PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D24

PROVIDER -
QRS 1996 DSH MediKan Days

Provider Nos.: 17-0040, 17-0086 and 17-0122

vs.

INTERMEDIARY -
Wisconsin Physicians Service

DATE OF HEARING -
July 21, 2009

Cost Reporting Periods Ended –
June 30, 1996; September 30, 1996

CASE NO.: 03-1199G

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ISSUE:

Whether the Intermediary should include all MediKan patient days, primary and secondary, in the Providers' disproportionate share hospital (DSH) 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 et seq. 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 (FI) and Medicare Administrative Contractors (MAC).[1] FI and MACs determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h and §1395 kk-1; 42 C.F.R. §§413.20(b) and 413.24(b).

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 proportion 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 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 one of the hospital-specific adjustments; specifically, the disproportionate share hospital (DSH) adjustment. The DSH adjustment requires the Secretary to provide increased PPS 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, for a hospital's cost reporting period. 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Medicare fraction's numerator is the number of

[1] Fiscal Intermediaries and MACs are hereafter referred to as intermediaries.

hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income, excluding patients receiving state supplementation only, and the denominator is the number of patient days for patients entitled to Medicare Part A. Id. 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 eligible for 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 frequently referred to as the Medicaid Proxy. Providers whose DSH percentages meet certain thresholds receive an adjustment which results in increased PPS payments for inpatient hospital services. 42 U.S.C. §1395ww (d)(5)(F)(ii).

In the mid-1990s, a controversy arose over the Secretary's interpretation of the DSH formula as set forth in the Medicaid statute. As described above, the numerator of the Medicaid fraction:

> is the number of the hospital's patient days for such period which consists of patients who (for such days) were ***eligible*** for medical assistance under a State plan approved under Title XIX …

42 U.S.C. §1395ww(d)(5)(F)(vi)(II) (emphasis added).

The regulation defining the Medicaid fraction for purposes of calculating a provider's DSH percentage in effect at the time of the controversy referred to the "number of patient days furnished to patients ***entitled*** to Medicaid." 42 C.F.R. §412.106(b)(4), (1993) (emphasis added). In applying the statute and the regulation, the Secretary's interpretation of eligibility required payment by Medicaid. However, HCFA ruling No. 97-2 (February 27, 1997), changed the prior policy of including in the DSH calculation only inpatient days of service which were actually paid for under a Medicaid State plan. The change in interpretation was in recognition of the holdings on this issue of the United States Courts of Appeals in the Fourth, Sixth, Eighth, and Ninth Circuits, which rejected the Agency's prior interpretation of including only patient days *paid* by Medicaid.

Thus, HCFA Ruling 97-2 conceded that the Medicaid fraction should include all days attributable to inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan, whether or not the hospital received payment for those inpatient hospital services.

The language in Ruling 97-2 and the implementing instructions regarding which individuals qualify as "eligible for medical assistance under a State plan approved under Title XIX" created a new controversy. Ruling 97-2 and the implementing instructions stated HCFA's policy that days attributed to individuals eligible for general assistance days (GADs) and other State-only funded programs (collectively, State-only program days) should be excluded from the DSH calculation. Intermediaries in certain States had historically allowed providers to include State-only program days applicable to health programs not contained in the relevant Medicaid State plans in their DSH calculations,

even though the statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) stated that only days attributable to individuals "eligible for medical assistance *under a State plan approved under Title XIX"* were to be included in the DSH calculation. (Emphasis added). Based on the Ruling and the implementing instructions, several of the intermediaries that previously had allowed inclusion of State-only program days in their providers' DSH calculations began amending their policies on this issue.

A number of states raised concerns with the need to repay the portion of the DSH payments attributable to the State-only program days. In response to these concerns, CMS decided to "hold harmless" hospitals that had received certain additional Medicare DSH payments, because guidance on how to claim these funds was not sufficiently clear.

