PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D22

PROVIDER
Cooper University Hospital
Camden, New Jersey

Provider No.: 31-0014

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Riverbend Government Benefits
Administrator

DATE OF HEARING -
September 18, 2007

Cost Reporting Period Ended –
December 31, 2000

CASE NO.: 04-0183

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ISSUE:

Whether the Medicare fiscal intermediary erred by not including in the calculation of the disproportionate share hospital (DSH) payment for fiscal year 2000 all of the Provider's inpatient days relating to patients who were not entitled to Medicare, but who qualified for medical assistance under the New Jersey Charity Care Program.

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 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.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The PPS statute 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," or "DSH" adjustment. The Secretary is required 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," expressed as a percentage for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi). The Medicare 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 hospital patient days for patients entitled to Medicare Part A. Id. 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 the hospital's patient days for such period. Id.; See also, 42 C.F.R. §412.106(b)(4). The Medicaid fraction is frequently referred to as the Medicaid Proxy and is the only fraction at issue in this case.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Provider, Cooper Hospital/University Medical Center (Provider), is a Medicare-certified academic medical center located in Camden, New Jersey. The Provider qualified for Medicare DSH payments and participated in New Jersey's Charity Care Program (Charity Care or CCP) during the fiscal year in question. The Charity Care Program partially reimburses hospitals for the costs associated with providing free or reduced charge care to indigent patients who do not qualify for Medicaid or any private or governmental sponsored insurance. Charity Care, which is initially priced based on the State Medicaid fee-for-service rates, is funded on both the federal and state levels, and has traditionally been included as a part of the New Jersey State Plan approved under Title XIX. More specifically, Charity Care is included in New Jersey's official State Medicaid Plan as a Medicaid DSH adjustment and has been approved as such by CMS. On May 12, 2003, Riverbend Government Benefits Administrator (Intermediary) issued the Provider's NPR for the subject cost reporting period. The Intermediary did not include Charity Care days in the Medicaid fraction of the Provider's DSH calculation. At issue here is whether Charity Care days for which the Provider is paid for indigent care through the New Jersey Medicaid assistance program should be included in the Medicaid fraction of the Provider's DSH calculation.

The Provider appealed the adjustment to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835- 405.1841. The Provider was represented by Mark H. Gallant, Esquire, and Kimberly Bane Hynes, Esquire, of Cozen O'Connor. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider argues that the language of the Medicare DSH statute is clear and unambiguous. Under the statute, the Medicaid fraction or proxy of the DSH calculation includes all 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 of this chapter, but who were not entitled to benefits under [Medicare] part A." 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). Because the Charity Care program patients were eligible for medical assistance under the New Jersey State Plan approved by CMS under Title XIX of the Social Security Act and subject to Federal matching funds, the inpatient

days attributable to these patients should be included in the Medicaid proxy for purposes of calculating the hospital's DSH payment.

The New Jersey Charity Care Program is included in attachment 4.19A of the "New Jersey State Plan Under Title XIX of the Social Security Act, Medical Assistance Program."[1] Patients who qualify for Charity Care either receive hospital services without charge or pay a reduced amount based on a sliding scale. Hospitals in New Jersey must inform all patients about the availability of the Charity Care Program (and all other forms of medical assistance). A hospital's Charity Care payment is based on "hospital-specific" documented charity care and is calculated from the charity care claims submitted by the hospital to the state's Fiscal Agent. Payments made to New Jersey hospitals for the Charity Care Program come from the Health Care Subsidy Fund, which is supported by funding that the State of New Jersey receives through the Medicaid DSH program. The Federal Government provides "federal financial participation" or "FFP" payments to the New Jersey Medicaid DSH program, including the Charity Care component.

The Provider asserts that the Board previously found that the New Jersey Charity Care Program (CCP) days should be included in the Medicaid proxy in Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/BlueCross and BlueShield of New Jersey, PRRB Dec. No. 99-D4 (October 30, 1998), based on the statutory principle that New Jersey hospitals are entitled to have included in the Medicaid proxy all days for which patients were eligible for medical assistance under the State plan, and that CCP patients were, in fact so eligible. The Provider asserts that no substantial changes have been made to the CCP or the State plan since that time which would alter the Board's decision to reach the same determination in the instant case. The Provider also asserts that the Board has addressed the issue of medical assistance programs under a state plan after CMS issued Program Memorandum (PM) A-99-62 (December 1, 1999), in Ashtabula County Medical Center et al. v. BlueCross BlueShield Association/ AdminaStar Federal, Inc., PRRB Dec. No. 2005-D49 (August 10, 2005) and in Washington State Medicare DSH Group II v. BlueCross BlueShield Association/ Noridian Administrative Services, PRRB Dec. No. 2007-D5 (November 22, 2006).[2] In those cases the Board found that the "clear and unambiguous" language of the federal DSH statute "does not limit the patients covered to Medicaid patients only, but that it includes patients who qualify for medical 'assistance' under . . . State plan[s] approved under Title XIX."

