PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D22

PROVIDERS –
Nazareth Hospital and
St. Agnes Medical Center
Philadelphia, PA

Provider Nos.: 39-0204 and 39-0022

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Highmark Medicare Services
(formerly Veritus Medicare Services)

DATE OF HEARING –
February 29, 2008

Cost Reporting Period Ended –
December 31, 2002

CASE NOs.: 04-2157 and 05-0706

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ISSUE:

Whether General Assistance (GA) days should be added to the numerator of the "Medicaid" proxy in the Disproportionate Share (DSH) payment calculation.

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 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.

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 payment 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 higher payments 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. 42 U.S.C. §1395ww(d)(5)(F)(vi). 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 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 these appeals are two acute care hospitals[1] located in the state of Pennsylvania. The Providers participated in the State of Pennsylvania's General Assistance (GA) Program, which provides medical assistance to uninsured low-income patients not eligible for other medical assistance programs, including Medicaid.

Highmark Medicare Services (Intermediary) issued NPRs for the Providers' cost reporting periods at issue without including GA days in the Medicaid fraction of the Providers' Medicare DSH calculations. The Providers in this case timely appealed the Intermediary's determinations to the Board.

The Providers were represented by Mark T. Bullock, Esquire, of Mercy Health System. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

INCLUSION OF GA 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 what days are counted in the Medicaid proxy of the Medicare DSH adjustment.

[1] Nazareth Hospital presented its case at a hearing on February 29, 2008. On January 20, 2009, St. Agnes Medical Center submitted a request for Case Number 05-0706, which raises the same legal issue regarding the Pennsylvania State plan, to be consolidated with Case Number 04-2157 since the two hospitals share common ownership and a decision had not yet been issued on the Nazareth Hospital case.

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.

The evidence established that the patients who qualify for medical assistance under the GA program are not eligible for Medicaid. The GA program is state funded and, except as discussed below, the State of Pennsylvania does not receive FFP for the inpatient services furnished to GA patients.

The dispute arises because the GA program is described in the Pennsylvania Medicaid State Plan under the section dealing with the Medicaid Disproportionate Share (Medicaid DSH) provisions. 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 GA program 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, i.e. what the Intermediary refers to as "traditional" Medicaid. The details of the state's Medicaid DSH program are required to be included in the Medicaid State Plan. Id.

PARTIES' STIPULATIONS:

The Providers and Intermediary stipulated as follows:

1) GA is a common acronym for General Assistance. General Assistance is a level of coverage included in the Pennsylvania State plan, enacted into the Pennsylvania Code by the Pennsylvania Legislature, to provide a mechanism to help publicly finance hospital care for low-income beneficiaries who would otherwise qualify as categorically or medically needy but for their income and/or resource levels exceeding qualification guidelines for Medicaid.

2) The Pennsylvania state plan at issue in this case operates under a §1915(b) waiver for the Medicaid Managed Care Program, Health Choices. The State plan includes provisions for reimbursing hospitals for certain services provided to low-income patients not eligible for traditional Medicaid under SSA §1902(a)(10)(A). These low-income patients include General Assistance beneficiaries.

3) General Assistance Days represent patient days of Pennsylvania Medical Assistance beneficiaries enrolled in the "State-Only funded" General Assistance Program. The days related to these beneficiaries are included in an alternate formula used to determine whether a Pennsylvania hospital qualifies for a DSH

payment under Section 1923(b) of the Social Security Act [42 U.S.C. §1396r-4(b)]. The hospital's total medical assistance cases, including General Assistance, are included in the determination of annual disproportionate share payments for each qualifying hospital, PA Code 55§1163.67(i)(1)(v).

4) The Pennsylvania General Assistance Days have been excluded from the DSH calculation by the Fiscal Intermediary since the expiration of the CMS issued hold harmless provision, Program Memorandum A-99-62, January 1, 2000.

5) The Pennsylvania State plan is approved under subchapter XIX by CMS. Included within the State plan is a provision for General Assistance level of coverage.

6) The Pennsylvania state plan is not a §1115 waiver plan.

7) Nazareth Hospital had General Assistance Medicaid eligible days for the period 1/1/02 – 12/31/02 equal to 847 days per patient log included with final position paper, Exhibit P-19.

8) The dollar impact of the exclusion of the General Assistance Days from the DSH calculation was filed on Nazareth Hospital's Medicare cost report as a protested item. The Fiscal intermediary, per [its] audit instructions, then issued an audit adjustment, #807, eliminating the protested item amounts.

PARTIES' CONTENTIONS:

The Providers contend that because the GA program was included in the Pennsylvania State Plan approved under Title XIX and the GA program qualified for federal financial participation under the Medicaid DSH program, GA patients are therefore "eligible for medical assistance under a State plan approved under [Title] XIX" and must be counted in the Medicaid fraction of the Medicare DSH adjustment.

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,[2] 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 GA program cannot be eligible for Medicaid, GA 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)[3] of the Medicaid statute; that is, the patient days must be Medicaid eligible, not merely low-income days that are counted solely for the Medicaid DSH adjustment.

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[2] 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."

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

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 Pennsylvania's GA 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 to decide is whether the state paid program, 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.

In prior decisions involving similar state programs, the Board had 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.[4] However, subsequent to the parties' hearing, 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.[5] Like the Pennsylvania GA 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."

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[4] 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) .

[5] 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.

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 only by 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 (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,
> (ii) the denominator of which is the total amount of hospital's charges for inpatient hospital services in the hospital in the period.

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 used in 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[6] and charity care.[7] 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 GA program is funded by "state and local governments" and thus is included in the low-income utilization rate, not the Medicaid inpatient utilization rate, GA patient days do not fall within the Medicaid statute's 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 consistently with the same phrase used in the Medicare statute.[8] GA patient days therefore would not 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 Pennsylvania GA program patient days from the Providers' Medicare DSH calculation.

DECISION AND ORDER:

The Intermediary properly excluded Pennsylvania GA 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.

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

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: March 23, 2010