PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON-THE-RECORD
2010-D5

PROVIDER -
New Jersey 2000/2001/2002 Charity Care DSH Groups

Provider Nos.: See Appendix I-III

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ Riverbend Government Benefits Administrator

DATE OF HEARING -
August 28, 2009

Cost Reporting Periods Ended -
12/31/2000; 12/31/2001; 12/31/2002

CASE NOs.: 03-0859G; 04-1027G and 05-1256G

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ISSUE:

Whether Intermediary properly excluded New Jersey Charity Care Program (NJCCP) days from the Medicare disproportionate share (DSH) calculation for fiscal year-ends (FYEs) 2000 to 2002 for the hospitals in this group appeal.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper 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 interpretive guidelines published by CMS. 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. 42 U.S.C. §1395ww(d)(5). This case involves one of the hospital-specific adjustments, specifically the "disproportionate share hospital," or "DSH" adjustment. The Secretary is required 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." 42 U.S.C. §1395ww(d)(5)(F)(v). The "disproportionate patient percentage" is the sum of two fractions, the "Medicare and Medicaid fractions," expressed as a percentage for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi). A provider whose DSH percentage meets certain thresholds receives an adjustment that results in increased

PPS payment for inpatient hospital services. 42 U.S.C. §1395ww(d)(5)(F)(ii). The Medicare fraction's numerator is the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income (SSI), excluding patients receiving state supplementation only, and the denominator is the number of hospital patient days for patients entitled to Medicare Part A. Id. See also, 42 C.F.R. §412.106(b)(2). The Medicare fraction is also referred to as the Medicare proxy or the SSI fraction. The Medicaid fraction's numerator is the number of hospital patient days for patients who 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. Id; See also, 42 C.F.R. §412.106(b)(4). The Medicaid fraction is also referred to as the Medicaid proxy.

The Medicaid fraction is the only fraction under the Title XVIII Medicare DSH statute at issue in this case. However, resolution of the Medicare DSH issue also involves the interpretation of a similar DSH provision in the Title XIX Medicaid statute 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:

The Providers in this group appeal for FYEs 2000 through 2002 are eight acute care hospitals located in New Jersey. The Providers participated in the State of New Jersey Charity Care Program which provides medical assistance to uninsured low-income patients not eligible for other medical assistance programs, including Medicaid.

Riverbend Government Benefits Administrator (Intermediary) issued NPRs for the Providers' cost reporting periods at issue without including NJCCP days in the Medicaid fraction of the Providers' Medicare DSH calculations. The Providers timely appealed the Intermediary's determinations to the Board.

The Providers were represented by Mr. Jeffrey Kolmer of CBIZ KA Consulting Services, LLC. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of Blue Cross Blue Shield Association.

INCLUSION OF NJCCP DAYS IN THE MEDICAID PERCENTAGE OF THE MEDICARE DSH ADJUSTMENT

The parties agree that resolution of the issue hinges on the meaning of the phrase "patients who for such days were eligible for medical assistance under a State plan approved under . . .[Title] XIX" as used in the Medicare statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). This phrase identifies those days that are to be counted in the Medicaid proxy of the Medicare DSH adjustment.

Title XIX of the Social Security Act, 42 U.S.C. §1396a et. seq; known as the Medicaid statute, provides for federal sharing of state expenses for medical assistance for low-

income individuals, provided the state program meets certain provisions contained in the Medicaid statute. The state must submit a plan describing the program and seek approval from the Secretary. If approved, the state may claim federal matching funds, known as federal financial participation (FFP), under the Title XIX Medicaid statute for the services provided and approved.

Neither party submitted any portion of the New Jersey state plan on which the merits of this case rely. However, the material facts appear to be undisputed. Moreover, Provider relies on the Board's prior decision in Cooper University Hospital [Decision 2008-D22][1] which furnishes considerable detail about the NJCCP and assists in clarifying the program's operation as it relates to the State plan.

The evidence establishes that the patients who qualify for medical assistance under NJCCP are not eligible for Medicaid. The NJCCP is state funded and the State of New Jersey does not receive FFP for the inpatient services furnished to NJCCP patients.[2]

The dispute arises because the NJCCP is described in the New Jersey Medicaid State Plan under the section dealing with the Medicaid Disproportionate Share (Medicaid DSH) provisions.[3] The Medicaid DSH program is similar to the Medicare DSH program in that it requires states that participate in Medicaid to make a payment adjustment to hospitals that "serve a disproportionate number of low income patients." 42 U.S.C. §1396r-4(a). The state receives FFP for its Medicaid DSH expenditures. It is undisputed that the NJCCP days are permitted as part of the Medicaid DSH calculation on which Medicaid DSH FFP is based, but they are not Medicaid inpatient days and so do not qualify for FFP for the inpatient services furnished. The details of the state's Medicaid DSH program are required to be included in the Medicaid State Plan. Id.

PARTIES' CONTENTIONS:

The Providers contend that Medicare statute and regulations require the inclusion of the NJCCP days in the Medicare DSH calculation because the Secretary counts New Jersey charity care patients as part of the state's total medical assistance expenditures. These patients are plainly Federal/State medical assistance patients. The Provider notes that in previous decisions the Board required the inclusion of charity care days in the DSH calculation.

