PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2013-D1

PROVIDER –
QRS 1995, 1996, 1998-2007
DSH/Pennsylvania General Assistance Days Group

Provider Nos.: 39-0009 and
39-0147

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Novitas Solutions, Inc.

DATE OF HEARING –
July 13, 2012

Cost Reporting Periods Ended –
See Appendix A

CASE NO.: 07-2447G

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ISSUE:

Whether medical assistance/general assistance days associated with patients covered under the Pennsylvania State Plan should be included in the numerator of the Medicaid proxy of the Medicare disproportionate share hospital (DSH) calculation pursuant to §1886(d)(5)(F)(vi)(II) of the Social Security Act,[1] as amended (Act).

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established under Title XVIII of the Act[2] to provide health insurance to the aged and disabled. 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 organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[3] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[4]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[5] Each 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).[6] 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 receipt of the NPR.[7]

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (PPS).[8] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[9]

The statutory provisions addressing the PPS are located in § 1886 of the Act[10] and they contain a number of provisions that adjust payment based on hospital-specific factors.[11] This case involves the hospital-specific DSH adjustment specified in § 1886(d)(5)(F)(i)(I). This provision

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[1] 42 U.S.C.A. § 1395ww(d)(5)(F)(vi)(II).
[2] 42 U.S.C. Ch. 7, Subch. XVIII.
[3] FIs and MACs are hereinafter referred to as intermediaries.
[4] *See* § 1816 and 1874A of the Act, 42 U.S.C. § 1395h and § 1395kk-1; 42 C.F.R. § 413.20 and 413.24.
[5] *See* 42 C.F.R. § 413.20.
[6] *See* 42 C.F.R. § 405.1803.
[7] *See* § 1878(a) of the Act, 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 405.1837.
[8] *See* § 1886(d) of the Act, 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.
[9] *See id.*
[10] 42 U.S.C. § 1395ww(d).
[11] *See* § 1886(d)(5) of the Act, 42 U.S.C. § 1395ww(d)(5).

requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[12]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (DPP).[13] The DPP is a proxy for utilization by low-income patients and determines a hospital's qualification as a DSH. It also determines the amount of the DSH payment to a qualifying hospital.[14]

The DPP is defined as the sum of two fractions expressed as percentages.[15] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. The Medicare/SSI fraction is defined in § 1886(d)(5)(F)(vi)(I) as:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this title, ...

The Medicare/SSI fraction is computed annually by CMS, and intermediaries use CMS' calculation to compute the DSH payment adjustment as relevant for each hospital.[16]

Similarly, the Medicaid fraction (also referred to as the Medicaid proxy) is defined in § 1886(d)(5)(F)(vi)(II) as:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the 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*, but who were not entitled to benefits under part A of this title, and the denominator of which is the total number of the hospital's patient days for such period.[17]

The intermediary determines the number of the hospital's patient days of service for which patients were eligible for medical assistance under a State plan approved under Title XIX but not

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[12] *See also* 42 C.F.R. § 412.106.
[13] *See* § 1886(f)(d)(5)(F)(i)(I) and (d)(5)(F)(v) of the Act, 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).
[14] *See* § 1886(d)(5)(F)(iv) and (d)(5)(F)(vii)-(xiv) of the Act, 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiv); 42 C.F.R. § 412.106(d).
[15] *See* § 1886(d)(5)(F)(vi), 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[16] 42 C.F.R. § 412.106(b)(2)-(3).
[17] (Emphasis added.)

entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[18]

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

This case includes two providers (the Providers), involving cost reporting periods 1995, 1996, and 1998-2007. [19] The Providers in this group appeal are acute care hospitals located in Pennsylvania that received payment under Medicare part A for services to Medicare beneficiaries. The Providers both participated in the Pennsylvania State Plan which provides medical assistance to uninsured low-income patients not eligible for other medical assistance programs, including Medicaid.

During the years in question, the intermediary was Highmark Medicare Services (Highmark). The Intermediary issued NPRs for the Providers' cost reporting periods at issue without including medical assistance/general assistance days in the Medicaid fraction of the Providers' Medicare DSH calculations. The Providers timely appealed the Intermediary's determinations to the Board.

The Providers were represented by J.C. Ravindran, C.P.A., of Quality Reimbursement Services, Inc. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., Lead Medicare Counsel of the BlueCross BlueShield Association.

BACKGROUND ON INCLUSION OF MEDICAL ASSISTANCE/GENERAL ASSISTANCE DAYS IN THE MEDICAID PERCENTAGE OF THE MEDICARE DSH ADJUSTMENT:

The parties agree that resolution of the issue before the Board hinges on the meaning of the phrase "patients who for such days were eligible for medical assistance under a State plan approved under [T]itle XIX" as used in § 1886(d)(5)(F)(vi)(II)[20] to describe the Medicaid fraction. This phrase identifies those days that are to be counted in the Medicaid proxy of the Medicare DSH adjustment.

