

**PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
ON THE RECORD
2013-D24**

PROVIDER –
LifePoint Hospital 05-07 DSH Pymt –
Inclusion Title XIX Eligible Days CIRP
Group

Provider Nos.: 18-0116 and
18-0132

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/
CGS Administrators, LLC

DATE OF HEARING
December 2, 2011

Cost Reporting Periods Ended -
2005-2007 (See APPENDIX I)

CASE NO.: 08-0120G

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ISSUE:

Whether days associated with patients covered under the Kentucky Hospital Care Program (“KHCP”) 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 Act² 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 MACs³ 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 inpatient prospective payment system (“IPPS”).⁸ Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁹

The statutory provisions addressing the IPPS are located in § 1886 of the Act¹⁰ 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

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

² Title XVIII of the Act was codified at 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 § 1886(d) of the Act, 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.

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 IPPS 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 of the

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)(1).

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) of the Act, 42 U.S.C. § 1395ww(d)(5)(F)(vi).

¹⁶ 42 C.F.R. § 412.106(b)(2)-(3).

¹⁷ (Emphasis added.)

Act¹⁸ but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.¹⁹

The patient days eligible for inclusion in the Medicaid fraction under the Title XVIII Medicare DSH statute is the only issue in these cases. However, resolution of the Medicare DSH issue also involves the interpretation of a similar Medicaid DSH provision in Title XIX of the Act and whether it applies 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 group case involves two providers (“Providers”), encompassing cost reporting periods 2005 through 2007.²⁰ The Providers are acute care hospitals located in Kentucky that received payment under Medicare Part A for services furnished to Medicare beneficiaries. The Providers participated in the Kentucky Hospital Care Program²¹ which provides medical assistance to uninsured low-income patients not eligible for other medical assistance programs, including the Medicaid program.

During the years in question, the Providers’ designated intermediary was National Government Services, Inc. (“Intermediary”).²² The Intermediary issued NPRs for the Providers’ cost reporting periods at issue excluding Kentucky Hospital Care Program days from 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 Stephen R. Price, Sr., Esq., of Wyatt, Tarrant & Combs, LLP. The Intermediary was represented by Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield 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)²³ to describe the Medicaid fraction. This phrase identifies those days that are to be counted in the Medicaid proxy of the Medicare DSH adjustment.

¹⁸ Title XIX was codified at 42 U.S.C. Ch. 7, Subch. XIX.

¹⁹ 42 C.F.R. § 412.106(b)(4).

²⁰ See Appendix I for a list of the Providers and fiscal year ends included in Case No. 08-0120G.

²¹ Kentucky Hospital Care Program is the uncompensated direct patient care provided by one or more hospitals in Kentucky. Hospitals may receive payments from the state for this care which may be reimbursed by the federal Medicaid program. See Kentucky State Plan Under Title XIX of the Social Security Act (excerpts available at Provider Exhibit P-3).

²² In October 2011, the Providers’ designated intermediary was changed to CGS Administrators, LLC (MAC Jurisdiction 15).

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

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.²⁴ If approved, the state may claim federal matching funds, known as federal financial participation (“FFP”) under Title XIX for the services provided and approved under the state Medicaid program.

PARTIES’ CONTENTIONS:

The Providers assert that the State of Kentucky provides medical assistance on behalf of low-income, uninsured patients through the Kentucky State Plan, as approved under Title XIX and, as such receives FFP directly, and, indirectly, through the Medicaid disproportionate share program. The Providers argue that the Kentucky Hospital Care Program (“KHCP”), is an adjunct to the Kentucky Medicaid program, and simply expands the Medicaid program to a larger population.²⁵ Thus, the KHCP days should be included in the Medicaid fraction of the Medicare DSH calculation.

The Providers contend that in order to qualify under Title XIX, the Kentucky Medicaid Program had to have a 42 U.S.C. § 1396r-4 DSH component in its State plan.²⁶ Under the DSH component that Kentucky chose to include in its State plan, which was approved by CMS, medical assistance is made available to additional individuals using Title XIX funds. The days of care attributable to those patients are referred to by the State as “KHCP” days.²⁷ Thus, the Providers argue, the KHCP days consist of patients who (for such days) were *eligible for medical assistance under a State plan approved under title XIX*.

The Providers relied on the 2007 decision of 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). Providers cite additional decisions supporting their position including *Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091, 1092, 1094 (9th Cir. 2005); *Jewish Hosp., Inc. v. Secretary of HHS*, 19 F.3d 270, 276 (6th Cir. 1994); *Legacy Emanuel Hosp. and Health Ctr. v. Shalala*, 97 F.3d 1261 (9th Cir. 1996); *Huntington Hosp., Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); and *Deaconess Health Servs Corp. v. Shalala*, 912 F. Supp. 438 (E.D. Mo. 1995), *aff’d and adopted*, 83 F.3d 1041 (8th Cir. 1996).²⁸

The Intermediary counters that the KHCP days cannot be considered days “eligible for medical assistance” under a State plan approved under Title XIX. Therefore these days cannot be included in the Medicaid fraction of the Medicare DSH calculation. The Intermediary notes that Section 1902(a)(10) of the Social Security Act describes specific “categories” of individuals eligible for “medical assistance”. While additional FFP is available for the KHCP through the Medicaid DSH programs, individuals eligible for KHCP are not included in those categories.