CMS issued guidance on State-only days to fiscal intermediaries, Program Memorandum A-99-62, on December 1, 1999 (Program Memo or PM). The Program Memo addressed the treatment of the State-only program days issue on both a prospective and retrospective basis. The first portion of the Program Memo addressed CMS' clarification of the issue for cost reporting periods beginning on or after January 1, 2000. For such future periods, CMS clarified that "the term 'Medicaid days' refers to days on which a patient is eligible for medical assistance benefits under an approved Title XIX State plan." The Program Memo provides an example of what days were not included in the term "Medicaid days." Specifically, it provided that the term "Medicaid days" does not refer to days such as those utilized by beneficiaries in State programs that were not Medicaid programs, but that provided medical assistance to beneficiaries of State-funded income support programs. Those beneficiaries were generally not eligible for health benefits under a State plan approved under Title XIX; therefore, according to the Program Memo, days utilized by those beneficiaries did not count in the Medicare disproportionate share calculation. Furthermore, the Program Memo declared that no State-only program days would be counted as Medicaid days for purposes of the DSH calculation for cost reporting periods beginning on or after January 1, 2000 for any provider.

The second portion of the Program Memo contained what amounted to a change in HCFA's policy regarding State-only program days applicable to cost reporting periods beginning *prior to* January 1, 2000 (the New Policy). Hospitals that could retain or receive payments under the New Policy were split into two groups. The first group included those hospitals that already had received payments reflecting the inclusion of the State-only program days (referred to as the past payment prong). For cost reporting periods beginning prior to January 1, 2000, CMS directed intermediaries not to disallow the portion of Medicare DSH payments previously made to hospitals attributable to the inclusion of the State-only program days in the Medicaid proxy component of the Medicare DSH formula. In addition, the Program Memo stated that for open cost reports, intermediaries were to allow only those types of State-only program days that the hospital *received* payment for in previous cost reporting periods settled before October 15, 1999.

The second group of hospitals addressed by the New Policy focused on those hospitals that did *not* receive a Medicare DSH payment based on the inclusion of the State-only

program days. For cost reports that were settled before October 15, 1999, if a hospital never received any DSH payment based on the erroneous inclusion of State-only program days and the hospital did not file a jurisdictionally proper appeal to the Board on this issue prior to October 15, 1999, then intermediaries were not to pay the hospital DSH funds based on the inclusion of these types of days for any open cost reports for periods beginning prior to January 1, 2000. The Program Memo further stated that on or after October 15, 1999, intermediaries were not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of State-only program days in the Medicare DSH formula. However, if for cost reporting periods beginning prior to January 1, 2000, a hospital that had not received payments reflecting the inclusion of State-only program days had filed a jurisdictionally proper appeal to the Board for any single fiscal year on this issue before October 15, 1999, the intermediary was to reopen any such cost report and revise the Medicare DSH payment to reflect the inclusion of these State-only program days in the Medicaid Proxy (referred to as the appeal prong).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This group appeal was brought by three Kansas providers who qualify for the DSH adjustment. The Providers consist of Via Christi Regional Medical Center, University of Kansas Hospital, and Stormont-Vail Regional Health Center. The Providers participate in the Kansas MediKan program. MediKan is a general assistance program that is operated and funded by the State and is considered a temporary program for individuals pursuing disability benefits. The program provides coverage as both a primary and a secondary payor. Traditionally, MediKan has been included as a part of the Kansas State Plan approved under Title XIX, and the Intermediary included MediKan days in the DSH calculation where MediKan was the primary payor but did not include days for which MediKan was the secondary payor. At issue in this case is whether all MediKan patient days should be included in the calculation of the Medicaid fraction to determine the Providers' DSH adjustment under the Medicare DSH statute or, alternatively, under the hold harmless provisions of the PM.

The Board previously heard this case and issued a decision in 2007.[2] In the Board's previous decision, the majority of the Board found that under the DSH statute, the DSH calculation includes all "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 [Medicare Part A benefits]. 42 U.S.C. §1395ww(d)(5)(F)(vi)(II)." The Board majority also found that MediKan is included in the State of Kansas' approved state plan under Title XIX, and that the MediKan program compensates hospitals that serve a disproportionately high number of low-income patients. The Board majority found that the language of the statute does not limit or qualify "eligible for medical assistance under a State Plan approved under Title XIX" and

[2] See QRS 96 DSH Medikan Days Group v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Kansas, PRRB Case No. 2007-D24, December 7, 2005, Medicare and Medicaid Guide (CCH) ¶ 81,698, vacated and remanded, CMS Administrator, May 25, 2007, Medicare and Medicaid Guide (CCH) ¶ 81,710.