As the New Jersey CCP is included in the State plan and receives FFP for the program under the New Jersey Medicaid DSH program, the Provider asserts that the Intermediary's position of refusing to include the New Jersey CCP days in the Medicaid proxy is inconsistent with applicable law and the Secretary's own regulations.

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[1] See, Provider Exhibit P-48; pgs. I-261, I-262, I-262.1.

[2] Those decisions do not relate to the New Jersey CCP program, but to medical assistance programs in the states of Ohio and Washington, respectively.

INTERMEDARY'S CONTENTIONS:

The Intermediary asserts that although the New Jersey CCP is referenced in the New Jersey Medicaid State plan, patients eligible for CCP are not eligible for the traditional Medicaid program under the New Jersey Medicaid State plan. Therefore, the individuals covered by the CCP are not covered by "medical assistance" as described in Section 1901 et seq. of the SSA, 42 U.S.C. §§1396 et seq. The Intermediary, therefore, concludes that the days related to the program should not be included in the Medicaid proxy as they are not "true" Medicaid days. The Intermediary asserts that this distinction is critical to the issue under dispute and argues that the program must be covered under section 1901 of the Social Security Act to be included in the Medicaid proxy.

It is the Intermediary's position, and that of the CMS Administrator in Ashtabula County Medical Center v. BCBSA/AdminaStar Federal Inc.[3] that while the enabling DSH statute, 42 U.S.C. §1886(d)(5)(F)(vi)(II) and its implementing Medicare regulation 42 C.F.R. §412.106(b)(4) use different words, they refer to exactly the same category of days and permit inclusion only if the patient was eligible for "Medicaid."

The statute at 1886(d)(5)(F)(vi)(II) states:

> . . . the 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. (emphasis added)

The regulation 42 C.F.R. §412.106(b)(4) states:

> *Second computation.* 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. (emphasis added)

The Intermediary contends that the statutory phrase "eligible for medical assistance under a State plan approved under Title XIX" has the same meaning as "eligible for Medicaid" as used in the regulation, and that the terms are interchangeable in the context of this appeal.

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[3] PRRB Dec. No. 2005-D49 (August 10, 2005), rev'd., CMS Adm. Dec., CCH Medicare Guide 81,442 (October 12, 2005), Exhibit I-3.

The Intermediary also argues that PM A-99-62 represented CMS' official position on the issue that a patient must be eligible for traditional "Medicaid" in order to be included in the Medicaid proxy:

> [f]or a day to be counted, the patient 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).

New Jersey Medicaid, like other Medicaid plans fulfilling Medicaid statutory mandates, provides medical assistance to low-income individuals who meet specific criteria. Generally, coverage includes inpatient hospital services. The New Jersey CCP is a safety net program for people who are uninsured, not eligible for other medical assistance programs, including New Jersey Medicaid, and who have no access to health insurance coverage. The Intermediary points out that the New Jersey Hospital Services Manual provisions for CCP clearly indicate that patients otherwise insured or receiving medical assistance from other private or government resources are not eligible for CCP:

> Hospitals shall make arrangements for reimbursement for services from private sources, and Federal, state and local government third party payers when a person is found to be eligible for such payment. Hospitals shall collect from any party liable to pay all or part of a person's bill, prior to attributing the services to charity care. . . .

The Manual also provides that:

> The Charity Care Program shall be the payer of last resort. . . .[4]

The Intermediary contends that these provisions clearly establish that specific patients receiving assistance from the New Jersey CCP for specific days therefore could not be "eligible" on those days for medical assistance under New Jersey's Medicaid Plan.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Provider presented uncontested testimony and evidence that establishes it qualified as a DSH hospital under Medicare and the New Jersey Charity Care Program (CCP). Under the CCP the Provider makes an initial determination of eligibility for any medical assistance programs available, which includes Charity Care as well as Medicaid. The Charity Care Program provides medical assistance to low-income New Jersey residents

[4] Hospital Service Manual, Charity Care section, Sections 10:52-11.5(e) and (k), Exhibit I-1 page 6.

otherwise ineligible for traditional Medicaid. Once a patient is approved for Charity Care, they are presented with a Charity Care card. The approved Charity Care card is audited by the State of New Jersey. Patients who qualify for Charity Care either receive hospital services without charge or pay a reduced amount based on a sliding scale depending on income level.