Title XIX of the Act provides for federal sharing of state expenses for medical assistance for low-income individuals under the Medicaid program provided the state Medicaid program meets certain provisions contained in Title XIX. The state must submit a plan describing the state Medicaid program and seek approval from the Secretary.[21] If approved, the state may claim federal matching funds, known as federal financial participation (FFP) under the Title XIX for the services provided and approved under the state Medicaid program.

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[18] 42 C.F.R. § 412.106(b)(4).
[19] *See* Appendix A for schedule of providers for this case.
[20] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).
[21] Relevant sections of Pennsylvania State Plan are included Providers' Final Position Paper, Exhibit P-1.

PARTIES' CONTENTIONS:

The Providers contend that the Medicare statute and regulations require the inclusion of the general assistance days in the Medicare DSH calculation because the Pennsylvania Charity Care Program was a part of the Pennsylvania State Plan and CMS reviewed and approved that plan. The Providers also contend that according to Program Memorandum A-99-62, state-only program days should be included in the DSH calculations. This memorandum allows strictly state funded program days to be included for cost reporting periods beginning on or before January 1, 2000. The Providers however dispute the policy's restriction to only those providers who had previously received payment for inclusion of these strictly state funded programs or had a properly pending appeal for this issue that was requested prior to October 15, 1999.

The Providers assert that the State of Pennsylvania provides medical assistance on behalf of low-income, uninsured patients through the Medicaid disproportionate share program which is a part of the Pennsylvania State Plan, approved under Title XIX and, as such receives Federal Financial Participation. The Providers relied on several case decisions. The U.S. District Court for the District of Columbia in *Adena Reg'l Med. Ctr. v. Leavitt*, 524 F. Supp. 2d 1 (D.D.C. 2007), *rev'd and reh'g en banc denied*, 527 F.3d 176 (D.C. Cir.,2008), *cert. denied*, 129 S. Ct. 1933 (2009). Additional decisions relied on by the providers are *Portland Adventist Medical Center, et al. v. Thompson,* 399 F.3d 1091 (9th Cir. 2005); *Phoenix Memorial Hospital v. Sebelius,* 622 F.3d 1219 (9th Cir. 2010) [22]

The Intermediary counters that days of care paid for by programs for low income patients who are not eligible for Medicaid – even if the programs are recited in the State plan approved by Medicaid – cannot be included. The Intermediary reasons that, Pennsylvania Medical Assistance/General Assistance program represents the State's political/financial decision to provide the additional benefits for persons who do not qualify for Medicaid. In order to be included in the Medicaid proxy, a state program must be covered as "medical assistance" as defined under § 1905(a) of the Act,[23] *i.e.*, the patient days must be Medicaid eligible, not merely low income days that Medicaid permits to be counted solely for the Medicaid DSH adjustment. In support of its position, the Intermediary primarily relies on the Circuit Court opinion in *Adena Regional Medical Center et. al.. v. Leavitt,* 527 F3d 176 (D.C. Cir. 2008)[24]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered the Medicare law and program instructions, the evidence presented and the parties' contentions. Set forth below are the Board's findings and conclusions.

The evidence establishes that beneficiaries of the Pennsylvania Charity Care Program are not eligible for Medicaid and the services provided under that program are not matched with federal funds except under the Medicaid DSH provisions.

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[22] *See* Providers' Final Position Paper at 19.

[23] 42 U.S.C. § 1396d(a). The Intermediary characterizes the services and eligibility requirements set out in § 1905(a) as "traditional" Medicaid coverage.

[24] *See* Intermediaries' Final Position Paper at 6

The Medicaid DSH provisions are similar to the Medicare DSH provisions. Section 1923(a) of the Act[25] mandates that a state Medicaid plan under Title XIX must include a provision for a payment adjustment to hospitals which serve a disproportionate number of low income patients, *i.e.*, it requires a Medicaid DSH adjustment for hospitals that is independent of the Medicare DSH adjustment at issue in this case. The Medicaid DSH adjustment is eligible for FFP even though the particular patient days counted for Medicaid DSH are not directly eligible for FFP because they do not qualify as "traditional Medicaid" services described in § 1905(a).

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

In prior decisions on similar state funded programs, the Board has interpreted the Medicare statutory phrase "medical assistance under a State plan approved under [T]itle XIX" to include any program identified in the approved state plan, *i.e.*, it has not limited the days counted to traditional Medicaid days.[26] Subsequent to those decisions, the U.S. Court of Appeals for the District of Columbia issued its decision in *Adena Reg'l Med. Ctr. v. Leavitt*, 527 F.3d 176, (D.C. Cir., 2008),[27] 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.[28] Like the Pennsylvania Charity Care 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 § 1923(c)(3)(B) of the Act (42 U.S.C. § 1396r-4(c)(3)(B)) "permits the states to adjust 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 the HCAP."[29]

Upon further review and analysis of § 1923, the Board finds language that persuades it that the term "medical assistance under a state plan approved under [T]itle XIX" excludes days funded by only the state and charity care days even though those days may be counted for Medicaid DSH purposes.

