PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D35

PROVIDER - Good Samaritan Regional Medical Center/Banner Health 94, 96, 97, 98, 99 DSH Calculation Groups/Samaritan 95 DSH Calculation Group

Provider Nos.: 03-0002, 03-0065, 03-0089, 03-0001
(See Attached Appendix)

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ BlueCross & BlueShield of Arizona

DATE OF HEARING -
March 18, 2004

Cost Reporting Periods Ended -
December 31, 1991 and
December 31, 1993 through
December 31, 1999

CASE NOs.: 95-0795, 97-1098, 00-3556G, 01-2892G, 01-2936G, 01-2937G, 02-1810G and 03-1423G

INDEX

ISSUE:

Whether the Intermediary improperly omitted certain inpatient hospital days from the numerator of the Medicaid low-income proxy used to calculate the Providers' disproportionate share hospital (DSH) adjustment.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due providers 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 portion 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.

Disproportionate Share Hospital Adjustment Statutory And Regulatory Background:

Short-term hospitals are paid for services provided to Medicare patients under a Prospective Payment System (PPS). Under PPS, inpatient operating costs are reimbursed based on a prospectively determined formula taking into account national and regional operating costs.

Section 1886(d)(5)(F)(i)(I) of the Social Security Act (SSA or the Act) specifies that the Secretary of the Department of Health and Human Services (Secretary) shall provide for an additional payment to hospitals that serve a significantly disproportionate number of low-income patients. The formula used to calculate a provider's DSH adjustment is the sum of two fractions, which are expressed as percentages. SSA §1886(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 first fraction is frequently referred to as the Medicare Proxy and the second fraction, 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).

In the mid-1990's a controversy arose over HCFA's interpretation of the DSH formula as set forth under the Act. Pursuant to the Act, the Medicaid component of the DSH formula:

> 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 . . .

SSA §1886(d)(5)(F)(vi)(II) (emphasis added).

HCFA's regulation governing a provider's DSH percentage in effect at the time of the controversy referred to the "number of patient days furnished to patients *entitiled* to Medicaid." 42 C.F.R. §412.106(b)(4) (1993) (emphasis added). In applying the statute and the regulation, HCFA's interpretation substituted the concept of payment and coverage by Medicaid for each day of care, for the statutory standard of "eligibility" for Medicaid coverage thereby limiting the DSH adjustment to inpatient hospital days of service that were actually paid by a Medicaid state agency. However, in HCFA Ruling No. 97-2[1] (February 27, 1997), HCFA changed its prior policy of including in the DSH calculation only inpatient days of service which were actually *paid* by a Medicaid state agency in recognition of the holdings on this issue of the United States Courts of Appeals in the Fourth, Sixth, Eighth, and Ninth Circuits, all of which rejected HCFA's prior interpretation of including only patient days *paid* by Medicaid. Thus, in HCFA Ruling 97-2, HCFA conceded that it should include in the Medicaid fraction 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 HCFA 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, in that it clarified HCFA's policy that days attributed to individuals eligible for general assistance and other state-only funded programs (collectively, "State-Only Program Days") should be excluded from the DSH calculation. Intermediaries in certain states historically had allowed providers to include

[1] See Provider Exhibit P-20.

State-Only Program Days funded with state-only dollars in their DSH calculations even though Section 1886(d)(5)(F)(vi)(II) of the Act states that only days attributable to individuals "eligible for medical assistance *under a State plan approved under Title XIX*" are to be included in the DSH calculation. (emphasis added). Based on HCFA 97-2, several of the intermediaries that previously had allowed inclusion of State-Only Program Days in the DSH calculations began amending their policies on this issue and notifying their providers that the erroneously paid funds would be recouped.

Congressional leaders in Pennsylvania and New York intervened on behalf of their constituent hospitals, citing under financial harm if HCFA recouped DSH payments that had been made to providers that had State-only days included in their DSH adjustments. Following pleas for reconsideration of the proposed repayment, HCFA agreed to abandon its effort to recoup these funds. HCFA's decision was communicated in a letter dated October 15, 1999. The letter stated that HCFA would "quickly clarify [its] Medicare DSH policy both to [its] fiscal intermediaries and to hospitals." Id.