that the statute applies equally to Medicaid patients and to patients eligible for medical assistance under a State Plan approved under Title XIX. Based upon its reading of the statute, the Board majority concluded that the MediKan program falls within the express language of the statute, and all MediKan patient days, both primary and secondary, should be included in the calculation of the Medicaid proxy. However, the Board majority did not make any factual findings or conclusion regarding whether the Providers could include these days in the DSH calculation under the "hold harmless" provisions of the CMS' Program Memorandum A-99-62 (December 1999).[3] On review, the CMS Administrator reversed the Board's decision that MediKan days were those of patients "eligible for medical assistance under a state plan approved under Title XIX of the Act." The CMS Administrator remanded to the Board to consider whether the Providers were entitled to claim MediKan days under the "hold harmless" provisions of the PM. In addition, the CMS Administrator noted that there was insufficient information to determine whether there was jurisdiction over the University of Kansas Hospital's appeal from its revised NPR and remanded the case to the Board to supplement the record and determine jurisdiction.

The Board received additional submissions from the parties concerning the remand issues. In a separate decision, the Board determined that it had jurisdiction over the MediKan secondary payor days from the University of Kansas Hospital's revised NPR because there was a request that the Intermediary consider these days as part of a settlement agreement. Even though they were not included in the final calculation, the settlement agreement gave the Provider the right to appeal the DSH days.[4] A hearing on the hold harmless issue was conducted on July 21, 2009.

While the CMS Administrator's remand order vacating the Board's previous decision specifically requested the Board to address the two issues noted above, the Board notes that since its earlier decision in this case, the U.S. Court of Appeals for the District of Columbia issued its decision in Adena Regional Medical Center v. Levitt, 527 F. 3d 176 (D.C.Cir. 2008)(Adena), in which it held that general assistance days were not "medical assistance under a State plan approved under [Title] XIX and should not be included in the DSH calculation." In the Board's recent decisions it has adopted a position in accordance with Adena and has revised its decision in this case to be consistent with Adena as well.[5]

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[3] The Memorandum was the issue as PM A-01-13 (January 25, 2001). The only change was the discard date for the Memorandum.

[4] See Board Jurisdictional Decision, June 18, 2009.

[5] See Nazarath Hospital and St. Agnes Medical Center v. BlueCross BlueShield Association/Highmark Medicare Services, PRRB Dec. No. 2010-D22, March 23, 2010, aff'd CMS Administrator Decision, May 17, 2010; Saint Barnabas 2000/2001/2002/2004 DSH Adjustment Group Appeals and St. Peter's University Hospital v. BlueCross BlueShield Association/Riverbend Government Benefits Administrator, PRRB Dec. No. 2010-D27, May 27, 2010, aff'd CMS Administrator Decision, June 29, 2010; and UPMC 2001-2007 DSH Medical Assistance Under State Medicaid Plan Groups v. BlueCross BlueShield Association/Highmark Medicare Services – PA, PRRB Case No. 2010-D33, May 27, 2010, aff'd CMS Administrator Decision, July 13, 2010.

STPULATIONS OF THE PARTIES:[6]

The following are stipulations of the Parties, dated December 1, 2005.

A. The MediKan Program

1. Certain residents of Kansas not eligible for Medicaid coverage but otherwise eligible for general assistance are eligible for health coverage under a program referred to as "MediKan."

2. MediKan provides coverage for, among other health services, inpatient hospital services.

B. The Statutory and Regulatory Basis of the MediKan Program

3. MediKan is included within the Kansas State Plan under Title XIX.

4. The State of Kansas adopted MediKan as part of the same statutory authority, Section 39-708c(a) of the Kansas State Statutes, by which it adopted the Medicaid program.

5. The same set of Kansas regulations, K.A.R. §§30-5-58 to 30-5-174, regulate the Kansas Medicaid and MediKan programs.

C. Funding of the MediKan Program

6. There is no direct federal funding of the MediKan program.

7. The Kansas Medicaid DSH adjustment computation includes Medicaid and MediKan patient days and thus there is indirect federal funding of the MediKan program.

D. MediKan Patient Days

8. During FYE's 6/30/96 and 9/30/96, the Providers furnished inpatient hospital services to persons eligible for MediKan.

