PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D6

PROVIDER -
Stormont-Vail Health Care
Topeka, Kansas

Provider No.: 17-0086

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Blue Cross & Blue Shield of Kansas

DATE OF HEARING –
August 8, 2006

Cost Reporting Period Ended -
September 30, 1995

CASE NO.: 04-0575

INDEX

ISSUE:

Whether the Intermediary's revised Notice of Program Reimbursement issued on July 25, 2003, that increased the Provider's Disproportionate Share Hospital (DSH) payment, included all Medicaid eligible days that would qualify for inclusion under HCFA Ruling 97-2.

MEDICARE STATUTORY AND REGULATIORY 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(b) and 413.24(b).

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 proportion 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 Medicare statute, Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.*, created a federally funded health insurance program for the elderly and disabled known as Medicare. This case arises under Part A of the Medicare program, which authorizes payments for, *inter alia*, certain inpatient hospital services and related post-hospital services. See 42 U.S.C. §§1395c, 1395d. The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). 42 U.S.C. §1395ww(d).

The PPS contains a number of provisions that adjust reimbursement based on hospital-specific factors. See 42 U.S.C. §1395ww(d)(5). This case involves one of the hospital-specific adjustments, the disproportionate share adjustment. The "disproportionate share hospital," or "DSH" adjustment, requires the Secretary to provide increased PPS reimbursement 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." See 42 U.S.C. §1395ww(d)(5)(F)(v). The "disproportionate patient percentage" is the sum of two fractions, the "Medicare and Medicaid fractions," for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The computation of the numerator of the "Medicaid" fraction is at the heart of this action. This calculation requires a determination of the total number of a hospital's inpatient days attributable to patients who " . . . were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were not entitled to benefits under Part A of this subchapter [Medicare]." (emphasis added). 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). From 1986 through 1997, the Secretary construed the first portion of this numerator calculation to include only those patients who actually received Medicaid payments from the state. See 42 C.F.R. §412.106(b)(4). Providers challenged this interpretation, and every circuit court that considered the Secretary's interpretation rejected it. The courts of appeals uniformly concluded that the numerator calculation must include all patient days for which a patient was eligible for medical assistance regardless of whether a state Medicaid program actually paid the hospital for services provided to the patient. See Cabell Huntington Hospital, Inc. v. Shalala, 101 F.3d 984, 988 (4th Cir. 1996); Legacy Emanuel Hospital and Health Center v. Shalala, 97 F.3d 1261, 1266 (9th Cir. 1996); Deaconess Health Services Corp. v. Shalala, 83 F.3d 1041, 1041 (8th Cir. 1996); Jewish Hospital, Inc. v. Sec'y Health and Human Services, 19 F.3d 270, 276 (6th Cir. 1994).

In February 1997, the Secretary of DHHS issued a ruling that rescinded the original interpretation of the statutory provision and prospectively mandated that in calculating the disproportionate patient percentage, the Medicaid numerator must include all Medicaid-eligible inpatient days "whether or not the hospital received payment for those inpatient hospital services." Heath Care Financing Administrative Ruling 97-2 at 2 (Feb. 27, 1997). In issuing the Ruling, the Secretary did not concede that the prior interpretation was incorrect. Instead, she stated that "although HCFA believes that its longstanding interpretation of the statutory language was a permissible reading of the statutory language, HCFA recognizes that, as a result of the adverse court rulings, this interpretation is contrary to the applicable law in four judicial circuits." According to the Secretary, the revised interpretation would apply prospectively, "in order to ensure national uniformity in calculation of DSH adjustments." The Ruling also expressly announced that the Secretary would not reopen past NPRs on the basis of this changed statutory interpretation.

In a decision rendered previous to this case, the Board held that it did not have jurisdiction over a group of providers whose request to the intermediary to reopen their cost reports to include Medicaid eligible days in the DSH calculation pursuant to Ruling 97-2 had been denied. That issue was eventually resolved in Monmouth Medical Center v. Thompson, 257 F.3d 807 (D.C.Cir. 2001) (Monmouth). In Monmouth, the court took

mandamus jurisdiction and ordered that the providers be paid. Subsequent to that ruling a large number of providers filed appeals in the same venue seeking a similar decision under the doctrine of *stare decisis*. Stormont –Vail Regional Medical Center (the Provider) was among the second group seeking mandamus relief. During the course of the litigation, the Provider signed a settlement agreement with CMS wherein the Intermediary was to reopen the Provider's cost report and apply the provisions of Ruling 97-2.

