

**PROVIDER REIMBURSEMENT REVIEW BOARD  
HEARING DECISION**

2003-D14

**PROVIDER –**  
Ingham Regional Medical Center

Provider No. 23-0167

**vs.**

**INTERMEDIARY –**  
United Government Services, LLC-WI



**DATE OF DECISION-**  
November 7, 2002

Cost Reporting Periods Ended-  
December 31, 1992

**CASE NO.** 96-1951

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Provider's Representative: Kenneth R. Marcus, Esq., West Bloomfield, Michigan  
Intermediary's Representative: Linda Swiderski, United Government Services  
(Wisconsin)

The decision set forth below involves the question of whether the Board has jurisdiction over the calculation of the disproportionate share adjustment where the issue is added to the appeal of an original Notice of Program Reimbursement.

### Background

From the Medicare program's inception in 1965 until 1983, hospitals were reimbursed the lower of their reasonable costs or customary charges for services provided to Medicare beneficiaries. 42 U.S.C. § 1395f (b)(1). In 1983, Congress established the Prospective Payment System (PPS), under which most acute care hospitals would be reimbursed on a prospectively determined rate for each Medicare inpatient, based upon the patient's diagnosis and other factors. 42 U.S.C. § 1395ww(d).

Because Congress was concerned about possible Medicare payment inequities for PPS hospitals that treat a disproportionate share of low-income patients, it directed the Secretary of the Department of Health and Human Services to provide for an additional payment amount for PPS hospitals serving a significantly disproportionate number of low-income patients. 42 U.S.C. § 1395ww(d)(5). This is referred to as the DSH calculation.

In the mid-1990's a controversy arose over the Health Care Financing Administration's (HCFA's, now the Centers for Medicare & Medicaid Services) application of the DSH formula. HCFA's regulation governing a provider's DSH calculation in effect during this fiscal year end referred to the "number of patient days furnished to patients entitled to Medicaid." 42 C.F.R. § 412.106(b)(4)(1992). In applying the statute and regulation, HCFA's interpretation substituted the concept of payment and coverage by Medicaid for each day of care for the statutory standard of "eligibility" for Medicaid coverage. However, in Health Care Financing Administration Ruling (HCFAR) 97-2 (February 27, 1997), the Agency changed its prior policy of including in the DSH calculation only inpatient days of service which were actually paid by a Medicaid plan. HCFA's change in interpretation was in recognition of the holdings on this issue in the United States Courts of Appeals in the Fourth, Sixth, Eighth, and Ninth circuits, which rejected HCFA's prior interpretation of including only patient days paid by Medicaid.

The Ruling also addressed how intermediaries were to deal with those providers whose cost reports had been previously settled or that had appeals pending. The relevant language of the ruling at issue in this jurisdictional challenge is as follows:

We will not reopen settled cost reports based on this issue.  
For hospital cost reports settled by fiscal intermediaries on or

after the effective date of this ruling, these days may be included. For hospital cost reports which have been settled prior to the effective date of this ruling, but for which the hospital has a jurisdictionally proper appeal pending on this issue pursuant to 42 C.F.R. § 405.1811 or 405.1835, these days may be included for purposes of resolving the appeal.

#### HCFA Ruling 97-2.

The Provider filed this appeal on March 20, 1996, from a Notice of Program Reimbursement dated September 28, 1995. The Provider appealed a number of issues including an adjustment to the disproportionate share (DSH) calculation that was not related to the question of reimbursement for the Medicaid eligible days component of the DSH calculation. On August 20, 1997, the Provider requested to add the issues of whether it was entitled to reimbursement for all Medicaid patients for which such patients were eligible for Medicaid (DSH/eligible days). Subsequently, the parties reached a settlement and the case was withdrawn. However, when the settlement agreement was not implemented, the case was reinstated pursuant to the Board's procedures. In its reinstatement request, the Provider once again added the issue of DSH/eligible days to the appeal. The Intermediary objected to the Board's jurisdiction over the DSH/eligible days issue.

#### Intermediary's Position

The Intermediary's position is that the Provider did not have a jurisdictionally proper appeal on the issue of DSH/eligible days prior to the issuance of the HCFAR 97-2 or within 180 days of the ruling dated February 27, 1997. Consequently, the Intermediary believes the prospective nature of the ruling deprives the Board of jurisdiction.

The Intermediary views the issue as whether the HCFAR 97-2 prevents the Board from ordering a reopening of the cost report to revise the DSH calculation. The Intermediary also cites Monmouth Medical Center v. Thompson, 257 F.3d 807 (D.C. Cir. 2001) (Monmouth) for the proposition that the Board lacks jurisdiction over denials of reopening of the cost report and cannot order reopenings over the DSH/eligible days issue. The Intermediary notes that the cost report was settled in September of 1995, and since that time, the Provider has not requested a reopening based on the ruling.

The Intermediary also contends that the issue cannot be added to the appeal because it is not a self-disallowance that may be appealed absent a cost report claim under the decision in Bethesda Hospital Association v. Bowen, 180 S.Ct. 1255 (1988) (Bethesda). The Intermediary contends that the Provider could not have known at the time it filed its cost report that the exclusion of DSH/eligible days was actually a self-disallowance because it was not until later that the Provider would know the costs would be allowed. The

Intermediary also references the settlement agreement for the proposition that the DSH eligible days would not be included in the DSH issue appealed to the Board.

#### Provider's Position

The Provider argues that the DSH/eligible days issue is a self-disallowed cost to which the decision in Bethesda applies and that it can add the DSH/eligible days issue to the appeal under the provisions of 42 C.F.R. § 405.1841(a)(1) at any time. The Provider maintains that it filed its cost report in accordance with the law in effect at the time, which was to exclude all eligible days in excess of those paid by the State's Medicaid policy. The Provider believes that the Intermediary's position irrationally requires the Provider to foresee a change in the law implemented through HCFAR 97-2 in order to claim a self-disallowed cost.

The Provider also contends that the Board should find that the DSH/eligible days issue was properly added to the appeal based on the language of 42 C.F.R. § 405.1841(a)(1) that permits issues to be added to pending appeals. The Provider does not believe that there is any obstacle to adding an issue to an appeal when a reinstatement has been requested. The Provider also contends that it did not waive its appeal rights by entering into a settlement agreement.

The Provider notes that the Intermediary poses a restriction on the Board's jurisdiction by characterizing the Provider's request for DSH reimbursement as a request for reopening. The Provider asserts that the appeal of this issue does not equate to a request to reopen.

Further, the Provider contends the settlement agreement merely acknowledges the Intermediary's refusal to resolve the DSH/eligible days issue in the administrative resolution. The Provider points out that HCFAR 97-2 does not address whether a provider has the right to add the DSH issue to pending appeals.

#### Findings of Fact, Conclusions of Law and Discussion

The Board concludes that it has jurisdiction over the DSH/eligible days issue.

The Board finds that the parties made a material error of fact in their contentions that the DSH/eligible days issue was not added to the appeal within the time frames the Intermediary argues are applicable. The Board's records reflect that the DSH/eligible days issue was added to the appeal on August 20, 1997, at the Provider's written request. Consequently, if the Board accepted the Intermediary's argument that the DSH/eligible days issue must be added to the appeal within 180 days of the issuance of HCFAR 97-2, the Provider would have met the requirements. The Board finds, however, that the ruling is not a final determination and does not trigger the 180 day appeal period. See, Monmouth, supra at 811-812 (HFCAR 97-2 is not a final determination).

The Board finds that the DSH/eligible days issue is a self-disallowed cost to which the decision in Bethesda applies. Further, the Board finds that the DSH/eligible days issue can be added to the appeal pursuant to 42 C.F.R. § 405.1841(a).

HCFA explained its policy regarding the inclusion of Medicaid days in the May 6, 1986 Federal Register. In that publication, the Agency stated that, for purposes of DSH reimbursement, Medicaid covered days included only those days that were payable under Title XIX. 51 Fed. Reg. 16,772, 16,777 (codified at 42 C.F.R. § 412.106). This policy precluded the inclusion of any Medicaid days other than those paid days under a state's Medicaid plan. The Medicaid days are recorded on Worksheet S-3 of the cost report and, for the cost reporting period under appeal here, the Provider was not permitted to claim all the days for which patients were eligible for Medicaid.

The Supreme Court in Bethesda held that where a provider files a cost report in full compliance with the Secretary's rules and regulations, providers are not barred from claiming dissatisfaction with the amount of reimbursement allowed by those rules and regulations. The Court recognized that it would be futile for providers to claim reimbursement beyond that and, in those situations, providers can claim dissatisfaction without incorporating the challenge on the cost report. Bethesda at 1258-1259. Clearly, the DSH/eligible days issue falls within this framework. The DSH policy precluded an intermediary from including all days for which patients were eligible for Medicaid payment.

The Intermediary's conclusion that the Provider was required to have a validly pending appeal of the DSH issue prior to or 180 days from the issuance of HCFAR 97-2 in order to be reimbursed for additional days is in error. HCFAR 97-2 states that "where cost reports have been settled prior to the effective date of this ruling, but for which a hospital has a jurisdictionally proper appeal pending on the issue pursuant to . . . 42 C.F.R. § 405.1835, these days may be included for purposes of resolving the appeal." (emphasis added). The Board concludes that, under the explicit language of the regulation, if a provider has a jurisdictionally proper appeal pending, it is permitted to add the DSH issue. 42 C.F.R. § 405.1841(a) provides that prior to the commencement of the hearing proceedings, a provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied.

The Board also rejects the Intermediary's characterization of the appeal as a request to reopen. Since an appeal is currently pending before the Board, the issue of whether the Provider is entitled to additional reimbursement for DSH/eligible days may be addressed by the Board.

Finally, the Intermediary asserts that the Provider's pursuit of the DSH issue violates what the Intermediary characterizes as a settlement agreement. The document referenced by the Intermediary is a letter sent by the Intermediary to "document the agreement." When discussing the DSH issue, the Intermediary states that "since no appeal was

pending on this issue prior to 2/27/97, the Medicaid eligible days will not be included in the DSH calculation.” As discussed above, that is not an accurate statement and the unilateral recitation of an inaccurate statement does not reflect the Provider’s waiver of its appeal rights. Even if the Board had accepted the Intermediary’s position, this case was reinstated under the Board’s procedures applicable to settlements that are not yet implemented by the Intermediary; therefore, limitations imposed are no longer in force.

Decision and Order

The Board finds that it has jurisdiction over the DSH/eligible days issue.

Review of this decision is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

Suzanne Cochran, Esq.  
Henry C. Wessman, Esq.  
Stanley J. Sokolove, CPA  
Gary B. Blodgett, DDS

DATE OF DECISION: January 30, 2003

FOR THE BOARD:

Suzanne Cochran, Esq.  
Chairman

Enclosure: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.