PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D36

PROVIDER –
Southern Christian Medical Center
(formerly known as Bella Vista del Suroeste)

Provider No.: 40-0110

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
First Coast Service Options, Inc. – FL
(formerly Cooperativa de Seguros de Vida de Puerto Rico)

DATE OF HEARING -
June 4, 2008

Cost Reporting Periods Ended -
December 16, 2002; December 31, 2000

CASE NOs.: 06-1431 and 06-2384

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ISSUE:

Whether the Intermediary improperly excluded certain days attributable to Puerto Rico Medicaid enrollees who were classified by the Administration De Seguros De Salute De Puerto Rico as category six, for which Puerto Rico receives no Federal matching funds in computing the fraction reflecting the percentage of inpatients who were entitled to medical assistance under an approved state plan (the Medicaid fraction) for purposes of the Medicare disproportionate share hospital 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 & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FI) and Medicare administrative contractors (MACs). FIs and MACs[1] determine payment amounts due the providers under Medicare law and interpretive guidelines published by CMS. 42 U.S.C. §§1395h and 1395kk-1; 42 C.F.R. §§413.20 and 24.

At the close of its fiscal year, a provider must submit a cost report 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 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 costs of inpatient hospital services are paid by Medicare primarily through the Prospective Payment System (PPS). 42 U.S.C. §1395ww(d). The statute contains a number of provisions that adjust PPS payments 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 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 for a

[1] FIs and MACs are hereinafter referred to as intermediaries.

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. 42 U.S.C. §1395ww(d)(5)(vi)(I); 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 hospital patient days for such period. 42 U.S.C. §1395ww(d)(5)(vi)(II); 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 at issue in this case.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Provider in this case is Southern Christian Medical Center (formerly known as Bella Vista del Suroeste).[2] The Provider participated in the Commonwealth of Puerto Rico's Medicaid program known as La Reforma.

The Commonwealth of Puerto Rico's Medicaid state plan (La Reforma) covers individuals up to 100% of Puerto Rico's poverty level. Individuals enroll in this program under Categories 1 through 5. Since Puerto Rican poverty levels are substantially less than the Federal level, Puerto Rico established a Category 6 to cover those individuals who are greater than 100% of the Puerto Rico poverty level but less than the Federal level. Category 6 is not part of Puerto Rico's state plan under Title XIX and does not receive matching Federal funds.[3]

Cooperativa de Seguros de Vida de Puerto Rico (Intermediary) issued NPRs for the Provider's cost reporting periods at issue without including inpatient days of Category 6 enrollees in the Medicaid fraction of the Provider's Medicare DSH calculations. The Provider timely appealed the Intermediary's determinations to the Board.

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 the days to be counted in the Medicaid proxy of the Medicare DSH adjustment.

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

[2] During the years at issue, Adventist Health System owned and operated the Provider.
[3] *See* Stipulations of the Parties 3-8.

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 the plan is approved, the state may claim Federal matching funds, known as federal financial participation (FFP), for the services provided under the approved state plan.

The individuals participating in Category 6 have incomes up to 200% of the Puerto Rico poverty level. That level, for fiscal year 2000, was less than 100% of the Federal poverty level. The evidence established that the Category 6 patients who qualify for assistance are funded entirely by the Commonwealth of Puerto Rico. The Commonwealth does not receive FFP for the inpatient services furnished to Category 6 patients.

The dispute arises because of the unique nature of the Puerto Rico Medicaid program. Unlike the Medicaid programs of the 50 States, Puerto Rico (as well as the other territories) is limited to a fixed amount for FFP. Puerto Rico is not required to cover the mandatory Medicaid eligibility groups up to the same income levels as the 50 States. Puerto Rico uses incomes up to 100% of its own poverty level, which is substantially lower than the Federal poverty level, to determine eligibility for medical assistance for which FFP will be received.[4]

The Provider was represented by Stephanie A. Webster, Esq. and Christopher L. Keough, Esq. of Vinson & Elkins LLP. The Intermediary was represented by Wallace Vasquez Sanabria, Esq.[5]

PARTIES' CONTENTIONS:

The Provider contends that the days of all Category 6 individuals should be included in the Provider's Medicare DSH calculation regardless of the extent to which the Commonwealth receives FFP for those individuals. The Provider argues that the Category 6 individuals are enrolled in, and receive medical assistance from the Puerto Rico Medicaid program and receive the same benefits as do individuals enrolled in the program under Categories 1 through 5. The Provider contends that the Category 6 individuals could have received FFP under the traditional state plan of one of the 50 states since the income and resources of these individuals fall below the Federal poverty level. The Provider contends that the Category 6 individuals could be "eligible for medical assistance" under a State plan and that CMS policy is to include in the Medicaid fraction days for "hypothetical eligibles" who could have been made eligible under a State plan.[6] The Provider contends that the intent of the statute is to provide additional

[4] The Puerto Rico poverty level does not change annually as does the Federal poverty level. For fiscal year 2000, one of the fiscal years at issue in this case, the Puerto Rico poverty level was less than 50% of the Federal poverty level. *See* Provider's Consolidated Position Paper at 7 and Providers Exhibits 4 and 5.

[5] As of March 1, 2009, First Coast Service Options, Inc. (FCSO) was awarded the contract to be the Medicare Administrative Contractor (MAC) for Puerto Rico, and the Part A intermediary contract of Cooperativa de Seguros de Vida de Puerto Rico was transferred to FCSO. The new representative for FCSO is Murray McGowan, Appeals Manager.

[6] *See* Provider's Consolidated Final Position Paper at 11.

payments to hospitals serving low-income patients and that the Category 6 patients are clearly low-income, with income and resources below the Federal poverty line.

The Intermediary contends that Program Memorandum A-99-62 (December 1999) specifically addresses the question at issue. The Intermediary cites the following language from the memorandum:

> Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, it must contact the State for assistance in doing so.

The Intermediary contends that since Category 6 beneficiaries are funded only by Puerto Rico and no FFP is paid by the Federal Government for them, the inpatient hospital days attributable to those beneficiaries cannot be included in calculating the Medicare DSH adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The question for the Board is whether the Puerto Rico Category 6 beneficiaries should be considered "eligible for medical assistance under a State Plan approved under [Title] XIX"[7] for purposes of the Medicare DSH adjustment, specifically the Medicaid fraction component, even though Puerto Rico does not receive FFP for those beneficiaries. The Board finds that Category 6 individuals are not eligible for medical assistance under an approved State Plan. If they were eligible under an approved State Plan, there would be FFP for the cost of those services. However, Puerto Rico did not receive FFP for the cost of their care.

Several courts have addressed this issue as it relates to the interpretation of the definition of the numerator of the Medicaid fraction used to calculate the Medicare DSH adjustment. The U.S. Court of Appeals for the District of Columbia, in its decision in Adena Regional Medical Center v. Leavitt, 527 F. 3d 176, (D.C. Cir., 2008), 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

[7] 42 U.S.C. §1395ww(d)(5)(vi)(II); 42 C.F.R. §412.106(b)(4).

calculation.[8] Like the Puerto Rico Category 6 beneficiaries, the care for HCAP patients was paid for solely by the State. Similarly, in Phoenix Memorial Hospital v. Sebelius, 2010 WL 3633179 (9th Cir., 2010), the Court held that patient days for 2 categories of low-income individuals that were included in Arizona's Medicaid plan but were 100% funded by the State were not "eligible for medical assistance" for purposes of the Medicare DSH calculation.[9]

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."[10]

Upon further analysis of the Medicaid DSH statute, 42 U.S.C. § 1396r-4, the Board is also convinced 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 that are used to calculate a Medicaid DSH payment. *See* 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.
>
> (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

[8] 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.

[9] *See also* Cooper University Hospital v. Sebelius, 2010 WL 3965896 (3rd Cir., 2010); Northeast Hospital Corp v. Sebelius, 699 F. Supp. 2d 81 (D D.C., 2010); and University of Washington Medical Center v. Sebelius, 674 F. Supp. 2d 1206 (W.D. Washington, 2009).

