PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D41

PROVIDER –
University Medical Center

Provider Nos.: 44-0193

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Service

DATE OF HEARING -
November 1, 2016

Fiscal Year End – October 31, 2008

CASE NO.: 13-1588

INDEX

ISSUES:

1. Whether the Medicare Administrative Contractor ("Medicare Contractor") determined Medicare reimbursement for Disproportionate Share Hospital ("DSH") payments in accordance with the Medicare statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi). Specifically, whether the numerator of the "Medicaid fraction" properly includes all "eligible" Medicaid days, regardless of whether such days were paid days.[1]

2. Whether the Provider Reimbursement Review Board ("Board") has jurisdiction over this issue.[2]

DECISION:

After considering the Medicare law, regulations, program instructions, arguments presented, and evidence submitted, the Board finds: 1) it lacks jurisdiction for any of the 374 days that Medicaid paid prior to the submission of the Provider's cost report and 2) it has jurisdiction for any of the 374 additional days that were not paid by Medicaid prior to the submission of the Provider's cost report.

The Board also finds the list submitted by University Medical Center ("University" or "Provider") identifying 5,843 days is valid to document the Medicaid eligible days used to settle the Provider's cost report. The Board remands the additional 374 requested days back to the Medicare Contractor to determine if Medicaid paid any of these days prior to the submission of the Provider's cost report. Any of the 374 requested days that were paid by Medicaid prior to the submission of the Provider's cost report should not be included in the Provider's DSH calculation. Any of the 374 requested days that were not paid by Medicaid prior to the submission of the Provider's cost report should be reviewed by the Medicare Contractor and included in the Provider's DSH calculation if they meet Medicare DSH payment criteria. Additionally, the Medicare Contractor should remove from the DSH calculation the 76 days (included in the 5,843 days) that the Provider later determined were not Medicaid eligible days.[3]

INTRODUCTION:

University is an acute care hospital located in Lebanon, Tennessee and is a member of the Health Management Associates ("HMA") hospital chain.[4] University's assigned Medicare Contractor during the time at issue was Wisconsin Physicians Service. University submitted its October 31, 2008 cost report claiming 5,843 Medicaid eligible days, in the numerator of the Medicaid fraction of the DSH calculation. The Medicare Contractor issued University's Notice of Program Reimbursement ("NPR") on October 15, 2012.[5]

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[1] Transcript ("Tr.") at 5-6 (issue as agreed by the parties).
[2] Tr. at 8.
[3] Provider's Post-Hearing Brief at 18 n.3.
[4] HMA was subsequently purchased by Community Health Systems ("CHS").
[5] Provider's Final Position Paper at 1.

University timely appealed the Medicare Contractor's determination on April 11, 2013, claiming that the Medicare Contractor failed to include all Medicaid eligible days in the DSH calculation. The Board held a live hearing on November 1, 2016. Donald H. Romano, Esq., of Foley & Lardner, LLP represented the Provider. Joe Bauers, Esq., of Federal Specialized Services, represented the Medicare Contractor.

STATEMENT OF FACTS:

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 subject to certain payment adjustments.[6] One of these payment adjustments, the DSH adjustment, increases the payment to hospitals that serve a disproportionate share of low-income patients.[7] The DSH adjustment is calculated, in part, by using the sum of two fractions - the Medicare or Supplemental Security Income ("SSI") fraction, and the Medicaid fraction.[8] The Medicaid fraction is at issue in this case.

