PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD

2000-D41

PROVIDER -
Faxton Hospital
Utica, New York

DATE OF HEARING-
December 1, 1999

Provider No. 33-0048

Cost Reporting Period Ended -
December 31, 1993

vs.

INTERMEDIARY - Blue Cross and Blue Shield Association/Empire Blue Cross and Blue Shield

CASE NO. 96-2423

INDEX

ISSUE:

Was the Intermediary's refusal to increase the Provider's disproportionate share percentage to include eligible Medicaid days where Medicare was the primary payor proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Faxton Hospital ("Provider") is a private not-for-profit hospital located in Utica, New York. The Provider has a total bed compliment of 166 beds, comprised of, 125 medical/surgical beds, 15 intensive care/coronary care beds, and 26 exempt physical medicine & rehabilitation beds. Empire Blue Cross and Blue Shield (Intermediary) indicates 170 beds with 144 acute. The Provider is recognized as a regional cancer center and a regional medical rehabilitation center. The Provider is located in an urban area of approximately 140,000 population. The Provider's service area has a high percentage of elderly. 17.5% of the population is aged 65 or older. The area in which the Provider is located has a lower than average per capita income of $17,900, as compared to $20,800 for the United states and $24,824 for New York State.

The following utilization statistics were applicable to the cost period ended December 31, 1993:

	Reported	Settled
Total patient days	42,397	42,270
Occupancy percentage	80.66	80.42
Medicare days	28,822	29,150
Medicare utilization	67.98	68.96

The Intermediary utilized Medicaid paid days as supplied by the New York State Department of Health to calculate the Provider's DSH adjustment. The 1993 Medicaid paid days equaled 3,696. The Provider did not receive a DSH Payment, since it did not meet the criteria of regulation 42 C.F.R. §412.106(c)(1)(1) for a DSH adjustment. The Intermediary's calculation of the Provider's disproportionate Share percentage is 12.32. The Provider did not meet the required DSH percentage of 15% as stated in the regulation.

The Provider received a Notice of Program Reimbursement (NPR) dated February 22, 1996. The Provider disagreed with the NPR and filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ .1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement in contention is approximately $679,671.

The Provider was represented by Michael J. Haile, Vice President of Finance at Faxton Hospital. The Intermediary was represented by Eileen Bradley Associate Counsel, Blue Cross and Blue Shield Association, Chicago.

PROVIDER'S CONTENTIONS:

The Provider contends that its calculation of the Medicaid low income proxy fraction is correct. The Provider points out that the intent of the Disproportionate Share Hospital ("DSH") adjustment factor is to provide additional reimbursement to hospitals that treat a disproportionate number of low income patients, since these patients are usually in poorer health and cost more to treat than others. Given the structure of the PPS reimbursement system, which bases reimbursement on national and regional average costs for treatment of particular diseases, the lack of such an adjustment would penalize hospitals treating disproportionate members of low income patients Rye Psychiatric Center v. Shalala 52 F. 3d 1163 (2nd Cir. 1995). Based on this intent of the DSH adjustment to recognize the number of low income patients days incurred, the Provider contends the inclusion of the dually Medicaid secondary payor days is justified. To do otherwise would be to suggest that an indigent patient that receives Medicare is no longer an indigent patient.

The Provider points out in Jewish Hospital, Inc. v. Secretary of HHS, 19 F.3d 270 (6th Cir, 1994), the legislative intent to include dually eligible/crossover days is outlined as follows:

> in the 1985 COBRA legislation, Congress, however, did mandate that disproportionate share adjustments be made by the Secretary. Both houses of Congress worked to define the provisions of COBRA. In H.R. Report 3128, the legislative body defined "low income patient" as follows: The term "low income patient" means, with respect to inpatient hospital services provided to a patient who was, or is determined to have been, entitled to medical assistance under title XIX with respect to some or all of such services during the hospital stay, and includes such an individual notwithstanding the fact that some or all of such services were paid for under this title. The House thus defined the "proxy" or measure for approximating the disproportionate share as that "percentage of the hospital's total patient days attributable to Medicaid patients (including Medicaid-eligible Medicare beneficiaries Medicare/Medicaid crossovers)."... This Court finds that the House of Representatives acted to substantially define the Medicaid proxy. Congress intended to include all days attributable to Medicaid beneficiaries in the proxy. Accordingly, an interpretation that is contrary to this intention must be stricken.

Jewish Hospital at 276.

The Provider points out that its position is supported by Deaconess Health Services Corp. v. Shalala, 912 F. Supp 438 (D.E. Mo. 1995). The ruling in this case stated that:

> if a person generally is eligible for medical assistance under a state plan approved by Medicaid while receiving Part A Medicare services, then

> all of the days during which such services were received during such eligibility should be included in the numerator of the Medicaid Low Income Proxy, whether or not the state Medicaid plan pays for all such days.

Deaconess at 447.

The Provider contends that this court ruling is referring to the same dually eligible days that have been appealed by the Provider for inclusion in the numerator of the Medicare Low Income Proxy.

The Provider contends that the above cited cases gives additional precedence for its interpretation of the appropriate calculation of the numerator of the Medicaid Low Income Proxy fraction. The Provider argues that HCFA Ruling No. 97-2 (February 27, 1997) provides the Intermediary with the authority to implement same. Since the timely filing of the Provider's initial appeal on this matter, HCFA had apparently acquiesced to various holdings of federal courts of appeals in four districts (including the cited Deaconess and Jewish Hospital cases) to change its interpretation of Medicaid days for inclusion in the Medicaid Low Income Proxy fraction. HCFA's new interpretation, contained in Ruling 97-2, states:

> the Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for those inpatient hospital services.

Id.

In other words, HCFA appears to interpret that the Medicaid Low Income Proxy fraction calculation numerator should include dually eligible days.

The Provider points out that Pursuant to HCFA Ruling No. 97-2, HCFA has remanded the Medicare fiscal intermediaries to determine amounts due and make appropriate payments for hospital cost reports which have been settled prior to the effective date of this ruling, but for which the hospital has a jurisdictionally proper appeal pending on this issue.

The Provider contends that subsequent to the issuance of HCFA Ruling No. 97-2, HCFA's Acting Deputy Director issued instructions on June 12, 1997 "..designed to address those details that may need further clarification".[1] Though HCFA Ruling 97-2 appeared to address the holdings of four U.S. district and circuit courts remanding the Secretary to include all eligible Medicaid days in the Medicaid

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[1] See Exhibit I-8.

fraction, as mandated by those courts, the June 12, 1997 instructions are contrary to those court holdings. More specifically, the ruling of the previously cited Deaconess case stipulated that:

> if a person generally is eligible for medical assistance under a state plan approved by Medicaid while receiving Part A Medicare services, then all of the days during which such services were received during such eligibility should be included in the numerator of the Medicaid Low Income Proxy, whether or not the state Medicaid plan pays for all such days.

Deaconess at 447.

The Provider argues that the Intermediary does not refute that the June 12,1997 instructions are contrary to Deaconess but rationalizes this disparity by stating "...HCFA's June 12,1997 clarifying instructions for the application of HCFA Ruling 97-2... were issued after the date of the Deaconess circuit court decision rendered on May 22, 1996". However, it is not the chronology of events which are in question, but whether the holding of this U.S. District Court, Eighth Circuit, is implemented in HCFA Ruling 97-2.

The Provider argues that in Incarnate World Health Services, Fort Worth Healthcare Corp. d/b/a St. Joseph Hospital et. al. v. Shalala, No. 3:95 CV -0851-R (D.N. TX 1997), Medicare & Medicaid Guide (“CCH”) §45,701 also found in the court's holding that HCFA Ruling 97-2:

> includes parenthetical surpluses that leaves room for interpretations that run contrary to this court's orders, the principal intermediary responsible for recalculating Plaintiff s DSH reimbursements ... remands confused about the manner in which the ... low income proxy is to be calculated in light of this Court's Orders,...there is a history of nonacquience and reluctance to comply with court orders by the secretary regarding this issue.

Id.

The court, no longer remanding the case to the Secretary, ordered that the following days be included in the DSH recalculation: (3) Zero Paid Medicare Secondary Days--Medicaid recipient had other insurance payments..

The Provider argues that the Intermediary is incorrect when it states:

> the inclusion of the Provider's dually eligible days would result in the Medicare program paying the provider twice for the same patient. The first payment would occur through the payment of the Medicare claim submitted by the Provider for the patient ... The second payment,

> would occur in connection with the calculation of the DSH payment for the Provider.

The Provider contends that this statement by the Intermediary, which is a rationale for their not including the dually eligible days, is contrary to Medicare reimbursement regulations and the DSH add-on itself. First of all, the intent of the Disproportionate Share Hospital adjustment factor is to provide additional reimbursement to hospitals that treat a disproportionate number of low income patients, since these patients are usually in poorer health and cost more to treat then others.

The Provider argues that the DSH add-on does not make the same payment twice, rather provides a modest add-on to the Medicare reimbursement. The Provider also contends that outside of coverage definitions, the SSI days included in the Medicare fraction, for which the Intermediary does not take exception, do not function any differently in the DSH calculation as the dually eligible days in the Medicaid fraction.

