PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2009-D38

PROVIDER –
Southwest Consulting 1999-2002 [State of] MA Uncompensated Care Days Group

Provider No.: Various

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ Associated Hospital Services

DATE OF HEARING -
March 4, 2009

Cost Reporting Periods Ended -
September 30, 1999 through 2002

CASE NOs.: 06-0316G; 06-0317G; 06-0318G and 06-0319G

INDEX

ISSUE:

Whether the Intermediary improperly computed the numerator of the Medicaid fractions that were used to calculate the Provider's disproportionate share hospital (DSH) payments for fiscal years 1999, 2000, 2001, and 2002 by excluding inpatient days attributable to individuals who received assistance under the Massachusetts Uncompensated Care pool for such days.

MEDICARE STATUTORY AND REGULATORY GENERAL BACKGROUND/DSH STATUTE:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal 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). 42 C.F.R. §405.1803. 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §§405.1835 – 405.1837.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). 42 U.S.C. §1395ww(d). The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. See, 42 U.S.C. §1395ww(d)(5). This case involves the hospital-specific "disproportionate share hospital" (DSH) adjustment, that requires the Secretary to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. §1395ww(d)(5)(F)(i)(I).

Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage (DPP)." See, 42 U.S.C. § 1395ww(d)(5)(F)(v). The DPP is the sum of two fractions, the "Medicare and Medicaid fractions," for a hospital's fiscal period. 42 U.S.C. §1395ww(d)(5)(F)(vi). The

Medicare fraction's numerator is the number of a hospital's patient days for such period which were made up of patients who (for such days) were entitled to both Medicare Part A and supplementary security income (SSI), excluding patients receiving state supplementation only, and the denominator is the number of patient days for patients entitled to Medicare Part A. See also, 42 C.F.R §412.106(b)(2). The Medicaid fraction's numerator is the number of hospital patient days for patients who (for such days) were eligible for medical assistance under a State Plan approved under Title XIX for such period but not entitled to benefits under Medicare Part A, and the denominator is the total number of the hospital's patient days for such period. 42 C.F.R. §412.106(b)(4). A provider whose DSH percentage meets certain thresholds receives an adjustment which results in increased PPS payment for inpatient hospital services. 42 U.S.C. §1395ww(d)(5)(F)(ii).

The Medicaid fraction included in the Title XVIII Medicare DSH statute is the only fraction at issue in this case. However, resolution of the Medicare DSH issue also requires interpretation of a similar DSH provision in the Title XIX Medicaid statute. The details of the Medicaid DSH provisions are discussed in more detail below.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Southwest Consulting 1999-2002 MA Uncompensated Care Days Group (the Provider) is a group of 13 Medicare participating, general, acute care hospitals located in Massachusetts.[1] Blue Cross and Blue Shield Association, the Associated Hospital Service and Mutual of Omaha are collectively referred to as the intermediary. The cost reporting periods at issue are the Provider's fiscal years ended September 30, 1999, 2000, 2001, and 2002. The parties filed stipulations specifically identifying the disallowances and adjustments at issue.

The Provider was represented by Christopher L. Keough, Esquire, of Vinson and Elkins, LLP. The Intermediary was represented by Arthur E. Peabody, Jr., Esq. of Blue Cross Blue Shield Association.

PARTIES' STIPULATIONS

The Providers and the Intermediary stipulated and agreed as follows concerning the disposition of the single issue in dispute common to each of these group appeals:

1. The issue in each of the above-captioned group appeals is:

   Whether the Intermediary improperly computed the numerator of the Medicaid fractions that were used to calculate the Providers' disproportionate share hospital ("DSH") payments for the fiscal years 1999, 2000, 2001 and 2002 by excluding inpatient days attributable to

[1] The fiscal years at issue consist of the following: 1999 (11 hospitals), 2000 (11 hospitals, 2001 (10 hospitals), and 2002 (13 hospitals).

individuals who received assistance under the Massachusetts Uncompensated Care pool for such days.

2. On September 6, 2006, the Board conducted a concurrent hearing on the same issue identified in the preceding paragraph 1 in appeals by another Massachusetts hospital, Beverly Hospital, Medicare provider number 22-0033, for the same four fiscal years ending in 1999, 2000, 2001, and 2002. Those appeals are assigned PRRB case numbers 04-1083, 04-1091, 04-1093 and 04-1950.[2]

3. The parties hereby stipulate and agree that the material facts and legal issues presented in the above-captioned group appeals for fiscal years 1999-2002 are the same in all pertinent respects as those presented to the Board with respect to the Massachusetts Uncompensated Care Pool issue in the Beverly Hospital appeals in PRRB case numbers 04-1083, 04-1091, 04-1093 and 04-1950. The parties, therefore, request that the Board issue the same decision in these group appeals as it issues in the Beverly Hospital appeals on the same issue for fiscal years 1999-2002.

4. The Providers agree that, within 30 days after the filing of these stipulations, they will submit for filing in the record of each of the above-captioned appeals additional copies of the post-hearing briefs and the exhibits that were submitted by the Provider and the Intermediary in the Beverly Hospital appeals, with respect to the Massachusetts Uncompensated Care Pool issue, in PRRB case numbers 04-1083, 04-1091, 04-1093 and 04-1950.

Subsequently the Providers and the Intermediary submitted "Additional Stipulations of the Parties" and agreed to the number of uncompensated care pool (UPC) days being claimed by the Providers. The providers contend that the agreed upon days should be included in the calculation of their Medicare DSH payments, subject to audit by the Intermediary.

BACKGROUND/FACTS

The State of Massachusetts (State) established an uncompensated care pool as a financing mechanism to distribute more equitably the burden of uncompensated care.[3] The State received Federal financial participation (FFP or Federal matching funds) for its expenditures on the assistance furnished through the UCP Medicaid DSH payments.[4]

The Intermediary excluded from the numerator of the Medicaid fraction of the Medicare DSH calculation inpatient days attributable to individuals who received assistance from

[2] On September 23, 2008 the Board issued decision 2008-D37 in those cases.
[3] Provider Final Position Paper ("FPP") at 6, and Exhibits P-1 and P-2.
[4] Provider FPP at 6-7. See 114.6 Mass. Code Regs. See Exhibit I-37, page 21, Provider Ex. 1 at 2.

the UCP. None of the patients that the Providers seek to count were determined eligible for Medicaid by the relevant state agency.

PARTIES' CONTENTIONS

The Intermediary contends that the UCP days may not be included in the numerator of the Medicaid fraction as the Providers failed to demonstrate that each of the individuals it wished to count was determined eligible for Medicaid by the relevant state agency. Massachusetts' UCP program specifically excludes those individuals participating in the Medicaid program and patients receiving assistance from the UCP are not necessarily eligible for Medicaid.[5] Moreover, CMS policy as described in Program Memorandum A-99-62, which permits inclusion of days not otherwise covered in some limited circumstances, provides no relief to the Providers but rather is consistent with the Intermediary's position.[6]

The Providers contend that the UCP days should be counted in the numerator of the Medicaid fraction because the UCP is part of the Medicaid DSH payment described in the CMS approved Medicaid State plan. Because CMS paid FFP on Medicaid DSH for UCP expenditures, and because CMS has the authority to pay matching funds only for State expenditures on medical assistance under the State plan, the UCP qualifies as "medical assistance under the State Plan" in accordance with the 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) computation at issue. Likewise, the recipients of UCP assistance are "eligible" for this medical assistance under the State plan, as they were the direct beneficiaries of the assistance.[7]

The Providers further assert that reimbursement from the UCP is based on a hospital's cost of inpatient hospital services furnished to individuals who qualified for assistance through the UCP. A hospital is entitled to payment from the pool based on the ratio of the hospital's free care costs in proportion to the total of all hospitals' free care costs and an allocated shortfall amount (the difference between total free care costs and funds available in the pool). The payment levels do not vary based on the volume or value of services furnished to other Medicaid recipients. As a result, UCP recipients are receiving a federally-funded benefit under the State plan that is indistinguishable in any material way from the benefit received by other Medicaid recipients under the State plan. Therefore, the days of inpatient care furnished to UCP recipients should be included in the Medicaid fraction.[8]

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[5] Intermediary Position Paper (FYE 2000) at 19-20; Exhibit I-37 at 7.
[6] Intermediary Position Paper (FYE 2000) at 14-15; Exhibit I-33.
[7] Provider FPP at 2-6.
[8] Id.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes as follows:

The evidence establishes that Massachusetts's UCP program beneficiaries are not eligible for Medicaid and the services provided under that program are not matched with federal funds except under the Medicaid DSH provisions.

Similar to the Medicare DSH provisions, 42 U.S.C. §1396r-4(a) mandates that a Title XIX Medicaid state plan must include a provision for a payment adjustment to hospitals which serve a disproportionate number of low income patients; that is, it requires a Medicaid DSH adjustment for hospitals that is independent of the Medicare DSH adjustment. 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 42 U.S.C. §1395d(a) of the Medicaid statute.

The question for the Board is whether the state paid program, not otherwise eligible for Medicaid coverage, and which is included in the state plan solely for the purpose of calculating the Medicaid DSH payment, constitutes "medical assistance under a State Plan approved under [Title] XIX" for purposes of the Medicare DSH adjustment, specifically the Medicaid fraction component.

The parties stipulated they wanted the same decision issued for this case as previously issued in Beverly Hospital Dec. No. 2008-D37. The Board in that decision interpreted the Medicare statutory phrase "medical assistance under a State plan approved under [Title] XIX" to include any program identified in the approved state plan, i.e. it did not limit the days counted to traditional Medicaid days. However, subsequent to the date of the parties' stipulations, the U.S. Court of Appeals for the District of Columbia issued its decision in Adena Regional Medical Center v. Leavitt, 527 F. 3d 176, (D.C. Cir., 2008), 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.[9] Like the UCP program, 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 the federal Medicaid statute, 42 U.S.C. §1396r-4(c)(3)B, allows states to calculate Medicaid 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 HCAP." Upon further analysis of the Medicaid DSH statute, 42 U.S.C. §1396r-4, the Board finds language that persuades us that the term "medical assistance under a State plan approved under [Title] XIX" excludes days funded only by the state and charity care days even though those days may be counted for Medicaid DSH purposes.

[9] The provider in Adena petitioned the U.S. Supreme Court to review the decision rendered by the U.S. Court of Appeals for the District of Columbia. On April 6, 2009 the Supreme Court denied review of that petition.

The Medicaid DSH statute describes how hospitals qualify for the Medicaid DSH adjustment. It establishes two distinct categories of low-income patients that are used to calculate a Medicaid DSH payment. 42 U.S.C. 1396r-4(b). The two categories, identified as the "Medicaid inpatient utilization rate" and the "low-income utilization rate," are defined 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 subchapter* [Title] XIX in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. (emphasis added)
>
> (b)(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of –
>
> (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 subchapter 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 service (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,

42 U.S.C. §1396r-4(b)(2)-(b)(3).

42 U.S.C. §1396r-4(b)(2)(i) specifically uses the term "eligible for medical assistance under a State plan," the exact language from the Medicare DSH statute in issue in this case. That phrase describes the days included in the "Medicaid inpatient utilization rate" for the Medicaid DSH adjustment. It is the "low-income utilization rate" description that clarifies what is and what is not included in "medical assistance under a State plan." The

components of the low-income utilization rate include "services rendered under a [Title] XIX State plan," the same category of patients described in the Medicaid utilization rate. However, the statute then adds as components subsidies for patient services received directly from State and local governments[10] and charity care.[11] 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 subsections adding those categories of days in the low income utilization rate would have been superfluous. As the UCP program is funded by "state and local governments" and thus is included in the low income utilization rate, not the Medicaid inpatient utilization rate, UCP patient days do not fall within the Medicaid statute definition of "eligible for medical assistance under a State plan" at 42 U.S.C. §1396r-4(b)(2)(i).

Statutory construction principles require us to apply the meaning Congress ascribed to the term "eligible for medical assistance under a [Title] XIX State plan" used in the Medicaid statute to the same phrase used in the Medicare statute. [12] UCP patient days therefore cannot be included in the Medicare DSH statutory definition of "eligible for medical assistance under a State plan" at 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). Accordingly, the Intermediary's adjustments properly excluded Massachusetts's UCP program patient days from the Provider's Medicare DSH calculation.

DECISION AND ORDER:

The Intermediary properly excluded Massachusetts's UCP days from the numerator of the Providers' Medicaid proxy. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

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Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.
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FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: August 28, 2009

[10] Subsection (b)(3)(A)(i).
[11] Subsection (b)(3)(B)(i).
[12] Atlanta Cleaners & Dyers, Inc. v. U.S., 286 U.S. 427, 433 (1932).