CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Norwalk Hospital	**Provider Cost Reimbursement Determination for Cost Year Ending: September 30, 2005**
Provider	
vs.	
BlueCross BlueShield Association/ National Government Services, Inc.	**Review of: PRRB Dec. No. 2012-D14 Dated: March 19, 2012**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period mandated in §1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. §1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The Provider commented, requesting that the Board's decision be affirmed. The Intermediary commented requesting that the Administrator reverse the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue is whether the Provider Reimbursement Review Board has jurisdiction over the Medicaid eligible days for which there was no adjustment made by the Intermediary within the Notice of Program Reimbursement (NPR).

The Board held that it has jurisdiction over the Provider's disproportionate share hospital (DSH) Medicaid eligible days issue and found that a total of 7,597 Medicaid eligible days would be allowable in the Provider's DSH calculation. The Board noted that the Intermediary challenged the Board's jurisdiction over the Medicaid eligible days issue because the Provider failed to claim the Medicaid eligible days on its cost report and therefore, the Intermediary did not make an adjustment to the Medicaid eligible days in

the NPR. With respect to Board jurisdiction, the Board found that, under the 1986 DSH Interim and Final Rules, an intermediary's finding on Medicaid patient days is a "determination" in and of itself (i.e., separate and distinct from the DSH adjustment decision process). The Board noted that if a hospital is dissatisfied with the intermediary's determination of its Medicaid days, the hospital can exercise it appeal rights in accordance with the regulations set forth in 42 C.F.R. Part 405. The Board then relied on several of its own rules with regard to framing issues for adjustments with multiple components.

Next, the Board found that HCFA Ruling 97-2 specifies that a hospital cannot report Medicaid day data that "cannot be verified by State records." In addition, the Board found that CMS, in implementing HCFA Ruling 97-2 and MMA §951, did not address how the practical impediment of the lack of availability and/or access to State data and the need to verify Medicaid eligibility may affect a Provider's appeal rights.[1]

The Board found that these practical impediments were similar to the legal impediment in *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399 (1988), where the U.S. Supreme Court found the Board had jurisdiction under §1878(a) of the Social Security Act. Thus, the Board found that the Court's holding in *Bethesda* allows jurisdiction in this case.

The Board noted that in 2008 CMS promulgated, as a Final Rule, 42 C.F.R. §405-1835(a)(1) to describe how a provider can preserve its rights to claim dissatisfaction and pursue a Board hearing. Noting that CMS describes the new §405.1835(a)(1)(ii) as "more akin simply to a presentment requirement" rather than "an exhaustion requirement, the Board found that under §405.1835(a)(1)(ii), the "presentment requirement" is not applicable to fiscal years that end prior to December 31, 2008, and thereby is not applicable to this case.

Finally, the Board concluded that in the cost report as filed in accordance with HCFA Ruling 97-2 and the regulations, the Provider used Medicaid days verified by the State and was dissatisfied that such days did not match its own records. Thus, the Board concluded that, since HCFA Ruling 97-2 prohibited reporting of days for patients that could not be verified by State records, Board jurisdiction is available under *Bethesda* for the difference being disputed.

SUMMARY OF COMMENTS

The Intermediary commented requesting reversal of the Board's decision concerning its jurisdiction over Medicare eligible days for which there was no adjustment made by the Intermediary within the NPR and, therefore, no adverse finding meeting the requirements of 42 C.F.R. §405.1801(a) and §405.1803. The Intermediary stated that the "repeated

[1] 51 Fed. Reg. at 31,457.

bites at the apple" that providers make by filing multiple, separate request to add eligible days for reimbursement must be addressed. The Intermediary contended that this review presents that opportunity.

The Intermediary commented that they relied on the number of paid and unpaid days reported by the Provider and that the Provider had ample time to establish a method for collecting the days or requesting the data from the appropriate State agency. In citing *Maple Crest Care Center*, PRRB Dec. 2003-D4 (November 7, 2002), the Intermediary commented that there was no impediment to an appropriate and timely re-opening request.

Moreover, the Intermediary contended the Board has not accurately applied the preamble language in 51 Fed. Reg. 31,454, 31,457 (Sept. 3, 1986, and, therefore, the Intermediary has requested that the Administrator review the meaning and significance of this regulation. The Intermediary commented that the Board references this *Federal Register* citation as a basis for exercising jurisdiction irrespective of whether the Intermediary has made any adjustment to Medicaid days or the DSH percentage. The Intermediary commented that this *Federal Register* only applies to interim payments and therefore, does not apply to the final DSH calculation. Finally, Intermediary referred to its Jurisdictional Brief in further support of its position.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Relevant to the jurisdictional issue raised in this case, the Medicare program provides for an additional payment to hospitals that serve a disproportionate share of low income patients that relies, in part, on Medicaid Inpatient days. The Medicaid program is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children.[2] The program is jointly financed by the Federal and State governments and administered by the States according to Federal guidelines.