²⁴ Relevant sections of the Kentucky State Plan are included as Provider Exhibit P-3.

²⁵ See Providers’ Final Position Paper at 8

²⁶ *Id.*, Exhibit 3 at 15.

²⁷ *Id.*, at 11

²⁸ *Id.*, at 15, 24-26

The Intermediary goes on to note Section 1923(b)(2) of the Social Security Act which specifically ties the phrase “eligible for medical assistance” to the categories at Section 1902(a)(10).²⁹ Thus, the Intermediary argues, the KHCP days cannot be considered days “eligible for medical assistance” under a State plan approved under Title XIX.

Additionally, the Intermediary notes that section 205.640 of the Kentucky Revised Statutes, (“KRS”) denies eligibility for the KHCP to anyone who is eligible for medical assistance or the Kentucky Children’s Health Insurance Program and cites a letter from the Commissioner for the Cabinet for Health and Family Services Department for Medicaid Services to hospital providers instructing that the hospital must screen the individual for Medicaid eligibility prior to making a determination of eligibility for DSH funding. This evidence demonstrates that eligibility for KHCP cannot be considered “medical assistance” for purposes of the Medicare DSH statute.³⁰

In support of its position, the Intermediary primarily relies on the decision of United States Court of Appeals for the District of Columbia in *Adena Reg’l Med. Ctr. v. Leavitt*, 527 F.3d 176 (D.C. Cir. 2008).³¹

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, for purposes of Medicare DSH calculations, KHCP beneficiaries are not “eligible” for Medicaid and the services provided under that program are not matched with federal funds *except* under the Medicaid DSH provisions.

The Medicaid DSH provisions are similar to the Medicare DSH provisions. Section 1923(a) of the Act³² 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).³³

The question for the Board is whether the Kentucky Hospital Care Program which is a state funded program not otherwise eligible for Medicaid coverage but which is included in the Kentucky 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.

²⁹ See Intermediary’s Final Position Paper at 6-7, and Exhibit I-6..

³⁰ See Intermediary’s Final Position Paper at 7-8 and Exhibits I-8 at 3 and I-9 at 1..

³¹ See Intermediary’s Final Position Paper at 9.

³² See 42 U.S.C. § 1396r-4(a).

³³ See 42 U.S.C. § 1396r-4(c)(3).

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.³⁴ Subsequent to those decisions, the U.S. Court of Appeals for the District of Columbia (“D.C. Circuit”) issued its decision in *Adena Reg’l Med. Ctr. v. Leavitt* (“*Adena*”),³⁵ 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.³⁶ Like the Kentucky Hospital 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 Act³⁷ “permits the states to adjust DSH payments ‘under a methodology that’ considers *either* ‘patients eligible for medical assistance under a State plan approved under [the Medicaid program] or ... low-income patients,’ ... such as those served under the HCAP.”³⁸

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:

(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*

³⁴ 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 Administrator Dec. (Oct. 12, 2005).

³⁵ 527 F.3d 176, (D.C. Cir., 2008), *cert. denied*, 129 S. Ct. 1933 (2009).

³⁶ *Adena*, 527 F.3d at 179.

³⁷ 42 U.S.C. § 1396r-4(c)(3)(B).

³⁸ *Id.* (emphasis added).

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. . . .³⁹

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), the second and third components include “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 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 KHCP is funded by “state and local governments” and, thus, is included in the low income utilization rate but not the Medicaid inpatient utilization rate, KHCP 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.⁴⁰ 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.⁴¹ KHCP patient days, therefore, cannot be included in the Medicare DSH statutory definition of “eligible for medical assistance under a State plan” at

³⁹ (Emphasis added.)

⁴⁰ 42 U.S.C. § 1396r-4(b)(2)

⁴¹ See *Atlanta Cleaners & Dyers, Inc. v. U.S.*, 286 U.S. 427, 433 (1932).

§ 1886(d)(5)(F)(vi)(II) of the Act.⁴² Accordingly, the Intermediary's adjustments properly excluded KHCP patient days from the Providers' Medicare DSH calculations.

DECISION AND ORDER:

The Intermediary properly refused to include Kentucky Hospital Care Program days in the numerator of the Medicaid proxy for the Medicare DSH calculation made for each of the Providers. 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: **AUG 19 2013**

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

APPENDIX I

Provider Number	Provider Name	FYE
18-0132	Lake Cumberland Regional Hospital	12/31/2005
18-0116	Jackson Purchase Medical Center	02/28/2006
18-0132	Lake Cumberland Regional Hospital	12/31/2006
18-0116	Jackson Purchase Medical Center	02/28/2007