



## Major Changes on the Medicare DSH Landscape



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Since its inception, the Medicare disproportionate share hospital (DSH) payment has been a frequent source of controversy and litigation, and the first half of 2010 has been a particularly active period.

Setting aside the significant changes on the way by virtue of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148), a number of court rulings and actions by the Centers for Medicare & Medicaid Services have furnished plenty of current grist for the mill for hospitals seeking, or considering, additional DSH reimbursement from the Medicare appeals process.

The Medicare DSH payment is a statutorily mandated payment, in addition to the base prospective payment system amount, for hospitals serving a disproportionately large percentage (e.g., 15 percent or greater) of low-income patients. Congress established a proxy for determining a hospital's "disproportionate share patient percentage" (DPP) that ultimately is used to calculate a hospital's DSH payment.

The DPP is calculated by adding the following two fractions:

**The Medicare Fraction (or SSI Ratio).** The numerator of the Medicare Fraction is the number of inpatient days for patients who are entitled to both Medicare Part A and to Supplemental Security Income (SSI), and the denominator is the total number of the inpatient days for patients who were entitled to Medicare Part A; and

**The Medicaid Fraction.** The numerator of the Medicaid Fraction is the number of inpatient days for patients who were eligible for medical assistance under a state plan approved under Title XIX (Medicaid), and the denominator is the total number of inpatient days at the hospital.

It is the interpretation and/or application of these two fractions that has been the source of controversy plaguing the DSH payment since its inception. Determining which days belong in the fractions, or whether certain days belong in one fraction rather than another, has been the subject of several pieces of litigation.

As the determination of the proper place for certain days can result in the shifting of millions of dollars between hospitals and the Medicare program, the cases are important for hospitals to follow.

### **Recent Court Decisions Provide Clarification**

Several courts recently have provided guidance on the appropriate interpretation of the statutory DSH payment. The season began with the finality of the *Baystate Medical Center v. Leavitt* decision, which found serious errors in the Medicare fraction and required CMS to correct flaws in its processes for calculating it. 545 F. Supp. 2d 20 (D.D.C. 2008).

This was followed by *Northeast Hospital Corporation v. Sebelius*, No. 09-cv-0180, D.D.C., March 30, 2010, in which the U.S. District Court for the District of Columbia weighed in on a number of DSH calculation questions, and *Metropolitan Hospital, Inc. v. HHS*, No. 1:09-cv-128, W.D. Mich., April 5, 2010, which addressed a single issue involving the inclusion of Medicare Part A dual-eligible days in the Medicaid fraction of the DSH calculation.

Finally, the D.C. District Court also recently ruled on an issue involving the inclusion of certain "state-only funded" program days in *Banner Health v. Sebelius*, No. 1:07-cv-01614, D.D.C., June 7, 2010.

*Northeast* serves as an excellent study because of the number of DSH issues involved in the case. First, the court addressed the hospital's complaint that its Medicare Fraction was inappropriately calculated and remanded the claim to CMS to determine whether CMS would follow the court's ruling in *Baystate*, which addressed the same issue.

In *Baystate*, the D.C. District Court ordered CMS to correct several errors and omissions in the Medicare Fraction that

were brought to light by the *Baystate* plaintiffs. The *Northeast* court simply chose to wait to see if CMS would apply those corrections to the *Northeast* plaintiff hospital.

The *Northeast* court then moved on to the next issue raised by the hospital; its argument that certain charity care days should be included in the Medicaid Fraction of its DSH calculation based on the fact that such charity care days were incorporated into payments made for Medicaid DSH under the state's Title XIX plan.

As with the Medicare Fraction issue, the court was guided by other recent cases involving failed attempts by hospitals to have charity care days so included. *See, e.g., Adena Reg'l Med. Ctr. v. Leavitt*, 527 F.3d 176, 178 (D.C. Cir. 2008)). Following this recent line of cases, the court refused to include charity care days in the Medicaid fraction of the DSH calculation because the patients were not themselves "eligible for assistance" under a state plan.

Next, the *Northeast* court addressed the issue of the appropriate fraction for dual-eligible Medicare Advantage enrollees and decided in favor of the hospital that such days belong in the Medicaid Fraction rather than the Medicare Fraction.

According to the court, once a patient enrolls in a Medicare Advantage (Part C) plan, he or she is no longer "entitled" to receive benefits under Part A as the Medicare Fraction of the DSH statute requires for counting purposes.

Finally, the *Northeast* court ordered CMS to include patient days associated with the days spent by inpatients in labor and delivery areas of the hospital, finding no statutory basis supporting the exclusion of such days as CMS had done. (Indeed, in a rule change, CMS already had reversed its policy with respect to labor and delivery days effective for cost reporting periods beginning on or after Oct. 1, 2009.)

*Banner Health* presented an interesting challenge for the court as it involved the Arizona Medicaid program, which is operated under a Section 1115 demonstration waiver in which only the "categorically needy" received direct federal financial participation.

Medically needy/medically indigent patients were covered under a state-only funded portion of the Arizona medical assistance program, although these patients were included in the Medicaid DSH calculation under the state plan.

Citing *Adena* and *Northeast*, the court ruled for CMS, finding that the patients eligible for state-only funded medical assistance were not part of the "State plan approved under Title XIX" regardless of the their inclusion in the Medicaid DSH court.

The court rejected the hospital's hypothetical arguments that the medically needy/medically indigent patients could have been in a state plan (i.e., but for the Arizona Section 1115 demonstration waiver program).

Like *Banner Health*, *Metropolitan Hospital* focused on a single, but important issue involving the hospital's argument that days for dual-eligible patients who have exhausted their Medicare Part A coverage ("non-covered dual-eligible days") should be included in the Medicaid fraction of the DSH calculation.

Following favorable DSH case precedent involving prior Medicaid eligible days disputes, the court agreed with the hospital and invalidated CMS's regulation (42 C.F.R. §412.106(b)), which excluded such dual-eligible days from the Medicaid fraction (and included them in the Medicare fraction—if the patients also were entitled to SSI).

According to the court, the patients belong in the Medicaid fraction because they are eligible for Medicaid and, at the time they have exhausted benefits, they no longer are "entitled" to Medicare Part A as the statute provides. The court went so far as to order the agency to instruct its fiscal intermediaries to include these days in the Medicaid fraction—an order that would soon be ignored.

These recent cases provide a mixed bag of results for hospitals. Hospitals hoping to include days in their Medicare DSH calculation based on a tie into the state Medicaid program other than direct eligibility (i.e., charity care or state-only funded days) will find an increasingly uphill battle ahead.

On the other hand, the shifting of non-covered dual-eligible days (whether coverage is exhausted or has shifted to Medicare Part C) from the Medicare Fraction to the Medicaid Fraction generally should provide additional reimbursement for hospitals.

Finally, CMS will be required to fix the flaws in its process for calculating the Medicare Fraction; yet, the recent court decisions are only half of the story.

### ***CMS Ruling 1498—Part Concession, Part Defiance***

On April 28, 2010, CMS issued Ruling 1498 (Ruling), implementing three major DSH policy changes that purportedly rendered "moot" thousands of DSH appeals pending before the Provider Reimbursement Review Board (PRRB). It may have been perceived by CMS to be the panacea to many DSH controversies, but the ink was barely dry on the Ruling before challenges arose.

The first DSH policy imposed by the Ruling is a direct response to the *Baystate* decision. Prior to issuing the Ruling, CMS published its proposed rule for the 2011 inpatient prospective payment system (IPPS), in which it explained the new data match processes that it is proposing to calculate the SSI Ratio based on a "global" application of its remedial efforts that were ordered by the *Baystate* court.

The Ruling requires that the methodology adopted by CMS in the final rule for fiscal year 2011 (or the methodology that

is applied to correct the Baystate Medical Center Medicare Fraction) be applied to all open cost reports and “properly pending” appeals before the PRRB for hospitals that have preserved the issue of the accuracy of their Medicare Fraction.

The second major DSH policy adopted by the Ruling involves the remand of appeals before the PRRB involving the exclusion from the DPP of non-covered dual eligible days.

The Ruling requires the remand and implementation of the policy adopted by CMS in fiscal year 2005, which purports to require the inclusion of non-covered dual eligible days in the Medicare Fraction (even though historically the agency treated the statutory term “entitled” to mean that a patient was actually entitled to receive payment, i.e., covered).

The Ruling would require the recalculation of DSH payments for all open and appealed cost reports for fiscal years *prior to Oct. 1, 2005*, i.e., retroactive to a period even *before CMS actually changed its rule to adopt the policy*.

The Ruling also presumes that from Oct. 1, 2005, forward such non-covered dual eligible days are properly included in the Medicare Fraction. However, the policy set forth in the Ruling (and the 2005 regulation) was explicitly rejected by the court in *Metropolitan Hospital* three weeks before the issuance of the Ruling.

That court, and a number of hospitals currently appealing the issue before the PRRB, contend that, according to the plain meaning of the statute, such non-covered dual eligible days properly belong in the Medicaid Fraction for all periods.

Nevertheless, CMS did not address *Metropolitan Hospital* in the Ruling, except to note that hospitals can appeal the revised DSH payment issued as a result of the Ruling's remand and the application of the CMS policy to include such days in the Medicare Fraction.

Finally, the third major DSH issue addressed in the Ruling concerns the remand of appeals involving the exclusion from the DSH calculation of labor/delivery room inpatient days. Previously, CMS had applied a policy excluding hours spent in labor rooms before the patient was admitted at the census taking hour under the erroneous theory that, since such costs represented ancillary services, they should not be included in the DSH payment calculation.

CMS revised this policy in its final IPPS rule for fiscal year 2010 (74 Fed. Reg. 43,900, 43,997), which was effective for cost reporting periods beginning on or after Oct. 1, 2009. The Ruling essentially grants retroactive application of the fiscal year 2010 rule change to all “properly pending” appeals before the PRRB (and open cost reports) on the issue of inclusion of labor and delivery days in the DPP. Like the other two DSH issues, the Ruling dictates that such appeals be remanded to the fiscal intermediaries to recalculate the hospital's DSH payment including such labor and delivery days.

The Ruling will require a massive shift of appeals from the PRRB to the fiscal intermediaries and the process likely will be unwieldy. The Ruling proposes two alternatives for determining which appeals will result in a DSH recalculation based on the Ruling.

In the first approach, the PRRB may evaluate each appeal and make a determination regarding whether such appeal is jurisdictionally proper and pending on an issue capable of receiving relief under the Ruling.

If the PRRB makes such a finding, it will remand the case to the intermediary for application of the Ruling. If the PRRB determines that the case is not “properly pending” on an issue affected by the Ruling, it will process the appeal through its normal adjudicative process.

Alternatively, hospitals may request on their own that their appeals be transferred to their fiscal intermediaries to make the “properly pending before the PRRB” determination instead of the PRRB.

Many of the appeals involving these issues are being prosecuted as group appeals, and the Ruling provides for a similar process for group appeals, although each hospital within the group ultimately will have to prove it is eligible for relief under the Ruling.

Hospitals will need to make certain that they have adequately compiled and submitted all jurisdictional materials to ensure they are entitled to relief under the Ruling.

The review process will be complex, and there is no time limit given in the Ruling for completing the DSH recalculation process. CMS is preparing more detailed instructions that, hopefully, will shed more light on the process and assist the intermediaries with this huge responsibility.

While CMS obviously believed its Ruling would substantially thin the herd of DSH appeals sitting before its PRRB, its policy with respect to non-covered dual eligible days simply invited criticism. Indeed, one group of hospitals recently sought and received “permission” from the PRRB to challenge the Ruling directly in federal court (as the PRRB lacks the authority to grant relief contrary to the Ruling).

Thus, the Ruling, itself, has become the subject of litigation.

## **Conclusion**

This year has ushered in one of the more active and important eras of the Medicare DSH payment. Hospitals should carefully evaluate the changing DSH landscape and evaluate and preserve any challenges to CMS policy through the Medicare appeals process.

Hospitals should consider the impact of the Ruling and the three issues it involves on their DSH payments, and determine the appropriate strategy for their institution. Ultimately, the Ruling will not end the contentious history of the

DSH payment. It will simply mark the beginning of a new era.

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