PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D19

PROVIDER -
St. Cloud Hospital
St. Cloud, Minnesota

Provider No.: 24-0036

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Noridian Administrative Services

DATE OF HEARING -
January 13, 2009

Cost Reporting Periods Ended -
June 30, 1997; June 30, 1998; June 30, 1999;
June 30, 2000

CASE NOs.: 05-1873; 05-1879; 05-1880 and 05-1881

INDEX

ISSUE:

Whether the Intermediary should have included all general assistance days in the computation of the Provider's Medicare Disproportionate Share (DSH) adjustment calculation for the Provider's fiscal years ended June 30, 1997, 1998, 1999, and 2000.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper 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 interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

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). The PPS statute contains a number of provisions that adjust payment based on hospital-specific factors. See, 42 U.S.C. 1395ww(d)(5). This case involves one of the hospital-specific adjustments, specifically the "disproportionate share hospital," or "DSH" adjustment. The Secretary is required to provide increased PPS payments 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," expressed as a percentage for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi). The Medicare fraction'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. The denominator is the number of hospital patient days for patients entitled to Medicare Part A. Id. The Medicaid fraction'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. 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 Medicaid fraction is frequently referred to as the Medicaid Proxy and is the only fraction at issue in this case.

On December 1, 1999, CMS issued Program Memorandum A-99-62 (hereinafter the "Program Memorandum") "to clarify the definition of eligible Medicaid days in Medicare disproportionate share policy and communicate this information to fiscal intermediaries, hospitals, Medicaid state agencies and Medicare managed care organizations." The Program Memorandum states in pertinent part:

> In practical terms this means that you are not to reopen any cost reports for cost reporting periods beginning before January 1, 2000 to disallow the portions of the Medicare DSH payments attributable to the erroneous inclusion of general assistance or other state-only health program, charity care, Medicaid DSH and/or ineligible waiver or demonstration population days if the hospital received payments for those days based on those cost reports…
>
> For cost reporting periods beginning before January 1, 2000, you are to continue to allow these types of days in the Medicare DSH calculation for all open cost reports only in accordance with the practice followed for the hospital at issue before October 15, 1999 (i.e., for open cost reports, you are to allow only those types of otherwise ineligible days that the hospital received payment for in previous cost reporting periods settled before October 15, 1999). For example, if, for a given hospital, a portion of Medicare DSH payment was attributable to the erroneous inclusion of general assistance days for only the out-of-State or HMO population in cost reports settled before October 15, 1999, you are to include the ineligible waiver days for only that population when settling open cost reports for cost reporting periods beginning before January 1, 2000. However, the actual number of general assistance and other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration days, as well as Medicaid Title XIX days, that you allow for the open cost reports must be supported by auditable documentation provided by the hospital.

At issue is the application of the Program Memorandum to the Providers' DSH calculations, specifically the Medicaid proxy.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Cloud Hospital (Provider) is a health facility located in St. Cloud, Minnesota. The Provider participates in the Minnesota General Assistance Medical Care program which provides health care coverage for low-income adults, ages 21-64, who have no dependent children and who do not qualify for state Medical Assistance. Medical Assistance is Minnesota's Medicaid program for low-income families with children, seniors and people with disabilities.

For cost reporting periods prior to 6/30/96, the Provider relied on Minnesota's State Medical Assistance List to identify persons eligible for medical assistance in the preparation of its cost reports. The Provider assumed that the State Medical Assistance List was a comprehensive listing that was not limited to patients eligible for Medicaid (as that term is used in the Medicaid proxy.) The Intermediary believed that the State's Medical Assistance List included only patients who were eligible for Medicaid. To the extent the Intermediary identified any General Assistance Medical Care (hereafter "GA") days during its audit, these days were excluded from the Medicaid Proxy. In 2006, the Provider conducted a retroactive examination of the State Medical Assistance List as adjusted by the Intermediary during the settlement process for the fiscal years ending June 30, 1994 through June 30, 1996. The Provider's analysis indicated that the adjusted listing included some GA days which were allowed in the settlement. Given the inclusion of those days in the periods prior to 1996, the parties are now in dispute over the proper treatment of GA days in the fiscal periods ending June 30, 1997 through June 30, 2000.[1] At specific issue is whether the hold harmless provisions of Program Memorandum A-99-62 require the continued inclusion of GA days in the Medicaid proxy.

The Provider appealed the issue to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835- 405.1841. The Provider was represented by Kenneth R. Marcus, Esquire, of Honigman Miller Schwartz and Cohn, L.L.P. The Intermediary was represented by Bernard M. Talbert Esquire, of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that hold harmless language of Program Memorandum A-99-62 is controlling in the circumstances of this case. Specifically, the memorandum states:

> For cost reporting periods beginning before January 1, 2000, you are to continue to allow these types of days in the Medicare DSH calculation for all open cost reports only in accordance with the practice followed for the hospital at issue before October 15, 1999 (i.e., for open cost reports, you are to allow only those types of otherwise ineligible days that the hospital received payment for in previous cost reporting periods settled before October 15, 1999).

[1] Consistent with its established policy, the Intermediary eliminated any GA days identified during its audits of FYE 1997-2000 from the Medicaid Proxy.

