PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2009-D32

PROVIDER -
Sharp Coronado Hospital and
HealthCare Center
Coronado, California

Provider No.: 05-0234

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC - CA

DATE OF HEARING -
November 20, 2008

Cost Reporting Periods Ended -
September 30, 2000 and September 30, 2001

CASE NOs.: 05-1133 and 06-0127

INDEX

ISSUES:

1. Whether the Intermediary's calculation of the Provider's disproportionate share hospital (DSH) payments, as it pertains to subacute unit days was proper.

2. Whether the Intermediary's calculation of the Provider's disproportionate share hospital (DSH) payments, as it pertains to Medicare Part A exhausted days for dual eligible patients was proper.

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 providers under Medicare law and under 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sharp Coronado Hospital and HealthCare Center (Provider) is a general, short-term hospital located in Coronado, California. The following are the relevant facts for each of the above issues.

STIPULATIONS:

On February 22, 2008 the parties jointly stipulated the following:[1]

[1] See Provider Exhibit PS-9.

1. During fiscal years ended September 30, 2000 and September 30, 2001 (FYEs 9/30/00 and 9/30/01), the Provider operated three subacute units, two on the first floor (also known as subacute units I and II) and one on the fourth floor (also known as subacute unit III).

2. The subacute unit on the fourth floor was adjacent to an acute care obstetrics and gynecology wing of the Provider.

3. The two subacute units on the first floor were not adjacent to an acute care unit or wing of the Provider, but there is an intensive care unit (which provides acute care level services payable under the prospective payment system) on the first floor of the Provider.

4. Each of the three subacute units is licensed by the State of California as a skilled nursing facility (SNF).

5. Effective April 1, 2000, none of the three subacute units was exempt from Medicare's inpatient hospital prospective payment system (IPPS).

6. Effective April 1, 2000, none of the three subacute units was certified by Medicare as a SNF and, effective April 1, 2000, none of the three subacute units participated in the Medicare program as a SNF.

7. Each of the three subacute units treated patients who required and received a level of care greater than that provided in SNF units but less than that provided in inpatient acute care units.

8. For FYE 9/30/00, upon the Intermediary's audit and review, the Intermediary and Provider agree that the two subacute units on the first floor had 4,210 Medicaid eligible days, and, in addition, 4,654 dual eligible exhausted days.[2] Further, upon the Intermediary's audit and review, the parties agree that the subacute unit on the fourth floor had 972 dual eligible exhausted days. Thus, the parties agree that there is no need to remand for a determination of the number of Medicaid or dual eligible Medicaid/Medicare days at issue.

9. For FYE 9/30/01, upon the Intermediary's audit and review, the Intermediary and Provider agree that the two subacute units on the first floor had 10,145 Medicaid eligible days, and, in addition, 9,191 dual eligible exhausted days. Further, upon the Intermediary's audit and review, the parties agree that subacute unit on the fourth floor had 2,364 dual eligible exhausted days. Thus, the parties agree that there is no need to remand for a determination of the number of Medicaid or dual eligible Medicaid/Medicare days at issue.

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[2] "Dual eligible exhausted days" refers to inpatients who are eligible for both Medicare and Medicaid but the days at issue were not paid or covered by Medicare because the patients' Medicare Part A benefits had been exhausted.

The Intermediary excluded the days attributable to patients furnished services on the two subacute units located on the first floor of the Provider. Specifically, the parties have stipulated that if the Provider prevails on this issue, there is no need for further audit and that there are 4,210 Medicaid eligible days at issue for FYE 9/30/2000 and 10,145 Medicaid eligible days at issue for FYE 9/30/2001.[3] In addition the Intermediary excluded all dual eligible Medicare Part A exhausted patient days associated with all three subacute units from the Provider's DSH computation. Thus, this dual eligible exhausted days issue involves patient days in all three subacute units on the first and fourth floor of the Provider. The parties have stipulated that if the Provider prevails on this issue, there is no need for further audit and that there are 5,626 dual eligible exhausted days at issue for FYE 9/30/2000 and 11,555 dual eligible exhausted days at issue for FYE 9/30/2001.[4]

The Provider's appeal meets the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Jon P. Neustadter, Esquire, of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by James Grimes, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