The Medicaid fraction is defined 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 [*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.[9]

In February 1997, the Centers for Medicare & Medicaid Services ("CMS") (formerly the Health Care Financing Administration ("HCFA")) issued HCFA Ruling 97-2, expanding the type of days that could be included in the numerator of the Medicaid fraction. This Ruling reiterated[10] that providers were responsible for collecting, verifying, and reporting Medicaid eligible days as part of the cost reporting process. Specifically, the Ruling stated:

> Pursuant to this Ruling, Medicare fiscal intermediaries will determine the [DSH] amounts due and make appropriate [DSH] payments through normal procedures. ***Claims*** [for Medicaid eligible days] *must,* of course, *meet all other applicable*

[6] 42 U.S.C. § 1395ww(d)(3); 42 C.F.R. Part 412.
[7] 42 U.S.C. § 1395ww(d)(5)(F); 42 C.F.R. § 412.106.
[8] 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added).
[10] CMS originally discussed the providers' responsibility to report Medicaid days in the May 1986 Interim Final Rule and the September 1986 Final Rule. *See, e.g.*, 51 Fed. Reg. 16772, 16777 (May 6, 1986) (stating that "[i]f a hospital disagrees with the intermediary's determination of its Medicaid patient days, it will be the hospital's *responsibility* to demonstrate to the intermediary that the Medicaid statistics reported on its cost report are incorrect or were improperly applied" (emphasis added)).

> *requirements.* This includes the requirement for data that are adequate to document the claimed [Medicaid eligible] days. *The* hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patient's inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.[11]

Additionally, 42 C.F.R. § 412.106(b)(4)(iii)(2008) states, "[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."

In 2003, Congress addressed a hospital's access to information needed to calculate the Medicare and Medicaid fractions, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA").[12] 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."[13] In implementing MMA § 951, CMS 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."[14]

CMS also 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]

The Provider filed its October 31, 2008 cost report on March 31, 2009,[16] five months after the Provider's fiscal year end, claiming 5,843 Medicaid eligible days.[17] The Medicare Contractor used all data the Provider submitted with its cost report and all information submitted during the desk review when issuing the Provider's NPR.[18] The Provider appealed the NPR, requesting

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[11] HCFA Ruling 97-2 at 4 (emphasis added).
[12] Pub. L. No. 108-173, § 951,117 Stat. 2066, 2427 (Dec. 8, 2003).
[13] (Emphasis added.)
[14] 70 Fed. Reg. 47278, 47438 (Aug. 12, 2005).
[15] *Id.* at 47442.
[16] Medicare Contractor's Final Position Paper at 4.
[17] Provider's Post-Hearing Brief at 2. The Medicare Contractor has stated the cost report contained 5,842 days rather than 5,843 days. It appears the difference of one day is attributed to one health maintenance organization day in the rehabilitation subunit. *See* Provider's Post-Hearing Brief Exhibit P-10 at 2.
[18] Medicare Contractor's Final Position Paper at 4.

additional Medicaid eligible days. University hired Quality Reimbursement Services ("QRS") in 2014 to identify additional Medicaid eligible days that were not included on University's cost report.[19]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

A. Board Jurisdiction

The Medicare Contractor challenged the Board's jurisdiction over the additional requested Medicaid days. The Medicare Contractor argues that the Provider is not challenging the Medicare Contractor's computations, but merely is requesting the inclusion of additional days not claimed by the Provider on its submitted cost report. The Medicare Contractor asserts that both the Board's decision in Danbury[20] and the Administrator's decision in Norwalk[21] make it clear that a provider has an obligation to submit Medicaid eligible day information as part of the cost reporting process or establish that there was a practical impediment preventing it from gathering this information.

In this case, the Medicare Contractor asserts that the Provider did not claim the additional Medicaid eligible days for which it now seeks reimbursement, nor did it adequately demonstrate that a practical impediment prevented it from claiming the additional days.[22] As a result, the Medicare Contractor believes the Board lacks jurisdiction over the additional Medicaid eligible days at issue in this case.[23]

University disagrees, and claims that it did not have access to the Medicaid eligibility of its patient population because of flaws in the Tennessee's matching system and the inherently retroactive nature of Medicaid eligibility determinations.[24] The Provider points out that in Bethesda,[25] the Supreme Court held that a provider could meet the dissatisfaction requirement absent an adverse finding from the Medicare contractor.[26]

