PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2004-D32

PROVIDER –
St. Joseph's Hospital
St. Paul, Minnesota

Provider No. 24-0063

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Noridian Administrative Services

DATE OF HEARING –
May 20, 2003

Cost Reporting Period Ended
August 31, 1995

CASE NO. 98-2100

INDEX

ISSUES:

1. Was the Intermediary's adjustment to the Provider's disproportionate share (DSH) payment proper?

2. Was the Intermediary's adjustment to the Provider' capital DSH payment proper?[1]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Joseph's Hospital (the Provider) is a 314-bed not-for-profit facility located in St. Paul, Minnesota.

On its fiscal year ended (FYE) August 31, 1995 cost report, the Provider claimed $604,035 in DSH payment. Noridian Administrative Services (Intermediary)[2] issued a Notice of Program Reimbursement (NPR) on September 29, 1997 in which it denied all of the DSH payments claimed by the Provider. On March 18, 1998 the Provider filed a timely request for a hearing before the Provider Reimbursement Review Board (Board) and has met all of the jurisdictional requirements of 42 C.F.R. §§405.1835-.1841. The impact on Medicare reimbursement is approximately $604,035.

Disproportionate Share: Statutory, Regulatory, and Medicare Program:

This case arises from a dispute over the amount of Medicare payments due the Provider, in particular its "disproportionate share" payment.

The Medicare Program's payment and audit functions are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by Centers for Medicare and Medicaid Services (CMS).

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 what proportion of those costs are to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a NPR. 42 C.F.R.§405.1803. A provider dissatisfied with the intermediary's final determination may file an appeal with the Board within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The Medicare statute 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. If a hospital has a DSH patient percentage that equals or exceeds 15%, is located in an

[1] Issue No. 2 is directly related to the Provider's primary DSH issue. A favorable result on the first issue will result in a favorable result in the second, based on the nature of the Intermediary's capital DSH adjustment and the mechanics of the cost report. Therefore, the facts and legal reasoning are only addressed to issue number 1.

[2] The original Intermediary was Blue Cross and Blue Shield of Minnesota.

urban area and has 100 or more beds, the hospital is eligible for DSH payment adjustment. 42 U.S.C. §1395ww(d)(5)(F)(v).[3] The determination of the "DSH patient percentage" is at issue in this case.

The formula used to calculate a provider's DSH adjustment is the sum of two fractions, often referred to as the Medicare Proxy and the Medicaid Proxy, expressed as percentages. SSA §1886(d)(5)(F)(vi). The Medicare Proxy'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. The Medicaid Proxy'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 entitled to 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). The second fraction is frequently 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. See 42 C.F.R. §412106(b)(4).

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

> is the 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) (emphasis added).

HCFA'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 *entitled* to Medicaid." 42 C.F.R. §412.106(b)(4) (1993) (emphasis added). In applying the statute and the regulation, HCFA's interpretation substituted the concept of payment by Medicaid for each day of care for the statutory standard of "eligibility" for Medicaid coverage. However, in HCFA Ruling No. 97-2 (February 27, 1997), HCFA changed its prior policy of including in the DSH calculation only inpatient days of service which were actually *paid* by a Medicaid State plan. HCFA'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 HCFA's prior interpretation of including only patient days *paid* by Medicaid.

Thus, in HCFA Ruling 97-2, HCFA 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.

[3] Social Security Act ("SSA") Section 1886(d)(5)(F(i)(I).

The language in HCFA 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. HCFA Ruling 97-2 and the implementing instructions stated HCFA's policy that days attributed to individuals eligible for general assistance days (GADs) 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. (emphasis added). 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.

A number of states raised concerns with the need to repay the portion of the DSH payments attributable to the State-Only Program Days. In response to these concerns HCFA decided to "hold harmless" hospitals that had received certain additional Medicare DSH payments, because guidance on how to claim these funds was not sufficiently clear.

HCFA issued its guidance to fiscal intermediaries, Program Memorandum A-99-62, on December 1, 1999 (Program Memo). The Program Memo addressed the treatment of the State-Only Program Days issue on both a prospective and retrospective basis. The first portion of the Program Memo addressed HCFA's clarification of the issue for cost reporting periods beginning on or after January 1, 2000. It is this provision that is at issue in this case. For such future periods, HCFA 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."[4] The Program Memo provides an example of what days were not included in the term "Medicaid days." Specifically, it 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.[5] Those beneficiaries were generally not eligible for health benefits under a State plan approved under Title XIX; therefore, according to the Program Memo, days utilized by those beneficiaries did not count in the Medicare disproportionate share calculation. Furthermore, the Program Memo 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 contained what amounted to a change in HCFA's policy regarding State-Only Program Days applicable to cost reporting periods beginning prior to January 1, 2000 (the New Policy). HCFA split the hospitals that could retain or receive

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[4] Program Memo at 2.

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

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, HCFA 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 stated 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. For cost reports that were settled before October 15, 1999, if 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 stated 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 the Medicare DSH formula. However, if for cost reporting periods beginning prior to January 1, 2000, a hospital that had not received payments reflecting the inclusion of State-Only Program Days and had 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 such cost report and revise the Medicare DSH payment to reflect the inclusion of these State-Only Program Days in the Medicaid Proxy.

Background of the Current Case:

The Provider filed its cost report for FYE August 31, 1995 in January, 1996, and included DSH payments of $604,305.[6] This was before the issuance of the HCFA Program Memorandum in December of 1999. The Provider's "as filed" DSH payment amount was based on its calculation that its DSH patient percentage was 16.2 percent.[7] In preparing its DSH Patient Percentage, the Provider utilized information from CMS for the Medicare Proxy and internal patient day reports for the Medicaid Proxy.[8] The internal reports included GADs, a type of state-only program day. During its audit, the Intermediary conducted a sample review of the patient day data included in the internal report and rejected the entire report because the sample had an unacceptable error rate based on the inclusion of GADs in the patient day report.[9] After refining its data, the Provider resubmitted it and the Intermediary again rejected it because it included non-Medicaid days, most of which were GADs.[10] The final Intermediary audit adjustment states that it was made: "[t]o disallow DSH since the Provider is including non-Medicaid days in their DSH

[6] Provider Exhibit 10-1.
[7] See Provider Exhibits 10-5 and 10-6 and Tr. at 58-60.
[8] Id. and Tr. at 59.
[9] Provider Exhibit 10-12.
[10] Id. and Tr. at 62-63.

calculation."[11]

Unlike other fiscal intermediaries in New York, Pennsylvania and several other states, the Minnesota Intermediary had adopted a policy to exclude GADs from the DSH calculation during the relevant time period.[12] This was despite the fact that the state Medicaid agency was never able to give the Intermediary definitive information as to whether or not the GADs were actually federally funded.[13]

Before the issuance of the CMS Program Memo, the Provider filed its appeal to the Board and included the DSH adjustment issue. The Hearing Request stated the following with respect to issue number 10:

> Adj. No. 46 – Disproportionate Share Adjustment
>
> We believe the DSH reimbursement is significantly understated. The intermediary did not properly recognize all appropriate DSH related days of service. Effect is 10,000.

After filing this appeal, the Provider transferred aspects of its DSH appeal to two separate group appeals without withdrawing its individual appeal of the Intermediary's DSH adjustment.[14]

After the Program Memo was issued, the Provider submitted a written inquiry to the Intermediary to determine whether it was eligible for relief.[15] CMS replied on June 7, 2001 that the Provider was not eligible.[16] Although acknowledging a timely appeal, CMS contended that "[e]ven though these appeals were filed before October 15, 1999, the wording in the appeals for both years (note 1996 also under appeal) does not specifically mention the types of days described in [the Program Memo]."[17]

The Provider was represented by J.D. Epstein, Esquire, and Gregory N. Etzel, Esquire, of Vinson & Elkins, L.L.P. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that this case revolves around two simple facts; (1) the Program Memo allows for automatic retrospective relief for providers with respect to GADs if those providers

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[11] Provider Exhibit 10-1.
[12] Provider Exhibits 10-19; 10-21; and Tr. at 145-146.
[13] Tr. at 140-142.
[14] See Provider Exhibits 10-2 and 10-3.
[15] Provider Exhibit 10-14 and Tr. at 73-74.
[16] Provider Exhibit 10-15.
[17] Id.

filed a jurisdictionally proper appeal to the Board on the issue of exclusion of "these types of days" from the Medicare DSH formula before October 15, 1999 even where such providers were not reimbursed based on the inclusion of such days in the past; and (2) the Provider filed such an appeal. The Provider wants CMS held to what it believes is the plain language of its Program Memo.

Even if the language in the original appeal was insufficient, the Provider contends that the regulations at 42 C.F.R. §405.1841(a) permit it add an issue to their appeals at any time prior to the commencement of the hearing. Since a provider can add an issue up to the hearing date, and St. Joseph's Hospital has such an appeal in place prior to the Program Memo deadline of October 15, 1999, the Provider believes it has properly appealed the GADs issue.

In any event, the Provider claims it had an appeal that did include GADs. The Provider asserts that its request for a Board hearing specifically included the DSH adjustment and complied with the CMS Pub. 15-1 §2921.1 (1998), which only requires a brief description of the basis for the dispute. The Provider clearly indicated that "[t]he intermediary did not include all appropriate DSH related days." Provider Exhibit 10-29. In addition, the Intermediary's audit adjustment No. 46 was attached to the hearing request itself, and it stated that it was made to "disallow DSH since the Provider is including non-Medicaid days in their DSH calculation." It can not be more clear that the Provider was appealing the Intermediary's refusal to include non-Medicaid days, (i.e., GADs) in the DSH calculation.