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[1] In Cooper, the Board reached a decision contrary to its decision in this case. After issuing Cooper, the D.C. Circuit court issued its decision in Adena Regional Medical Center v. Leavitt, 527 F.3d 176, (D.C. Cir., 2008). The Board has reconsidered its prior decisions in light of Adena. See discussion, infra.

[2] In Cooper, the evidence established that Medicaid participates in payment for these claims only through the Medicaid DSH payment, rather than FFP for the direct hospital services provided, as it does when a patient is eligible for Medicaid. "Payments made to New Jersey hospitals for the Charity Care Program come from the Health Care Subsidy Fund, which is supported by funding that the State of New Jersey receives through the Medicaid DSH program." See the Board's Cooper decision at page 4; see also Provider's Final Position Paper at page 9 in this case.

[3] See footnote 2, supra.

The Intermediary counters that "eligible for medical assistance under a State plan approved under [Title] XIX" is the statute's "longhand description of Medicaid" and, consistent with the Secretary's use of the term in the implementing regulation,[4] the terms "medical assistance" and "Medicaid" are interchangeable in the Title XIX Medicaid context. The Intermediary reasons that because the State plan provides that patients who are eligible for the NJCCP cannot be eligible for Medicaid, NJCCP days must be excluded from the Medicaid proxy of the Medicare DSH calculation. The Intermediary asserts that this distinction is critical. The state program must be covered under 42 U.S.C. §1396d(a)[5] of the Medicaid statute; that is, the patient days must be Medicaid eligible, not merely low income days that Medicaid permits to be counted solely for the Medicaid DSH adjustment.

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 New Jersey NJCCP 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 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 42 U.S.C. §1396d(a) of the Medicaid statute.

The question for the Board is whether the state paid program, not otherwise eligible for Medicaid coverage and that 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 in the Medicaid fraction component.

In prior decisions on similar state programs, the Board has 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 has not limited the days counted to traditional Medicaid days.[6] Subsequent to those decisions, the U.S. Court of

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[4] In 42 C.F.R. §412.106(b)(4), the Secretary substitutes the term "eligible for Medicaid" for "eligible for medical assistance under a state plan approved under Title XIX."

[5] Section 1396d(a) sets out services and eligibility requirements that the Intermediary characterizes as "traditional" Medicaid coverage.

[6] See e.g., Ashtabula County Medical Center et al. v. BlueCross BlueShield Association/ AdminaStar Federal, Inc., (Ashtabula) PRRB Dec. No. 2005-D49 (August 10, 2005) rev'd CMS Adm. Dec., CCH Medicare Guide 81,442 (October 12, 2005) .

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.[7] Like the NJCCP 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 for 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 it that the term "medical assistance under a state plan approved under [Title] XIX" excludes days funded by only the state and charity care days even though those days may be counted for Medicaid DSH purposes.

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

[7] 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.

> (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 second category, 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. But then the statute adds as components subsidies for patient services received directly from State and local governments[8] and charity care.[9] 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 NJCCP program is funded by "state and local governments" and thus is included in the low income utilization rate, but not the Medicaid inpatient utilization rate, NJCCP patient days do not fall within the Medicaid DSH 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 the Board 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. [10] NJCCP 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 NJCCP program patient days from the Providers' Medicare DSH calculations.

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

DECISION AND ORDER:

The Intermediary properly refused to include New Jersey Charity Care Program days in the numerator of the Providers' Medicaid proxy. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: November 6, 2009

APPENDIX I

Year 2000 New Jersey Charity DSH Group Appeal
Schedule of Providers in Group
Case No. 03-0859G

PROVIDER NUMBER	PROVIDER NAME	FYE
31-0015	Morristown Memorial Hospital	12/31/2000
31-0054	Mountainside Hospital	12/31/2000
31-0051	Overlook Hospital	12/31/2000
31-0012	Valley Hospital	12/31/2000
31-0077	General Hospital at Passaic	12/31/2000
31-0091	Memorial Hospital of Salem Cty	12/31/2000
31-0032	South Jersey Hospital	12/31/2000
31-0047	Shore Memorial Hospital	12/31/2000

APPENDIX II

Year 2001 New Jersey Charity DSH Group Appeal
Schedule of Provider in Group
Case No. 04-1027G

PROVIDER NUMBER	PROVIDER NAME	FYE
31-0015	Morristown Memorial Hospital	12/31/2001
31-0054	Mountainside Hospital	12/31/2001
31-0051	Overlook Hospital	12/31/2001
31-0012	Valley Hospital	12/31/2001
31-0077	General Hospital at Passaic	12/31/2001
31-0091	Memorial Hospital of Salem Cty	12/31/2001
31-0032	South Jersey Hospital	12/31/2001
31-0047	Shore Memorial Hospital	12/31/2001

APPENDIX III

Year 2002 New Jersey Charity DSH Group Appeal
Schedule of Provider in Group
Case No. 05-1256G

PROVIDER NUMBER	PROVIDER NAME	FYE
31-0015	Morristown Memorial Hospital	12/31/2002
31-0054	Mountainside Hospital	12/31/2002
31-0051	Overlook Hospital	12/31/2002
31-0077	General Hospital at Passaic	12/31/2002
31-0032	South Jersey Hospital	12/31/2002
31-0047	Shore Memorial Hospital	12/31/2002