FACTS:

The Provider is a general short-term acute care hospital located in Topeka, Kansas.
As noted above, this case arises out of the settlement agreement entered into by the Provider and CMS subsequent to the commencement of an action in the United States District Court for the District of Columbia. Stormont-Vail Health Care, Inc. v. Thompson, Case No. 1:02CV01917 (CKK), Stipulation of Settlement and Dismissal.[1] The settlement agreement provides that the Intermediary is to reopen the Provider's Medicare cost report for the fiscal year ending September 30, 1995 and apply the provisions of HCFAR 97-2. The settlement also contains the following language:

> After the Hospital receives notice of the reopening of its FY 1995 Medicare cost report, the Hospital shall submit any additional information that it believes is necessary for the Intermediary to apply the payment provisions of HCFAR 97-2 to the Hospital's FY 1995 Medicare DSH payment. Because the additional information that the Hospital plans to submit to the Intermediary is expected to include information from other entities, including the State of Kansas[,] the Hospital shall have the time necessary to obtain the information that it plans to submit to the Intermediary.

In addition, CMS' Attorney Advisor reiterated the need for third party information in a January 31, 2003 memorandum to the CMS Kansas Regional Office. Exhibit I-3. It stated that the Provider should be given all the time necessary to obtain information from the State of Kansas and other third party payors. Therefore, no deadline for submission of the information was to be imposed.

Pursuant to the settlement agreement, the Provider submitted to the Intermediary 202 qualifying days. In 2003, Blue Cross Blue Shield of Kansas (the Intermediary) reopened the Provider's cost report to include the additional 202 days submitted by the Provider. The Intermediary then issued the revised NPR which forms the basis of this appeal. The Provider later received additional information from the State of Kansas indicating that another 750 days were also Medicaid eligible. Exhibit I-10 (September 2, 2004 dated letter from the Provider to the Intermediary indicating that it had received information regarding unpaid Medicaid days which had not been accepted until eligibility was

[1] Exhibit 1 of Provider's reply to Intermediary's position paper.

verified by the State of Kansas). The Intermediary refused to reopen and incorporate this new information in a revised NPR.

The Provider filed a timely appeal from the Intermediary's 2003 revised NPR. The Intermediary challenged the Board's jurisdiction asserting that it did not disallow any of the DSH days claimed by the Provider when it reopened its cost report. The additional days the Provider is now seeking to include in the DSH calculation were days it failed to claim during the implementation of the settlement agreement. Consequently, the Intermediary asserted that there was no determination over which the Board had jurisdiction.

The Board concluded that it had jurisdiction over the inclusion of the number of Medicaid eligible days in the DSH calculation under the provisions of 42 C.F.R §405.1869. This regulation allows the Board to affirm, modifying or reverse a determination of an intermediary with respect to a cost report and to make other modifications to the cost report even when those matters were not considered by the Intermediary. The Board reasoned that the Intermediary was directed to effectuate a settlement agreement that included information from the State of Kansas or other third parties and it was specifically directed not to impose deadlines for submission of information.

Subsequent to the Board's jurisdiction determination, the parties entered into Stipulations, two of which are especially pertinent to the Board's decision on the merits:

> 8. There are additional days that meet the criteria of HCFA 97-2. Although the Provider submitted support for such additional days to the Intermediary, receipt of which the Intermediary acknowledges, the exact number can be determined by audit.
>
> 9. Respecting that the Provider and Intermediary cannot stipulate to a board decision, the parties agree, given the Board's assumption of jurisdiction as articulated in its November 4, 2005 jurisdictional decision, that an appropriate Board decision under Reg. 42 C.F.R. §405.1871 would be finding that the Provider's DSH payment must be increased to include all additional days that can be identified and verified which meet the criteria of HCFA 97-2 with a remand to determine the precise number of additional days and recalculate the DSH accordingly.

The Provider was represented by Kenneth R. Marcus, Esquire, of Honigman Miller Schwartz and Cohn. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Parties' stipulation reflects their understanding that the Board's jurisdiction decision, when coupled with the stipulation that at least some of the days in dispute meet the HCFAR 97-2 criteria, effectively dictates the Board's determination on the merits and the Board concurs. The purpose of the settlement agreement was to include in the DSH computation all days that are proper under HCFAR 97-2. We also concur that the proper remedy is a remand to the Intermediary for verification of the data submitted to support inclusion of the additional days.

DECISION AND ORDER:

The Provider's DSH payment must be increased to include all additional days that can be verified as having met the criteria of HCFAR 97-2. The matter is remanded to the Intermediary to determine the number of days that should be included in the determination of Provider's DSH payment and to recalculate the DSH payment accordingly.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: November 30, 2006

Suzanne Cochran
Chairperson