HCFA then issued its guidance to fiscal intermediaries, Program Memorandum A-99-62, on December 1, 1999 (the Program Memo)[2] addressing treatment of the State-Only Program Days on both a prospective and retrospective basis. For cost reporting periods beginning on or after January 1, 2000, HCFA declared that no State-Only Program Days would be counted as Medicaid days for purposes to the DSH calculation for any provider. It further 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." Program Memo at 2. Several examples of days that HCFA interpreted as not being "Medicaid days" were set out in an attachment.

For cost reporting periods beginning January 1, 2000, HCFA declared that hospitals could retain or receive DSH payments that included State-Only Program Days provided the hospitals met certain criteria. Hospitals were split into two groups. The first group included hospitals that had already received payments reflecting the inclusion of State-Only Days. For cost reporting periods beginning prior to January 1, 2000, HCFA 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 addition, the Program Memo explained that for open cost reports, intermediaries were to allow only those State-Only Program Days if the hospital had *received* such payment in previous cost reporting periods settled before October 15, 1999.

The second group of hospitals focused on those that did *not* receive a Medicare DSH payment based on the inclusion of the State-Only Program Days but that had claimed the days in an appeal. For cost reports that were settled before October 15, 1999, if a hospital had never received any DSH payment based on the erroneous inclusion of State-Only Program Days and the hospital had not filed a jurisdictionally proper appeal with 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. Moreover, intermediaries

[2] See Provider Exhibit P-21.

were instructed 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 a hospital had filed a jurisdictionally proper appeal with the Board for a given fiscal year on this issue before October 15, 1999, the intermediary was to reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these State-Only Program Days in the DSH calculation.

BACKGROUND ON THE AHCCCS PROGRAM AND PROCEDURAL HISTORY OF THIS CASE**:**

Prior to 1982, the State of Arizona did not have a Medicaid program. In 1982, the State of Arizona proposed, and the Secretary of Health and Human Services approved, a plan to establish an experimental Medicaid program called Arizona Health Care Cost Containment System (AHCCCS). AHCCCS[3] was approved under the provisions of §1115 of the Medicaid Act, 42 U.S.C. §1315, which allow the Secretary to waive mandatory requirements of a traditional Medicaid program. Under 1115 waivers, a state may expand eligibility, change the scope of services provided, restrict a beneficiary's freedom of choice, limit providers that may participate in the program or modify methods of reimbursement.

Pursuant to its 1115 waiver, AHCCCS is a state plan approved by the Secretary. The Secretary approved AHCCCS, and all of its programs and sub-programs, as part of Arizona's 1115 Waiver, irrespective of how the programs and sub-programs are funded.[4]

The AHCCCS program covers the following three groups of individuals pertinent to this case:[5]

1. Medically Indigent/Medically Needy (MI/MN). Eligibility for MI/MN assistance requires a person to have an annual income less than 40% of the federal poverty level and ineligible for other AHCCCS eligibility categories.

2. Eligible Low Income Children (ELIC): Eligibility for ELIC requires a person to have an annual income below the federal poverty level and to be under 14 years of age.

3. Eligible Assistance Children (EAC): Eligibility for EAC assistance requires a person to have an annual income below the federal poverty level, to be eligible to receive food stamps, and to be under 14 years of age.

The MI/MN, ELIC and EAC categories of assistance (collectively referred to as the State-funded eligibility group) were approved under the AHCCCS waiver program, and

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[3] See Provider Exhibits P-2-5.
[4] See, Provider Exhibits P-2, P-3 and P-13.
[5] See, Stipulations of the Parties - #6.

were state-only categories of assistance even though the state could have included them as optional Medicaid eligibility categories receiving direct FFP. The issue in this case is whether these Arizona State funded days, MI/MN, ELIC and EAC, qualify as "Medicaid days" for purposes of determining the Providers' Medicare DSH for fiscal years 1991 and 1993 through 1999.

This case involves four short-term acute care hospitals that were operated by Samaritan Health System until a 1999 merger with Banner Health System (Providers). Each of the individual facilities is located in the state of Arizona and is reimbursed under the AHCCCS for medical services furnished to qualified low income patients.