The Provider contends that the additional reimbursement afforded through the DSH add-on is in the same spirit as other Medicare add-ons that reimburse a modest add-on to a provider to recognize its unique costs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that HCFA's instructions for the application of HCFA Ruling 97-2 issued to all regional offices on June 12, 1997, states in pertinent part:

> The definition of Medicaid days for purposes of the Medicaid disproportionate share adjustment calculation includes all days that a beneficiary would have been eligible for Medicaid benefits, whether or not Medicaid paid for any services. This includes, but is not limited to, days that are determined to be medically necessary but for which payment is denied, days that are utilized by a Medicare beneficiary prior to an admission approval, days that are paid by a third party, and days that an alien is considered a Medicaid beneficiary, whether or not it is an emergency service.
>
> However, 42 C.F.R. § 412.106(b) precludes the counting of any patient days furnished to patients entitled to both Medicare Part A and Medicaid. Therefore, once the State has verified the eligibility of the hospital's patient data for Medicaid purposes, the intermediary must determine if any of these days are dual entitlement days and subtract them from the calculation.

Id.

The Intermediary maintains that HCFA instructions for the application of HCFA Ruling 97-2 issued to all regional offices on June 12, 1997 clearly reveals that dually eligible days should not be included in the Medicaid day count for the calculation of a provider's DSH adjustment. The Intermediary contends that these instructions require the intermediary not to include dually eligible days or dual entitlement days in the Provider's Medicaid day count for its DSH calculation. Accordingly, the Intermediary did not include these days in the numerator of the ratio that calculates the Provider's disproportionate share percentage. As a result the Provider did not meet the applicable threshold requirement for a DSH adjustment as set forth in 42 C.F.R. §412.106(c).

The Intermediary asserts that the inclusion of the Provider's dually eligible days result in the Medicare program paying the Provider twice for the same patient. The first payment would occur through the payment of the Medicare claim submitted by the Provider for the patient. The inclusion of dually eligible days in the numerator of the ratio that results in the Provider's disproportionate share percentage would make the Provider eligible for reimbursement under the DSH adjustment. The second payment, would occur in connection with the calculation of the DSH payment for the Provider. The DSH payment would represent Medicare's second payment to the Provider for the same patient.

The Intermediary points out that HCFA's June 12, 1997 clarifying instructions for the application of HCFA Ruling 97-2,were issued after the date of the Deaconess circuit court decision rendered on May 22, 1996.

The Intermediary argues that HCFA Ruling 97-2 provides for counting in the Medicaid fraction, the number of days of inpatient services for patients eligible for Medicaid on that day, regardless of whether the hospital received payment from Medicaid for those inpatient services. It does not apply to days for patients entitled to both Medicare Part A and Medicaid.

CITATIONS OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Regulations 42 C.F.R.:

§§405.1835-.1841	-	Board Jurisdiction
§412.106 et. seq.	-	Special Treatment: Hospital that serve a Disproportionate Share of Low Income Patients

2. Cases:

Rye Psychiatric Clinic v. Shalala, 52 F. 3d 1163 (2nd Cir. 1995).

Jewish Hospital Inc. V. Secretary of HHS, 19 F.3d 270 (6th Cir. 1994).

Deaconess Health Services Corp. V. Shalala, 912 F. Supp 438 (D.E. Mo. 1995).

Incarnate World Health Services, Fort Worth Healthcare Corp.d/b/a St. Joseph Hospital et.al. V. Shalala, No. 3:95-CV-0851 (D.N. TX. 1997), Medicare & Medicaid Guide ("CCH") § 45,701.

3. Other:

HCFA Ruling 97-2 February 27, 1997

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions and evidence presented, finds and concludes that the Provider did not meet the criteria of regulation 42 C.F.R. §412.106, and is therefore not entitled to a Disproportionate Share adjustment.

The Board notes that the regulation at 42 C.F.R. §412.106(b)(4) includes only patients entitled to Medicaid and does not include patients entitled to Medicare part A. It states:

> The fiscal intermediary determines, for the hospital's cost reporting period, the number of patient days furnished to patients entitled to Medicaid but not to Medicare part A, and divides that number by the total number of patient days in that same period.

Id. (Emphasis added).

The Board notes that this is reiterated in HCFA Ruling 97-2 Instructions which states:

> [H]owever, 42 C.F.R §412.106(b)(4) precludes the counting of any patient days furnished to patients entitled to both Medicare Part A and Medicaid. Therefore, once the State has verified the eligibility of the hospital's patient data for Medicaid purposes, the intermediary must determine if any of these days are dual entitlement days and subtract them from the calculation.

Id.

The Board therefore finds that the two above mentioned sections to be the ruling regulations in this case and finds that the Intermediary was correct in not counting the Medicare days.

The Board notes that in two of the cases cited by the Provider: Jewish Hospital and Deaconess, the main issue was entitlement vs. eligibility. This is not the same as Medicare and Medicaid eligibility. The Board finds that entitlement vs eligibility means that the Intermediary should count eligible days,

whether or not the Provider was paid for those days, but not count days where the patient was entitled to both Medicare and Medicaid.

DECISION AND ORDER:

The Intermediary's adjustment of the Provider's disproportionate share percentage was proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq.
Charles R. Barker

Date of Decision: March 28, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman