PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2003-D36

PROVIDER –
Castle Medical Center
Kailua, Hawaii

Provider No. 12-0006

vs.

INTERMEDIARY – Blue Cross and Blue Shield Association/United Government Services, LLC - CA

DATE OF HEARING -
April 30, 2002

Cost Reporting Periods Ended -
December 31, 1994

CASE NO. 98-1973

INDEX

ISSUE:

Was the Intermediary's adjustment to disproportionate share hospital payments proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Castle Medical Center ("Provider") is a member of Adventist Health System West, a nonprofit chain organization located in Kailua, Hawaii. Blue Cross of California ("Intermediary") issued a Notice of Program Reimbursement ("NPR") for the cost report period ended December 31, 1994 on September 19, 1997. The Provider's appeal was timely filed with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and it has met the jurisdictional requirements of these regulations.

The Provider was represented by Patric Hooper, Esquire, of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by James Grimes, Esquire, of the Blue Cross and Blue Shield Association.

Disproportionate Share ("DSH"): Relevant Medicare Statutory, Regulatory and Programmatic Background:

From the Medicare program's inception in 1965 until 1983, hospitals were reimbursed the lower of their reasonable costs or customary charges for services provided to Medicare beneficiaries. 42 U.S.C. § 1395f(b)(1); see generally Good Samaritan Hosp. v. Shalala, 508 U.S. 402 (1993). In 1983, Congress established the Prospective Payment System("PPS"), under which most acute care hospitals were no longer reimbursed based upon their reasonable costs. 42 U.S.C. §1395ww(d). Instead, under PPS, hospitals are reimbursed a prospectively determined rate for each Medicare inpatient, which is based upon the patient's diagnosis and other factors.

Because Congress was concerned about possible Medicare payment inequities for PPS hospitals that treat a disproportionate share of low-income patients, it directed the Secretary of the Department of Health and Human Services to provide for an additonal payment amount for PPS hospitals serving a significantly disproportionate number of low-income patients. 42 U.S.C. § 1395ww(d)(5).

Under section 1886(a)(2)(B) of the Social Security Act (the "Act" or "SSA"), codified at 42 U.S.C. § 1395ww, the Secretary is directed to provide for appropriate adjustments to the limitation on payments that may be made under the PPS for the reasonable operating costs of inpatient hospital services, including

those deemed necessary to take into account "the special needs of psychiatric hospitals and of Public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under Part A of this title."

Section 1886(d)(5)(F)(i)(I) of the Act specifies that the Secretary shall provide for an additional payment to hospitals that serve a significantly disproportionate number of low income or Medicare Part A patients. The formula used to calculate a provider's DSH adjustment is the sum of two fractions, which are expressed as percentages. SSA § 1886(d)(5)(F)(vi).

The Medicare Proxy

The first fraction's numerator is the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income, excluding patients receiving state supplementation only, and the denominator is the number of patient days for patients entitled to Medicare Part A. Id. This fraction is referred to as the Medicare proxy.

The Medicaid Proxy

The second fraction's numerator is the number of hospital patient days for patients who were eligible for medical assistance under a State plan approved under Title XIX for such period, but not eligible for 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). This fraction is referred to as the Medicaid Proxy.

Providers whose DSH percentages meet certain thresholds receive an adjustment which results in increased PPS payments for inpatient hospital services. SSA § 1886(d)(5)(F)(ii). This case involves whether the appropriate data was used to calculate the DSH percentage.

In the mid-1990's, a controversy arose over Health Care Financing Administration's ("HCFA," currently called the Centers for Medicare and Medicaid Services ("CMS")) interpretation of the DSH formula as set forth under the Act. Pursuant to the Act, the Medicaid component of the DSH formula consists of:

> [t]he number of the hospital's patient days for such period which consists of patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX . . .

SSA § 1886(d)(5)(F)(vi)(II).

CMS's regulation governing a provider's DSH percentage in effect at the time of the controversy referred to the "number of patient days furnished to patients entitiled to Medicaid." 42 C.F.R. § 412.106(b)(4) (1993). In applying the statute and the regulation, CMS's interpretation substituted the concept of payment and coverage by Medicaid for each day of care for the statutory standard of "eligibility" for Medicaid coverage. However, CMS changed its prior policy of including in the DSH calculation only inpatient days of service which were actually paid by a Medicaid state plan.[1] CMS's change in interpretation was in recognition of the holdings on this issue of the United States Courts of Appeals in the Fourth, Sixth, Eighth, and Ninth Circuits, which rejected CMS's prior interpretation of including only patient days paid by Medicaid. Thus, in CMS Ruling 97-2,[2] CMS conceded that it should include in the Medicaid fraction all days attributable to inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan, whether or not the hospital received payment for those inpatient hospital services.