Title XIX describes how hospitals qualify for the Medicaid DSH adjustment. Specifically, § 1923(b) establishes two distinct categories of low-income patients that are used to calculate a Medicaid DSH payment. The two categories, identified as the "Medicaid inpatient utilization rate" and the "low-income utilization rate," are defined in subsection (b)(2) and (b)(3), in pertinent part, as follows:

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[25] 42 U.S.C. § 1396r-4(a).
[26] *See, e.g., Ashtabula County Med. Ctr. v. Blue Cross Blue Shield Ass'n,* PRRB Dec. No. 2005-D49 (Aug. 10, 2005) *rev'd* CMS Adm. Dec. (Oct. 12, 2005).
[27] *Cert. denied*, 129 S. Ct. 1933 (2009).
[28] *Adena*, 527 F.3d 179 at 180.
[29] *Id.*, at 180 (brackets, ellipses, and citation in original; footnote and underline emphasis added.)

> (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 title* [*i.e.*, Title XIX of the Act] 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 title ... 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, 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. ...[30]

Subsection (b)(2) specifically uses the term "eligible for medical assistance under a State plan," the exact language from the Medicare DSH statute in issue in this case. That phrase describes the days included in the "Medicaid inpatient utilization rate" for the Medicaid DSH adjustment.

It is the second category, the "low-income utilization rate," that clarifies what is and what is not included in "medical assistance under a State plan." Subsection (b)(3) defines the term "low-income utilization rate" to include three components. In paragraph (A)(i)(I) of this subsection, there is the first component consisting of "services [furnished] under a State plan under this title [XIX]," the same category of patients described in the Medicaid utilization rate. In paragraphs (A)(i)(II) and (B)(i), there are the second and third components consisting of "cash subsidies for patient services received directly from State and local governments" and "charity care" respectively. 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

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[30] (Emphasis added.)

hospital days and charity care days, the subsections adding those types of days in the "low income utilization rate" would have been superfluous.

Based on the above, the Board concludes that, because the Pennsylvania Charity Care Program is funded by "state and local governments" and, thus, is included in the low income utilization rate but not the Medicaid inpatient utilization rate, Pennsylvania Charity Care Program patient days do not fall within the Medicaid DSH statute definition of "eligible for medical assistance under a State plan" at § 1923(b)(2) of the Act.[31] Statutory construction principles require the Board to apply the meaning Congress ascribed to the term "eligible for medical assistance under a State plan" used in the Medicaid statute to the same phrase used in the Medicare statute.[32] Pennsylvania Charity Care Program patient days, therefore, cannot be included in the Medicare DSH statutory definition of "eligible for medical assistance under a State plan" at § 1886(d)(5)(F)(vi)(II) of the Act.[33] Accordingly, the Intermediary's adjustments properly excluded Pennsylvania Charity Care Program patient days from the Providers' Medicare DSH calculations.

DECISION AND ORDER:

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

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, CPA
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: NOV 20 2012

[31] 42 U.S.C. § 1396r-4(b)(2).
[32] *See Atlanta Cleaners & Dyers, Inc. v. U.S.*, 286 U.S. 427, 433 (1932).
[33] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

APPENDIX A

Summary of Participating Providers

	Provider No.	Provider Name	FYE
1	39-0009	Saint Vincent Health Center	06/30/1995
2	39-0147	Monongahela Valley Hosp.	06/30/1995
3	39-0009	Saint Vincent Health Center	06/30/1996
4	39-0147	Monongahela Valley Hosp.	06/30/1998
5	39-0009	Saint Vincent Health Center	06/30/1999
6	39-0147	Monongahela Valley Hosp.	06/30/1999
7	39-0009	Saint Vincent Health Center	06/30/2000
8	39-0147	Monongahela Valley Hosp.	06/30/2000
9	39-0009	Saint Vincent Health Center	06/30/2001
10	39-0009	Saint Vincent Health Center	06/30/2002
11	39-0009	Saint Vincent Health Center	06/30/2003
12	39-0147	Monongahela Valley Hosp.	06/30/2003
13	39-0009	Saint Vincent Health Center	06/30/2004
14	39-0147	Monongahela Valley Hosp.	06/30/2004
15	39-0009	Saint Vincent Health Center	06/30/2005
16	39-0147	Monongahela Valley Hosp.	06/30/2005
17	39-0147	Monongahela Valley Hosp.	06/30/2006
18	39-0009	Saint Vincent Health Center	06/30/2007
19	39-0147	Monongahela Valley Hosp.	06/30/2007