The Provider argues that requiring a provider to specifically recite the exact type of days being appealed in its hearing request is arbitrary and absurd, because the Provider would have to predict what type of special words were needed to protect its rights. The Intermediary clearly indicated in its audit adjustment that it was disallowing DSH due to GADs, therefore, there is no lack of clarity, and there was no reason for the Intermediary to have sought CMS guidance, required only where the appeal is general.[18]

Although the Provider notes that the Board has upheld the Program Memo in United Hospital v. Blue Cross and Blue Shield Association/Noridian Government Services, PRRB Case No. 2002-D23, June 27, 2002, unreported, declined rev. CMS Administrator, August 12, 2002, aff'd, United Hospital v. Thompson, 2003 W.L. 21356086 (D. Minn. 2003) (United), it contends that the facts in this case can be distinguished. The Provider notes that the provider in United added the GADs issue to its previous appeal after the October 15, 1999 deadline; in this case the Provider's appeal included the GADs before the deadline.

The Intermediary acknowledges that the appeal regarding DSH was filed before the deadline, but asserts that GADs were only part of the reason for rejection; numerous other flaws were also cited for the disallowance. The appeal request was general, and the position paper never specifically addressed the issue with respect to GADs. The Intermediary indicates that the purpose of the hold harmless provision was to expedite resolutions that were reasonably well

[18] See Intermediary Exhibit 2, Program Memo Questions and Answers, No. 15.

perfected. Reflecting the difficulty over the issue, the Program Memo clearly indicated that the days at issue should never have been included in the Medicaid Proxy. However, CMS decided not to litigate where a provider had established a clear claim of entitlement to include GADs in a previously filed appeal. The Intermediary points out that the Provider filed its position paper in December 1999, after the Program Memo was issued on October 15, 1999, but makes no specific reference to the GADs issue. The Provider's transfer of the two DSH issues to group appeals only vaguely notes that it hopes that differences with the Intermediary can be resolved. The Intermediary's position on GADs was known in December of 1999, thus, the paper rebuts any notion that the Provider had any focused complaint about rejection of GADs in its DSH claim.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board finds that the Provider is covered under Program Memo A-99-62 because it claimed GADs in its initial and subsequent submissions to the Intermediary. This issue was specifically mentioned in the Intermediary's audit adjustment denying reimbursement, and the Provider properly appealed that specific audit adjustment. The need for any specific language in the appeal was unknown at the time the Provider filed its appeal and should not be used to deny its otherwise valid appeal of GADs.

It is undisputed the Provider did include GADs in the days it submitted to the Intermediary in its DSH calculations. The Intermediary denied all of the Provider's DSH data and, therefore, denied the GADs that the Provider claimed. The Intermediary audit workpapers clearly identify all of the reasons for denying the Provider's DSH data. The language in the workpapers clearly indicates that it was the Provider's inclusion of non-Medicaid days, and, specifically, "General Assistance" days, in the data that caused the Intermediary to deny the entire DSH payment.[19] The Intermediary used the following language in its audit adjustment report in the NPR:[20]

> To disallow DSH since the Provider is including non-Medicaid days in their DSH calculation.
> (42 CFR 412.106, Subpart G)
> 16-8B-1

[19] Its audit workpapers, attached to its appeal stated: [d]uring the review of Medical Assistance RAs, it was noted that a number of patients were not Medicaid (there were General Assistance, Alternative Care and Medicare patients noted). Based on the number of noted from the sample (5 out of 25 items were errors), it is reasonable to conclude that the report that the provider used to determine the number of Medicaid Days includes non-Medicaid patients. . . .

The Provider submitted a third report . . . . The result of a review include: no RAs supplied for five of the patients, five patients were General Assistance and one patient was BCBS of MN. Intermediary Audit Workpaper. Provider Exhibit 10 at 1.

[20] Provider Exhibit 10-1.

The Provider specifically addressed Intermediary audit adjustment 46 in its appeal and made reference to workpaper 16-8B-1. Based upon the audit adjustments and the underlying workpapers, the Board finds that the Intermediary intended to disallow GADs and the Provider intended to appeal their disallowance.

The Board finds that other circumstances also support the Provider's claim that it intended to appeal GADs. First, the Provider appealed this audit adjustment before the issuance of the Program Memo and therefore could not have been aware that CMS would require any special phrases to be used in order to appeal the GADs issue. Second, the Provider timely requested that the Intermediary consider granting it relief under the Program Memo. Third, the Provider transferred other issues out of its DSH appeal but retained in its instant appeal the failure to include non-Medicaid days. And finally, the Board does not believe that the initial position paper was intended to substantially address any specific DSH issue. The Provider stated that it was attempting to resolve differences with the Intermediary and hoped to have a resolution before a final filing would be necessary. This does not support the contention that the Provider failed to properly appeal any of the aspects of the denials in the workpaper that formed the basis of the general audit adjustment.

The Board finds that the Provider's alternate arguments are moot since it has found that the Provider's appeal did include the GADs issue.

DECISION AND ORDER:

The Intermediary's determination that the Program Memo does not apply to the Provider was incorrect. The Intermediary's determination is reversed. The Board remands the matter to the Intermediary to recalculate the Provider's DSH payment.

Board Members Participating:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA
Anjali Mulchandani-West

FOR THE BOARD:

DATE: August 12, 2004

Suzanne Cochran, Esquire
Chairman