Medicaid, under Title XIX of the Social Security Act, establishes two eligibility groups for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.[3] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) [42 USC 601 et seq.] and Supplemental

[2] Section 1901 of the Act.
[3] Section 1902(a)(10) (A) of the Act.

Security Income or SSI.[4] Participating States may elect to provide for payment of medical services to those aged blind or disabled individuals known as "medically needy" whose incomes or resources, while exceeding the financial eligibility requirements for the categorically needy (such as SSI recipient) are insufficient to pay for necessary medical care.[5]

In order to participate in the Medicaid program a State must submit a plan for medical assistance to CMS for approval. The State plan must specify, inter alia, the categories of individuals who will receive medical assistance under the plan and the specific kinds of medical care and services that will be covered.[6] If the State plan is approved by CMS, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.[7]

In addition to the medical assistance provided under Title XIX, the Social Security Amendments of 1965[8] established Title XVIII of the Social Security Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[9] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[10] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[11] However, concerned with increasing costs, Congress enacted Title VI

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[4] Relevant to this case, eligibility for SSI generally confers automatic eligibility for Medicaid. However, Congress allows States to retain more restrictive pre-1972 eligibility standards for determining whether new SSI recipients qualified for Medicaid under the State plan.

[5] Section 1902(a)(10)(C)(i) of the Act.

[6] *Id.* §1902 et seq. of the Act.

[7] *Id.* Within broad Federal rules States enjoy a measure of flexibility to determine "eligible" groups, types and range of services, payment levels for services, and administrative and operating procedures. In particular, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for medical assistance under the State plan.

[8] Pub. Law No. 89-97.

[9] Section 1811-1821 of the Act.

[10] Section 1831-1848(j) of the Act

[11] Under Medicare, Part A services are furnished by providers of services.

of the Social Security Amendments of 1983.[12] This provision added Section 1886(d) to the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[13] These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based diagnosis related group (DRG) subject to certain payment adjustments.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low income patients, pursuant to Section 1886(d)(5)(F)(i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for an additional payment amount for each subsection (d) [IPPS] hospital" serving "a significantly disproportionate number of low-income patients …."[14]

There are two methods to determine eligibility for a DSH adjustment, one of which is the "proxy method". To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage. That is, depending upon whether a hospitals is urban or rural a hospital most have a certain minimum "disproportionate share patient percentage" in order to be eligible for a disproportionate share payment. Section 1886(d)(5)(F)(vi) of the Act states that the term "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" and the "Medicaid low-income proxy" and, respectively, are defined as follows:

> (I) the fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act and the denominator of which is the number of such hospital's patients days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this title.

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[12] Pub. Law No. 98-21.

[13] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

[14] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See also 51 Fed. Reg. 16,772, 16,773-16,776 (1986).

> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patients days for such period which consists of patients who (for such days) were eligible for medical assistance under a State Plan approved under title XIX, but who were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital patients days for such period. (Emphasis added).

CMS implemented the provisions of the Act at 42 C.F.R. §412.106. The regulation explains the criteria to be eligible for payment and the calculation of the disproportionate share patient percentage at 42 C.F.R. §412.106. The first computation, the "Medicare/SSI proxy" is set forth at 42 C.F.R. §412.106(b)(2)(2005), and generally consists of a ratio of covered patient days furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation to total number of patient days that furnished to patients entitled to Medicare Part A. The second computation, the "Medicaid-low income proxy" is set forth at 42 C.F.R. §412.106(b)(4)(2005) and provides that:

> (4) Second computation. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
> (ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

CMS revised 42 C.F.R. §412.106(b)(4) to conform to HCFA Ruling No. 97-2, which was issued in light of Federal Circuit Court decisions disagreeing with CMS' interpretation of a certain portion of Section 1886(d)(5)(vi)(II) of the Act. Regarding HCFA Ruling 97-2,[15] CMS stated that:

> This Ruling announces the Health Care Financing Administration (HCFA) determination to change its interpretation of section 1886(d)(5)(F)(vi)(II) of the Social Security Act (the Act) and 42 CFR 412.106(b)(4) to follow the holdings of the United States Courts of Appeals for the Fourth, Sixth, Eighth, and Ninth Circuits. Under the new interpretation, the Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for those inpatient hospital services.
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> Although HCFA believes that its longstanding interpretation of the statutory language was a permissible reading of the statutory language, HCFA recognizes that, as a result of the adverse court rulings, this interpretation is contrary to the applicable law in four judicial circuits.
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> In order to ensure national uniformity in calculation of DSH Adjustments, HCFA has determined that, on a prospective basis, HCFA will count in the Medicaid fraction the number of days of inpatient hospital services for patients eligible for Medicaid on that day, whether or not the hospital received payment for those inpatient hospital services. This would not include days for which no Medicaid payment was made because of the patient's spenddown liability, because an individual was not eligible for Medicaid at that point.
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> Pursuant to this Ruling, Medicare fiscal intermediaries will determine the amounts due and make appropriate payments through normal procedures.

