PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2014-D1

PROVIDER –
Owensboro Medical Health System
Owensboro, Kentucky

Provider No.: 18-0038

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
CGS Administrators, LLC

DATE OF HEARING –
March 3, 2013

Cost Reporting Periods Ended –
May 31, 2003; May 31, 2004 and
May 31, 2005

CASE NOs.: 06-0615; 06-0651;
06-2373

INDEX

ISSUE:

Whether medical assistance/general assistance days associated with patients covered under the Kentucky State Plan should be included in the numerator of the Medicaid proxy of the Medicare disproportionate share hospital ("DSH") calculation pursuant to § 1886(d)(5)(F)(vi)(II) of the Social Security Act,[1] as amended ("Act").

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Act[2] to provide health insurance to the aged and disabled. The Centers for Medicare and Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[3] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[4]

Providers are required to submit cost reports annually, with reporting periods based on each provider's accounting period. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[5] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement ("NPR").[6] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of the NPR.[7]

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").[8] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[9]

The statutory provisions addressing the IPPS are located in § 1886(d) of the Act[10] and they contain a number of provisions that adjust payment based on hospital-specific factors.[11] This case involves the hospital-specific DSH adjustment specified in § 1886(d)(5)(F)(i)(I). This

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[1] 42 U.S.C.A. § 1395ww(d)(5)(F)(vi)(II).
[2] The Act was codified at 42 U.S.C. Ch. 7, Subch. XVIII.
[3] FIs and MACs are hereinafter referred to as intermediaries.
[4] *See* §§ 1816 and 1874A of the Act, 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[5] *See* 42 C.F.R. § 413.20.
[6] *See* 42 C.F.R. § 405.1803.
[7] *See* § 1878(a) of the Act, 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 - 405.1837.
[8] *See* § 1886(d) of the Act, 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.
[9] *See* 42 C.F.R. Part 412.
[10] 42 U.S.C. § 1395ww(d).
[11] *See* § 1886(d)(5) of the Act, 42 U.S.C. § 1395ww(d)(5).

provision requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[12]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[13] The DPP is a proxy for utilization by low-income patients and determines a hospital's qualification as a DSH. It also determines the amount of the DSH payment to a qualifying hospital.[14]

The DPP is defined as the sum of two fractions expressed as percentages.[15] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. The Medicare/SSI fraction is defined in § 1886(d)(5)(F)(vi)(I) as:

> [T]he 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 patient 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, ...

The Medicare/SSI fraction is computed annually by CMS, and intermediaries use CMS' calculation to compute the DSH payment adjustment as relevant for each hospital.[16]

Similarly, the Medicaid fraction (also referred to as the Medicaid proxy) is defined in § 1886(d)(5)(F)(vi)(II) 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 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's patient days for such period.[17]

The intermediary determines the number of the hospital's patient days of service for which patients were eligible for medical assistance under a State plan approved under Title XIX but not

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[12] *See also* 42 C.F.R. § 412.106.
[13] *See* §§ 1886 (d)(5)(F)(i)(I) and (d)(5)(F)(v) of the Act, 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[14] *See* §§ 1886(d)(5)(F)(iv) and (d)(5)(F)(vii)-(xiv) of the Act, 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiv); 42 C.F.R. § 412.106(d).
[15] *See* § 1886(d)(5)(F)(vi), 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[16] 42 C.F.R. § 412.106(b)(2)-(3).
[17] (Emphasis added.)

entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[18]

The Medicaid fraction is the only fraction at issue in these cases. However, resolution of the Medicare DSH issue also involves the interpretation of a similar Medicaid DSH provision in Title XIX of the Act and its application to the Medicare DSH Medicaid fraction. The details of the Medicaid DSH provisions are discussed in more detail below.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Owensboro Medical Health System ("Provider") is an acute care hospital located in Kentucky. These cases involve the Provider's cost reporting periods for 2003, 2004, and 2005. During these cost reporting periods, the Provider participated in both Part A of the Medicare program and the Kentucky Hospital Care Program ("KHCP") [19] which provides medical assistance to uninsured low-income patients not eligible for other medical assistance programs, including Medicaid.

During the years in question, the Provider's designated intermediary was Adminastar Federal ("Intermediary"). The Intermediary issued NPRs for the Provider's cost reporting periods at issue without including medical assistance/general assistance days in the Medicaid fraction of the Provider's Medicare DSH calculations. The Provider timely appealed the Intermediary's determinations to the Board.

The Provider was represented by Stephen R. Price, Sr., Esq., of Wyatt, Tarrant & Combs, LLP. The Intermediary was represented by Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield Association.

BACKGROUND ON INCLUSION OF MEDICAL ASSISTANCE/GENERAL ASSISTANCE DAYS IN THE MEDICAID PERCENTAGE OF THE MEDICARE DSH ADJUSTMENT:

The parties agree that resolution of the issue before the Board hinges on the meaning of the phrase "patients who for such days were eligible for medical assistance under a State plan approved under [T]itle XIX" as used in § 1886(d)(5)(F)(vi)(II)[20] to describe the Medicaid fraction. This phrase identifies those days that are to be counted in the Medicaid proxy of the Medicare DSH adjustment.

Title XIX of the Act[21] provides for federal sharing of state expenses for medical assistance for low-income individuals under the Medicaid program provided the state Medicaid program meets certain provisions contained in Title XIX. The state must submit a plan describing the state

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[18] 42 C.F.R. § 412.106(b)(4).

[19] The KHCP addresses the uncompensated direct patient care provided by one or more hospitals in Kentucky. Under KHCP, hospitals may receive payments from the state for this care which may be reimbursed by the federal Medicaid program. *See* Kentucky State Plan Under Title XIX of the Social Security Act (excerpts available at Provider Exhibit P-6).

[20] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

[21] Title XIX of the Act is codified at 42 U.S.C. Ch. 7, Subch. XIX.

Medicaid program and seek approval from the Secretary.[22] If approved, the state may claim federal matching funds, known as federal financial participation ("FFP") under the Title XIX for the services provided and approved under the state Medicaid program.

PARTIES' CONTENTIONS:

The Provider contends that the Medicare statute and regulations require the inclusion of the general assistance days in the Medicare DSH calculation because the KHCP was a part of the Kentucky State Plan and CMS reviewed and approved that plan. The Provider also contends that according to Program Memorandum A-99-62, state-only program days should be included in the DSH calculations. This memorandum allows strictly state funded program days to be included for cost reporting periods beginning on or before January 1, 2000. The Provider, however, disputes the policy's restriction to only those providers which had previously received payment of these strictly state funded programs or had a properly pending appeal for this issue that was requested prior to October 15, 1999.

The Provider asserts that the State of Kentucky provides medical assistance on behalf of low-income, uninsured patients through the Medicaid disproportionate share program which is a part of the Kentucky State Plan, approved under Title XIX and, as such, receives FFP. The Provider relied on several case decisions including: (1) *Adena Reg'l Med. Ctr. v. Leavitt*, 524 F. Supp. 2d 1 (D.D.C. 2007), *rev'd and reh'g en banc denied*, 527 F.3d 176 (D.C. Cir. 2008), *cert. denied*, 129 S. Ct. 1933 (2009); and (2) *Portland Adventist Med. Ctr. v. Thompson,* 399 F.3d 1091, 1092, 1094 (9th Cir. 2005).[23]

The Intermediary counters that days of care paid for by programs for low income patients who are not eligible for Medicaid – even if the programs are recited in the State plan approved by Medicaid – cannot be included. The Intermediary reasons that KHCP days are clearly defined by state law as being for those patients who are not eligible for "medical assistance". In order to be included in the Medicaid proxy, a state program must be covered as "medical assistance" as defined under § 1905(a) of the Act,[24] *i.e.*, the patient days must be Medicaid eligible, not merely low income days that Medicaid permits to be counted solely for the Medicaid DSH adjustment. In support of its position, the Intermediary primarily relies on the following three Circuit Court decisions: (1) *Adena Reg. Med. Ctr. v. Leavitt,* 527 F.3d 176 (D.C. Cir. 2008); (2) *University of Washington Med. Ctr. v. Sebelius,* 634 F.3d 1029 (9th Cir. 2011); and (3) *Cooper Univ. Hosp. v. Sebelius,* 636 F.3d 44 (3rd Cir. 2010).[25]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered the Medicare law and program instructions, the evidence presented and the parties' contentions. Set forth below are the Board's findings and conclusions.

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[22] Relevant sections of Kentucky State Plan are included Provider's Supplemental Final Position Paper, Exhibit P-6.
[23] *See* Provider's Supplemental Final Position Paper at 19, 30.
[24] 42 U.S.C. § 1396d(a). The Intermediary characterizes the services and eligibility requirements set out in § 1905(a) as "traditional" Medicaid coverage.
[25] *See* Intermediary's Supplemental Final Position Paper at 19.

The evidence establishes that beneficiaries of KHCP are not eligible for Medicaid and the services provided under that program are not matched with federal funds *except* under the Medicaid DSH provisions.

The Medicaid DSH provisions are similar to the Medicare DSH provisions. Section 1923(a) of the Act[26] mandates that a state Medicaid plan under Title XIX must include a provision for a payment adjustment to hospitals which serve a disproportionate number of low income patients, *i.e.*, it requires a Medi*caid* DSH adjustment for hospitals that is independent of the Medi*care* DSH adjustment at issue in this case. The Medicaid DSH adjustment is eligible for FFP even though the particular patient days counted for Medicaid DSH are not directly eligible for FFP because they do not qualify as "traditional Medicaid" services described in § 1905(a).[27]

The question for the Board is whether the KHCP is a state funded program not otherwise eligible for Medicaid coverage and that is included in the Kentucky State Plan solely for the purpose of calculating the Medi*caid* DSH payment constitutes "medical assistance under a State plan approved under [T]itle XIX" for purposes of the Medi*care* DSH adjustment, specifically in the Medicaid fraction component.

In prior decisions on similar state funded programs, the Board has interpreted the Medicare statutory phrase "medical assistance under a State plan approved under [T]itle XIX" to include any program identified in the approved state plan, *i.e.*, it has not limited the days counted to traditional Medicaid days.[28] Subsequent to those decisions, the U.S. Court of Appeals for the District of Columbia issued its decision in *Adena Reg'l Med. Ctr. v. Leavitt*,[29] and concluded that the days related to beneficiaries eligible for the Ohio Hospital Care Assurance Program ("HCAP") should not be included in the Medicaid proxy of the Medicare DSH calculation.[30] Like the KHCP in Kentucky, the Ohio HCAP patients could not qualify for Medicaid but the HCAP days were included in the Medicaid DSH calculation. The D.C. Circuit pointed out that § 1923(c)(3)(B) of the Act[31] "permits the states to adjust DSH payments 'under a methodology that considers *either* 'patients eligible for medical assistance under a State plan approved under [Medicaid] or ... low-income patients,' ...such as those served under the HCAP."[32]

Upon further review and analysis of § 1923, the Board finds language that persuades it that the term "medical assistance under a state plan approved under [T]itle XIX" excludes days funded by only the state and charity care days even though those days may be counted for Medicaid DSH purposes.

Title XIX describes how hospitals qualify for the Medicaid DSH adjustment. Specifically, § 1923(b) establishes two distinct categories of low-income patients that are used to calculate a Medicaid DSH payment. The two categories, identified as the "Medicaid inpatient utilization

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[26] 42 U.S.C. § 1396r-4(a).
[27] 42 U.S.C. § 1396r-4(c)(3).
[28] *See, e.g., Ashtabula County Med. Ctr. v. Blue Cross Blue Shield Ass'n,* PRRB Dec. No. 2005-D49 (Aug. 10, 2005), *rev'd*, Administrator Dec. (Oct. 12, 2005).
[29] 527 F.3d 176 (D.C. Cir. 2008), *cert. denied*, 129 S. Ct. 1933 (2009).
[30] 527 F.3d at 180.
[31] 42 U.S.C. § 1396r-4(c)(3)(B).
[32] 527 F.3d at 180 (brackets, ellipses, and citation in original; footnote and underline emphasis added).

rate" and the "low-income utilization rate," are defined in subsection (b)(2) and (b)(3), in pertinent part, as follows:

> (b)(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were *eligible for medical assistance under a State plan approved under this title* [*i.e.*, Title XIX of the Act] in a period ... , and the denominator of which is the total number of the hospital's inpatient days in that period. ...
>
> (b)(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of –
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> (A) the fraction (expressed as a percentage)-
> (i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for *patient services under a State plan* under this title ... and (II) the amount of the *cash subsidies for patient services received directly from State and local governments*, and
> (ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and
>
> (B) a fraction (expressed as a percentage)-
> (i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and
> (ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period....[33]

Subsection (b)(2) specifically uses the term "eligible for medical assistance under a State plan," the exact language from the Medicare DSH statute that controls in this case. That phrase describes the days included in the "Medicaid inpatient utilization rate" for the Medicaid DSH adjustment.

It is the second category, the "low-income utilization rate," that clarifies what is and what is not included in "medical assistance under a State plan." Subsection (b)(3) defines the term "low-income utilization rate" to include three components. In paragraph (A)(i)(I) of this subsection, there is the first component consisting of "services [furnished] under a State plan under this title [XIX]," the same category of patients described in the Medicaid utilization rate. In paragraphs

[33] (Emphasis added.)

(A)(i)(II) and (B)(i), the language of the second and third components articulate "cash subsidies for patient services received directly from State and local governments" and "charity care" respectively. If Congress had intended the term "eligible for medical assistance under a State plan" (the only category of patients in the Medicaid utilization rate) to include the state funded hospital days and charity care days, the specific language used in these subsections adding those types of days in the "low income utilization rate" would have been superfluous.

Based on the above, the Board concludes that, because the KHCP is funded by "state and local governments" and, thus, is included in the low income utilization rate but not the Medicaid inpatient utilization rate, KHCP patient days do not fall within the Medicaid DSH statute definition of "eligible for medical assistance under a State plan" at § 1923(b)(2) of the Act.[34] Statutory construction principles require the Board to apply the meaning Congress ascribed to the term "eligible for medical assistance under a State plan" used in the Medicaid statute to the same phrase used in the Medicare statute.[35] KHCP patient days, therefore, cannot be included in the Medicare DSH statutory definition of "eligible for medical assistance under a State plan" at § 1886(d)(5)(F)(vi)(II) of the Act.[36] Accordingly, the Intermediary's adjustments properly excluded KHCP patient days from the Provider's Medicare DSH calculation.

DECISION AND ORDER:

The Intermediary properly refused to include Kentucky Hospital Care Program days in the numerator of the Provider's Medicaid proxy. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, CPA
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: NOV 19 2013

[34] 42 U.S.C. § 1396r-4(b)(2).
[35] *See Atlanta Cleaners & Dyers, Inc. v. U.S.*, 286 U.S. 427, 433 (1932).
[36] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).