In considering the parties' arguments, the Board looks to its decision in Barberton,[27] in which the Board addressed its jurisdiction to hear a Medicaid eligible days case with a similar fact pattern. In Barberton, the Board concluded that, pursuant to the concept of futility in Bethesda,[28] the

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[19] Tr. at 44.
[20] *Danbury Hosp. v. BlueCross BlueShield Ass'n/Nat'l Gov't Servs., Inc*., PRRB Dec. No. 2014-D3 (Feb 11, 2014).
[21] *Norwalk Hosp. v. BlueCross Blue Shield Ass'n/Nat'l Gov't Servs., Inc.*, PRRB Dec. No. 2012-D14, *vacated*, CMS Adm'r Dec. (May 21, 2012).
[22] Medicare Contractor's Jurisdictional Challenge at 4.
[23] *Id.* at 6.
[24] Provider's Post-Hearing Brief at 6.
[25] *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*"), 485 U.S. 399 (1988).
[26] *Id.* at 404-05.
[27] *Barberton Citizens Hosp. v. CGS Adm'rs, LLC/ Blue Cross and Blue Shield Ass'n* ("*Barberton*"), PRRB Dec. No. 2015-D5 (Mar. 19, 2015), *declined review*, CMS Adm'r Dec. (Apr. 22, 2015).
[28] 485 U.S. at 404. Under the narrow facts in *Bethesda*, the Supreme Court held that 42 U.S.C. § 1395oo(a) permitted the Board to exercise jurisdiction over a provider's "self-disallowed" claim on "a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations[,]" when such "[p]roviders know that . . . the intermediary is

Board has jurisdiction over a hospital's appeal of additional Medicaid eligible days for the DSH adjustment if that hospital has "established that a practical impediment, through no fault of its own, prevented it from identifying and/or verifying with the relevant State the Medicaid eligible days at issue prior to the filing of the cost reports at issue."[29]

In addition, CMS acknowledges, in the preamble to its November 13, 2015 Final Rule, that providers may have difficulty obtaining data from State agencies regarding Medicaid eligible days:

> We have identified only one circumstance where a provider may have difficulty obtaining sufficient information to make an appropriate cost report claim within the allotted time for cost report submission. This circumstance may occur if a hospital experiences difficulty obtaining sufficient information from State agencies for the purpose of claiming DSH Medicaid-eligible patient days.[30]

Based on the above, the Board concludes it has jurisdiction over any days verified or paid by the State after the filing of the cost report as University demonstrated that a practical impediment existed due to retroactive enrollment and various mismatch issues, which made it impossible for University to have all of its Medicaid days verified prior to submission of its cost report.[31] However, the Board finds it does not have jurisdiction over any Medicaid eligible days where the State paid or verified the days prior to the submission of University's cost report, as the Provider should have known these days were Medicaid eligible and claimed these days on its cost report.

B. Determining the Number of Medicaid Eligible Days

The Medicare Contractor asserts that University failed to maintain and submit documentation to support its Medicaid eligible days. Specifically, the Medicare Contractor claims that University could not identify which Medicaid eligible days it claimed, and was paid for, on its finalized cost report. The Medicare Contractor asserts that it needs this list to ensure the additional 374 days University is requesting were not already included in the Provider's DSH payment.[32]

University disagrees, and believes it has given the Medicare Contractor a list identifying the 5,843 days on the finalized cost report. University's witness described the processes the Provider went through to support its original claim of 5,843 days.[33] University states, as part of the process it went through to document the 5,843 days it originally claimed, it discovered 76

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without power to award reimbursement except as the regulations provide, and that any attempt to persuade the intermediary to do otherwise would be futile."

[29] *Barberton* at 2.

[30] 80 Fed. Reg. 70298, 70559 (Nov. 13, 2015).

[31] Provider's Post-Hearing Brief at 6.

[32] The Medicare Contractor points out that the Provider made Exhibit P-3 Tab A, which identifies the 374 additional Medicaid eligible days the Provider is requesting, part of the record on the day of the hearing.

[33] Tr. at 32-39.

days included in the original 5,843 days that should be removed from the DSH calculation, as they are not eligible days.[34]

Additionally, University is requesting an additional 374 Medicaid eligible days as part of this appeal.[35] University explains that the Medicare Contractor refused to audit the additional 374 days because the Medicare Contractor did not believe the listing of 5,843 days was an accurate list.

The Board recognizes that 42 C.F.R. § 413.20 requires the provider to maintain sufficient financial records to assure proper payment and permits the Medicare contractor to examine such records to ascertain the amount of payment due. The Board understands the Medicare Contractor was concerned with the accuracy of the listing of 5,843 days because it was missing 12 hospital stays consisting of 31 days that the Medicare Contractor believes were included in the finalized cost report.[36]

The Board finds evidence that the listing of 5,843 days submitted by the Provider documents the days paid on University's settled cost report. Specifically, the Board finds that the Provider identified a listing of 6,110 days that came from the Provider's cost report files.[37] These 6,110 days included the 31 days that concerned the Medicare Contractor.[38] The Provider's consultant reviewed these 6,110 days and removed ineligible days, including duplicates and Part A days, which resulted in a total of 5,843 days – the number of days on the Provider's finalized cost report.[39] The Board is confident the listing of 5,843 days can be used to document the Medicaid eligible days on University's cost report.

The Board orders the Provider to submit documentation supporting the requested 374 additional days to the Medicare Contractor including, but not limited to, the date of the Medicaid payment (when applicable), the location of the service and Medicaid eligibility. The Medicare Contractor shall exclude from the DSH calculation any of the 374 additional days where Medicaid payments were made prior to the cost report submission. The Medicare Contractor shall review the documentation for the remaining days to determine if they should be included in the DSH calculation.[40] Finally, the Medicare Contractor should disallow the 76 days included in the original 5,843 days that the Provider has identified as not being Medicaid eligible days.[41]

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[34] Tr. at 65-66. *See also* Provider's Post-Hearing Brief at 21 and Exhibit P-11.
[35] Tr. at 212. *See also* Provider's Exhibit P-3 Tabs A, C, D and E.
[36] Medicare Contractor's Post-Hearing Brief at 9-10.
[37] Tr. at 59.
[38] Tr. at 57-58.
[39] Tr. at 59-60. *See also* Provider's Exhibit P-3 Tabs A and B. *See* Provider's Post-Hearing Brief Exhibit P-10 at 1, where the Medicare Contractor has agreed that the 31 days are not eligible days, but still believes they were in the submitted cost report.
[40] If the Provider does not submit the necessary documentation to the Medicare Contractor, the additional days should not be included in the DSH calculation.
[41] Provider's Post-Hearing Brief at 18 n.3. *See also* Provider's Exhibit P-3 Tab A and Tab B at 24.

DECISION AND ORDER:

After considering the Medicare law, regulations, program instructions, arguments presented and evidence submitted, the Board finds: 1) it lacks jurisdiction for any of the 374 days that Medicaid paid prior to the submission of the Provider's cost report and 2) it has jurisdiction for any of the 374 additional days that were not paid by Medicaid prior to the submission of the Provider's cost report.

The Board also finds the list submitted by the Provider identifying 5,843 days is valid to document the Medicaid eligible days used to settle the Provider's cost report. The Board remands the additional 374 requested days back to the Medicare Contractor to determine if Medicaid paid any of these days prior to the submission of the Provider's cost report. Any of the 374 requested days that were paid by Medicaid prior to the submission of the Provider's cost report should not be included in the Provider's DSH calculation. Any of the 374 requested days that were not paid by Medicaid prior to the submission of the Provider's cost report should be reviewed by the Medicare Contractor and included in the Provider's DSH calculation if they meet Medicare DSH payment criteria. Additionally, the Medicare Contractor should remove the 76 days (included in the 5,843 days) that the Provider later determined were not Medicaid eligible days.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

/s/
Charlotte F. Benson, CPA
Board Member

DATE: June 27, 2018