PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D2

PROVIDER –
LAC 98 DSH/Non-Federal Low-Income Days Group

Provider Nos.: Various
See Appendix (Schedule of Providers in Group)

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ National Government Services - CA

DATE OF HEARING –
April 6, 2007

Cost Reporting Period Ended –
June 30, 1998

CASE NO.: 01-1674G

INDEX

Page No.

ISSUES:

1. Whether the Providers are entitled to have general relief (GR) days included in the calculation of their disproportionate share percentage pursuant to the hold harmless provisions of Program Memorandum A-99-62.

2. Whether the failure to allow the Providers to include GR days in the calculation of their disproportionate share percentage was arbitrary and capricious and in violation of law.

MEDICARE STATUTORY AND REGULATORY 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 portion 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.

Short-term acute care hospitals, such as the hospitals in this case, are reimbursed under Medicare's Prospective Payment System (PPS) for inpatient hospital services. As such, the Providers are entitled to additional program payments if they 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 disproportionate share hospital (DSH) adjustment, and how large an adjustment it receives, depends on its "disproportionate patient percentage," which is the sum of two calculations. The first calculation, or Medicare fraction, is the number of the hospital's patient days made up of patients who were entitled to both Medicare Part A and Supplemental Security Income divided by the hospital's total number of Medicare patient days. The second calculation, or Medicaid fraction, is the number of a hospital's patient days consisting of patients who were

eligible for medical assistance under a State plan approved under Title XIX of the Social Security Act (Act) but who were not eligible for Medicare Part A (Medicaid days) divided by the hospital's total number of patient days. 42 U.S.C. § 1395ww(d)(5)(F)(vi).

Initially, CMS maintained that Medicaid days included only those days for which the hospital received Medicaid payment for inpatient hospital services. However, after several circuit court rulings, CMS issued Ruling No. 97-2 (February 1997) holding that Medicaid days should also include those days for which a patient was "eligible" for Medicaid benefits even if the hospital received no Medicaid payment for its services.

In addition, in December of 1999, CMS issued Program Memorandum A-99-62 which did two things. First, it clarified what days should and should not be included in the Medicaid fraction for cost reporting periods beginning on or after January 1, 2000; and second, it communicated a "hold harmless" provision CMS had previously established in October 1999 regarding DSH program payments made to hospitals for cost reporting periods beginning before January 1, 2000 attributable to the "erroneous inclusion of general assistance or other State-only health program. . . days" in the Medicaid fraction. In part, the memorandum explained that most hospitals and intermediaries relied upon Medicaid days data obtained from Medicaid State agencies to compute Medicare DSH payments and that some of those agencies commingled otherwise ineligible days with allowable Title XIX days.

With respect to the "hold harmless" provisions, the memorandum states:

> 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 from 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. . . . Where, for cost reporting periods beginning before January 1, 2000, a hospital filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula *on or after* October 15, 1999, reopen the *settled* cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, but only if the hospital appealed, before October 15, 1999, the denial of payment for the days in question in previous cost reporting periods. . . . (Emphasis in original)
>
> You are to continue paying the Medicare DSH adjustment reflecting the inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for all open cost reports for cost reporting periods beginning before January 1, 2000, to any hospital

> that, before October 15, 1999, filed a jurisdictionally proper appeal to the PRRB specifically for this issue on *previously* settled cost reports. (Emphasis in original)

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This appeal involves six hospitals (Providers) located in Los Angeles, California that are owned and operated by the County of Los Angeles. During their fiscal year ended (FYE) June 30, 1998, the Providers furnished health care services to patients covered under Medi-Cal, California's Medicaid program approved under Title XIX of the Act, and to other patient groups through the Medi-Cal program whose care was funded entirely with state monies (state-only funds).[1] Each of the Providers claimed and qualified for a Medicare DSH adjustment for the cost reporting period under appeal based, in part, upon their total Medi-Cal days, which included both the days of care paid for with state-only funds, as well as the days of care furnished for all Medicaid eligible patients. However, none of the Providers claimed patient days attributable to General Relief (GR)[2] patients. Blue Cross of California (Intermediary)[3] audited the Providers' cost reports and made adjustments to the total claimed Medi-Cal days that did not include the Providers' GR days in their DSH calculations.[4]

The Providers appealed the Intermediary's DSH adjustments that did not include GR days in their Medicaid fraction to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy exceeds $50,000.

The Providers are represented by Anita D. Lee, Esquire, Principal Deputy County Counsel, Health Services Division, County of Los Angeles. The Intermediary is represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Providers contend that each Provider in their group is eligible to have GR days included in its FYE 1998 DSH calculation based upon the hold harmless provisions of Program Memorandum (PM) A-99-62. The memorandum instructs intermediaries to reopen final determinations to include payment for such days if a hospital appealed, before October 15, 1999, the denial of such days in previous cost reporting periods. In this case, each provider, with the exception of Rancho Los Amigos which was not

---

[1] In contrast to the state-only funded patient care, the Federal Government shares in the cost of services to Medicaid eligible individuals through matching funds termed "Federal Financial Participation."

[2] General relief or "GR" refers to the cash assistance provided by the county, pursuant to statute, to Low-Income individuals.

[3] National Government Services has replaced Blue Cross of California as the Providers' intermediary.

[4] Providers' Revised Position Paper at 4.

reimbursed under PPS until July 1, 1997, appealed the calculation of its DSH adjustment in FYE June 30, 1989, 1990, and 1991.[5]

The Providers also contend that CMS' policy to include state-only funded days in the Medicaid fraction "only" if a hospital had appealed the exact issue prior to October 15, 1999, is arbitrary and capricious and violates the Providers' equal protection rights. Specifically, failure to include GR days in the calculation of the Providers' (including Rancho Los Amigo's) Medicaid fraction would violate the Administrative Procedure Act and the Equal Protection component of the Due Process clause set forth in the 5th Amendment to the United States Constitution by treating similarly situated entities differently.

The Intermediary contends that the hold harmless provision of PM A-99-62 protects hospitals with cost reports through the end of December 31, 1999, that received payment in the past for specific types of erroneous patient days that had been included in their DSH calculations. In the instant case, the Providers are not seeking this type of protection since GR days had never been included in their DSH calculations.[6] Moreover, the Providers' reliance on PM A-99-62's instruction to intermediaries to reopen cost reports "only if the hospital appealed, before October 15, 1999, the denial of payment for the days in question in previous cost reporting periods" is improper. The Providers did not raise GR days as a specific issue until it was mentioned in a January 14, 2000[7] letter to the Board; nowhere in the Providers' prior appeal records do they express their belief that GR days should be included in the Medicaid fraction.

The Intermediary also contends that it is beyond the Board's scope of authority to address the Providers' argument that PM A-99-62 is arbitrary and capricious. However, the Intermediary cites to United Hospital v. Thompson, 383 F.3d 728 (8th Circuit, 2004), where the court found that PM A-99-62 had a rational basis and was a proper exercise of the Secretary's authority (affirming the Board's Dec. No. 2002-D23).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering Medicare law and guidelines, the parties' contentions, and the evidence presented, the Board finds and concludes that the Providers are not entitled to include the GR patient days at issue in this case in the Medicaid fraction of their DSH calculations.

The Providers argue that the GR days qualify for inclusion in their DSH determinations based upon the hold harmless provision of PM A-99-62, which states:[8]

> 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

[5] Providers' Revised Position Paper at 7. Exhibit P-8 at 2, ¶5.
[6] Intermediary's Revised Position Paper at 6. Exhibit P-8 at 6, ¶16.
[7] Exhibit S-7 to the Joint Stipulation of Facts.
[8] Transcript (Tr.) at 15.

> appeal to the PRRB on the issue of the exclusion of these types of days from 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.

It is undisputed that the Providers had never received payments reflecting the inclusion of GR days in their DSH calculations and that they had previously filed appeals with the Board on the issue of their DSH determinations.[9] However, the Providers' claim is not in line with the clear intent and purpose of the program memorandum.

The hold harmless provisions of PM A-99-62 are designed to provide relief to hospitals that had a genuine expectation of payment, or disagreement with the treatment or exclusion of certain patient days from their DSH determinations prior to October 15, 1999. Therefore, assuming the Providers' previously filed appeals were "jurisdictionally proper" as required by the program memorandum,[10] the question becomes a matter of whether or not the Providers' pending appeals reflect a genuine expectation of payment based upon the inclusion of GR days in their DSH calculations, or a genuine disagreement with the exclusion of these patient days. Contrary to the Providers' arguments, the Board finds the evidence in this case does not support the Providers' claim.

The record shows that the Providers routinely included non-Federally funded state-only patient days in their cost report submissions, and that these days were used to determine their DSH reimbursement. However, the record also shows that the Providers never included GR days in their as-filed cost reports, which the Board concludes indicates the Providers' understanding that GR days were not allowable for the purpose of Medicare DSH determinations.

In addition, the Providers had filed several appeals with the Board which included disputes over the number of patient days used in their DSH determinations. While these appeals show the Providers' awareness that a claim could be made to include GR days in the DSH calculation, they were never mentioned by name.

There is also a clear distinction between the GR days at issue in this case and the patient days that have been brought before the Board in other cases involving the Medicaid fraction. As explained in PM A-99-62, the hold harmless provisions were prompted by

---

[9] Exhibit P-8 Joint Stipulation of Facts at ¶ 6.

[10] As shown above, the hold harmless provision of Program Memorandum A-99-62 requires the Providers to have filed a "jurisdictionally proper appeal" to the Board before October 15, 1999. The memorandum emphasizes that the appeal be "<u>on the issue of the exclusion of these types of days from the Medicare DSH formula</u>." Therefore, it is unclear whether CMS is referring to the jurisdictional requirements for a Board hearing at 42 C.F.R. §405.1835 or whether CMS has established a jurisdictional requirement strictly applicable to the hold harmless provision, i.e., in order to be jurisdictionally proper the Providers' appeals must have used precise wording to describe the patient days being challenged; for example: "Los Angeles County general relief days" as opposed to a more general description such as "Medicaid eligible days."

the fact that most hospitals and intermediaries relied upon Medicaid days data obtained from Medicaid State agencies to compute Medicare DSH payments and that some of those agencies commingled otherwise ineligible days with allowable Title XIX days. In other words, the erroneous patient days of concern to CMS were, in some way, connected to State Medicaid programs or State Medicaid payment systems in a manner that allowed them to become commingled. However, that is not the case with the GR days at issue. The source of the GR days is the County of Los Angeles' financial and statistical systems and they have not been commingled with state data.[11]

In summary, there is no evidence that the Providers expected to be paid based upon the inclusion of GR days in their DSH determinations or had a disagreement with the treatment of GR days prior to October 15, 1999. Therefore, the Providers do not qualify for additional DSH payments pursuant to the hold harmless provisions of PM A-99-62.

Finally, the Providers argue that they should be entitled to include GR days in their DSH determinations even if they do not qualify under the hold harmless provision of PM A-99-62. The Providers argue that CMS' policy to allow non-Federal low-income days in the DSH determinations "only" if a hospital appealed the exact issue prior to October 15, 1999, is arbitrary and capricious because it treats alike entities differently. Notably, PM A-99-62 does not simply expand upon the pertinent law and regulations, but actually provides for Medicare payments that CMS acknowledges providers would not otherwise be entitled to under the statute. However, whether CMS has the authority to provide for such payments, and to prescribe the circumstances under which they may be made, is beyond the scope of the Board's discretion and authority.

DECISION AND ORDER:

The Providers are not entitled to include GR days in the calculation of their DSH payment pursuant to the hold harmless provisions of Program Memorandum A-99-62. The Intermediary's adjustments are affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West, C.P.A.
Yvette C. Hayes

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

[11] Exhibit P-3 at ¶ 5-9 – Declaration of Helen M. Jew, Chief Program Audits and Reimbursement, County of Los Angeles Department of Health Services.

DATE: October 11, 2007