PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

On the Record
2024-D01

PROVIDER–
Sacred Heart Hospital

Provider No.:
39-0197

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc. – (J-L)

RECORD HEARING DATE –
September 29, 2023

Fiscal Year Ending –
June 30, 2010

Case No. –
14-2200

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor's determination of the Provider's disproportionate share hospital ("DSH"') payment for fiscal year ("FY") 2010 should be revised to include additional Medicaid patient days that were excluded from the numerator of the Medicaid fraction.[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the FY 2010 DSH calculation for Sacred Heart Hospital ("Sacred Heart" or "Provider") should be revised to include an additional 174 Medicaid-eligible days in the numerator of the Medicaid fraction. Accordingly, the Board remands this appeal to the Medicare Contractor to revise Sacred Heart's FY 2010 cost report to add an additional 174 Medicaid-eligible days to the number of Medicaid-eligible days on Worksheet S-3, Part I, Column 5, Line 2. This revision will increase the total from 2,964 to 3,138 and result in an estimated increase of Sacred Heart's FY 2010 disproportionate share percentage from 14.99 percent to 15.69 percent on Worksheet E, Part A, Line 4.03.

STATEMENT OF FACTS AND PROCEDURAL HISTORY

Sacred Heart is an acute care hospital paid under Medicare's inpatient prospective payment system ("IPPS"). The period at issue in this appeal is FY 2010. Sacred Heart's designated Medicare contractor[2] is Novitas Solutions ("Medicare Contractor").[3]

On August 16, 2013, the Medicare Contractor "issued a Notice of Program Reimbursement ("NPR") for this cost reporting period [to the Provider]."[4] By letter dated January 30, 2014, the Provider timely filed this appeal with the Board seeking to include the additional Medicaid-eligible days in the numerator of the DSH Medicaid fraction.[5]

On September 29, 2023, the parties submitted Stipulations and a Consent Request for a Hearing on the Record. The parties stipulated, in part:

> 4. The parties have now reached an agreement on the cost report adjustments necessary to resolve this appeal. Attached as Exhibit 1 to this stipulation is a copy of the MAC's audit adjustment report reflecting the parties' agreement. The agreed upon adjustments would add 174 Medicaid-eligible days to the Provider's number of Medicaid-eligible days on Worksheet S-3, Part I, Column 5, line 2, increasing the number from 2,964 to 3,138,

[1] Stipulations and Consent Request for a Hearing on the Record (hereinafter "Stip.") (Sept. 29, 2023) at ¶ 1.
[2] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[3] Medicare Contractor's Final Position Paper (Aug. 7, 2023) (hereinafter "Contractor's FPP") at 2.
[4] Stip. at ¶ 2.
[5] *Id.* at ¶ 3.

and would increase the Provider's disproportionate share percentage from 14.99% to 15.69% on Worksheet E, Part A, Line 4.03.

5. Notwithstanding the agreement on the necessary adjustments, the MAC believes that it is unable to enter into an administrative resolution at this time due to binding instructions from CMS precluding any MAC adjustment to the Provider's Disproportionate Patient Percentage or DSH payment calculations for periods prior to October 1, 2013.

6. Due to the binding instructions from CMS referenced in stipulation five, above, the parties have come to an agreement on resolving this appeal but are unable to sign an administrative resolution at this time.[6]

On September 29, 2023, the Board granted the Record Hearing Request and issued the Notice of Hearing on the Record.

STATUTORY AND REGULATORY BACKGROUND

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the Inpatient Prospective Payment System ("IPPS").[7] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[9] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[10]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[11] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment that should be paid to a qualifying hospital.[12] The DPP is defined as the sum of two fractions expressed as percentages.[13] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both fractions consider whether a patient was "entitled to benefits under part A."[14]

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[6] *Id.* at ¶¶ 4-6.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See e.g.* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.l06(d).
[13] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(vi).
[14] *See e.g.* 42 C.F.R. § 412.106(b)(3) & (4).

The fraction at issue in this case is the Medicaid fraction, which the statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) defines as:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[15]

The DSH regulation at 42 C.F.R. § 412.106(b)(4) (2009) requires the Medicare Contractor to calculate the Medicaid fraction for a hospital's cost reporting period by "determin[ing] . . . 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."

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

As noted above, the issue in this appeal is whether the Provider's DSH payment for the FY 2010 should be revised to included additional patient days that were excluded from the numerator of the Medicaid fraction. The parties have agreed to the following stipulation to resolve this issue:

> The agreed upon adjustments would add 174 Medicaid-eligible days to the Provider's number of Medicaid-eligible days on Worksheet S- 3, Part I, Column 5, line 2, increasing the number from 2,964 to 3,138, and would increase the Provider's disproportionate share percentage from 14.99% to 15.69% on Worksheet E, Part A, Line 4.03.[16]

However, the parties further stipulated that "the [Medicare Contractor] believes that it is unable to enter into an administrative resolution at this time due to binding instructions from CMS precluding any [Medicare Contractor] adjustment to the Provider's Disproportionate Patient Percentage or DSH payment calculations for periods prior to October 1, 2013."[17]

Consistent with 42 C.F.R. § 412.106(b)(4) *and* based on the Board's finding of jurisdiction, the parties' stipulations, the parties' agreement to conduct a hearing on the record, and the record before the Board, the Board accepts the data in ¶ 4 of the Stipulations and finds that the cost reporting period's DSH calculation for the Provider should be revised to include an additional 174 Medicaid-eligible days in the numerator of the Medicaid fraction. Accordingly, the Board remands this appeal to the Medicare Contractor with direction to apply the proposed audit adjustments reflected in and attached to the Stipulations agreed to by the parties, and to make the additional DSH payment calculated for the cost reporting period as a result of those adjustments.

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[15] (Emphasis added.)
[16] Stip. at ¶ 4.
[17] *Id.* at ¶ 5.

Specifically, the Board directs the Medicare Contractor to add an additional 174 Medicaid-eligible days to the number of Medicaid-eligible days on the Provider's settled cost report at Worksheet S-3, Part I, Column 5, Line 2. This adjustment would, thereby, increase the figure reported from 2,964 days to 3,138 days and result in an estimated increase in the Provider's disproportionate share percentage on the Provider's settled cost report at Worksheet E, Part A, Line 4.03 from 14.99 percent to 15.69 percent.[18]

DECISION AND ORDER

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the FY 2010 DSH calculation for the Provider should be revised to include an additional 174 Medicaid-eligible days in the numerator of the Medicaid fraction. Accordingly, the Board remands this appeal and directs the Medicare Contractor to revise the Sacred Heart's FY 2010 cost report to add an additional 174 Medicaid-eligible days to the number of Medicaid-eligible days on Worksheet S-3, Part I, Column 5, Line 2. This revision will increase the total from 2,964 days to 3,138 days and result in an estimated increase in Sacred Heart's FY 2010 disproportionate share percentage on Worksheet E, Part A, Line 4.03 from 14.99 percent to 15.69 percent.

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

10/23/2023

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[18] *Id.* at ¶ 4.