Services*, 19 F.3d 270, 274-75 (6th Cir. 1994), the term "entitled" as it is used in the definition of the Medicare fraction at 42 U.S.C. §1395ww(d)(5)(F), was defined as follows:

> [t]o 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."

The explicit language of the DSH statute limits inclusion in the Medicaid fraction to those individuals or beneficiaries "eligible for medical assistance under state plan approved under XIX" and "not entitled to benefits under part A." 42 C.F.R. §412.106(b)(4) (emphasis added). In that services to Medicare beneficiaries enrolled in an HMO were paid under

Part A during the fiscal periods prior to the effective date of Part C, the DSH statute requires those days be excluded from the Medicaid percentage.[4]

DECISION AND ORDER:

The Board finds that the Intermediary properly excluded Medicare HMO days from the Medicaid fraction.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: March 16, 2011

[4] The Board reached a different decision in *QRS 1999-2003 DSH Part C Days Group v. Blue Cross Blue Shield Association*, Case No. 09-0003GC *et al*, 2011-D19 released concurrently with this decision. That case involved fiscal periods to which Part C is applicable.