PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2008-D7

PROVIDER –
St. Mary's Hospital – Milwaukee
Milwaukee, WI

Provider No.: 52-0051

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services, LLC-WI

DATE OF HEARING –
November 14, 2006

Cost Reporting Period Ended –
June 30, 2000

CASE NO.: 03-1056

INDEX

ISSUE 1:

Whether CMS improperly calculated St. Mary's Hospital's Medicare disproportionate share hospital (DSH) adjustment by excluding fifty two (52) patient days from the Supplemental Security Income (SSI) fraction.

ISSUE 2:

Whether the intermediary improperly calculated St. Mary's Medicare DSH adjustment by excluding 366 Long Term Respiratory Unit (LTRU) patient days from the Medicaid proxy of the DSH calculation.

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.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). See, 42 U.S.C. §1395ww(d). The PPS statute contains a number of provisions that adjust reimbursements based on hospital-specific factors. See 42 U.S.C. §1395ww(d)(5). This case involves the hospital-specific DSH adjustment, which 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 (DPP)." See, 42 U.S.C. § 1395ww(d)(5)(F)(v). The DPP is the sum of two fractions, the "Medicare and Medicaid fractions," for a hospital's fiscal period. 42 U.S.C. §1395ww(d)(5)(F)(vi). The first fraction's

numerator is the number of a hospital patient days for such period who (for such days) were entitled to both Medicare Part A and SSI, excluding patients receiving state supplementation only, and 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 (for such days) 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. 42 U.S.C. §1395ww(d)(5)(F)(ii).

The SSI program is administered by the Social Security Administration (SSA); therefore, identifying patients who were entitled to SSI during their hospitalization requires access to SSA's SSI data.

To implement the DSH legislation, the number of patient days for those patients entitled to both Medicare Part A and SSI is determined by matching data from the MEDPAR file, which is Medicare's database of hospital inpatients, with a file created for CMS by SSA to identify SSI - eligible individuals. Although the intermediary calculates the DPP, it is CMS that develops the SSI fraction.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Mary's Hospital- Milwaukee (Provider) is a not-for-profit, acute care hospital located in Milwaukee, Wisconsin. On September 28, 2002, the United Government Services, LLC (Intermediary) issued the Provider's NPR for the fiscal year ended (FYE) June 30, 2000. The Provider filed a timely appeal with the Board. The Provider was represented by Steven B. Roosa, Esq. of Reed Smith, LLP. The Intermediary was represented by Bernard M. Talbert, Esq. of Blue Cross Blue Shield Association.

ISSUE 1: BACKGROUND

The parties stipulated to the following facts:

After the Provider filed its appeal, its consultant, working on the Provider's behalf, requested that CMS provide the source data for the Provider's SSI fraction used to settle the cost report at issue. In response to the request, CMS furnished the Provider a data file from the Medicare Provider Analysis and Review (MEDPAR) database and an additional data file that CMS obtained from SSA. This SSA data file included a list of certain patients and the days that they were entitled to SSI. A comparison of the MEDPAR and SSA data files revealed that the SSA data file, for the time period at issue in this case, includes 52 more SSI days than the MEDPAR file.

The parties further stipulated that the SSA data file is an accurate data source for determining

which patients are entitled to SSI. CMS' calculation of the SSI fraction did not include the 52 SSI days referenced above. With respect to such days, the patient in each instance was entitled to Medicare.

ISSUE 1: PARTIES' CONTENTIONS

The Provider contends that the statute at 42 U.S.C. §1395ww(d)(5)(F) does not afford the Secretary any discretion as to which SSI days should be included in the numerator of the SSI fraction. All SSI days must be included as long as the patient was entitled to both SSI and Medicare Part A.

The Intermediary argues that CMS has the discretion to rely upon a generally available data source that facilitates an SSI percentage calculation (used with a second percentage) to estimate the impact of serving a disproportionate number of low-income patients. The Provider's institutional-specific approach is a more complicated methodology. Since the concept underlying the PPS is to simplify the determination of Medicare payments and to apply uniform standards, and the DSH adjustment itself is an estimation of a specific phenomenon (i.e., the number of low-income patients), the use of the MEDPAR data is appropriate.

ISSUE 1: FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board finds that, consistent with its previous decision to deny expedited judicial review[1] in Oakwood Hospital and Medical Center (Dearborn, Mich.) v. Blue Cross Blue Shield Ass'n/ United Government Services, LLC (Wis.) PRRB Dec. No. 2006-D2 (Nov. 16, 2005), the inclusion of additional SSI days is purely a legal question as to whether CMS must recalculate the DSH adjustment using additionally identified days. There is nothing in the statute, regulations, or CMS Rulings that would preclude CMS from recalculating a provider's DSH adjustment. Further, the Board finds, as it did in Baystate Medical Center (Springfield Mass.) v. Mutual of Omaha Insurance Co., PRRB Dec. No. 2006-D20 (March 17, 2006), that an approximation of the DSH percentage is not permitted by statue or regulation. The Medicare law requires the calculation to be accurate. In this case, it is undisputed that a comparison of the MEDPAR and SSA data files provided by CMS to the Provider revealed that the SSA file, which is an accurate data source, includes 52 more SSI days than the MEDPAR file (and CMS's calculation). Accordingly, such days should be included in the calculation.

