PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D1

PROVIDER -
Roanoke 93 DSH Medicaid Percentage Group

Provider No.: 39-0001

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ National Government Services

DATE OF HEARING -
October 2, 2007

Cost Reporting Periods Ended -
June 30, 1990 and June 30, 1991

CASE NO.: 96-1627G

INDEX

ISSUE:

Whether the Medicaid percentage component of the Provider's disproportionate share hospital (DSH) adjustment has been properly computed to contain all Medicaid patient days including Medicaid eligible days.

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 reimbursement 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 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." See, 42 U.S.C. §1395ww(d)(5)(F)(v).

The "disproportionate patient percentage" or "DPP" 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, and 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, 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 Medicaid fraction is frequently referred to as the Medicaid Proxy and is the only fraction at issue in this case.

The computation of the numerator of the Medicaid fraction is at the heart of this action. From 1986 through 1997, the Secretary construed the first portion of this numerator calculation to include only those patients who were both eligible for Medicaid payments under the relevant state Medicaid plan and who actually received such payments from the state. See 42 C.F.R. §412.106(b)(4). Providers challenged this interpretation, and every circuit court that considered the Secretary's interpretation rejected it. The courts of appeals uniformly concluded that the numerator calculation must include all patient days for which a patient was eligible for Medicaid assistance regardless of whether a state Medicaid program actually paid the hospital for services provided to the patient. See Cabell Huntington Hospital, Inc. v. Shalala, 101 F.3d 984, 988 (4th Cir. 1996); Legacy Emmanuel Hospital and Health Center V. Shalala, 97 F.3d 1261, 1266 (9th Cir. 1996); Deaconess Health Services Corp. v. Shalala, 97 F.3d 1041, 1041 (8th Cir. 1996); Jewish Hospital, Inc. v. Sec'y of Health and Human Services, 19 F.3d 270, 276 (6th Cir. 1994).

In February 1997, the Secretary of DHHS issued a ruling that rescinded the original interpretation of the statutory provision and prospectively mandated that in calculating the disproportionate patient percentage, the Medicaid numerator must include all inpatient days of patients who were eligible for Medicaid "whether or not the hospital received payment for those inpatient hospital services." Heath Care Financing Administrative (HCFA) Ruling 97-2 (Feb. 27, 1997).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Community Medical Center (the Provider), the sole remaining provider[1] in this group, is an acute care hospital located in Scranton, Pennsylvania. The Provider submitted cost reports for its fiscal years ended (FYEs) June 30, 1990 and June 30, 1991. Veritus Medicare Services,[2] the Provider's original intermediary found that the Provider was not eligible for a DSH adjustment in FYE 1990 but was eligible for a DSH adjustment for FYE 1991.

This appeal was initially filed as a group appeal on March 22, 1996. A lead intermediary, United Government Services, LLC, subsequently called National Government Services (the Intermediary) was assigned to the group. At the request of the Providers in the group

[1] This case originally had several providers in the group. As a result of various steps noted in the Board's letter of November 2, 2006, only one provider, Community Medical Center (39-0001) remains in the appeal. See, Intermediary Exhibit I-5.

[2] Formerly, Blue Cross of Western Pennsylvania. See, Transcript (Tr.) at 18 and 52.

on December 7, 2004, this case was reorganized. In a letter from the Board dated November 2, 2006, Exhibit I-5, the case was restructured so that the only provider remaining in the group appeal was Community Medical Center. A Notice of Hearing was subsequently sent to the Provider on November 17, 2006 setting this case for a hearing on October 2, 2007. Shortly, after the Notice of Hearing was sent, the Intermediary sent a letter to the Provider. See Intermediary Letter, November 28, 2006. In the letter, the Intermediary noted the upcoming hearing date and requested that the Provider submit a listing of the additional Medicaid eligible days it wished to claim so the Intermediary's review could be completed prior to the hearing. The Intermediary specifically requested that the Provider submit its data by December 27, 2006.[3]

No evidence was actually submitted by the Provider until Friday, September 28, 2007 for the Tuesday, October 2, 2007 hearing at which time it submitted Exhibits P-5 through P-14. Tr. at 9. At the hearing, the Intermediary objected to the untimely submission of the Provider's exhibits because there was no good cause shown for not submitting them well in advance of the scheduled hearing date. Tr. at 7-8. The Board postponed making a decision on the Intermediary's motion to exclude the evidence at the hearing and heard arguments from the parties concerning the new evidence. Tr. at 76.