When the Provider filed its FY 2000 cost report, it included Charity Care days in its as-filed costs as part of its DSH calculation. It also separately notified the Intermediary by letter dated June 14, 2002 that it was claiming a total of 5,518 Charity Care days under protest for FY 2000. The 5,518 Charity Care days claimed in FY 2000 cost report were approved by the State's fiscal agent, Unisys and audited by the Intermediary under a contract with the State. When calculating the Provider's FY 2000 DSH adjustment, the Intermediary did not include the Charity Care days that the Provider had claimed on its FY 2000 cost report. The exclusion of the 5,518 Charity Care days from the calculation of the Provider's FY 2000 DSH adjustment resulted in a reimbursement impact of approximately 1.4 million dollars.

The Medicaid DSH program in New Jersey is set forth at attachment 4.19A (pages I-256 through I-300) of the New Jersey State Plan and includes a detailed description of the Charity Care Program. See Exhibit P-48. The Charity Care Program is part of the New Jersey State Plan, which was approved by CMS under Title XIX and which serves New Jersey DSH hospitals. The payment that the Provider receives through the Charity Care DSH payments relate to specific, identifiable patients. Charity Care day claims are subject to audit on behalf of the State and the inpatient days in question were all audited and found by Unysis to be for persons who indeed satisfied the Charity Care criteria. The Intermediary has not contested the accuracy of Cooper's Charity Care day count. The Federal government pays FFP for the New Jersey Medicaid DSH program, including the Charity Care component.

The dispute lies in the Intermediary's refusal to include CCP days in the numerator of the Provider's Medicaid proxy because it concluded that these days do not pertain to patients "entitled to Medicaid" as required by 42 C.F.R. §412.106(b)(4). Under the Medicare statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)(II), the Medicaid proxy of the DSH calculation includes all hospital "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 of this chapter, but who were not entitled to benefits under [Medicare] part A." The Provider has asserted that the New Jersey Charity Care Program was included in the New Jersey State Plan approved under Title XIX and that the New Jersey Charity Care Program received federal financial participation only if the hospital qualified for and received Medicaid DSH.

The Intermediary asserts that the Medicare statute, when read in conjunction with its implementing regulation, limits "medical assistance" to traditional Medicaid. The Intermediary argues that "eligible for medical assistance under a State Plan approved under Title XIX" is the statute's "longhand description of Medicaid" as used in the regulation, and the terms "medical assistance" and "Medicaid" are interchangeable in the

context of this appeal. The Intermediary reasons that because the State plan states that patients who are eligible for the Charity Care Program cannot be eligible for Medicaid or any other assistance program, the same preclusion should apply to the Federal DSH Medicaid proxy. The Board does not concur.

The Board finds that the purpose of the DSH statute is to compensate hospitals for the additional costs associated with treating low-income patients. The plain language of the statute requires all days relating to patients eligible for medical assistance under a State Plan approved under Title XIX to be included in the Medicaid proxy. The Board finds no overriding rationale to limit the term "eligible for medical assistance under a State plan approved under Title XIX" to the Intermediary's Medicaid-eligible definition. Although the patients in the New Jersey Charity Care Program do not qualify for "Medicaid" under Section 1901 of the Social Security Act, CMS nevertheless participates in payment for these claims through the Medicaid DSH payment. Such payment recognizes that New Jersey Charity Care Program patients should qualify for medical assistance under a State plan approved under Title XIX. 42 C.F.R §430.10, states in part:

> [t]he State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program . . . .

The Board has previously specifically addressed the issue of New Jersey's CCP in Jersey Shore, supra., and has addressed other similar charity programs in the States of Ohio and Washington in Ashtabula County Medical Center, supra., and Washington State Medicare DSH Group II, supra. The Board finds no circumstances in this case that would alter its reasoning or rationale found in the previous decisions. In addition, the United States District Court for the District of Columbia recently issued a decision in favor of the plaintiff in Adena Regional Medical Center v. Leavitt, 5-24 F. Supp.2d 1 (D.D.C., 2007), which rejected the Intermediary's exclusion of Ohio Hospital Care Assurance Program (HCAP) patient days.[5] In that case, the court ruled that the "Secretary's exclusion of HCAP patients is inconsistent with the plain language of the statute and cannot be upheld." The ruling in Adena is consistent with the Board's previous decision in Ashtabula and with its current decision. Accordingly, the Intermediary's adjustments improperly excluded New Jersey Charity Care program patient days from the Provider's Medicare DSH calculation.

DECISION AND ORDER:

The Intermediary's refusal to include New Jersey Charity Care Program days in the numerator of the Provider's Medicaid proxy is reversed. The Board remands this issue to the Intermediary to include 5,518 Charity Care days of service furnished by the Provider to patients eligible for medical assistance under the State's Charity Care Program in the Provider's DSH calculation.

[5] The HCAP program is the same program in dispute in Ashtabula, Id.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: March 28, 2008