9. During FYE's 6/30/96 and 9/30/96, the Providers furnished services to persons eligible for MediKan who were included in the State of Kansas paid days total on the Medicaid Provider Summary Report because the MediKan program paid the Providers for furnishing services to such persons. Such days are referred to in the parties' respective pleadings in this case as "primary" MediKan days.

10. During FYE's 6/30/96 and 9/30/96, the Providers furnished services to

[6] Parties' Joint List of Exhibits Prepared for Board Hearing, Exhibit 3.

persons eligible for MediKan who were not included in the State of Kansas paid days total on the Medicaid Provider Summary Report, because the MediKan program did not pay the Providers for furnishing services to such persons. Such days are referred to in the parties' respective pleadings in this case as "secondary" MediKan days.

11. In computing the Medicare disproportionate share adjustment ("DSH") for the Providers for FYE's 6/30/96 and 9/30/96, the Intermediary was not aware the MediKan days were included in the Medicaid Provider Summary Report and, inadvertently, the Intermediary included primary MediKan days in the numerator of the Medicaid Ratio.

12. In computing the Medicare disproportionate share adjustment ("DSH") for the Providers for FYE's 6/30/96 and 9/30/96, the Intermediary did not include secondary MediKan days in the numerator of the Medicaid Ratio.

E. The Parties' Dispute Whether MediKan Consititutes "Medical Assistance" For Purposes Of The Medicare DSH Statute

13. The Medicare DSH statute, 42 U.S.C. §1395(d)(5)(F)(vi), requires the Intermediary to include in the Medicaid ratio "the number of 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."

14. The Providers contend that MediKan days constitute "medical assistance" for purposes of the Medicare DSH statute, and thus should be included in the Medicaid Ratio because MediKan.

15. The Intermediary contends that only traditional Medicaid days constitute "medical assistance" for purposes of the Medicare DSH statute, and that MediKan days should not be included in the numerator of the Medicaid Ratio.

16. Thus, at issue for the Board to decide is whether MediKan coverage comes within the definition of "the number of 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."

F. The Parties' Dispute The Application Of The Program Memorandum Hold Harmless Provision

17. Program Memorandum A-99-62 (December 1, 1999) (the "Program Manual [sic]") sets forth the following hold harmless provision:

> For cost reporting periods beginning before January 1, 2000, you are to continue to allow these types of days in the Medicare DSH calculation for all open cost reports only in accordance with the practice followed

> by the hospital at issue before October 15, 1999 (i.e., for open cost reports, you are to allow only those types of otherwise ineligible days that the hospital received payment for in previous cost reporting periods settled before October 15, 1999).

18. The Intermediary contends that only the primary MediKan days come within the scope of the Program Memorandum hold harmless provision.

19. The Providers contend that the primary and secondary MediKan days come within the scope of the Program Memorandum hold harmless provision.

20. Thus, at issue for the Board to decide is whether primary and secondary MediKan days come within the scope of the Program Memorandum hold harmless provision.

G. The Parties' Dispute The Application Of the Program Memorandum Reopening Provision

21. The Program memorandum sets forth the following reopening provision:

> The Program Memorandum instructed the Intermediary to reopen and include patient days such as MediKan "[i]f, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999. . . ."

22. The appeals of two of the Providers in the instant case were filed before October 15, 1999; Via Christi Regional Medical Center (March 22, 1999) and Stormont –Vail Regional Medical Center (February 5, 1999).

23. Via Christi Regional Medical Center and Stormont-Vail Regional Medical Center contend that the reopening provisions applies to their appeals because their appeals included appeal of the DSH adjustment, although the appeal did not specify exclusion of secondary MediKan days.

24. The Intermediary contends that the reopening provision does not apply to the appeals of appeals of Via Christi Regional Medical Center and Stormont-Vail Regional Medical Center because their appeals did not present a claim that MediKan secondary days were erroneously excluded from the Medicaid DSH proxy.

25. Thus, at issue for the Board to decide is whether the appeals of Via Christi Regional Medical Center and Stormont-Vail Regional Medical Center come within the scope of the reopening provision of the Program Memorandum.

PARTIES' CONTENTIONS:

The Providers argue that the language of the Medicare DSH statute is clear and unambiguous. Under the statute, the DSH calculation includes all "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 [Medicare Part A benefits]." 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). The State of Kansas adopted the MediKan program to furnish health services to those persons eligible for medical assistance who do not meet all the technical qualifications for Medicaid as a part of the same statutory authority by which it adopted the Medicaid program. Kansas State Statutes §39-708c(a). Further, MediKan is part of the Kansas State Plan approved under Title XIX, and Kansas MediKan program days should, therefore, be included in the DSH calculation. The Providers also note that in previous cases involving the same issue, the PRRB determined that such programs of medical assistance should be included in the DSH calculation.[7]

The Providers also contend that they all qualify for hold harmless under the past payment prong of the PM and that Via Christi and Stormont-Vail also qualify for relief under the appeal prong. With respect to the past payment prong, the Providers note that the Intermediary included MediKan days in the DSH adjustment, but only when MediKan was the primary coverage. The Providers assert that all MediKan days – primary and secondary – should have been included because, there is no distinction between Medicaid "paid" and "unpaid" days; Ruling 97-2 applies equally to MediKan days and therefore there should be no distinction between "paid" (primary) and "unpaid" (secondary) MediKan days.

With respect to the appeal prong, the PM instructs intermediaries to reopen and include patient days such as MediKan "[i]f, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the [Board] on the issue of the exclusion of these days from the Medicare DSH formula before October 15, 1999 . . ." The Providers note that the appeal prong provision of the PM was addressed in St. Joseph's Hospital v. Blue Cross Blue Shield Association/Noridian Administrative Services, (St. Joseph's).[8] In St. Joseph's, the Board found that the provider had appealed the issue prior to October 15, 1999 and that since the provider had appealed prior to the issuance of the PM, it could not have been aware that CMS would require any special phrases be used in order to appeal general assistance or other State-only days. The CMS Administrator reversed the Board on this issue, holding that the wording of the appeals had to specifically mention the type of days described in the PM. The District Court,

[7] See Ashtabula County Medical Center et.al. vs. BlueCross and BlueShield Association/AdminiStar Federal, Inc., PRRB Dec. No. 2005-D49 (August 10, 2005) rev'd, CMS Administrator Decision (October 11, 2005); Jersey Shore Medical Center vs. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Dec. No. 99-D4 (October 30, 1998).

[8] PRRB Dec. No. 2004-D32, August 12, 2004, Medicare and Medicaid Guide (CCH) ¶81,265, rev'd, CMS Administrator, October 13, 2004, Medicare and Medicaid Guide (CCH) ¶81,183, rev'd, St. Joseph's Hospital v. Leavitt, 425 F. Supp. 2d 94 (D.D.C. 2006).

however, agreed with the Board that it was not proper for CMS to require the use of "magic words" in filing its appeal. The Providers point out that, as in St. Joseph's, Via Christi and Stormont-Vail filed appeals of their DSH adjustment prior to October 15, 1999 and should not be required to mention any special words in their appeals.

The Intermediary contends that while the Kansas MediKan statutory scheme is part of the overall approved State Medicaid Program, it does not automatically bring MediKan beneficiaries under the Medicaid DSH proxy. The Intermediary argues that the enabling DSH statute and its implementing regulation at 42 C.F.R. §412.106(b)(4) use different terms,[9] but when read collectively, clearly mean Medicaid only. Days for patients who were eligible for medical assistance under an approved State plan can only be for patients who fall into the categories identified in §1902(a)(10)(A)(i) of the Social Security Act. To obtain MediKan payments, Kansas hospitals must comply with Kansas State Statute §39-708c(a), which requires that individuals not be eligible for Medicaid under the State plan. Accordingly individuals receiving benefits through the MediKan program are not eligible for Medicaid, and the patient days attributed to those patients cannot be included in the Medicaid proxy.

The Intermediary acknowledges that the Providers received payment for their MediKan primary days during the relevant period and under the past payment prong, the Intermediary has held the Providers harmless for the additional payments resulting from the erroneous inclusion of these ineligible days. At the same time, the Intermediary indicates that the Providers were not previously paid for MediKan secondary days and therefore had no expectation of receiving payment for these days. Since the Providers have not received any erroneous payment for MediKan secondary days, they cannot receive payments for the period in dispute here under the past payment prong. The Intermediary also contends that the Providers are not entitled to payment for MediKan secondary payment days under the appeal prong of the PM. The Intermediary points out that even though the Board and Court in St. Joseph's did not require the provider to use special words in their appeal statements, both noted that there was clear evidence in the record that the provider claimed general assistance days in both its initial and subsequent submissions to its intermediary. The Intermediary claims that under St. Joseph's, the Providers must have some evidence that they intended to included MediKan secondary days in their appeal and there is no evidence of that in their appeals.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare and Medicaid laws, program instructions and the parties' arguments, the Board finds and concludes as follows:

[9] 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) defines patient days included in the numerator of the Medicaid proxy as those days pertaining to "patients eligible for medical assistance under a state plan approved under subchapter XIX of this chapter." 42 C.F.R. §412.106(b)(4) requires that "The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period."

The evidence establishes that Kansas MediKan program beneficiaries are not eligible for Medicaid and the services provided under the MediKan program are not matched with federal funds except under the Medicaid DSH provisions.[10]

Similar to the Medicare DSH provisions, the Medicaid statute at 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 federal financial participation (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 Board is revisiting the question of whether the State-only 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 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.[11] However, the U.S. Court of Appeals for the District of Columbia more recently 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.[12] Like the Kansas MediKan 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," as used in the Medicare DSH statute, 42 U.S.C. §1395ww(d)(5)(vi)(II), 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

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[10] See Stipulation 5, 6 and 7.

[11] 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. Decision (October 11, 2005).

[12] 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.

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 in paragraphs (2) and (3) with respect to the periods at issue as follows:

> (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)
>
> (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 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 hospital's charges for inpatient hospital services in the hospital in the period.[13]

[13] Paragraphs (2) and (3) were amended by Section 701(b)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 to add language applicable to payments made on or after January 1, 2001, clarifying that inpatient days (in the case of the Medicaid inpatient utilization that defined in paragraph (2) or revenues for patient services in the case of the low-income utilization rate defined in paragraph (3) would be counted regardless of whether the Medicaid eligible patient to whom hospital services were provided received them on a fee-for-service basis or through a managed a care entity.

42 U.S.C. §1396r-4(b)(2)-(b)(3).

The Medicaid statute at 42 U.S.C. §1396r-4(b)(2) 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 type of patients for whom days are included in the "Medicaid inpatient utilization rate" for the Medicaid DSH adjustment. It is the second category of days included, the "low-income utilization rate" description in 42 U.S.C. §1396r-4(b)(3), that clarifies what is and what is not included in the term "medical assistance under a State plan." The components of the low-income utilization rate include "patient services rendered under a State plan under this subchapter," the same category of patients described in the Medicaid utilization rate. However, then the statute adds as components subsidies for patient services received directly from state and local governments[14] and charity care.[15] 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 clauses adding those categories of days in the low income utilization rate would have been superfluous. As the MediKan program is funded by "state and local governments" and thus is included in the low-income utilization rate, not the Medicaid inpatient utilization rate, MediKan 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).

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.[16] General assistance (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 properly excluded Kansas MediKan program patient days from the Providers' Medicare DSH calculations.

Even though the Board finds that the Providers are not entitled to include MediKan days in the DSH calculation under the statute, the Board considered whether the Providers are entitled to include MediKan primary and secondary days in the DSH calculation under either the past payment prong or the appeal prong of the hold harmless provisions in the Program Memorandum.

Under the past payment prong, PM A-99-62 instructed intermediaries not to disallow the portion of the Medicare DSH adjustment payments previously made to hospitals attributable to the erroneous inclusion of, *inter alia*, State-only health program charity care, or Medicaid DSH, and/or ineligible waiver or demonstration population days on the Medicaid days factor used in the Medicare DSH formula. This instruction was consistent with the CMS' determination that hospitals and intermediaries relied, for the most part, on Medicaid days data obtained from State Medicaid agencies to compute Medicare DSH payments and that some of those agencies comingled the types of otherwise ineligible

[14] Subsection (b)(3)(A)(i)(II).
[15] Subsection (b)(3)(B)(i).
[16] Atlanta Cleaners & Dyers, Inc. v. U.S., 286 U.S. 427, 433 (1932).

days listed above with Medicaid Title XIX days in the data transmitted to hospitals and/or intermediaries.[17] The Board finds that under these circumstances, the facts in this case indicate that the Providers met the past payment prong for MediKan primary days but not for MediKan secondary days.