ISSUE 2: BACKGROUND

The parties stipulated with respect to the Medicaid proxy, there were 366 patient days (for one patient) in the Provider's long term respiratory unit for which the patient was eligible for Medicare, but had exhausted Medicare inpatient benefits because of the length of stay. This patient was eligible for Medicaid for each of the 366 inpatient days. The Intermediary did not allow the Provider to include the 366 days in the numerator of the Medicaid proxy. Additionally,

[1] See 42 C.F.R. §405.1842

the 366 days are not included in the numerator or the denominator of the SSI fraction.

ISSUE 2: PARTIES' CONTENTIONS

The Provider argues that the 366 days should be included in the Medicaid proxy calculation on the basis that the Provider was not "entitled" to payments for such days as the patient exhausted its coverage for such days. The Provider explains that "eligible" "means qualifying for coverage or potential coverage because a patient is a participant in the program, whereas "entitled" means "paid." As support, the Provider cites the following language from the Sixth Circuit's decision in Jewish Hospital, Inc. v. Secretary of Health and Human Services, 19 F.3d 270, 275 (6th Cir. 1994).

> . . . Congress spoke of "eligibility" in the Medicaid proxy and "entitlement" in the Medicare proxy. See U.S.C.§1395ww(d)(5)(F). The Secretary would have this Court conflate eligibility with entitlement. Adjacent provisions utilizing different terms, however, must connote different meanings. To be *entitled* to some benefit means that one possesses the *right* or *title* to that benefit. Thus, the Medicare proxy *fixes* the calculation upon the absolute right to receive an independent and readily defined payment.
>
> By way of contrast, the Medicaid proxy speaks solely of *eligibility*. While Congress intended to refer to the qualification for Medicaid benefits in the calculation of this proxy, Congress could not have intended to fix its calculation on the actual payment of benefits in the state administered program. Had Congress intended that result, it would have also defined the Medicaid proxy in terms of entitlement to state Medicaid payments. Rather, Congress defined the Medicaid proxy with respect to eligibility for and not actual payment of benefits.

The Intermediary argues that the 366 days at issue should not be counted in the Medicaid proxy calculation citing as support, the following language from the CMS Administrator's reversal of the Board's decision[2] in Alhambra Hospital:

> The Administrator finds that the statutory phrase in the Medicaid proxy "but who were not entitled to benefits under Medicare Part A of this title" can reasonably be interpreted to prevent the inclusion of the days at issue in the numerator of the Medicaid proxy. The Medicaid low-income proxy specifically excludes from its calculations patients entitled to Medicare Part A and limits its proxy to Medicaid-only eligible patients. The relevant language of the Medicaid proxy indicates that it is the status of the Medicare patient, as opposed to the coverage of the

[2] Alhambra Hospital, 2005-D47 (July 29, 2005), rev'd CMS Admr. (9/30/05).

> day under Medicare, which determines whether a patient day is included in the numerator of the Medicaid proxy. The phrase "but who were not entitled to benefits under Part A" does not indicate that days for which Medicare is not paid should be included in the numerator of the Medicaid proxy. Consequently, it is reasonable to conclude that the phrase "entitled to benefits under Part A," as used in this Clause II phrase, refers to the status of the patient, as a Medicare beneficiary, rather than whether the patient was entitled to coverage by Medicare for the day at issue.

ISSUE 2: FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

Consistent with the Board's decision finding in Alhambra Hospital[3], the Board finds that the Intermediary improperly eliminated from the DSH calculation patient days for patients who otherwise were entitled to both Medicare and Medicaid benefits, but who had exhausted their benefits. Such days should be included in the calculation of the Medicaid proxy in the determination of the DSH adjustment in accordance with both the plain language of 42 U.S.C. §1395ww(d)(5)(F) and Congressional intent. Accordingly, the DSH Medicaid fraction should be revised to permit the Provider to include the 366 LTRU days.

DECISION AND ORDER:

The Intermediary's determination of the DSH Medicare percentage is reversed and this case is remanded to the Intermediary to recalculate the DSH Medicare percentage consistent with this decision.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West, C.P.A.

FOR THE BOARD:

DATE: November 16, 2007

Suzanne Cochran, Esq.
Chairperson

[3] Id.