The Provider appealed the adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider is represented by Christopher L. Crosswhite, Esquire, of Duane Morris, LLP. The Intermediary is represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider acknowledged that the documents were not submitted until Friday, September 28, 2007 for the hearing held on Tuesday, October 2, 2007. The Provider argues that its late exhibits should be allowed for several reasons. First, the Provider indicated that the Board on previous occasions has permitted late submission of evidence and even new position papers from the parties. Second, the Provider indicates that some of the exhibits are not new or never before seen evidence but reflect calculations made by its original intermediary or were prepared by the original intermediary or furnished to the original Intermediary by HCFA. (Exhibits P-12 through P-14 and Tr. at 12-14). In addition, some of the documentation had been submitted to the local original intermediary that usually handles this Provider, as opposed to the lead Intermediary assigned to this group appeal. Tr. at 31-32, 51 and 52. Third, the Provider states that it did not provide the documentation requested by the lead Intermediary for the group because it did not consider it the proper intermediary for the case. Tr. at 36. The Provider stated that a telephone call was made and a message left about the matter but that no letter was sent to point out the perceived error so it could be corrected and no contact was made with the Intermediary's representative until immediately prior to the hearing. Tr. at 37-40 and 69-71.

[3] See, Intermediary Exhibit 4.

The Provider contends that when the Intermediary made calculations to determine whether it qualified for DSH adjustment payments, and if so, the amount of those payments, the number of Medicaid patient days included in the calculations were below the number of Medicaid days that should have been included. The Provider believes that the Intermediary did not include unpaid days for patients who were eligible for Medicaid. The Provider asserts that the failure to include all days for Medicaid-eligible patients is in conflict with current Medicare policy and the decisions of all federal appellate courts that have addressed the inclusion of Medicaid-eligible days in the DSH adjustment.

The Provider presented evidence concerning four categories of days that should be included in its DSH calculations. First, the Provider asserts that the number of Medicaid days should be updated to match the number reported in the State of Pennsylvania's Medicaid Audited Adjustment Report. The state Medicaid agency's audit adjustment reports show the number of days originally claimed on the FY 1990 and FY 1991 cost reports as well as the total number of Medicaid days, for the applicable periods, that were adjusted upwards by 283.5 days for 1990 and by 187 days for 1991. Exhibit P-8 and P-9. The Provider indicates that the audit reports from the state are reliable and should be used to update the Provider's paid Medicaid days. Tr. at 114-116.

Second, the Provider argues that a large number of Medicaid eligible patient days paid for by out-of-state Medicaid agencies, were not included in the number of Medicaid days claimed on its cost report but should be counted in the DSH adjustment calculation. The Provider presented a listing by fiscal year of out-of state Medicaid patients and the number of days it claims should be included – 208 days in 1990 and 74 in 1991. Exhibit P-5.

Third, the Provider argues that inpatient days for Medicaid-eligible patients that were denied and not paid should be allowed because the patients were eligible for Medicaid. The Provider presented a listing purporting to show the Medicaid denials by date, the number of days denied, and, in some instances, a reason for the denial. Exhibit P-6.

Fourth, the Provider presented evidence of a Medicaid-eligible patient whose stay spanned several fiscal years. Exhibit P-7 and Tr. at 137-138. The Provider asserts that Medicaid inpatient days for this patient would normally have been included in the fiscal year the patient was discharged; however, due to the extraordinary length of stay for this patient, the intermediary did not include the entire length of stay in the Provider's 1993 fiscal year. Tr. at 149-151. Instead, the Intermediary only allowed up to the number of days actually in that fiscal year. Id. As a result, the Provider seeks to claim the earlier days in their respective fiscal years. The Provider states that the settlement agreement reached in 1993 case was confidential and could not be admitted into this proceeding. Tr. at 151-152. The evidence concerning the special patient includes a remittance advice, a summary of charges and proof of the patient's eligibility for Medicaid. Exhibit P-7.

The Intermediary requests that the Board exclude Provider Exhibits P-5 through P-14 for being untimely with no good cause shown for not submitting them well inadvance of the scheduled hearing date. Tr. at 8. The Intermediary indicates that the Provider did not

respond to its requests for documentation and should not be allowed to submit new evidence that is at the heart of the substance of the issue at the very last minute. Tr. at 7-8. The Intermediary also argues that even if the new evidence is admitted, the Provider has not presented sufficiently auditable documentation to support its request for additional DSH days in the record created at the hearing. Tr. at 182-189. At best, it is a starting point in terms of the audit process to determine what might be included if it was remanded to the Intermediary. With respect to the state Medicaid audit adjustment report, the Intermediary indicates that it does not know if these days represent a timing or payment issue that really relate to a prior year – there is no clear information in the record. Tr. at 188. For the out-of-state Medicaid days, the Intermediary indicates that this list of days generated by the Provider is not supported by any remittance advices. Id. The same is true for the Provider-generated data with respect to denied Medicaid days. Id. There are a lot of questions that can be asked about the days for the patient's stay that spanned several fiscal years for which there are no answers. Tr. at 189. As a result, the Provider has failed to meet its burden of proof to include those days.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

The Intermediary's motion to exclude Exhibits P-5 through P-14 is granted because of the Provider's untimely submission of evidence without good cause and because the evidence submitted does not relate to the arguments presented in the Provider's position paper.

Board Instructions, Part II, Section B, Subsection IV(b), indicates that the parties' final position papers are expected to contain all documentary evidence and corroboration for the positions taken. In this case, the Provider's position paper only addressed the issue of eligible versus paid days. See, Provider Position Paper, July 17, 2003 at 5-10. The Provider's position paper did not contain any documentation concerning any eligible but unpaid days.

The Board observes that this case went through procedural steps that affected the composition of the providers in the group. Initially, there were a number of providers in the group from the state of Virginia and United Government Services was assigned as the lead intermediary. In a letter from the Board dated November 2, 2006, Exhibit I-5, the case was restructured so that the only provider remaining in the group appeal was Community Medical Center. A Notice of Hearing was subsequently sent to the Provider on November 17, 2006 setting this case for a hearing on October 2, 2007. Shortly, after the Notice of Hearing was sent, the lead Intermediary sent a letter to the Provider. See Intermediary Letter, November 28, 2006. In the letter, the Intermediary noted the upcoming hearing date and requested that the Provider submit a listing of the additional Medicaid eligible days they wished to claim so the Intermediary's review could be completed prior to the hearing. The Intermediary specifically requested that the Provider submit its data by December 27, 2006, Exhibit I-4.

The evidence in the record indicates that the Provider did not send any evidence to support its claim for additional Medicaid days until Friday, September 28, 2007 for the Tuesday, October 2, 2007 hearing. Tr. at 9. The Provider states that it received the letter requesting data, but did not respond in writing to the Intermediary to correct the situation, and only had contact with the Intermediary by telephone shortly before the pre-hearing conference. Tr. at 44-47 and 70-71. The Board observes that a Notice of Hearing was sent almost 11 months prior to the hearing date, that the Intermediary sent a request to the Provider to obtain documentation and that the Provider did not submit any evidence until immediately before the hearing. It is also noted that if the Provider had concerns regarding which intermediary should be handling the case, it did not take steps to resolve the matter with the Intermediary. The Board finds that there is no justification for the extremely late submission of evidence in this case.

CMS resolved the eligible versus paid days issue in HCFA Ruling 97-2 and, therefore, the purpose of this hearing should be to examine any days for which there was Medicaid eligibility but for whatever reasons those days were not paid for by the Medicaid program. The Board points out that most of the evidence presented by the Provider pertains to paid days, not eligible but unpaid days. The Board believes that the extremely late submission and the nature of that data submission being unrelated to the issue addressed in the position paper sufficiently disadvantages the Intermediary and justifies the granting of the Intermediary's motion.

In the event that the Board's decision to exclude Exhibits P-5 through P-14 from the record is overturned, the Board considered the merits of the evidence so it will not be necessary to remand the case. Each of the four categories of days is discussed below:

State Medicaid Audit Adjustment Report

The Provider presented an updated audit adjustment report from the state of Pennsylvania Medicaid agency that indicates that the original number of Medicaid days reported should be increase by 283.5 days in FYE 1990 and by 187 days in FYE 1991. The Provider requests that the DSH calculations be updated to include the corrected amount of days paid for these fiscal years. The Board finds that the Provider's DSH calculation should include all Medicaid days. The state Medicaid agency audit adjustment report represents an updated count of the Provider's actual Medicaid days paid in the fiscal years in question. While these days represent "paid" days, as opposed to "eligible but unpaid days," they none-the-less should be counted in the Provider's DSH calculation. The Board finds that the state's audit adjustment report is sufficient documentation that additional paid days should be added to the Provider's DSH calculation.

Out-of-State Days

The Provider argues that a large number of its Medicaid eligible patient days, that are paid for by out-of-state Medicaid agencies, were not included in the number of Medicaid days claimed on its cost report but should be counted in the DSH adjustment calculation. The Provider presented a listing by fiscal year of patients it claims are out-of state

Medicaid patients and the number of days that should be included. No testimonial or documentational evidence such as remittance advices was presented to support the fact that these claims were paid or to otherwise prove their Medicaid eligibility. The Board finds that the Provider did not present sufficient auditable documentation to support its claim for out-of-state Medicaid days.

Medical Assistance Denials

The Provider argues that inpatient days for Medicaid-eligible patients that were denied and not paid should be allowed because the patients were eligible for Medicaid. The Provider presented a listing purporting to show the dates of stay for the Medicaid denials, the number of days denied, and in some instances, a reason for the denial. There is no indication of the source of the data used to create the listing, and no testimony clarified any Board questions concerning what the data represents. The Board further notes that for many of the denied days, the reason provided is "lesser level of care;" it is unclear if this means that these patients were not eligible for inpatient care as opposed to eligible but not paid. The Board finds that the Provider did not submit sufficient auditable documentation to support its claim for Medical Assistance denied days.

Special Long Stay Patient

The Provider presented evidence of a Medicaid-eligible patient whose stay spanned several fiscal years. The Provider asserts that Medicaid inpatient days are normally included in the fiscal year in which the patient is discharged. However, due to the extraordinary length of this patient's stay, the Intermediary did not include the entire length of stay in the Provider's 1993 fiscal year when the stay ended. Instead, the Intermediary only allowed up to the number of days actually in that fiscal year. Tr. at 149-151. As a result, the Provider seeks to claim the remainder of days in the respective earlier fiscal years as well. While the basis of the Provider's claim for additional days may be valid, the Board finds that the Provider did not have evidence concerning the actions taken by the Intermediary in the 1993 case; Tr. at 151-152, however, there was evidence in the record that payments may have been made for this patient in earlier fiscal years. See, Remittance Advice for Patient 39 in Exhibit P-7 and Tr. at 155-156. Based on its review of the documentary evidence in the record, the Board was unable to determine the number of days allowed in FYE 1993, how many days should have been allowed in each of the earlier fiscal years, and whether any of the days paid in earlier fiscal years were included in the earlier State paid claims reports. Furthermore, the Provider offered no testimony clarifying the documentation submitted. The Board finds that the Provider did not submit sufficient auditable documentation to support its claim for additional days related to the special long stay patient.

DECISION AND ORDER:

The Board excludes Exhibits P-5 through P-14 due to their late submission without good cause and because the evidence submitted does not relate to the arguments presented in the Provider's position paper.

In the alternative, the Board finds that the state Medicaid agency audit adjustment report supports the Provider's claim for additional Medicaid days. The Board finds that the Provider did not submit sufficient documentation to support its out-of-state Medicaid days, Medical Assistance denied days and special long stay patient days.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A. (inactive)

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman

DATE: October 21, 2008