[10] Adena, 527 F.3d at 179.

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, and

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

42 U.S.C. § 1396r-4(b)(2) specifically uses the term "eligible for medical assistance under a State plan," the exact language from the Medicare DSH statute at 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, however, the "low-income utilization rate" description that clarifies what is and what is not included in "medical assistance under a State plan." The low-income utilization rate includes "services [rendered] under a [Title] XIX State plan," the same category of patients described in the Medicaid utilization rate. However, the low-income utilization rate also includes subsidies for patient services received directly from State and local governments[11] and charity care.[12] 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 program is funded by "state and local governments" (in this case the Commonwealth of Puerto Rico) and thus is included in the low income utilization rate, not the Medicaid inpatient utilization rate, Category 6 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).

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.[13] Category 6 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).

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[11] Subsection (b)(3)(A)(i).

[12] Subsection (b)(3)(B)(i).

[13] Atlanta Cleaners & Dyers, Inc. v. U.S., 286 U.S. 427, 433 (1932).

The Board finds the Provider incorrectly argues that the Category 6 days should be included in the numerator of the Medicaid fraction because these beneficiaries could be eligible for medical assistance under the Medicaid plans of one of the 50 states. This argument is not consistent with the plain meaning of the Medicare statute. The definition of the numerator of the Medicaid proxy in the Medicare statute clearly states that days are to be included for beneficiaries who are "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 parties stipulated that Puerto Rico Category 6 beneficiaries are not eligible for medical assistance under the approved Puerto Rico Medicaid plan or the Medicaid plan of any other State.[14]

The Provider also argues that the Puerto Rico Category 6 beneficiaries should be considered "hypothetical eligibles" and therefore should be included in the Medicaid fraction, citing a prior Board decision, Good Samaritan Regional Medical Center/Banner Health.[15] The Provider's reliance on this case is misplaced. In Good Samaritan, the "hypothetical eligibles" were individuals who were made eligible for Medicaid under the Arizona section 1115 waiver[16] but who could have been made eligible as an optional eligibility group had Arizona chosen to establish its Medicaid program through a State plan rather than a section 1115 waiver. In either case, the Arizona beneficiaries would have qualified as eligible for Medicaid under the approved Arizona Medicaid program. In contrast, the Puerto Rico Category 6 beneficiaries did not qualify for eligibility under an approved State Plan.[17]

The Board finds that the Intermediary correctly relied on Program Memorandum A-99-62 in excluding the inpatient days for Puerto Rico's Category 6 beneficiaries from the numerator of the Medicaid proxy. The Program Memorandum clearly explains that "the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the beneficiary must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan)."[18]

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[14] Stipulation of the parties, stipulation 7.

[15] Good Samaritan Regional Medical Center/Banner Health 94, 96, 97,98,99 DSH Calculation Groups/Samaritan 95 DSH Calculation Group v. BlueCross Blue Shield Association/ BlueCross & Blue Shield of Arizona, PRRB Dec. No. 2007-D35. *See* Provider Consolidated Position Paper at 11.

[16] The Arizona Medicaid program was established through a waiver under section 1115 of the Social Security Act, 42 U.S.C. §1315.

[17] It should be noted that the Administrator reversed the Board's decision in Good Samaritan, and clearly stated that the inpatient days for Arizona beneficiaries for whom no FFP was received did not qualify for inclusion in the numerator of the Medicaid proxy. *See* Good Samaritan Regional Medical Center/Banner Health 94, 96, 97,98, 99 DSH Calculation Groups/Samaritan 95 DSH Calculation Group v. BlueCross Blue Shield Association/BlueCross & Blue Shield of Arizona, CMS Administrator Decision, Review of PRRB Dec. No. 2007-D35.

[18] *See* Program Memorandum A-99-62 (December 1999) at 1.

DECISION AND ORDER:

The Intermediary properly refused to include Puerto Rico Category 6 beneficiary days in the numerator of the Provider's Medicaid fraction. The Intermediary's adjustments are 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: June 22, 2011