The parties have stipulated that certain residents of Kansas, not eligible for Medicaid coverage, but otherwise eligible for general assistance, are eligible for health coverage under the State-only funded MediKan program.[18] When the State paid for inpatient services under the MediKan program, these days were included in the State of Kansas paid days total on the Medicaid Provider Summary Report. Because the Intermediary was unaware that MediKan primary days were included in the State of Kansas paid days total on the Medicaid Provider Summary Report, the Intermediary inadvertently included them in the numerator of the Medicaid ratio.[19] The Intermediary has acknowledged that the Providers erroneously received payment for their MediKan primary days during the relevant period, and under the past payment prong, the Intermediary has held the Providers harmless for the additional payments resulting from the erroneous inclusion of these days. The Intermediary has included MediKan primary days with calculation for DSH payments and those days are, therefore, not in dispute.

On the contrary, when the State did *not pay* for inpatient days for person eligible for Medikan, these days were not included in the State of Kansas paid days total on the Medicaid Provider Summary Report.[20] The parties have stipulated that the Intermediary consequently did not include MediKan secondary days in the numerator of the Medicaid ratio.[21] Even though the parties acknowledged that the Providers submitted their cost reports based on the State Medicaid Provider Summary Report, which did not include MediKan secondary days,[22] the Board also examined the record to determine whether there were any instances in which MediKan secondary days may have also been included in the Providers DSH calculation. With respect to Via Christi, the Board reviewed correspondence on which days were excluded from the DSH calculation.[23] The Board determined that these days did not include MediKan secondary days; rather the disallowed days related to non-PPS days.[24]

With respect to Stormont-Vail, however, the Board reviewed evidence that the Intermediary did include some MediKan secondary days in settling a prior cost report.[25] The Intermediary representatives explained:

> Regarding Exhibit 20, and that is the end of a case, a long, prolonged

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[17] See PM at 3.
[18] See Stipulations 1 and 6.
[19] See Stipulation 11.
[20] See Stipulations 8 – 12.
[21] See Stipulation 12 and see also Tr. at 86 and 87.
[22] Tr. at 86-87.
[23] See Exhibit 4.
[24] See Tr. at 85-87 and Providers' September 2, 2009 letter, No. 1, response to Board Member Hayes' question 2 for basis of Board's determination.
[25] See Exhibit 20 at 17.

> proceeding for Stormont-Vail for a different period that wound up at the Board under a completely different issue, eventually a favorable indication to the provider to go back and come up with its best eligible day claimed, and this was after WPIC [a different fiscal intermediary] became the - - succeeded under that contract to the Kansas providers. They did include MediKan secondary days in the DSH resolution of that case earlier in 2009. We looked at that action. We looked at the position asserted by Blue Cross/Blue Shield of Kansas and the association in the first proceeding. We look at the position that was asserted against the University of Kansas in this proceeding when they attempted to add in MediKan secondary days back in 2003 and very publicly and very strongly Blue Cross and Blue Shield of Kansas said no. Now, the Board can disagree with that, but to the extent that there is an inconsistency between what happened at the end of the case that's in Exhibit 20 and the proceedings that have gone to date, that latter allowance is simply an error. It's an action outside of this case.

Tr. at 59-60.

The Providers' representative did not dispute the Intermediary's explanation.[26] The Providers' response to the Board's November 9, 2009 post hearing request for further information failed to clarify the circumstances any further.[27]

Subsequent correspondence indicated that the Intermediary decided not to follow through on the reopening but that it did not reflect a decision by the Intermediary on the merits of the MediKan secondary days issue.[28]

The Board finds the Intermediary made a clear delineation between primary and secondary MediKan days as to what was allowed and disallowed. The Intermediary's actions, at no time during the relevant cost report periods, during the time leading up to the filing of these appeals, or during the pendency of this appeal, raised any expectation of Providers being allowed to include secondary MediKan days in the DSH calculation. To allow the secondary days based on the Intermediary's allowing primary days, as the Provider insists is warranted, or allowing secondary days based on the Intermediary's having mistakenly included some in another settlement two years after the Board's original decision was remanded, would exacerbate the error identified in the hold harmless provisions. It does not fulfill the purpose of the hold harmless to maintain the status quo or protect reasonable expectations. The Board concludes that the past payment prong of the hold harmless provision is not applicable. MediKan secondary days are properly excluded.