The language in CMS Ruling 97-2 and the implementing instructions regarding which individuals qualify as "eligible for medical assistance under a State plan approved under Title XIX" created a new controversy. CMS Ruling 97-2 and the implementing instruction stated CMS's policy that days attributed to individuals eligible for general assistance and other state-only funded programs (collectively, "State-Only Program Days") should be excluded from the DSH calculation. Intermediaries in certain states historically had allowed providers to include State-Only Program Days applicable to health programs not contained in the relevant Medicaid state plans in their DSH calculations even though Section 1886(d)(5)(F)(vi)(II) of the Act states that only days attributable to individuals "eligible for medical assistance under a State plan approved under Title XIX" are to be included in the DSH calculation. Based on the Ruling and the implementing instructions, several of the intermediaries that previously had allowed inclusion of State-Only Program Days in their providers' DSH calculations began amending their policies on this issue.

CMS issued its guidance to fiscal intermediaries, Program Memorandum A-99-62, on December 1, 1999 (the "Program Memo"). The Program Memo addressed treatment of the State-Only Program Days issue on both a prospective and retrospective basis. The first portion of the Program Memo addressed CMS's clarification of the issue for cost reporting periods beginning on or after January 1, 2000. For such future periods, CMS clarified that "the term 'Medicaid days'

refers to days on which a patient is eligible for medical assistance benefits under an approved Title XIX State plan." (Program Memo, at 2). The Program Memo

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[1] HCFR 97-2 (Feb. 27, 1997)

[2] Program Memorandum A-99-62- Provider Exhibit P-5

then discussed what days were not included in the term "Medicaid days." As an example, the Program Memo provided that the term "Medicaid days" does not refer to days such as those utilized by beneficiaries in state programs that were not Medicaid programs but that provided medical assistance to beneficiaries of state-funded income support programs.[3] Those beneficiaries were generally not eligible for health benefits under a State plan approved under Title XIX; and, therefore, according to the Program Memo, days utilized by those beneficiaries did not count in the Medicare disproportionate share calculation.

The Program Memo further declared that no State-Only Program Days would be counted as Medicaid days for purposes of the DSH calculation for cost reporting periods beginning on or after January 1, 2000 for any provider.

The second portion of the Program Memo communicated CMS's policy regarding State-Only Program Days applicable to cost reporting periods beginning prior to January 1, 2000 (the "New Policy"). CMS split the hospitals that could retain or receive payments under the New Policy into two groups. The first group included those hospitals that already had received payments reflecting the inclusion of the State-Only Program Days. For cost reporting periods beginning prior to January 1, 2000, CMS directed intermediaries not to disallow the portion of Medicare DSH payments previously made to hospitals attributable to the inclusion of the State-Only Program Days in the Medicaid Proxy component of the Medicare DSH formula. In addition, the Program Memo explained that for open cost reports, intermediaries were to allow only those State-Only Program Days that the hospital received payment for in previous cost reporting periods settled before October 15, 1999.

The second group of hospitals addressed by the New Policy focused on those hospitals that did not receive a Medicare DSH payment based on the inclusion of the State-Only Program Days. The Program Memo provided that, if for cost reports that were settled before October 15, 1999, a hospital never received any DSH payment based on the erroneous inclusion of State-Only Program Days and the hospital did not file a "jurisdictionally proper appeal" to the Board on this issue prior to October 15, 1999, then intermediaries were not to pay the hospital DSH funds based on the inclusion of these types of days for any open cost reports for periods beginning prior to January 1, 2000. The Program Memo further explained that on or after October 15, 1999, intermediaries were not to accept

reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of State-Only Program Days in

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[3] The Program Memo contained an exhibit that outlines other types of days that also did not qualify as Medicaid days for purposes of the DSH calculation.

the Medicare DSH formula. However, if for cost reporting periods beginning prior to January 1, 2000, a hospital that did not receive payments reflecting the inclusion of State-Only Program Days filed a jurisdictionally proper appeal to the Board for any single fiscal year on this issue before October 15, 1999, the intermediary was to reopen any unaudited cost report and revise the Medicare DSH payment to reflect the inclusion of these State-Only Program Days in the Medicaid Proxy.

Thus the Program Memo announced several major statements of policy: (1) effective for cost reporting periods beginning after January 1, 2000, State-Only Program Days would be excluded from the Medicare DSH calculation for all providers; (2) for cost reporting periods beginning prior to January 1, 2000, hospitals that had received DSH payments based on the inclusion of State-Only Program Days in cost reports settled before October 15, 1999 could keep the funds and could be paid a DSH payment that includes those same State-Only Program Days in open cost reports; and (3) for cost reporting periods beginning prior to January 1, 2000, hospitals that had not received such payments but which had filed appeals on the issue prior to October 15, 1999 could receive the funds without having to pursue an appeal.

FACTS:

The Provider claimed the following five different types of Medicaid days, totaling 12,824, in its calculation of disproportionate share hospital payments:

1. Regular Medicaid Days (fee-for-service days);

2. Quest Days (state assistance program approved for Medicaid under a "waiver" effective August 1994);

3. SNF Waitlisted Days (Days in which patients received skilled nursing facility services while the Provider was waiting to transfer the patients to another facility).[4]

4. ICF Waitlisted Days (Days in which patients received intermediate care facility services while the Provider was waiting to transfer the patients to another facility.)

5. No Pay days. (Days for which patients were eligible for Medicaid but which were not paid by Medicaid).

[4] Referred to as Medi-Medi days in Provider's position paper.

These categories of Medicaid days were totaled, identified and claimed originally by the Provider in its 1994 cost report based on patient discharge dates. Those Medicaid days of services rendered during the 1994 fiscal year ending December 31, 1994, were not included in the 1994 cost report count if the patient was discharged after December 31, 1994.

The Intermediary audited the 1994 cost report. In its initial NPR, issued September 19, 1997, the Intermediary disallowed all Medicaid Quest Days, (2,910 days), disallowed 22 of the ICF Waitlisted Days, and disallowed all No-Pay Days, (442 days). Therefore, the Intermediary originally disallowed 3,374 of the total Medicaid days claimed of 12,824 days, leaving a total of 9,450.

The Provider timely appealed the original NPR on March 18, 1998. Among the adjustments appealed was the adjustment disallowing the Medicaid days from the DSH calculations. In its initial appeal, the Provider argued that the adjustment was improper because it did not include the General Assistance ("GA") days from the Medicaid HMO (Med-Quest), which took effect on August 1, 1994.

Subsequently, the Intermediary revised its initial NPR to "ensure the Medicare DSH calculation considers Quest and No-Pay Days." The Intermediary used the Provider's Quest Days count to estimate the allowable Medicaid Days to calculate the DSH for the 1994 fiscal year.

As a result, the originally allowed number of Medicaid days was increased in a revised NPR. The increase in allowable days was due primarily to including Quest Days and all Waitlisted Days in the total allowable day count for DSH payment purposes.

The Provider appealed the revised NPR to challenge the continued refusal of the Intermediary to allow No-Pay Days, as well as all "Title XIX waiver days" (Quest Days).

Prior to August 1, 1994, Hawaii operated a fee-for-service Medicaid system for which it received Federal Financial Participation ("FFP"). Hawaii also separately provided health insurance benefits to certain non-Medicaid beneficiaries, including GA and State Health Insurance Program ("SHIP") patients, through separate State funded programs. Effective August 1, 1994, the Hawaii Medicaid program changed as a result of the implementation of the Medicaid Quest Program for which the Hawaii State Medicaid Agency requested and received a Title XIX waiver. While some patients, such as patients qualifying for Aid to the

Blind, continued to receive services under the Hawaii fee-for-service portion of the Medicaid Program, many others, such AFDC recipients, began receiving services through the Quest Program, a Medicaid managed care program. Most

relevant and significant to this case is that the waiver also allowed the Medicaid program in Hawaii to expand coverage to GA and SHIP patients.