During the cost reporting periods at issue the Providers included in their Medicaid proxy inpatient days attributable to individuals in the aforementioned State-funded eligibility group. Blue Cross Blue Shield of Arizona (Intermediary) reviewed the Providers' cost reports and excluded these patient days from the Providers' DSH calculations, thereby reducing the Providers' DSH adjustments.

The Providers appealed the Intermediary's exclusions to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $15,000,000.[6]

The Providers were represented by Christopher L. Keough, Esq. of Vinson & Elkins, L.L.P. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association

STIPULATION OF FACTS:

On March 17, 2004, the parties submitted a joint stipulation of facts, which includes the following:

> 1. All individuals covered under AHCCCS are enrolled in contracted managed care plans.
>
> 2. The AHCCCS program covers the State-funded eligibility groups at issue in this case. The individuals in each of these groups have an income below the federal poverty income level.
>
> 3. During the cost reporting periods at issue, the State did not receive Federal Financial Participation (FFP) for the costs attributed to the State-funded eligibility groups. However, CMS subsequently approved an expansion of the federally funded portion of the AHCCCS program to include these individuals.
>
> 4. The Intermediary included total AHCCCS inpatient days in the Providers' 1986 through 1989 DSH calculations. These inpatient days included days attributable to the State-funded eligibility groups.

[6] Exhibit P-1.

> 5. During the subject cost reporting periods, the State did receive FFP for the DSH payments AHCCCS made to hospitals. The AHCCCS DSH payment considers AHCCCS revenues, which includes revenues attributable to services furnished by a hospital to individuals in the State-funded eligibility groups.

PARTIES' CONTENTIONS:

The Intermediary contends that patient days whose costs are not funded by Title XIX are not counted as Medicaid days.[7] The Intermediary asserts its position is supported by 42 U.S.C. §1395ww(d)(5)(F)(vi) which states that the numerator of the Medicaid proxy is "the number of the hospital's patient days . . . which consists of patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX."

The Intermediary contends that its position is supported by Medicare's Hospital Audit Program and Audit Quality Review Program which state that days associated with "general medical assistance programs operated and funded exclusively by the State (not Title XIX) are not counted as Medicaid days." Also, 61 Federal Register No. 170 at 46207 (Aug. 30, 1996) states "[i]f a State chooses to adopt some sort of a waiver program and elects to cover people who would not have otherwise been eligible for care, those persons will not be included as Medicaid days in the current formula. . . ."[8]

The Intermediary disagrees with the Providers' reliance upon the hold-harmless portion of Program Memorandum A-99-62 that directs intermediaries to allow, for open cost reports, "those types of otherwise ineligible days that the hospital received payment for in previous cost reporting periods settled before October 15, 1999." The Providers' DSH reimbursement had not included State-funded eligibility group patient days since 1990, and the Providers had no expectation of being reimbursed for these days throughout the subject cost reporting periods. The Providers did not claim these days in the subject as-submitted cost reports, nor did they include the issue under protested amounts. Questions and Answers pertaining to Memorandum A-99-66, issued by CMS, address this issue as follows:

> [i]f the hospital abandoned its expectation of receiving payment in those open cost reports. . . and did not even include this issue in the "protested amount" line, the intermediary should not continue paying the Medicare DSH adjustment reflecting the inclusion of these types of days for those years.[9]

The Intermediary notes that the AHCCCS State-funded eligibility group programs at issue did not come under Title XIX of the Act until April 1, 2001, but were under Title XXI until that time.

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[7] Intermediary's Position Paper at 2.
[8] Intermediary's Position Paper at 3.
[9] Exhibit I-12 at Q-16.

The Intermediary cites the CMS Administrator's decision reversing the Board in Castle Medical Center v. Blue Cross Blue Shield Association/United Government Services LLC, PRRB Dec. No. 2003-D36, July 16, 2003, aff'd. in part and rev'd. in part, CMS Administrator, September 12, 2003 (Castle). In that case, the Administrator found that certain State-funded general assistance days could not be included in the provider's DSH calculation because they were attributable to patients eligible for medical assistance under Title XI of the Act rather than Title XIX.