[15] *See also* CMS Transmittal A-01-1 (January 25, 2001) which provides: "Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid as described in this memorandum cannot be counted."

> Claims must, of course, meet all other applicable requirements. *This includes the requirement for data that are adequate to document the claimed days. The hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patient's inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed.* Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.[16] (Emphasis added).

During this period, CMS also spoke to the data requirements to receive disproportionate share payments for both interim payments and final payments with respect to the Medicare/SSI proxy and the Medicaid proxy. Originally, regarding the data necessary to receive a disproportionate share payment, the Secretary provided in the Federal Fiscal Year (FFY) 1986 IPPS interim rule that:

> The number of patient days of those patients entitled to Medicaid but not to Medicare Part A will be determined by the hospital's Medicare fiscal intermediary based on Medicaid statistical data reported on the hospital's Medicare cost report. Total Medicaid inpatient days will include all covered days attributable to Medicaid patients including any inpatient days for Medicaid patients who are members of a health maintenance organization.
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> Section 1886(d)(5)(F)(vi)(II) of the Act describes Medicaid patient days at those"… which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX … ." Therefore, Medicaid covered days will include only those days for which benefits are payable under title XIX. Any day of a Medicaid patient's

[16] The Ruling stated that: "For all cost reporting periods beginning on or after February 27, 1997, the Medicare disproportionate share adjustment will be determined by including in the calculation of the Medicaid fraction set forth in section 1886(d)(5)(F)(vi)(II) of the Act the additional days as set forth above. IV. EFFECTIVE DATE This Ruling is effective February 27, 1997." HCFA Ruling 97-2, (1997 WL 835500). CMS also issued a Memorandum dated June 12, 1997, which explained that: "Regardless of the type of allowable Medicaid days, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate document to substantiate the number of Medicaid days claimed…."

> hospital stay that is not payable by the Medicaid program will not be counted as a Medicaid patient day since the patient is not considered eligible for Medicaid coverage on those days. For example, if a patient is hospitalized for 15 days and is eligible for Medicaid benefits for 10 of those days, only the 10 covered days will be considered Medicaid patient days for purposes of determining a hospital's disproportionate patient percentage.
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> The process we will use for making payments to hospitals that serve a disproportionate share of lowincome patients will be similar to the process we use to make the additional payment for the indirect medical education costs; that is, we will make interim payments based on the latest available data subject to a year-end settlement on a cost reporting period basis. For purposes of making these interim payments, the initial determination of a hospital's eligibility for this payment will be made by the hospital's Medicare fiscal intermediary based on Medicaid statistical data as reported on the hospital's most recent cost report and the SSI and Medicare data to be supplied by HCFA central office. If a hospital disagrees with the intermediary's determination of its Medicaid patient days, it will be the hospital's responsibility to demonstrate to the intermediary that the Medicaid statistics reported on its cost report are incorrect or were improperly applied. Medicaid data submitted by the hospital, whether on the cost report or furnished subsequently, are subject to intermediary audit to ensure their accuracy.[17] (Emphasis added).

Subsequently, in the FFY 1987 final IPPS rule the Secretary stated that:

> Comment: One commenter was concerned about the lack of discussion in the interim final rule about how a hospital can apply for a disproportionate share adjustment. In particular, the commenter wants to know the means by which an adjustment is sought, the relative roles between HCFA and the fiscal intermediary, the time requirement for an application, and the criteria against which the application will be judged.
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> Response: It is not necessary for hospitals serving a disproportionate number of low income patients as defined under §412.106(b)(1) to formally apply for a disproportionate share adjustment. The Medicare fiscal intermediaries have been given instructions to make a determination concerning each hospital's eligibility for an adjustment under §412.106(b)(1) based on Medicaid data from the hospital's latest available cost report and the

[17] 51 Fed. Reg. 16,772, 16,777 (May 6, 1986) ("Medicare Program; Federal Fiscal Year 1986 Changes to the Inpatient Hospital Prospective Payment System, Interim final rule with comment period.")

