

# Provider Reimbursement Review Board: 2013 Year in Review

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## Executive Summary

*The Provider Reimbursement Review Board (PRRB) issued 39 decisions in fiscal year 2013. The CMS Administrator reviewed 10 of those decisions. Both district courts and courts of appeal released decisions that further reviewed the determinations of CMS and the PRRB. In addition, the U.S. Supreme Court released a much-anticipated decision related to the filing of appeals with the PRRB. What follows is a topical review of some of the major decisions of the year.*

## Auburn Regional

The U.S. Supreme Court unanimously held that the 180-day statutory deadline for filing appeals to the PRRB is not “jurisdictional,” the Secretary’s regulation providing for a three-year extension of the deadline for “good cause” is a permissible interpretation of the statute, and a presumption of equitable tolling does not apply in the context of administrative appeals by providers under the Medicare Act (*Sebelius v Auburn Regional Medical Center*, January 22, 2013, Ginsburg, R). Therefore, the District of Columbia Circuit Court’s judgment (*Auburn Regional Medical Center v Sebelius*, 642 F.3d 1145, June 24, 2011) was reversed and remanded.

## DSH Calculation—Dual Eligibles

**Allina Health System v. Sebelius, D.D.C., Oct. 8, 2013.** A fiscal intermediary’s determination that dual eligible patients did not fall into the category of individuals who were “not entitled to benefits under Medicare Part A” and therefore did not include them in the Medicaid fraction of the disproportionate share hospital (DSH) adjustment formula was upheld. Allina Health Systems (Allina) alleged that its disproportionate share hospital adjustments from fiscal years (FYs) 1993 through 2003 were improperly calculated. Namely, Allina argued that through the intermediary, HHS Secretary Sebelius inappropriately interpreted the definition of the numerator in the Medicaid fraction, which is “patient days for patients ‘eligible for [Medicaid]’ but not ‘entitled to benefits under Part A’” and that dual-eligible exhausted benefit days and Medicare secondary payer days should serve in the Medicaid fraction of the DSH adjustment formula. The court disagreed, finding the Secretary’s interpretation of the fraction to be appropriate, and noted that being eligible does not equate to being entitled. The court ruled that the days were appropriately excluded from the fraction.

**Maine Type 6 Medicaid Dual Eligible Days DSH Groups,** Review of PRRB Decision No. 2013-D9, May 30, 2013. Non-Supplemental Security

Income (SSI) type 6 Medicare/Medicaid dual-eligible days (non-SSI type 6 days) are not included in the Medicaid fraction when calculating the providers' DSH adjustment. The providers are liable for the overpayments because neither the "hold harmless" provision of CMS Program Memorandum (PM) A-99-62 (hold harmless provision) nor the "without fault" provision of section 1870 of the Social Security Act (without fault provision) applies.

## Other DSH Calculation Cases

**Nazareth Hospital v. Sebelius, E.D. Penn., April 8, 2013.** Two Pennsylvania hospitals claimed that the Secretary of the Department of Health and Human Services' (Secretary's) calculation of the DSH adjustment for Medicare payments to the hospitals for serving a disproportionate share of low-income patients during 2002 was unconstitutional because it excludes beneficiaries of state-only assistance programs from the Medicaid fraction, while including similarly situated individuals who receive assistance under a demonstration project funded through Soc. Sec. Act sec. 1115. The regulation dictating the calculation was a change from the Secretary's prior policy, which counted only patients who were eligible for Medicaid under the approved state plan, and the Secretary did not satisfactorily articulate why the hospitals' non-Medicaid-eligible general medical assistance (GA) hospital inpatients should not also be regarded as Medicaid beneficiaries for purposes of the Medicare DSH calculation. The Secretary was ordered to recalculate the Medicare DSH adjustments owed to the hospitals for the fiscal year ending December 31, 2002 and remit payment plus interest.

**University of Kansas Hospital Authority, et al v. Sebelius, D.D.C., July 15, 2013.** The decision by the CMS Administrator to uphold a decision of the PRRB not to include days of disabled patients treated under a state-funded health insurance program in the Medicaid fraction of the Medicare DSH calculation for fiscal year 1996 was in accordance with Soc. Sec. Act sec. 1886(d)(5)(F)(vi)(II).

**QRS DSH Florida General Assistance Days Group,** Review of PRRB Decision No. 2013-D23, September 25, 2013. The intermediary properly did not include general assistance and charity care days from the numerator of the providers' Medicaid fraction of the Medicare DSH equation. The CMS Administrator affirmed the decision of the PRRB, which upheld the decision of the intermediary. The CMS Administrator found that the HHS Secretary has interpreted the phrase

at Soc. Sec. Act sec. 1886(d)(5)(F)(iv) "patients who (for such days) were eligible for medical assistance under a state plan approved by Title XIX" to mean eligible for Medicaid, and documents how this definition has been consistently used by CMS and upheld by the courts.

**QRS 1995, 2001-2002, 2004-2005 Missouri DSH/General Assistance Days Group,** Review of PRRB Decision No. 2013-D10, June 20, 2013. The CMS Administrator has found that the Intermediary properly excluded Missouri Charity Care Program (MCCP) patient days from the numerator of the Provider's Medicaid proxy of the Medicare DSH calculation. The Administrator decided that the patients, whose charity care and bad debts were included in the computation of the Medicaid DSH formula, were not eligible for "medical assistance" as set forth in the Medicaid Act, which requires entitlement for payment of part or all of a service under an approved state Medicaid plan. As such, the decision of the PRRB, upholding the Intermediary's decision to exclude the days, was affirmed.

**QRS 1993-2007 DSH/Iowa Indigent Patient/Charity Care (GA) Group v. Blue Cross Blue Shield Assn/Wisconsin Physician Service,** Review of PRRB Dec. No. 2013-D2, January 15, 2013. The decision of the intermediary to exclude Iowa Charity Care Program days from the numerator of the Medicaid fraction for the calculation of Medicare DSH payments was proper. The Iowa Indigent Patient/Charity Care (GA) Group's (Iowa Group's) argument that Medicaid provided funding via the Medicaid DSH payment for particular days does not mean that these individuals were eligible for Medicaid and therefore should be included in the Medicare calculation. The fact that Medicaid pays for some days for some individuals is different from whether or not those individuals are eligible for Medicaid. Statutes, regulations and CMS guidance require that to be included in the Medicare DSH Medicaid numerator the person must be eligible for Medicaid under an approved state plan. Medicaid may have paid for those individuals under a section 1115 waiver, even though those individuals were not Medicaid eligible. Section 1115 waivers can allow for expanded populations to be covered as long as the total amount spent is the same as if there was not waiver.

**QRS 1995, 1996, 1998-2007 DSH/Pennsylvania General Assistance Day Group v. Blue Cross Blue Shield Association/Novitas Solutions,** Review of PRRB Decision No. 2013-D1, January 15, 2013. The intermediary and the PRRB correctly decided that the patient days attributable to individuals who were not eligible for Medicaid, but were eligible for assistance through pro-

grams funded by the state or local government, were not countable as Medicaid days in computing the Medicare fraction used to calculate the hospital's DSH adjustment. Only the patient days attributable to individuals who actually were eligible for Medicaid are countable.

## Bad Debt

### **District Hospital Partners LP v. Sebelius, D.D.C.**

**March 26, 2013.** A group of hospitals successfully challenged the HHS Secretary's denial of payment for Medicare bad debts, requiring the Secretary to revisit the bad debt claims and pay them accordingly. The hospitals claimed the bad debts only to have them disallowed by the Secretary because of the ongoing efforts by an outside collection agency. The denial prompted this appeal.

**Lakeland Regional Health System v. Sebelius, D.D.C., July 16, 2013.** The CMS Administrator properly denied Medicare reimbursement to Lakeland Regional Health System for certain bad debts that were pending at an outside collection agency when Lakeland submitted them as "uncollectible" under 42 C.F.R. sec. 413.89. No bad debt may be deemed uncollectible if collection efforts are ongoing, either internally or through an outside agency.

Writing in *Dennis Barry's Reimbursement Advisor*, Paige Fillingame, an associate at King & Spalding, LLP, in Houston, TX, noted that "this decision, contrary to several other decisions of the D.C. District Court, has renewed the issue of when and how providers should claim their bad debts." Fillingame noted that while "the court ruled that the CMS administrator had properly decided the case in favor of the fiscal intermediary ... [the court] failed to address several significant decisions from the DC district court that are directly contrary to its position," including the *District Hospital Partners decision* noted above, and *Foothill Hosp. v. Leavitt*, 558 F. Supp. 2d 1 (D.D.C. 2008).

Fillingame concluded, "Given the *non sequitur* characteristics of the district court's ruling, it would be wise for Lakeland to provide the D.C. Circuit with the opportunity to issue binding precedent on the issue, though there is no guarantee its decision would align with those of *Foothill* and *District Hospital*. Providers should consider carefully the risks associated with filing a bad debt case in the D.C. district court. What previously was a clear win for providers has now become an open question."

**Maine Medical Center v. Blue Cross Blue Shield Association/National Government Services**, Review of PRRB Decision No. 2013-D3, January 18, 2013. A voluntary non-profit short-term hospital, Maine Medical

Center, failed to meet the regulatory and CMS manual guidelines for crossover bad debt in the hospital's cost reports that ended September 30, 2002 and September 30, 2003. According to the CMS Administrator, regardless of any omissions by the state to provide the Medicaid remittance advice, Maine Medical Center was required to bill for and produce remittance advice before including crossover bad debt claims on its cost reports. Failure to include the remittance advice, therefore, constituted Maine Medical Center's failure to meet the necessary criteria for Medicare bad debts and the crossover bad debt claims were appropriately denied.

*No bad debt may be deemed uncollectible if collection efforts are ongoing, either internally or through an outside agency.*

## Medicaid Eligibility

### **QRS UMHC 1991-1996 DSH/Michigan General Assistance Days Group v Blue Cross Blue Shield Association/Wisconsin Physicians Service**, Review of PRRB

Decision No. 2013-D21, September 25, 2013. A CMS Administrator has found that individuals covered by the Michigan Indigent/Charity Care Program (MICCP) are not eligible for medical assistance under Medicaid, which requires entitlement for payment of part or all of a service under an approved state Medicaid plan. As such, the Administrator found that the Intermediary's disallowance of MICCP patient days in the numerator of the Medicaid fraction was proper. The applicable statute requires that the individual be eligible for Medicaid for the patient days to be counted in the numerator of the Medicare DSH payment. The [decision of the PRRB](#), upholding the Intermediary's decision, was affirmed.

## SNF Routine Cost Limits

**Blumberg Ribner 91-99 SNF 112% Peer Mean Group v Blue Cross Blue Shield Association/Palmetto GBA c/o First Coast Service Options**, Review of PRRB Decision No. 2013-D18, July 9, 2013. The CMS Administrator found that the Intermediary's application of

Provider Reimbursement Manual (PRM 15-1) sec. 2534 to limit the skilled nursing facilities' (SNFs) exception to routine cost limits (RCL) to 112 percent of the mean *per diem* routine service costs for hospital-based SNFs was correct. The Administrator determined that limiting the SNF exception was consistent with Congress's intentions, CMS's policies, and with [Soc. Sec. Act sec. 1888](#) and [42 CFR sec. 413.30](#).

## Cost of Educational Activities

**UMDNJ--University Hospital**, Review of PRRB Decision No. 2013-D13, June 26, 2013. The PRRB improperly exercised its discretion to decline jurisdiction of the appeals of the University of Medicine and Dentistry of New Jersey (UMDNJ) Hospital, but the denial of UMDNJ's claims for reimbursement for the costs of educational activities related to its nursing and allied health education programs was correct. Because the order of the District Court for the District of Columbia directed the PRRB to exercise jurisdiction to decide the matter, the PRRB could not refuse to do so. However, the PRRB's conditional ruling that UMDNJ was not entitled to reimbursement was correct because reimbursement would have redistributed the university's costs to the Medicare program.

## Eligibility for Hearing

**The Phoenix Clinic v. Wisconsin Physician Services**, Review of PRRB Decision No. 2013-D4, March 20, 2013. In an appeal to the CMS Administrator regarding whether an intermediary improperly disallowed on a global basis all of the costs claimed by The Phoenix Clinic for cost reporting year 2009, the appeal was remanded for further consideration to determine whether the community mental health center (CMHC) was a "provider of services" for the purposes of a hearing. This is because, under 42 C.F.R. sec. 405.1801(b), non-provider entities participating in Medicare Part A do not qualify as a provider for the purposes of appeals.

## Cost Reports

**Canonsburg General Hospital v. Sebelius, D.D.C., Oct. 17, 2013**. A hospital-based skilled nursing facility (SNF) could not challenge the validity of *Provider Reimbursement Manual* (PRM) sec. 2534.5 because it had litigated the same issue in 2001 and lost. Under the doctrine of *res judicata*, the SNF could not make bring the issue of the validity of the manual provision under

the Administrative Procedure Act (APA) because the court had decided the same question in the 2001.

## Mergers

**New England Deaconess Hospital v. Sebelius, D.D.C., April 29, 2013**. The HHS Secretary's decision to deny Medicare reimbursement for a hospital's loss due to asset depreciation was not arbitrary and capricious because substantial evidence supported the conclusion that the hospital did not receive reasonable consideration when it merged with another hospital. Under pre-1997 regulations, if a provider merged with another entity, the surviving entity was eligible for reimbursement on any loss realized as a result of depreciation of the merged provider's Medicare assets, as long as the merger was an arm's-length transaction between unrelated parties. The evidence supported the Secretary's conclusions that the hospital's attempts to merge were driven by matters other than sale price and that, even using the hospital's retrospective appraisal, the depreciable assets were transferred for 60 percent of their fair market value.

**Catholic HealthCare West v Sebelius, D.D.C. Jan. 29, 2013**. The Secretary of HHS was granted summary judgment on her decision denying Marian Medical Center's (Marian) reimbursement claim arising from the merger of Marian, Mercy Healthcare Ventura County (Mercy), and Catholic Healthcare West (CHW). "The sizable gap between the 'purchase price' and the value of Marian's assets, as well as the other circumstances surrounding the merger," the District Court for the District of Columbia said, "constitute substantial evidence that supports the Secretary's finding that reasonable consideration was not exchanged, and that therefore, the merger was not a bona fide sale." CWH's motion for summary judgment was denied.

**Memorial Hermann Hospital v. Sebelius, 5th Cir., July 12, 2013**. Memorial Hermann Hospital System (MHHS) did not provide any evidence on appeal that the requirement that merging hospitals meet the *bona fide* sales requirement to receive an adjustment for the depreciation of assets was in violation of the APA, or that the merger of Hermann Hospital and Memorial Hospital Systems was a *bona fide* sale. The HHS Secretary has been applying the requirement of a *bona fide* sale in order for a hospital to receive an adjustment for the depreciation of assets via a merger in a reasonable and consistent manner and her interpretation of what constitutes a *bona fide* sale is in accordance with Medicare law. Finally, MHHS did not provide any reason for



the Fifth Circuit to differ from the finding of numerous other circuit courts on this issue.

## Wage Index

**Atrium Medical Center et al v. Sebelius, S.D. Ohio, Jan. 8, 2013.** The Secretary's decision to include short-term disability and shift incentive hours in the wage index is not arbitrary and capricious, and, therefore, must be sustained. While the hospitals choose to pay short-disability payments through their payroll systems, this method of compensating an employee for paid time off is the functional equivalent of an extended period of sick leave. The Secretary has always included hours for paid sick leave in the wage index and the hospitals do not contend that this decision was arbitrary and capricious. It is not, therefore, arbitrary and capricious for the Secretary to treat the functional equivalent of sick leave as if it were sick leave and include it in the index. With respect to shift incentives, it is hardly arbitrary and capricious for the Secretary to treat employees on certain shifts the same way the hospitals do, *i.e.*, as if they had actually worked extra hours.

## Resident training

**Borgess Medical Center v. Sebelius, D.D.C., Sept. 4, 2013.** Two hospitals were not entitled to reimbursement for costs associated with offsite resident training during fiscal years 2000 through 2004 because hospitals may not split the costs of nonhospital training and their affiliation agreements with the medical school did not satisfy federal requirements. The hospitals successfully challenged the denials before the PRRB, but the CMS Administrator reversed the decision of the PRRB. The court concluded that the decision of the Administrator was reasonable and not arbitrary, capricious, or in violation of the law, so the Secretary's motion for summary judgment was granted.

## FTE counts

**Kaiser v. Sebelius, D.C. Cir., March 5, 2013.** A consortium of hospitals was entitled to have erroneous

resident full-time equivalent (FTE) counts from its 1996 and 1998 cost reports corrected because modifying the FTE counts did not require an adjustment to the total reimbursement for either closed reporting period. Due to a cap on the number of FTEs imposed by Congress in 1997, 1996 FTE counts dictated the maximum reimbursement for subsequent reporting periods. The hospitals discovered an error in the FTE counts for 1996 and 1998, which affected their reimbursement for later cost reporting periods. Although 42 C.F.R. §405.1885 prohibits determinations from being reopened more than three years from the date the intermediary issues the notice of program reimbursement, modifying FTE counts in closed years did not constitute a "reopening."

*It is not arbitrary and capricious for the Secretary to treat the functional equivalent of sick leave as if it were sick leave...*

## Conclusion

PRRB decisions are highly fact-specific, as seen by its 2013 determinations involving DSH calculations. These decisions are not easy to overturn: upon review, the CMS Administrator tended to affirm the PRRB's decisions. Furthermore, because federal courts are often limited to determining whether the CMS Administrator's decisions were arbitrary and capricious, many 2013 federal court cases were dismissed, or issued opinions upholding CMS decisions.

This white paper is one of a series providing a retrospective look at key health care topics in 2013. The other white papers include "Medicare and Medicaid Litigation: 2013 Year in Review," "Drugs and Medical Devices: 2013 Year in Review," and "Food Litigation on Misleading and Deceptive Labeling Claims: 2013 Year in Review."

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