PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D24

PROVIDER –
QRS 96 DSH MediKan Days Group

Provider Nos:. Various (See Attached Schedule)

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
BlueCross & BlueShield of Kansas

DATE OF HEARING -
December 7, 2005

Cost Reporting Periods Ended -
June 30, 1996 and September 30, 1996

CASE NO.: 03-1199G

INDEX

	Page No.
Issue	**2**
Medicare Statutory and Regulatory Background	**2**
Statement of the Case and Procedural History	**3**
Parties' Contentions	**3**
Findings of Fact, Conclusions of Law and Discussion	**4**
Decision and Order	**5**
Dissenting Opinion of Elaine Crews Powell,	**6**

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. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 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.

In 1983, Congress changed hospital reimbursement under the Medicare program by enacting Public Law 98-21, which created the Prospective Payment System (PPS). PPS 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 reimbursement 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." See 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 fiscal period. 42 U.S.C. § 1395ww(d)(5)(F)(vi). The first fraction's numerator is the number of 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 second 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 second 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. SSA §1886(d)(5)(F)(ii).

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. As discussed above, calculation of the DSH adjustment uses two fractions that reflect the number of low income patients served. The first fraction is based upon the number of low-income Medicare patients served by the provider and is not at issue in this case. The second fraction accounts for 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. § 1395 ww(d)(5)(F)(vi)(II). In this case, 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 development of the second fraction to determine the Providers' DSH adjustment.

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.[1]

[1] Ashtabula County Medical Center et.al. vs. Blue Cross and Blue Shield Association/AdminiStar Federal, Inc., PRRB Dec. No. 2005-D49 (August 10, 2005) rev'd, CMS Administrator Decision (October 11,

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,[2] 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 Sec.1902(a)(10)(A)(1) through XVIII 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.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

It is undisputed that 42 U.S.C. §1395ww(d)(5)(F) governs the MediKan issue. 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). It is also undisputed 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 Intermediary asserts that the Federal statute, when read collectively with its implementing regulation, limits medical assistance to Medicaid. The Intermediary argues that "eligible for medical assistance under a State Plan approved under Title XIX" is the statute's formal description of Medicaid as used in the regulation, and the terms are interchangeable in the context of this appeal. The Board does not see the nexus between the statute as quoted and the Intermediary's conclusion. The language of the statute does not limit or qualify "eligible for medical assistance under a State Plan approved under Title XIX." The Board considers the language clear and unambiguous and finds that the statute applies equally to Medicaid patients and to patients eligible for medical assistance under a State Plan approved under Title XIX.

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 (August 26, 1998).

[2] 42 U.S.C. §1395ww(d)(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 CFR §1412.106(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 Intermediary also argued that Kansas State Statute §39-708c(a) precludes patients who are not eligible for medical assistance from participation in MediKan and further argues that such preclusion must also apply to the DSH Medicaid proxy. The Board does not concur. MediKan provides medical services for patients who could not otherwise afford them and who are not eligible for Medicaid. Congress clearly intended that medical services be provided to indigent patient populations, and it does not appear that the limitation in the Kansas statute was intended to limit the Federal statute. Regardless, the Board considers the Federal statute the controlling authority in this case and, as discussed earlier, that authority does not contain the limitation on medical assistance that the Intermediary proposes.

The Board concludes that the Federal statute includes patients eligible for medical assistance under a State Plan approved under Title XIX, without exception/limitation. Coupled with the undisputed facts of the case, the Board also concludes 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 used to determine the Providers' DSH adjustment.

DECISION AND ORDER:

The Intermediary's adjustment improperly excluded MediKan patient days from the Providers' DSH calculation. MediKan patient days, both primary and secondary, should be included in the calculation of the Medicaid proxy to determine the Providers' DSH adjustment.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A. (Dissenting Opinion)
Anjali Mulchandani-West
Yvette C. Hayes

DATE: March 30, 2007

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

Dissenting Opinion of Elaine Crews Powell

As to Jurisdiction

The majority accepted jurisdiction over the Provider's appeal from a Revised Notice of Program Reimbursement (RNPR) regarding the inclusion of MediKan secondary payer days in the DSH adjustment computation. I respectfully dissent.

The RNPR dated April 17, 2003 from which the University of Kansas Hospital appealed the DSH MediKan secondary payer days issue resulted from the Intermediary's reopening of the Provider's FYE 1996 cost report to implement the settlement of a court case emanating from the Medicaid paid v. eligible days controversy.[3] The RNPR did not address, nor did the Intermediary adjust, MediKan secondary payer days. It was not until after the RNPR was issued in 2003 that the Provider filed an appeal seeking to have these general assistance days included in the Medicaid fraction. It is undisputed that the Provider never claimed these days in its 1996 as-filed cost report and that the State never paid any of these days.

42 C.F.R. 405.1835 entitled **Right to Board Hearing** addresses the circumstances under which a provider has a right to Board hearing, stating in relevant part:

> (a) *Criteria.* The provider…has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if:
>
> (1) An intermediary determination has been made with respect to the provider....

42 C.F.R. § 405.1889 makes it clear that a revision of a previous determination of the amount of program reimbursement due a provider following a reopening "shall be considered a separate and distinct determination" for the purpose of filing an appeal to the Board. In my opinion the use of the declarative word "shall" in the regulation leaves no room for interpretation – if an item is not revised in the RNPR, it cannot be appealed from that determination. According to the Provider's Revised Final Position Paper:

> …for the 1996 fiscal years on appeal in this case, the Centers for Medicare and Medicaid Services ("CMS") had not issued any guidance prohibiting the inclusion of "state-only" patient days, such as MediKan days, from the DSH adjustment computation. . . . . Thus, for the 1996 fiscal years on appeal, there was no prohibition against inclusion of such days.[4]

Since there was no prohibition against claiming the MediKan secondary payer days, the

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[3] See, Providers' Group Jurisdictional Documents, Exhibit 3, Tab D, page 2. The Intermediary's explanation of the reopening adjustment reads: "Effectuation of Settlement in the Case of Univ. of Kansas Hosp. Auth. V. Thompson, Case No. 1:02CV01925 (D.D.C.) (FYE June, 1996), Application of HCFAR 97-2 to Medicare DSH adjustment."

[4] See, Provider's Revised Final Position Paper at 5.

Provider should have claimed these unpaid GA days in its as-filed cost report. In my opinion, the inclusion of these secondary payer days is an issue that has arisen as the DSH issue has evolved over the years, and the Provider probably never thought about claiming them until many years after the cost report for 1996 was filed and settled. Clearly, it saw a chance to make a claim for these days when the 1996 cost report was reopened and adjusted in April, 2003. However, since the Intermediary made no determination regarding MediKan secondary payer days in the RNPR, I find that the Board does not have jurisdiction. Therefore, University of Kansas Medical Center should be dismissed from this group appeal.

As to the Merits

The Board majority found that University of Kansas Medical Center (UKMC, the Provider) was entitled to have MediKan secondary payer days included in the computation of its DSH adjustment under the hold harmless provisions of HCFAR 99-62. Again, I dissent.

A close review of the record in this case revealed that the Providers' attorney made absolutely no claim that the UKMC had a valid DSH appeal pending before the Board as of the October 15, 1999 deadline established by the Ruling. Other than being listed on the *Schedule of Providers in Group* form in the Jurisdictional Documents binder in this case, all other documents in the record including the *Stipulations of the Parties*, the Providers' oral argument as contained in the transcript, and the Providers' Post Hearing Brief are all silent regarding UKMC's appeal of DSH before the cutoff date. For example, in his oral argument, the Providers' counsel made an overt claim that the other two providers in the group had the requisite appeals pending before the deadline. He stated:

> In this particular instance, as indicated in Paragraph 22 [of the *Stipulations of the Parties*] two of the three providers did have jurisdictionally proper appeals pending before the Board prior to the specified October 15, 1999 date. Namely, Via Christi Regional Medical Center filed its appeal on March 22 of '99 and Stormont-Vail Regional Medical Center filed its appeal on February 5 of 1999. As indicated in [paragraph] 23 [of the *Stipulations of the Parties*], both of those providers contend that the reopening provision applies to their appeals because the appeals did include a DiSH (sic) adjustment, although the appeals did not specify exclusion of secondary MediKan days.5 (Emphasis added.)

In his Post Hearing Brief, the Providers' attorney again discusses the *Stipulations* and mentions the same two providers.6 I found nothing in the record in this case that demonstrates that UKMC had the requisite appeal pending before October 15, 1999, and the Provider's attorney never raised a claim that UKMC qualifies under the hold harmless

5 See, Tr. at p. 26, line 9-25 and p. 27, lines 1-14. Similar language is also found at Tr. p. 74, lines 4-18; Provider's Revised Final Position Paper, pgs. 7, 33-35.

6 See, Provider's Post Hearing Brief at 7.

provisions of HCFAR 99-62, either orally or in writing. When all of these facts are considered, even if the Board has jurisdiction, UKMC does not qualify for the relief afforded by the hold harmless provisions of HCFAR 99-62.

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Elaine Crews Powell, CPA