Under the alternate appeal prong of the PM, if a hospital filed a jurisdictionally proper appeal to the Board "on the issue of the exclusion of these types of days from the

[26] See Tr. at 69.
[27] See Provider's December 3, 2009 response to Board questions, question 3 at 4.
[28] See Intermediary's December 17, 2009 letter, Question 3.

Medicare DSH formula before October 15, 1999," the intermediary may reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days.[29] It is undisputed that two of the Providers in this case, Via Christi and Stormont-Vail, filed appeals before October 15, 1999.[30] The Providers contend that the appeal prong applies because their appeal included the DSH adjustment even though they acknowledge the appeals make no reference to the exclusion of MediKan secondary days. The Intermediary contends that the appeal prong does not apply because their appeals did not specifically claim MediKan secondary days were excluded from the DSH calculations nor did they meet the any of the requirements established by the Board and Court in St. Joseph, supra.

In St. Joseph, neither the Board nor the Court required that the provider use any special words in its appeal request; however, both found evidence in the record that general assistance days had been claimed and denied in the audit adjustment and that the provider appealed that specific audit adjustment. In this case, the Board has thoroughly searched the record and also requested additional evidence from the parties post-hearing showing any claim for MediKan secondary days. The Board found none.[31]

Via Christi's appeal request to the Board dated March 22, 1999 included DSH in Issue No. 1.[32] The appeal request only stated "that a portion of Medicaid patient days were not included when calculating eligible payments" and that "the SSI ratio used was understated."[33] The appeal also referred to specific audit adjustments.[34] The Board requested further information from the parties concerning the nature of the audit adjustments and any audit workpapers associated with these adjustments.[35] In response, neither party could locate any audit adjustments or associated workpapers;[36] however, the Provider acknowledged that it "did not claim, and thus the Intermediary did not consider *secondary* MediKan days in computing the DSH Adjustment."[37] The only disallowance related to Via Christi was for non-PPS days. The first indication of Via Christi's intent to claim MediKan secondary days was when it added this issue to the appeal on April 17, 2003.[38]

The Stormont-Vail initial appeal request, stated only that the "Intermediary did not determine Medicare reimbursement for [DSH] payments in accordance with Medicare statute 42 U.S.C. Section 1395ww(d)(5)(c)(i)" and referenced an adjustment number. It also asserted that the SSI ratio was understated.[39] There is no evidence to indicate any

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[29] See PM at 4.
[30] See Stipulation 22.
[31] See Providers' December 3, 2009 Response to Board Questions, Question 1 at 1-2 and Question 2 at 4.
[32] See Exhibit 3.
[33] Id.
[34] Id.
[35] See Board's November 9, 2009 letter, Question 1.
[36] See Providers' December 3, 2009 letter and Intermediary's December 17, 2009 letter, Responses to Board Question 1.
[37] Id. at Question 1, point 2 on page 2. See also Exhibit 4 and Tr. at 85-87.
[38] See Exhibit 5, Provider Letter Requesting to Add Issue and Transfer to Group Appeal, Issue 2 - DSH MediKan Days.
[39] See Exhibit 6.

exclusion of MediKan secondary days until Stormont-Vail added that issue to the appeal on April 25, 2003.[40]

The Providers' appeals failed to indicate, directly or indirectly, any dissatisfaction regarding secondary MediKan days in the DSH calculation until several years after the deadline. To allow the secondary days based solely on primary days having been included in the calculation without either party apparently even knowing they were among the State's listing,[41] would exacerbate the error identified in the hold harmless provisions rather than fulfilling its purpose. The Board concludes that the appeal prong of the hold harmless provision is not applicable. MediKan secondary days are properly excluded.

DECISION AND ORDER:

MediKan days are not days for patients who were "eligible for medical assistance under a State plan approved under title XIX" and are therefore properly excluded from the Medicaid fraction of the Medicare DSH adjustment. The Providers do not meet the criteria in PM A-99-62 to permit inclusion of MediKan secondary days in the Medicaid fraction of the Medicare DSH adjustment. The Intermediary's determination is affirmed.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: April 6, 2011

[40] See Exhibit 7.
[41] See Stipulation 11.