ISSUE NO.1 - - Subacute Unit Days

The Provider contends that the Board should follow its prior decision in Alhambra[5] where it found that the subacute units were not exempt from PPS and therefore the days should be included in the DSH calculation. The Intermediary responds that the two subacute units on the first floor of the Provider do not meet the Alhambra 9th Circuit Court's criteria for inclusion of the patient days in DSH calculation, because the subacute units and the routine inpatient acute care unit are not adjacent to one another. Further, CMS' instructions in JSM-108[6] (August 24, 2004) allows counting of only those days attributable to subacute units that are located within areas of the hospital that are used for inpatient acute care services. These instructions were applicable only to hospitals located within the Ninth Circuit for discharges before October 1, 2003. The Provider's two subacute units on the first floor do not meet the requirements for an area generally used for inpatient care services because the area around the first floor subacute units included cafeteria, kitchen and storage areas, none of which provide acute care services.

The Provider contends that CMS cannot eviscerate the impact of the *Alhambra* Ninth Circuit decision through an informal memorandum that purports to interpret or limit a Federal Court of Appeals Decision.

Further, the Intermediary and CMS may not retroactively apply the 2003 version of the

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[3] See Provider Exhibit PS-9 at Stipulation(s) 8, 9.
[4] Id. Also see the Provider's Supplemental Reply Position Paper at 2.
[5] Alhambra Hospital v. Blue Cross Blue Shield Association/Blue Cross of California, PRRB Dec. No. 1998-D85 (August 28, 1998) rev'd by HCFA Administrator Dec. No. October 14, 1998.
[6] See Provider Exhibit PS-5.

DSH regulation. The Provider contends CMS is collaterally estopped from calculating DSH payments differently than required by the *Alhambra* court and from relitigating issues decided in the *Alhambra* case, noting that the Board's decision was upheld on appeal to the Ninth Circuit in Alhambra Hospital v. Thompson, 259 F.3d 1071 (9th Cir. 2001). Therefore, the Provider is entitled to a favorable decision based on the doctrines of precedent and *stare decisis.*[7] Finally, CMS' interpretation of *Alhambra* is incorrect, and is entitled little if any deference under Macktal v. U.S. Dept. of Labor, 171 F.3d. 323 (5th Cir. 1999). (See PS-13).

ISSUE NO. 2 - - Medicare Part A Exhausted Days

The Provider contends that the DSH statute requires the inclusion of Medicare Part A exhausted days for dual eligible subacute unit patients in the Medicaid proxy. Excluding exhausted Part A days from the DSH calculation frustrates the purpose of DSH payments. The PRRB has opined on multiple occasions that days associated with otherwise dually eligible patients who have exhausted their Medicare Part A benefits should be counted in the Medicaid proxy of the DSH calculation.[8] There is no reason why the Board should not reach the same conclusion once again with respect to this case. Further, CMS policy statements show that the Medicare Part A exhausted days should be included in the DSH calculation in some capacity.

The Intermediary contends that although CMS changed its policy to allow all dual-eligible days for patients that exhausted Medicare Part A coverage for discharges on or after October 1, 2004, the change was not retroactive to the cost reporting periods in dispute. The Intermediary's determination not to include the dual-eligible days in the Medicaid fraction is in accordance with Program regulations at 42 C.F.R. §412.106(b)(4) (2000). The Intermediary observes that in CMS Ruling No. 97-2, it acquiesced to the holdings of federal circuit court decisions in regard to counting the Medicaid patients on the basis of eligibility rather than Medicaid's payment for the related services. Finally, in

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[7] Precedent is "[a]n adjudged case or decision of a court, considered as furnishing an example of authority for an identical or similar case afterwards arising or a similar question of law." Black's Law Dictionary 1176 (6th ed. 1990). The "[p]olicy of courts to stand by precedent and not to disturb settled point[s]" is referred to as the doctrine of *stare decisis*.