> Supplemental Security Income (SSI)/Medicare percentages that have been supplied by HCFA central office. The intermediaries have reviewed the disproportionate share statistical data for each hospital they service and have begun making interim payments (subject to year-end settlement) for those hospitals that they have identified as disproportionate share hospitals.
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> As we stated in the interim final rule (51 FR 16777), hospitals may submit additional Medicaid and total patient day data to their fiscal intermediaries if they believe that their latest cost report does not accurately reflect these data. However, additional data supplied are subject to intermediary review and verification.
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> We are evaluating the need to publish regulations to outline procedures and requirements for hospitals to follow in applying for a disproportionate share adjustment based on the patient revenue criteria under section 1886(d)(5)(F)(i)(II) of the Act, as set forth in regulations at §412.106(b)(2).[18]

Thus, for purposes of receiving interim payments for DSH during a cost report period, and thus prior to the filing of that year's cost report, the Intermediary relies on the last filed cost report's historical data as a proxy for the current year data in order to make interim payments. To the extent that a provider may be experiencing a higher number of Medicaid inpatient days, as compared to the last filed cost report, the provider may present such data to the Intermediary to document the need for a higher interim payment.[19]

Regarding the implementation of certain documentation requirements set forth in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub Law No 108-173,) the Secretary stated in the FFY 2006 IPPS proposed rule that:

> Implementation of Section 951 of Pub. L. 108-173 (MMA)
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> Section 951 of Publ. L. 108-173 requires the Secretary to arrange to furnish the data necessary for hospitals to compute the number of patient days used in calculating the disproportionate patient percentages. The provision is not specific as to whether it applies to the patient day data used to determine the Medicare fraction or the Medicaid fraction. We are interpreting section 951

[18] 51 Fed. Reg. 31,457-58 (Sept 3, 1986) ("Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1987 Rates")

[19] Reading this text, the Board incorrectly concluded that CMS was referring to a final intermediary determination when CMS was in fact referring to an interim payment determinations based on historical data.

to require the Secretary to arrange to furnish to hospitals the data necessary to calculate both the Medicare and Medicaid fractions. With respect to both the Medicare and Medicaid fractions, we also are interpreting section 951 to require CMS to arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records, in the case of the Medicare fraction, against the CMS' records, and in the case of the Medicaid fraction, against the State Medicaid agency's records. Currently, as explained in more detail below, CMS provides the Medicare SSI days to certain hospitals that request these data. Hospitals are currently required under the regulation at §412.106(b)(4)(iii) to provide the data adequate to prove eligibility for the Medicaid, non-Medicare days.

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The numerator of the Medicaid fraction includes hospital inpatient days that are furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A. Under the regulation at §412.106(b)(4)(iii), hospitals are responsible for proving Medicaid eligibility for each Medicaid patient day and verifying with the State that patients were eligible for Medicaid on the claimed days. The number of Medicaid, non-Medicare days is divided by the hospital's total number of inpatient days in the same period. Total inpatient days are reported on the Medicare cost report. (This number is also available in the hospital's own records.)

Much of the data used to calculate the Medicaid fraction of the DSH patient percentage are available to hospitals from their own records or from the States. We recognize that Medicaid State plans are only permitted to use and disclose information concerning applicants and recipients for "purposes directly connected with the administration of the [State] plan" under section 1902(a)(7) of the Act. Regulations at 42 C.F.R. §431.302 define these purposes to include establishing eligibility (§431.302(a)) and determining the amount of medical assistance (§431.302(b)). Thus, State plans are permitted under the currently applicable statutory and regulatory provisions governing the disclosure of individually identifiable data on Medicaid applicants and recipients to provide hospitals the data needed to meet their obligation under §412.106(b)(4)(iii) in the context of either an "eligibility inquiry" with the State plan or in order to assist the hospital, and thus the State plan, in determining the amount of medical assistance.

In the process of developing a plan for implementing section 951 with respect to the data necessary to calculate the Medicaid fraction, we asked our regional offices to report on the availability of this information to hospitals and on any problems that hospitals face in obtaining the information that they need. The information we received suggested that, in

the vast majority of cases, there are established procedures for hospitals or their authorized representatives to obtain the information needed for hospitals to meet their obligation under §412.106(b)(4)(iii) and to calculate their Medicaid fraction. There is no uniform national method for hospitals to verify Medicaid eligibility for a specific patient on a specific day. For instance, some States, such as Arizona, have secure online systems that providers may use to check eligibility information. However, in most States, providers send a list of patients to the State Medicaid office for verification. Other States, such as Hawaii, employ a third party private company to maintain the Medicaid database and run eligibility matches for providers. The information that providers submit to State plans (or third party contractors) differs among States as well. Most States require the patient's name, date of birth, gender, social security number, Medicaid identification, and admission and discharge dates. States or the third parties may respond with either "Yes/No" or with more detailed Medicaid enrollment and eligibility information such as whether or not the patient is a dual-eligible, whether the patient is enrolled in a fee-for-service or HMO plan, and under which State assistance category the individual qualified for Medicaid.[FN4]

((FN4) Bear in mind that States and hospitals should, in keeping with the HIPAA Privacy Rule, limit the data exchanged in the context of these inquiries and responses to the minimum necessary to accomplish the task.)

We note that we have been made aware of at least one instance in which a State is concerned about providing hospitals with the requisite eligibility data. We understand that the basis for the State's objections is section 1902(a)(7) of the Act. The State is concerned that section 1902(a)(7) of the Act prohibits the State from providing eligibility data for any purpose other than a purpose related to State plan administration. However, as described above, we believe that States are permitted to verify Medicaid eligibility for hospitals as a purpose directly related to State plan administration under §431.302.

In addition, we believe it is reasonable to continue to place the burden of furnishing the data adequate to prove eligibility for each Medicaid patient day claimed for DSH percentage calculation purposes on hospitals because, since they have provided inpatient care to these patients for which they billed the relevant payors, including the State Medicaid plan, they will necessarily already be in possession of much of this information. We continue to believe hospitals are best situated to provide and verify Medicaid eligibility information. Although we believe the mechanisms are currently in place to enable hospitals to obtain the data necessary to calculate their Medicaid fraction of the DSH patient percentage, there is currently no

> mandatory requirement imposed upon State Medicaid agencies to verify eligibility for hospitals. At this point, we believe there is no need to modify the Medicaid State plan regulations to require that State plans verify Medicaid eligibility for hospitals. However, should we find that States are not voluntarily providing or verifying Medicaid eligibility information for hospitals, we will consider amending the State plan regulations to add a requirement that State plans provide certain eligibility information to hospitals.[20] (Emphasis added).

The Secretary stated in the FFY 2006 IPPS final rule that:

> 4. Calculation of the Medicaid Fraction
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> In addition, *we believe it is reasonable to continue to place the burden of furnishing the data adequate to prove eligibility for each Medicaid patient day claimed for DSH percentage calculation purposes on hospitals because, since they have provided inpatient care to these patients for which they billed the relevant payers, including the State Medicaid plan, they will necessarily already be in possession of much of this information. We continue to believe hospitals are best situated to provide and verify Medicaid eligibility information.* Although we believe the mechanisms are currently in place to enable hospitals to obtain the data necessary to calculate their Medicaid fraction of the DSH patient percentage, there is currently no mandatory requirement imposed upon State Medicaid agencies to verify eligibility for hospitals. At this point, we continue to believe there is no need to modify the Medicaid State plan regulations to require that State plans verify Medicaid eligibility for hospitals. However, should we find that States are not voluntarily providing or verifying Medicaid eligibility information for hospitals, we will consider amending the State plan regulations to add a requirement that State plans provide certain eligibility information to hospitals. (Emphasis added).
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> Comment: Several commenters encouraged CMS to amend the Medicaid State plan requirements to require States to furnish Medicare eligibility data to requesting hospitals. Several commenters believed that variability in how State Medicaid agencies collect and manage Medicaid data make the process to convert and match hospital records to State Medicaid records extremely time-consuming and complex. The commenter believed that requiring every State to report Medicaid eligibility data in the same manner would decrease hospitals' administrative work. Several other commenters suggested that

[20] 70 Fed. Reg. 23,306, 23,434-35 (May 4, 2005) ("Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates")

> CMS not make any change to the States' requirements at this time, but continue to consider this idea as an option for the future. Another commenter suggested that CMS amend the State plan requirements to include a requirement that the States must make Medicaid eligibility information available in a timely manner, such as 90 days after receipt of a hospital's request. This commenter believed that States should be prohibited from charging hospitals a fee for accessing the data. Several commenters suggested that CMS modify the Medicaid State plan requirements to require that any contract between the State Medicaid agency and an MCO specify that the MCO would be required to submit reliable utilization data to the State to verify managed care days/patients.
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> Response: We are dedicated to working with the State Medicaid agencies to ensure that hospitals have access to data to verify Medicaid eligibility. While the commenters expressed concern that some hospitals find it burdensome to adapt the Medicaid eligibility data available from the States to their records, we do not believe these types of data processing concerns are significant enough to warrant changes to the State plan requirements. We are also aware that not all State agencies have the resources available to modify their systems in a standardized way. We note that the Center for Medicaid and State Operations in CMS has communicated CMS' expectation of compliance with hospitals' requests for Medicaid eligibility information to the State Medicaid agencies. If the State Medicaid agencies refuse to provide data to enable hospitals to calculate their DSH Medicaid fraction and meet their obligations under our regulations at §412.106(b)(4)(iii), we will consider amending the Medicaid State plan requirements to require the State agency to release the information to the requesting hospitals.[21]

Notably, the MMA provision as implemented by CMS continued to require providers to furnish adequate data to prove eligibility for each Medicaid Day "claimed" for the DSH percentage. That is, CMS specifically requires Providers to verify that the days "claimed" on the cost report should be counted by the Intermediary in calculating eligibility for and the amount of the DSH payment.

The cost reporting process arises from the authority set forth, inter alia, under section 1815(a) of the Social Security Act, which provides:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services

[21] 70 Fed. Reg. 47,278, 47,438-49 (August 12, 2005)("Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006" Final Rule.)

> furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly)…., from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

Consequently, Medicare providers are required to file cost reports annually.[22] After receipt of the cost report, the Intermediary issues a Notice of Program Reimbursement or "NPR", which reflects a determination by the intermediary of the total amount due the Provider. Both the statute and regulation provide a mechanism for providers to appeal such a determination if certain criteria are met. Section 1878(a) of the Social Security Act provides that:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board… and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1886 and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—
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> (1) such provider —
> (A)(i) is dissatisfied with a final determination[23] of the organization serving as its fiscal intermediary…as to the amount of total program

[22] 42 C.F.R. §413.24.

[23] A "final determination" is not defined in the Act, but is defined in the regulation at 42 C.F.R. §405.1801(2005). Section 405.1801(a)(3) states that for the purposes of appeal to the Board, "intermediary determination" is synonymous with "intermediary's final determination" and "final determination of the Secretary" as those latter two terms are used in section 1878 of the Act. Section 405.1801(a)(1) defines "intermediary determination," with respect to the cost reimbursement system, as: A determination of the amount of total reimbursement due the provider pursuant to §405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

> reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report, or
> (ii) is dissatisfied with a final determination[24] of the Secretary as to the amount of payment under subsection (b) or (d) of section 1886…
> (2) the amount in controversy is $10,000 or more, and
> (3) such provider files a request for hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination….

An "intermediary's final determination," is represented by a Notice of Program Reimbursement or NPR which is issued after the close of the provider's cost reporting period and the provider's submission of a timely cost report. 42 C.F.R. §405.1803 explains that upon receipt of the cost report the Intermediary will furnish within a reasonable period of time a notice reflecting the total amount of reimbursement due the provider. Pursuant to, inter alia, paragraph (b) the Intermediary must include in each notice appropriate reference to the law, regulation, CMS Rulings or program instructions to explain why the Intermediary "determination of the amount of program reimbursement differs from the amount claimed."

In implementing section 1878 of the Social Security Act, the regulations at 42 C.F.R. §405.1835 (2005) state in relevant part:

> (a) Criteria. The provider (but no other individual, entity, or party) has a right to a hearing before the Board about any matter designated in §405.1801(a)(1), if:
> (1) An intermediary determination has been made with respect to the provider; and
> (2) The provider has filed a written request for a hearing before the Board under the provisions described in §405.1841(a)(1); and
> (3) The amount in controversy (as determined in §405.1829(a)) is $10,000 or more.

The regulations at 42 C.F.R. §405.1841 (2005) state in relevant part:

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[24] 42 C.F.R. §405.1801(a)(2) states that, with respect to a hospital that receives payments for inpatient hospital services under the prospective payment system, (part 412 of this chapter, an intermediary determinations, means: [T]he total amount of payment due the hospital, pursuant to §405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the determination."

> (a) General requirements.
> (1) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in §405.1835(c). *Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied*, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position.

Thus, by law, the criteria for Board jurisdiction includes that a provider must demonstrate that it is "dissatisfied" with the amount of program reimbursement. With respect to the issue of "dissatisfaction" under Section 1878(a)(1), the United States Supreme Court in *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399 (1988), stated:

> The submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.

However, the Court in *Bethesda*, recognized a distinction between a Provider that self-disallowed a claim pursuant to a Medicare regulation that it intended to challenge before the Board and a Provider that failed to claim all reimbursement to which it was entitled to under the regulations. Drawing the distinction the Court stated:

> Thus, petitioners stand on different grounds than do providers who bypass a clearly prescribed exhaustion requirement or who fail to request from the intermediary, reimbursement for all costs to which they are entitled under applicable rules. While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.

This language in *Bethesda* recognizes that a hospital that does not request reimbursement for all of the costs to which it is entitled to be reimbursed on its cost report does not meet the necessary dissatisfaction requirement for Board jurisdiction.[25]

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[25] The Administrator recognizes that two Court of Appeals decisions, in circuits other than where this Provider is located, have reached conclusions contrary to CMS' application of both section 1878 and the ruling in *Bethesda* with respect to the dissatisfaction criteria.

The issue in this case is whether the Provider is able to demonstrate that it meets the dissatisfaction requirement necessary for Board jurisdiction over the DSH Medicaid eligible days issue. The Provider acknowledged, in the "Provider's Model Form A - Individual Appeal Request", dated January 21, 2009, that there was no adjustment relating to its claim for Medicaid days. The Provider stated in its appeal request that:

> Issue 2: Disproportionate Share Hospital Payment - Hospital's Medicaid Eligible Days
>
> Description of the Issue
> Whether the Intermediary properly excluded Medicaid eligible days from the DSH calculation.
> Statement of the Legal Basis
> The Provider contends that the Intermediary did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR §412.106(b) of the Secretary's Regulations. The Intermediary, contrary to the regulation, failed to include all Medicaid eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> The Provider contends that its finalized cost report did not accurately reflect its Medicaid paid and unpaid eligible days. The information obtained from the State of Connecticut agencies did not reconcile with the Provider's underlying records. The finalized Medicaid days total did not include paid and eligible days adjudicated and processed after the cutoff date, used by the Intermediary, and did not include all out of State paid and eligible days.
>
> Audit Adjustment Number(s): Self Disallowed. See Tab. 4.
> Estimated Reimbursement Amount: $663,000. See Tab. 5.

Pursuant to the "Provider's Model Form A - Individual Appeal Request" at Tab 4 of the request for a hearing, the Provider stated:

> TAB 4 - APPLICABLE AUDIT ADJUSTMENT REPORT PAGES

MaineGeneral Medical Center v. Shalala, 205 F.3d 493 (1 st Cir. 2000) and *Loma Linda University Medical Center v. Leavitt*, 492 F.3d 1065 (9 th Cir. 2007).

> 7.2[26] - Self-Disallowed Items
> A. Authority Requires Disallowance
> The cost report did not contain specific audit adjustments related to Medicare Disproportionate Share ("DSH") because it did not qualify for DSH pursuant to 42 C.F.R. §412.106 at the time of filing or audit of the cost report. Therefore, the issues were self-disallowed.

The cost report worksheets comparing the as-filed cost report and the finalized cost report show there was no adjustment on the finalized cost report as the Intermediary accepted the number of Medicaid days submitted by the Provider on Worksheet S-3, Part I of the as-filed cost reported filed March 31, 2006.[27] For example, both the as-filed and final cost report shows 4,736 Medicaid days claimed and allowed for Adult and Pediatrics. The stipulation states that the Provider submitted in its appeal a claim for 7,868 Medicaid days as part of the DSH calculation. As shown in the Provider's "DSH Calculation" in its January 27, 2011 final position paper, the 7,868 Medicaid days in the stipulation are "total days" that the Provider states should be counted and not days "in addition" to those already claimed on the cost report. Thus, the Provider apparently failed to claim approximately 3,000 Medicaid days.

The Provider alleged it self-disallowed within the spirit of Bethesda thus allowing for jurisdiction. The Provider also stated that the State listing of Medicaid days is not always available at the time of filing the cost report and that CMS stated hospitals need not formally apply for a DSH adjustment. Therefore, the Provider claimed it may demonstrate dissatisfaction with the intermediary's determination of reimbursement despite not having made a claim for the days on the cost report.[28] The Provider argued it was dissatisfied because the finalized cost report did not accurately reflect its Medicaid paid and unpaid eligible days compared to a State list of days. The Board similarly stated that "the Provider

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[26] Rule 7.2 refers to the "PRRB Filing and Issue Statement and Claim of Dissatisfaction." The Board rules cannot confer jurisdiction beyond that granted under section 1878 of the act and 42 CFR 405.1801 *et seq.*

[27] See Intermediary Jurisdictional Challenge at Exhibit I-1(Audit Adjustment Report); I-2 (copy of Provider's as-filed cost report showing e.g. Total Adult and Peds Title XIX line 5 as 4,736 days; Exhibit I-3, (final settled cost report showing Title XIX Adult and Peds line 5 as 4,736 days.)

[28] The Provider suggests it also "self-disallowed", as it did not qualify for the DSH payment at the time of filing for its cost report. However, the Provider does not challenge the qualifying regulatory or statutory criteria. In addition, the Provider also referenced (without citation) prior Board jurisdictional decisions on this issue that supports this position. The Administrator was not on notice of the PRRB decisions in Brookville Regional Hospital, PRRB Case No. 07-2806 and Middlesex Hospital, PRRB Case No. 07-1989, and, therefore, they were not subject to Administrator review. See Intermediary Exhibits I-9 and I- 10.

used the Medicaid days verified by the State" and "is dissatisfied that such days did not match its own records." On its face, both the Board and the Provider acknowledged that the Provider was dissatisfied with its own reporting of Medicaid days. The Administrator concludes that the Provider failed to demonstrate that it was dissatisfied with the Intermediary's determination of the number of its Medicaid days.[29]

The Administrator notes that in this instance the Provider omitted approximately 40 percent of its Medicaid days which would seem to indicate an issue with the Provider's in-house method of accurately capturing these days and the collection of accurate historical data from which estimates could be derived and a baseline measure of the accuracy of its reporting could be made.[30] The Provider also submitted no documentation to support its claim that it was impossible to obtain the necessary data in time to file a claim for these days on its cost report, thereby justifying a practical impediment basis for Board jurisdiction in this case.[31] The record does not demonstrate whether the Provider

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[29] Regarding the 2008 rule, the Board noted that the preamble at 73 Fed. Reg. 30,190, 30,194 (May 23, 2008). (Final Rule) stated: "We acknowledge that there may be instances in which a provider may be uncertain as to whether Medicare payment is incorrect because it does not have access to underlying data (for example, data from a State agency). Accordingly, we have revised §405.1811(b)(2)(i) and §405.1835(b)(2)(i) to allow a provider to explain why it is unable to determine whether payment is correct as a result of not having access to underlying information." However, the Administrator finds that this discussion of §405.1811(b)(2)(i) and §405.1835(b)(2)(i), must be read consistent with the extensive discussion on "self disallowance and protesting claims and thus presupposes that a provider has submitted a claim for costs to the Intermediary, consistent with the policy set out therein, and the foregoing discussion does not negate that requirement.

[30] To collect accurate historical data requires that the Provider consistently and annually identify the number of Medicaid days in prior periods. Interim payments, themselves, are based on historical data supplemented by current cost reporting data as requested and supplemented by a provider.

[31] The foregoing CMS pronouncements in *Federal Registers*, CMS Rulings and Program Memorandum regarding State Medicaid data all relate to the requirement that a Provider has the burden to furnish data verifying the patient days "claimed" in order to receive payment (i.e., Providers are required to use State data to verify those days which were reported on the cost report in order for the Intermediary to "count" it in the DSH calculation) and does not address the timing of that verification except that such data is required for the day to be "counted" for payment by the Intermediary. Technically, CMS did not state in HCFAR 97-2 that the State data is required to file a claim for these days, but stated that such "claimed" days must be verified to be "counted" by the Intermediary in the DSH calculation. As noted, HCFAR 97-2 stated: "*As the intermediaries may require*, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for

used due diligence in establishing methods of accurately capturing these days; and requesting and following up to obtain the State listings. The record shows that the Provider claimed approximately 60 percent or at least 4,786 of these days on its cost report prior to receipt of the State verification of the total 7,597 days (which includes the verification of the 4,786 days) in the State listing.[32] The Provider did not explain the difference in these days from those it did not claim (i.e., whether it had State verification for these days other than the State listing at issue when it filed or whether it relied upon its internal recordkeeping for those days.)[33]

Moreover, even assuming *arguendo* that there could be a practical impediment to claiming all the costs for which one is entitled to receive payment that could rise to the level of a Bethesda-type self disallowance, the facts in this case do not demonstrate such practical impediment existed here. As noted, the Provider did not submit any evidence as to the internal methods it used to accurately capture all Medicaid days, nor the actions it took to acquire the State day listing and thus did not demonstrate that there existed in fact a practical impediment to claiming these days. Moreover, for similar reasons even if, (again assuming *arguendo*,) that there was jurisdiction under section 1878(a) pursuant to a *Loma Linda* analysis, the exercise of discretionary jurisdiction would not be justified under paragraph (d) in light of the lack of evidence of the Provider's due diligence in attempting to timely and accurately claim these days on the cost report.

Medicaid cannot be counted." In addition, CMS Program Memorandum Transmittal A-01-141 (December 14, 2011) was issued to clarify CMS expectations on the audit and settlement of cost reports. The Transmittal sets out the timeframes for providers to submit documentation for auditing after submission of the cost report and the Medicare cost report submission requirements and the requirements for a complete cost report.

[32] The record shows an electronic mail from a consultant to the Provider, dated January 13, 2011, (see attachment to Provider's January 27, 2011 final position paper), indicating a reopening request for FY 2005 was intended to be sent to the Intermediary. The record does not show whether a timely reopening request was in fact made. CMS Program Memorandum Transmittal A-01-141 states that: "The Intermediary is to "Consider the provider's culpability in failing to submit proper supporting documentation on a timely basis when you are rendering a decision on the allowability of a reopening and when prioritizing issues for administrative resolution if a timely appeal is filed."

[33] That is, the Provider seems to raise two different issues: a claim that it could not file the cost report with any Medicaid days without State verification and, concurrently, a claim that it did not know about certain days until receiving the State listing.

DECISION

The Administrator finds the Board does not have jurisdiction over Provider's request for a hearing regarding the issue of Medicaid eligible days. Therefore, the decision of the Board is vacated with respect to Medicaid eligible days issue consistent with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 5/21/12

/s/
Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services