The Quest Program included Medicaid coverage for all current eligibles in the AFDC-related, GA, and SHIP Programs. This feature expanded Medicaid eligibility for the patients of these programs, some of which had previously been supported by State-only funds. The cost of these services, including GA and SHIP patients, is shared by the federal government throughout the five-year period of the waiver program. The actual Quest Medicaid expenditures in which the federal government shares take the form of capitated Medicaid payments to the Medicaid "HMOs" for all Quest-covered beneficiaries, including GA and SHIP beneficiaries.

The Provider included in the numerator of its calculation of its disproportionate share percentage various days of care furnished to various categories of patients eligible for medical assistance under the Hawaii State Medicaid Plan. Among the days included were "no pay Medicaid as secondary payor days" and days representing services provided to patients enrolled in the Quest Program. In the Intermediary's initial audit of the cost report, it made an audit adjustment excluding various kinds of Quest days, such as general assistance days. On the revised NPR, the Intermediary disallowed additional days covered by the Quest program and the "no pay Medicaid as secondary payor days."

PROVIDER'S CONTENTIONS:

STATE ONLY DAYS

The Provider asserts that State-Only Program Days should be included in the Provider's DSH calculation for FYs 1992 and 1993, based on CMS's implementation of the New Policy in the Program Memo.[5] The Provider contends that the New Policy amounted to a substantive rule for which CMS failed to provide general notice.

QUEST DAYS

The Provider contends that all Quest Days, including those Quest Days that represent patients in programs which were previously State funded programs, must be included in the Medicaid eligible days used to calculate DSH payments,

effective August 1, 1994, the date the Hawaii Quest Program went into effect. The Provider points out that with respect to Quest Days, including GA and SHIP Days, the plain language of the Medicare statute is clear. All days for patients

[5] Program Memorandum A-99-62 – Provider Exhibit P-5.

eligible for Medicaid, effective August l, 1994 onward, under the Quest Program, must be counted in the Medicaid proxy because all days represent patients eligible for Medicaid under a State Plan approved by the federal government. The Provider points out that, during the Board hearing, the Intermediary's witness conceded that all Quest Days, including GA and SHIP Days, were eligible for medical assistance under a State Plan approved under Title XIX.[6]

In Jewish Hospital v. Shalala, 19 F.3d 270 (8th Cir. 1994), ("Jewish Hospital") the court concluded that the governing Medicare statute requires the Secretary to include all eligible Medicaid patient days in the DSH calculation, not simply those patient days for which Medicaid actually made payment. The Provider points out that in a similar ruling in Legacy Emanual Hospital and Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996) ("Legacy Emmanual Hospital"), the court made it quite clear that the Secretary of the Department of Health and Human Services must follow the plain language of the Medicare statute and the intent of Congress with respect to the determination of the type of days to be used to calculate a provider's DSH payment.

The Provider contends that the plain language of the Medicare statute requires all Quest days to be included in a provider's DSH calculation. This congressional mandate must be followed regardless of the language of the Medicare regulations. However, even assuming for argument purposes, that the Medicare regulation implementing the specific Medicare definition of DSH days is applicable, it is clear that all Quest days satisfy the requirements of the applicable regulation as it existed in 1994. In 1994, the controlling Medicare regulation, 42 C.F.R. § 412.106(b)(4), like the statute itself, stated that the Medicaid proxy included computation of those days associated with beneficiaries who were entitled to Medicaid but not to Medicare Part A. Because the Quest days, including the GA and SHIP days, meet the regulatory definition, they must be included in the DSH calculation.

The Provider maintains that the fact that CMS amended the Medicare regulation at 42 C.F.R. § 412.106, effective January 20, 2002, to provide specifically that "for purposes of counting days under paragraph (b)(4)(I) of the regulation, hospitals may include all days attributed to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act," does not negate the fact that under the regulation as it existed in 1994 (and, more importantly, under the controlling Medicare statute), all Quest

days are required to be included in the DSH calculation since all Quest patients, including GA and SHIP patients, become Medicaid eligible effective August 1, 1994.

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[6] Tr. at 166

The Provider also contends that the Quest days must be included in the DSH calculation for the fiscal year 1994 under the December, 1999, Medicare memorandum. The Program Memorandum assumes that the inclusion of Title XIX waiver days prior to January 1, 2000, is erroneous. However, the Memorandum then goes on to discuss the situation in which hospitals are, nevertheless, entitled to include such days in their DSH calculation for pre-January, 2000 cost reports. Those requirements are discussed in the second full paragraph of the Memorandum on page 4.[7] It states that "if, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days in the Medicare DSH formula before October 15, 1999, reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days."

The Provider argues that it comes within the provisions of the above mentioned Memorandum. As the Intermediary testified at the hearing, the Provider filed two timely Board appeals (filed before October 15, 1999). In its appeals the Provider argued that eligible Medicaid days for DSH purposes should include all Title XIX and Title XIX Waiver Days. Therefore, even independent of the Medicare statute and regulation, the Intermediary must allow all Quest days in the DSH calculation for the 1994 cost report under the "hold harmless" provisions of the December, 1999 Program Memorandum.[8]

MEDICAID NO-PAY DAYS

The Provider points out that No-Pay Days represent those situations in which Medicaid did not pay for services provided to Medicaid eligible patients because the patient had other insurance which was the primary payor and Medicaid, therefore, the secondary payor.

The Provider argues that these No-Pay Days should be included in the calculation of the DSH payment for the entire fiscal year, and that it is entitled to the 442 "No Pay" days. On page 2 of the December, 1999 Program Memorandum, "days for which payment is made by a third party" are specifically listed as being included

in total Medicaid days for purposes of the DSH calculation. The No-Pay days in question are precisely such days.

MEDI-MEDI (WAIT LIST) DAYS

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[7] Tr. at 140-141.

[8] Provider Exhibit P-7.

The Provider contends that the "Medi-Medi" Days should be included in the DSH calculation for the 1994 fiscal year. Those days reported by the Provider for 1994 were ICF and SNF "waitlisted" days and represent the days during which Medicaid patients received SNF or ICF services from the Provider while the Provider was waiting to transfer the patients to some other facility. Medicaid actually paid for the "waitlisted" days, but at a rate less than the rate applicable to Medicaid acute care services. To the extent that the Medi-Medi days are actually included in the first proxy as SSI Patients, they should not be included in the Medicaid patient day count under the second proxy. Since none of the "waitlisted" days were actually paid by Medicare, these days are not in the SSI statistics and, therefore, they will not be duplicated if they are included in the total number of Medicaid days in the Medicaid proxy. If they are not included in the Medicaid proxy, they will be omitted altogether in violation of the clear intent of the Medicare statute requiring Medicaid-eligible days to be included in the Medicaid proxy.

The Provider points out that according to the Medicare statute, Medicaid days are to be counted in the Medicaid proxy so long as the patients "were not entitled to benefits under Part A of the Medicare Program." The waitlisted patients were not entitled to Medicare benefits for those services furnished during the time they were waitlisted, because Medicare does not provide benefits for such a level of care in a hospital. Therefore, the statute requires the inclusion of these days in the Medicaid proxy.

The Provider maintains that the Medicaid days included in the 1994 cost report were based on patient discharge dates. In the case of a patient who was admitted to the hospital on December 25, 1994, but not discharged until January 10, 1995, none of the sixteen patient days would have been included in the 1994 cost report. Subsequent to the filing of the 1994 cost report, the Intermediary requested all providers in Hawaii to use admission dates rather than discharge dates. The Provider points out that it recalculated the days using admission dates and the admission dates should be used in the calculation of the DSH.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment to the Provider's DSH is in accordance with the regulation at 42 C.F.R. § 412.106. It applied the SSI percentage that it was required to use pursuant to procedures established by CMS

in the Federal Register. The regulations require the Intermediary to use the SSI percentage provided by SSA in calculating the DSH adjustment.

The Intermediary points out that under § 1886(d)(F)(vi) of the Act, the measure for determining low-income patient days is the total number of inpatient days attributable to patients entitled to both Medicare Part A benefits and Federal SSI

benefits (excluding State supplementation) divided by the total number of Medicare patient days, plus the number of Medicaid patient days divided by total patient days. Consistent with the statute, the regulations at 42 C.F.R. § 412.106 set forth the methodology for determining hospitals DSH adjustment.

The Intermediary contends that its calculation of the DSH percentage is also in accordance with CMS's clarification contained in the Federal Register dated August 30, 1991. CMS's clarification states that:

> [w]e believe it was the intent of Congress in enacting section 1886(d)(F)(vi)(ll) of the Act to include only patient days for which the Medicaid recipient was eligible to have his or her care paid for by the Medicaid program in the determination of the disproportionate share patient percentage, as provided in the September 3, 1986, Federal Register (at 51 FR 31460) which first implemented the disproportionate share adjustment. We believe it is reasonable to assume that Congress anticipated that the Medicare cost report would serve as the primary source for Medicaid patient day statistics, and that it is appropriate to define Medicaid days consistent with the method that we require for reporting those days on the cost report. This is also consistent with our method of counting Medicare patient days in the Medicare portion of the disproportionate share calculation. In addition, we believe this interpretation, that only Medicaid covered days should be counted, is consistent with the statutory theme as a whole, since the formula in section 1886(d)(5)(F)(vi) of the Act does not purport to identify all indigent patients. Rather, it refers to certain Medicare and Medicaid patients as an objectively determined proxy for the indigent. Thus, under any reading of the statute, it is not expected that all indigent patients would be included in the formula. A Medicaid eligible recipient who has exhausted his or her benefits is similar to the indigent patient who is not eligible for Medicaid at all, and so it is logical to treat each in the same manner for the purpose of determining the disproportionate patient percentage.

The Intermediary points out that HCFAR 97-2 announced CMS's new interpretation of section 1886(d)(5)(vi)(ll) of the Act and 42 C.F.R. § 412.106(b)(4). Under the new interpretation, the DSH adjustment is to be calculated including all inpatient hospital days of service for patients who are

eligible on that day for medical assistance under a State Medicaid plan, whether or not the hospital received payment for those inpatient hospital service. The Intermediary additionally points out that according to HCFA's Memorandum dated June 12, 1997, if a cost report was settled prior to February 27, 1997, the hospital filed a jurisdictionally proper appeal on the issue (Medicaid days) and the hospital submits documentation to support a recalculation of Medicaid days, the

Medicaid days should be recalculated according to the principles contained in HCFAR 97-2. However, this memorandum also states that no action is required unless and until the hospital submits the necessary data with evidence of its jurisdictionally proper appeal.

The Intermediary contends that the Provider has not submitted documentation to support a recalculation of Medicaid days. Such documentation is required in accordance with 42 C.F.R. § 413.20, 42 C.F.R. § 413.24 and CMS Pub. 15-1 § 2304. The regulation at 42 C.F.R. § 413.20 states:

> (a) General. The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

The Intermediary also points out that the regulation at 42 C.F.R. § 413.24 states:

> (a) Principle. Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.
>
> (b) Adequacy of cost information. Adequate cost information must be obtained from the provider's records to support payments made for services rendered to beneficiaries. This requirement of adequacy implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

The Intermediary further points out that the above provision is further addressed in CMS Pub. 15-1 § 2304, which states:

> Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable costs, capable of being audited.
>
> Financial and statistical records should be maintained in a consistent manner from one period to another. . .

The Intermediary contends that the Provider has not submitted any evidence to show that there is Federal participation available with respect to the Quest Program days. In its memorandum dated June 12, 1997, CMS states that:

> [w]hile we do recognize days utilized by Medicaid beneficiaries through a Managed Care Organization (MCO) or Health Maintenance Organization (HMO), days that are utilized by State-only eligibility groups for which no Federal participation is available are not considered to be Medicaid beneficiaries under Title XIX . . . . State records should distinguish between individuals eligible under the State plan and individuals who are only eligible under a demonstration project waiver.

The Intermediary contends that its adjustment to the Provider's DSH is in accordance with 42 C.F.R. § 412.106. The Intermediary argues that its calculation of the DSH percentage is in accordance with CMS's clarification contained in the Federal Register dated August 30, 1991. The Provider has not submitted documentation to support a recalculation of Medicaid days. Therefore, the Intermediary contends that it is unable to resolve this issue related to the Medicaid percentage for cost the reporting period subject to appeal by applying HCFAR 97-2.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Provider's appeal was timely filed. The Board finds that the Provider, by claiming the Title XIX waiver days, encompassed all of the appealed categories.

QUEST PATIENTS:

The Board finds that the Intermediary's refusal to include all Quest days in the calculation of the Provider's DSH payment calculation beginning on and after August 1, 1994 is inconsistent with the provisions of the controlling Medicare statute. Specifically, under 42 U.S.C. § 1395ww(d)(5)(F)(vi), all Medicaid eligible patient days must be included in the DSH payment calculation. Effective August 1, 1994, and thereafter, all Quest Days, including GA and SHIP Days, represent days for which patients were eligible for Medicaid. The courts have consistantly required all eligible Medicaid patient days to be included in the DSH payment calculation because of the plain language of the controlling Medicare statute. See Jewish Hospital and Legacy Emanual Hospital, supra.

The Board finds that the implementation of the Quest Program expanded eligibility for a variety of patients, including those patients who formerly had been covered in the State-only funded GA and SHIP Programs. With the implementation of the Title XIX waiver, these patients became Medicaid eligible patients. Under the terms and conditions of the Medicaid waiver, federal financial participation was available for the State expenditures associated with all Quest patients. Therefore, the Board finds that all Quest days, including the GA and SHIP Days, represent days of services furnished to patients who were eligible for medical assistance under a State plan approved under Title XIX.

The Board notes that while the plain language of the governing Medicare statutory provisions requires all Quest Days to be included in the Medicaid proxy for purposes of calculating the Provider's DSH payment, the implementing Medicare regulation, 42 C.F.R. § 412.106(b)(4), as it existed in 1994, also requires all Quest Days, including GA and SHIP Days, to be included in the calculation of the Provider's DSH payment. The fact that the regulation was amended effective January 20, 2000, to specify that Title XIX waiver days representing expanded Medicaid populations should be included in the Medicaid proxy does not mean that the regulation, as it existed in 1994, when interpreted in light of the plain language of the Medicare statute, prohibited the inclusion of such days. To the contrary, the January 29, 2000, amendment to the federal regulation simply confirms the treatment required under the statute.

The Board furthers finds that, under the December, 1999 Program Memorandum, the Intermediary is required to include all Quest days, including GA Days and SHIP Days, to calculate the Provider's DSH payment for the 1994 fiscal year because the Provider filed a jurisdictionally proper PRRB appeal requesting the inclusion of all Quest Days in the calculation of the DSH payment prior to October 15, 1999. The Board finds that by referring to "GA Days" and all "Title XIX waiver days," the Provider adequately described those days to be included in the calculation of its DSH payment.

NO-PAY DAYS

The Board finds that the No-Pay Days represent Medicaid eligible days, and that they are required to be included in the calculation of the DSH payment for the Provider's 1994 fiscal year. There is no evidence that any of these days are for days in which the patient was also entitled to Medicare Part A benefits.

MEDI-MEDI DAYS

The Board finds that, to the extent Medi-Medi days are actually included in the first proxy as SSI Patients, they should not be counted in the Medicaid patient day count under the second proxy. The Board finds that the waitlisted patients were not entitled to Medicare benefits for those services furnished during the time they were waitlisted. Since none of the waitlisted days were actually paid by Medicare, these days are not in the SSI statistics and, therefore, they will not be duplicated if they are included in the total number of Medicaid days in the Medicaid proxy. If they are not included in the Medicaid proxy, they will be omitted altogether in violation of the clear intent of the Medicare statute requiring Medicaid eligible days to be included in the Medicaid proxy.

ADMISSION DATE VERSUS DISCHARGE DATE

The Board finds that the Provider's use of the admission date in calculating the days was reasonable as the Intermediary instructed the Provider to use the admission date rather than the discharge date. The Provider was able to adjust the number of days from days counted using discharge dates to days counted using admission dates. The days identified in the Provider's exhibits should be used as the basis for the Intermediary to revise its adjustments determining the appropriate number of days to be included in the Provider's DSH payments for the 1994 fiscal year.

DECISION AND ORDER:

QUEST DAYS

The Intermediary's refusal to include all Quest Days in the Medicaid proxy is reversed. The Intermediary should confirm the number of Quest days included in Provider's Exhibit P-13 and include those days in the Provider's DSH payment calculation.

NO-PAY DAYS

The Intermediary's refusal to include these days in the Provider's Medicaid proxy is reversed. The Intermediary should confirm the number of No-Pay Days in Provider's Exhibit P-13 and use that number of days to calculate the Provider's DSH payment.

MEDI-MEDI DAYS

The Intermediary's refusal to include these days in the Provider's Medicaid proxy is reversed. The Intermediary should confirm the number of Medi-Medi Days in Provider's Exhibit P-13 and include the revised numbers in calculating the Provider's payment.

Board Members Participating:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary B. Blodgett

DATE: July 16, 2003

FOR THE BOARD

Suzanne Cochran, Esquire
Chairperson