[8] See Jersey Shore Med. Ctr. v. Blue Cross and Blue Shield Ass'n/Blue Cross and Blue Shield of New Jersey, PRRB Dec. No. 99-D4, Medicare & Medicaid Guide (CCH) ¶80,083 (Oct. 30, 1998), vacated and remanded on other grounds, HCFA Administrator, Medicare & Medicaid Guide (CCH) ¶80,153 (Jan. 4, 1999); see, also, Presbyterian Med. Ctr. of Philadelphia v. Aetna Life Ins. Co., PRRB Dec. No. 96-D75, 1996-2 Transfer Binder (TB), Medicare & Medicaid Guide (CCH) ¶44,702 (Sep. 30, 1996), vacated and remanded on other grounds, HCFA Adm'r, Medicare & Medicaid Guide ¶45,032 (Nov. 29, 1996); Edgewater Med. Ctr. v. Blue Cross & Blue Shield Ass'n/ Blue Cross & Blue Shield of Illinois, PRRB Dec. No. 2000-D44, Medicare & Medicaid Guide (CCH) ¶80,434 (Apr. 7, 2000). (The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and were eligible for reimbursement under the State's Medicaid plan.")

Further, as explained above, the Board has ruled that the exact type of patient days at issue in this case should be included in the Medicaid proxy of the DSH calculation. See Alhambra Hosp. v. Blue Cross/Blue Shield Association/United Gov't Services, PRRB Dec. No. 2005-D47, Medicare & Medicaid Guide (CCH) ¶81,371 (July 29, 2005) rev'd by CMS Admin. (Sept 30, 2005) Medicare & Medicaid Guide (CCH) ¶81,441.

the CMS Administrator's Review of the PRRB's decision in Edgewater Medical Center (Chicago, Illinois) v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Illinois, PRRB Dec. Nos. 2000-D44 and D-45, April 7, 2000, Medicare and Medicaid Guide (CCH) ¶¶80,434 and 80,435 aff'd by CMS Adm. Dec. June 19, 2000, Medicaid Guide (CCH) ¶80,525, CMS clarified that dual eligible patients who were eligible for Medicare Part A but had exhausted their Medicare Part A benefits, should not be included in the Medicaid fraction of the DSH calculation.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the parties' contentions and the evidence submitted, the Board finds and concludes that both types of days, subacute unit patient days and Medicare Part A exhausted benefit days for dual eligible patients should be included in the Medicaid fraction of the DSH calculation.

The Ninth Circuit's Alhambra decision found that the DSH regulation is plain on its face and requires the inclusion of the subacute patient days as part of the DSH reimbursement. The Board considers this decision binding precedent in the Ninth Circuit and it controls the outcome of these cases. As it did in Alhambra, the Board finds that CMS' and Congress had always intended that subacute unit days and Medicare Part A exhausted days be included in the DSH calculation. The Board's analysis of authorities indicates that CMS had traditionally assumed that such days were already included in the SSI percentage of the DSH calculation and should not, therefore, be included in the Medicaid proxy. After examining that assumption, CMS found that the days had not been included and attempted to include them through a series of guidance statements that produced conflicting positions relative to their treatment within the DSH calculation.

The Provider also argued that Medicare Part A exhausted days for dual eligible patients should be included in its Medicaid proxy based collectively upon the fact that these patients are eligible for Medicaid but are no longer entitled to Medicare Part A benefits and the applicability of the Ninth Circuit's decision in Alhambra. In the alternative, the Provider contends that these days should at least be included in the Medicare SSI percentage, rather than completely excluded from the DSH calculation.

The Intermediary contends that prior to October 1, 2004, it was CMS' policy to include dual eligible patients in the Medicare fraction (if the Medicare part A coverage was not exhausted), but not the Medicaid fraction. Effective October 1, 2004, CMS issued its final instructions which required that all Part A exhausted days be included in the Medicare SSI percentage.

The Board finds that the final instruction accommodates the original intent of Congress and CMS to include these days in the DSH calculation. However, CMS' policy on the inclusion of Part A exhausted days in the Medicare fraction applies only to discharges occurring on or after October 1, 2004. Therefore, for the September 30, 2000 and 2001 fiscal years at issue, the Board concludes that the days for subacute unit patients that had

exhausted their Medicare Part A benefits should be included in the calculation of the Medicaid proxy in the determination of the Provider's DSH adjustment.

DECISION AND ORDER:

The Providers' claimed subacute and Part A exhausted benefit days are properly included in the Medicaid fraction of the DSH calculation. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: July 15, 2009