There is no dispute that the Provider included some GA patients as inpatients in its filed cost reports or that the Intermediary allowed some GA days as inpatient days in its computation of the Provider's DSH adjustment for the FYEs 1994 through 1996.[2] The Provider argues that the inclusion of GA days is the practice that the Provider followed before October 15, 1999 and that the language of the Program Memorandum requires that the Intermediary "continue to allow these types of days in the Medicare DSH calculation for all open cost reports." The Provider contends that application of the hold harmless provision of the Program Memorandum requires the Intermediary to include within the DSH calculation all of the GA patients that the Provider treated as inpatients for FYEs 1997 through 2000.

INTERMEDARY'S CONTENTIONS:

The Intermediary acknowledges that the DSH calculations for the FYEs 1994 through 1996 included some GA patient days.[3] However, the Intermediary contends that its audit policy was clearly established. GA days did not belong in the Medicare DSH calculation and the Intermediary would disallow any attempt to count such days.[4] The Intermediary notes that in FYEs 1994 through 1996, the Intermediary's audit failed to identify some GA days and those days were included in error. However, their erroneous inclusion establishes no discernable practice to support hold harmless relief. Accordingly, the Intermediary contends that the Provider is not eligible for hold harmless treatment in subsequent years.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' stipulations, the Board finds and concludes as follows:

The issue before the Board centers on the practices established by the parties for the treatment of GA days. Cost reports filed by the Provider and audits performed by the Intermediary for fiscal years ended June 30, 1994, 1995 and 1996, confirm that the practice of the Provider was to rely on the Minnesota State Medical Assistance List.[5] The list included 81, 111 and 94 GA days for fiscal years (FYs) 1994, 1995 and 1996 respectively.[6] Consistent with its policy, the Intermediary disallowed all GA days that it identified during its audits.[7] Some GA days were nevertheless allowed and paid because the Intermediary erroneously considered them Medical Assistance days or missed them during the audit sampling process.[8] Neither party discovered the erroneously paid GA days until a retroactive analysis was completed in 2006.[9] That analysis also revealed that the Provider made no other claim for GA days and, accordingly, 3382 GA days in FY

[2] Stipulations of the Parties (hereinafter "Stipulations"), ¶ 11-13.
[3] Id.
[4] Stipulations, ¶ 10d.
[5] Stipulations, ¶ 10a.
[6] Stipulations, ¶ 11a, 12a, 13a.
[7] Stipulations, ¶ 10d.
[8] Id.
[9] Stipulations, ¶10e.

1994, 2922 GA days in FY 1995 and 3836 GA days for FY 1996 went unclaimed. The Board concludes that GA days were mistakenly claimed and paid in FYs 1994, 1995 and 1996 and that both parties were unaware of that mistake until 2006. The Board finds that the Intermediary's "practice" prior to October 15, 1999, was to disallow all GA days. The fact that some days went undetected because they were either not identified as GA or were missed due to the sampling process does not alter the fact that the firmly established Intermediary practice was to disallow all GA days.

It is the Provider's position that payment of even a single GA day by mistake triggered entitlement of all such days in subsequent years. However, the parties have stipulated that "[f]or cost reporting periods following FYE 6/30/1996, although the Provider treated GA Patients as inpatients, the Provider did not include such GA Patients in its cost report claim for the DSH Adjustment."[10] Therefore, the Board concludes that there were no days claimed to which the Program Memorandum applies and the Provider's claim must fail.

The Provider also alleges that it should be allowed to amend its cost reports to include all GA days that it identified in 2006. The Program Memorandum specifically prohibits addition of these days and states, in pertinent part: "Furthermore, on or after October 15, 1999, you are not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula." The Board finds no basis to grant the addition of the days in contravention of the Program Memorandum.

The Provider further alleges that failure to claim the GA days should not be a bar to application of the hold harmless provision because it was merely following the Intermediary's directive in not claiming GA days after 1996. The Program Memorandum addresses this issue and indicates that where, as here, a hospital did not receive payments reflecting the erroneous inclusion of ineligible days, the hold harmless provision could nevertheless be applied if the Provider "filed a jurisdictionally proper appeal to the PRRB *on the issue of the exclusion of theses types of days from the Medicare DSH formula* before October 15, 1999." (Emphasis in original). The Provider made no such filing and, absent such filing, the hold harmless provisions of the Program Memorandum do not apply.

In summary, the Board finds that the Program Memorandum requires that a Provider make a claim either through its cost report or through an appeal prior to Oct 15, 1999, of a "denial of payment for the days in question in previous cost reporting periods." In this case, the Provider did neither. The Board may not grant hold harmless treatment for the cost reporting periods subsequent to 1996.

DECISION AND ORDER:

The Provider's circumstances do not meet the requirements for hold harmless treatment imposed by Program Memorandum A-99-62. The Intermediary properly excluded

[10] Stipulations,¶ 14a

Minnesota's General Assistance Medical Care days from the computation of the Provider's Medicare disproportionate share hospital (DSH) adjustment calculation for the Provider's fiscal years ended June 30, 1997, 1998, 1999, and 2000.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith Braganza C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: April 15, 2009