PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D59

PROVIDER –
Hospital Dr. Pedro Zamora

Provider No. 40-0079

vs.

INTERMEDIARY –
Cooperativa de Seguros de Vida de Puerto Rico

DATE OF HEARING -
October 11, 2002

Cost Reporting Period Ended
June 30, 1997

CASE NO. 00-1344

INDEX

ISSUE:

Was the Intermediary's adjustment to the disproportionate share, (DSH), computation proper?

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

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 Prospective Payment System ("PPS") for the reasonable operating costs of inpatient hospital services. 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. This is referred to as the DSH adjustment.

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 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. The denominator is the number of patient days for patients entitled to Medicare Part A. Id. 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. 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. Providers whose DSH percentages meet certain thresholds receive increased PPS payments for inpatient hospital services. SSA §1886(d)(5)(F)(ii).

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

Eventually, services covered only by State programs ("State-only days") were determined not to be includable in the Medicaid percentage; however, in the meantime, some intermediaries had erroneously paid additional sums to providers based on state-only days. Once the controversy was resolved, intermediaries began an effort to recoup the payments erroneously made. This effort created a new controversy. As a result, HCFA determined that providers that met certain criteria would be "held harmless" from recoupment of the erroneous payments. HCFA's policy was set out in Program Memorandum A-99-62 dated December 1, 1999 (the "Program Memo").

FACTS:

Hospital Dr. Pedro J. Zamora ("Provider") was owned by The Department of Health of The Commonwealth of Puerto Rico prior to June 29, 1996. On that date, The Department

of Health and Medwest, Inc., a corporation organized under the laws of the Commonwealth of Puerto Rico, entered into a Health Facilities Transfer of Operations and Sublease Agreement. Medwest, Inc. ("Medwest") operated the Provider from July 1, 1996 until October 28, 1998. On October 7, 1998, Medwest, Inc. filed for protection under the provisions of Chapter 11 of the Bankruptcy Code. Thereafter the bankruptcy was converted to a Chapter 7 bankruptcy.

The Provider timely filed its cost report for the period ended June 30, 1997. On September 30, 1999, Cooperativa de Seguros de Vida de Puerto Rico ("Intermediary") sent the Provider a Notice of Program Reimbursement ("NPR"). The Provider is contesting the adjustment made to the DSH calculation in the June 30, 1997 cost report wherein the Intermediary excluded state-only days, referred to here as category 6 claims. The Provider does not dispute that the services in issue here are not includable in the DSH calculation under the regulation. It argues, however, that it met the criteria for having these days included under the hold harmless provisions of the Program Memo. The Provider appealed the Intermediary's adjustment to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of the Medicare regulations at 42 C.F.R §§ 405.1835-405.1841. The amount of Medicare reimbursement in contention is approximately $125,000.

The Provider was represented by Carmen D. Conde Torres, Esq. The Intermediary was represented by Wallace Vasquez Sanabria, Esq.

PROVIDER'S CONTENTIONS:

The Provider contends that it qualifies for the hold harmless provisions of CMS Memorandum A-99-62, which allows for category 6 patients to be included in the DSH calculation. The hold harmless clause applicable to approval of Category 6 claims requires:

> a) That the cost reporting period had begun before January 1, 2000.
> b) That the cost reporting period remained open at the time the Memorandum was issued.
> c) After October 15, 1999 no requests to reopen cases previously settled would be allowed.

The Provider argues that the 1997 cost report was its first cost report and, therefore, there were no prior cost reports upon which similar adjustments were made and not appealed. The basis for its claim is that the transfer and sublease was a change of ownership and that Medwest is the new Provider. The Provider contends that the Intermediary knew that Medwest was the true and legal provider of services and the legal recipient of the payments made for the cost reporting period ended June 30, 1997. The Provider argues that if it were not the legal Provider, the Intermediary made illegal payments to an entity it knew was not the legitimate recipient of those payments.

The Provider argues that the 1997 cost report was its first cost report and, therefore, there were no prior cost reports upon which similar adjustments were made and not appealed. The Provider further argues that the cost report for the year in contention was open at the time the Program Memorandum was issued, since the Notice of Program Reimbursement ("NPR") provided 180 days from September 30, 1999 to file an appeal.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider does not qualify under the hold harmless clause of transmittal A 99-62 because, for the prior year ended June 30, 1996, a similar adjustment was made but not appealed to the Board. Since the Provider did not appeal the Intermediary's adjustment at that time, it is barred from doing so now. With respect to the year ended June 30, 1997, the NPR was issued on September 15, 1999, and an appeal was not filed before October 15, 1999 as required by the Program Memorandum.

The Intermediary argues that the Provider's contention that there was a change of ownership and that the prior year cost report treatment should therefore not be considered is not valid. The Intermediary contends that the Provider remained under the ownership of the Department of Health and that Medwest, Inc. only operated the facility for the Provider. Therefore, since there was no change of ownership, the Provider is not entitled to the hold harmless clause of the Program Memorandum A-99-62.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, parties' contentions, and evidence presented, finds and concludes that the Provider is not entitled to include the category 6 patient days in the DSH calculation.

The Board finds that the owner of the facility remained the Department of Health of the Commonwealth of Puerto Rico, in that the Health Facilities Transfer of Operations and Sublease Agreement with Medwest Corporation was not a change of ownership. The Board finds that the letter from CMS State Operations confirms and reinforces its conclusion that there was not a change of ownership of the Provider.

The Board finds that for the prior cost reporting period ended June 30, 1996, the Intermediary made an adjustment denying the Provider's entitlement to the category 6 days in calculating the DSH adjustment. The Provider did not appeal this determination to the Board.

The Medicare regulation at 42 C.F.R. 412.106 does not permit the inclusion of category 6 days in the computation of DSH. However, Program Memorandum A-99-62 does allow for the inclusion of those days for periods beginning prior to January 1, 2000, subject to the following conditions:

> Settled cost reports will be reopened if the provider filed a jurisdictionally proper appeal to the PRRB for cost reporting

periods beginning before January 1, 2000 concerning the issue of exclusion of these types of days from the Medicare DSH payment.

The Board finds that since the Provider did not file an appeal for the June 30,1996 cost report, and since there was no change of ownership, the Provider is barred from utilizing the hold harmless provisions of Program Memorandum A-99-62.

DECISION AND ORDER:

The Intermediary's adjustment of the DSH days was proper. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, C.P.A.

DATE: September 24, 2003

FOR THE BOARD:

Suzanne Cochran
Chairman