The Intermediary also disagrees with the Providers' argument that Program Memorandum A-99-66 is arbitrary and results in inequitable treatment for hospitals that complied with CMS policy regarding State-funded eligibility group days. The Intermediary cites United Hospital v. Thompson, No 02-3479, 2003 U.S. Dist. LEXIS 9942 (D. Minn 2003), aff'd. 383 F.3d 728 (8th Cir. 2004), where the court found that Program Memorandum A-99-66 does not violate the equal protection of hospitals.

Also, the Intermediary contends that the fact that the federal government shares in the costs of AHCCCS' DSH payments to hospitals has no significance in the instant case.[10] The Medicaid DSH comes primarily from sections 1923 and 1924 of the Act, and they can not be used to broaden 42 U.S.C. § 1395ww(d)(5)(F)(vi) stating "patients who (for such days) were eligible for medical assistance under. . . under Title XIX. . . ."

The Providers contend that the subject patient days should be included in the Medicaid proxy pursuant to the DSH statute.[11] The patients at issue were eligible for medical assistance under AHCCCS' plan approved by the Secretary, and the State received FFP for AHCCCS DSH payments made to hospitals for these individuals. Moreover, the patients whose days are at issue were "eligible" for assistance under a State plan that could have been approved under Title XIX by virtue of their low-income status, and these days were included in the fully federally funded portion of the AHCCCS plan since 2001.

The Providers also contend that even if the subject patient days are otherwise ineligible for inclusion in the Medicaid proxy, they are entitled to be included (for at least some of the subject cost reporting periods) pursuant to the hold-harmless provisions of Program Memorandum A-99-66. It is undisputed that the Intermediary included these types of days in the Medicaid proxy in prior cost reporting periods ended in 1986 through 1989. Moreover, these days were included in the interim payments made to Good Samaritan Hospital in its 1990 through 1992 cost reporting periods.

Finally, the Providers explain that there is a second prong to Program Memorandum A-99-66 that allows hospitals to include otherwise ineligible days in their Medicaid proxy if they appealed the exclusion of these days to the Board before October 15, 1999. The Providers contend this deadline is arbitrary and capricious and should be waived because it results in disparate treatment of similar hospitals. The Providers assert that CMS must

[10] Intermediary's Post-Hearing Brief at 5.
[11] Providers' Post-Hearing Brief at 28.

uniformly apply its policies. Therefore, if a type of patient day is eligible for inclusion in the DSH calculation for some DSH hospitals, then it must be included in the calculation for all DSH hospitals.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, parties' contentions, and evidence presented, finds and concludes as follows:

This case turns on the interpretation of two statutes: 42 U.S.C. §1395ww(d)(5)(F)(vi) which establishes the DSH adjustment, and 42 U.S.C. §1315 which authorizes the Secretary to approve "experimental, pilot, or demonstration projects" to promote innovative approaches to meeting the health care needs of low-income individuals. In a similar case, the 9th Circuit Court of Appeals addressed the interpretation of these two statutes. In Portland Adventist Medical Center v. Thomas, 399 F.3d 1091 (9th Cir. 2005) (Portland), the court found that the plain language of the DSH and 1115 waiver statutes led it to conclude that DSH must include all patients eligible for medical assistance under Title XIX without regard to how they became eligible. This includes patients who became eligible for Medicaid as a result of the §1115 waiver provisions. The Board agrees with the reasoning in Portland, and applying similar reasoning, finds for the Providers in this case. The Board also finds that all patients eligible for medical assistance under a State plan approved under Title XIX must be included in the DSH adjustment without regard to whether the state receives direct FFP for this low-income population.

Title XIX of the Act (Medicaid) authorizes the use of federal funds to help states offset the costs of providing medical assistance to eligible low-income individuals. See 42 U.S.C. §1396 et seq. To receive these funds, a state must submit a "State plan" for approval by the Secretary, and it must administer the plan according to Medicaid requirements. 42 U.S.C. §1396d(a). These requirements regulate the manner in which the plan is implemented as well as which individuals may be covered. See 42 U.S.C. §1396(d)(a). Only expenditures made under an approved Medicaid State plan become eligible for federal matching payments. 42 U.S.C. §1396d (a)-(b).

Ordinarily, State plans must meet the requirements of the Medicaid statute to receive funding. However, Congress has authorized the Secretary, through Section 1115 of subchapter XI of the Act, to approve "experimental, pilot, or demonstration projects" that go beyond these requirements in order to promote innovative approaches to meeting the health care needs of low-income individuals. 42 U.S.C. §1315. These projects must, in the judgment of the Secretary, be "likely to assist in promoting the objectives of . . . [Title] XIX." 42 U.S.C. §1315a. The Secretary may waive the Medicaid requirements set forth in 42 U.S.C. §1396a for these demonstration projects, and the costs of such projects "shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under [Title XIX]." 42 U.S.C. §1315a(1) - (2) (emphasis added).

The State of Arizona does not have a traditional Medicaid program. Instead, it operates its entire Medicaid program as a Section 1115 waiver project. The State of Arizona submitted its waiver proposal in May 1982, and the Secretary approved the waiver on July 13, 1982. The Board finds that under the Section 1115 waiver, AHCCCS is the "State plan" approved by the Secretary. The approval includes all the AHCCCS programs and sub-programs, irrespective of how the programs and sub-programs were funded, because the waiver statute requires that all costs of the demonstration project be regarded as expenditures under the State plan.

The Board agrees with the Portland Court's conclusion that:

> [t]he plain language of the statute requires us to conclude that §1115 does not confer on the Secretary discretion to characterize expenditures as Title XIX (Medicaid) expenditures for some purposes and not for others. On the contrary, while the provision gives the Secretary discretion in *approving* projects, the provision *requires* the Secretary to regard expenditures under §1115 projects designed to assist low income patients as Title XIX expenditures for the duration of such projects, and therefore to regard §1115 expansion populations as receiving medical assistance under a state plan approved under Title XIX.

Id. at 1099 (emphasis in original).

The Board is also persuaded by two additional factors that support the inclusion of the State-funded eligibility group days in the DSH calculation. First, even though AHCCCS does not receive direct FFP for these beneficiaries, it funds its capitation and DSH payments to providers with all of the funds it receives from the federal, state and local governments. Without this indirect funding, AHCCCS would not be able to finance and maintain coverage for all of the low-income populations eligible under its State plan. These facts are similar to those in Castle, in which the Board found that "capitated Medicaid payments to Medicaid 'HMOs' for all Quest covered beneficiaries, including GA [General Assistance] . . ." resulted in a de facto sharing of the costs of the program as a whole between federal, state, and local governments. As in Castle, the Board finds that the lack of direct FFP does not prohibit a population from being considered part of the "State plan approved under Title XIX." 42 U.S.C. §1395ww(d)(5)(F)(vi); 42 C.F.R. §412.106(b)(4).

Second, AHCCCS could have included the State-funded eligibility group as optional groups under a traditional Medicaid state plan (even without a waiver) and could have received direct FFP.[12] Instead, Arizona chose to include this low-income population in its State plan, but for its own reasons, chose not to accept FFP funding for this group. The Board observes that in Legacy Emmanuel Hospital and Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996), low-income populations do not stop being low-income merely because the state did not pay for their services, and in a similar vein, concludes

[12] The Board notes that in 2002, AHCCCS changed its State plan to include the State-funded eligibility group population as an optional group and has received direct FFP since that time. See e.g., Tr. at 47.

that AHCCCS' State-funded eligibility group did not stop being low-income merely because the state chose to bear the entire cost.

The Board's finding for the Providers based upon the plain language of the 1115 waiver and DSH statutes obviates the need to address the Providers' argument that they are also entitled to include State-funded eligibility group days in their DSH calculations under the hold harmless provision of Program Memorandum A-99-62.

DECISION AND ORDER:

The Board finds that the Intermediary's removal of the subject State-funded eligibility group patient days from the Providers' DSH calculations was improper. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

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

DATE: May 17, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman