PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D39

PROVIDER -
Southwest Consulting 95-01
Disproportionate Share Hospital
Georgia Indigent Care Trust Fund

Provider Nos.: Various

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Blue Cross Blue Shield of Georgia

DATE OF HEARING -
September 11, 2008

Cost Reporting Periods Ended -
December 31, 1995; December 31, 1996
December 31, 1997; December 31, 1998
December 31, 1999; December 31, 2000
December 31, 2001 and June 30, 2000

CASE NO.: 04-1799G

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ISSUE:

Whether inpatient hospital days attributable to individuals who applied to the Providers for, and received, assistance under Georgia's Indigent Care Trust Fund ("ICTF") should be counted in the number of Medicaid-eligible days in the numerator of the Medicaid fraction used to calculate the Medicare disproportionate share hospital (DSH) payments to the Providers.

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 and 413.24.

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. §405.1835-405.1837

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 Providers in this appeal are Memorial Health University Medical Center, for its fiscal periods ending December 31, 1995 through 2001, and The Medical Center, for its fiscal period ending June 30, 2000. Both facilities are located in Georgia and both participate in the state's Indigent Care Trust Fund (ICTF). ICTF 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 government sponsored insurance. The program is a general assistance program that is funded at both the Federal and State levels and has traditionally been included as a part of Georgia's Medicaid State Plan approved under Title XIX.[1] For the periods under appeal, the Intermediary removed ICTF days from the Medicaid fraction of the Providers' DSH calculation. At issue in this case is whether ICTF days for which the Providers are paid for indigent care through Georgia's Medicaid assistance program, should be included in the Medicaid fraction of the Providers' DSH calculation.

The Providers appealed the adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835- 405.1841. The Provider was represented by Christopher L. Keough, Esquire, and J. Harold Richards, Esquire, of King and Spalding L.L.P. The Intermediary was represented by Bernard M. Talbert Esquire, of Blue Cross Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers contend that the plain 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). The Providers argue this language controls the disposition of the issue before the Board and its meaning was addressed by the District of Columbia Circuit Court in Adena Regional Medical Center v. Leavitt (hereinafter Adena).[2] In Adena, the D.C. Circuit accepted CMS's interpretation that the term

[1] Stipulations of the Parties, ¶ 4.
[2] Adena Regional Medical Center v. Leavitt, No. 07-5273, 2008 WL 2221811 (D.C. Cir. May 30, 2008).

"medical assistance" in the Medicare DSH statute must be given the same meaning that is given to the same term in the Medicaid statute.[3] The holding affirms the Secretary's interpretation provided in a 2002 letter to all State Medicaid Directors,[4] to mean that individuals whose service costs factor into Medicaid DSH payment calculations are thereby receiving "medical assistance" as defined in section 1905(a) of the Social Security Act, 42 U.S.C. §1396(a).

It is undisputed that ICTF days are included in the Medicaid DSH payment made under Georgia's approved State plan.[5] It is also undisputed that the state received Federal Medicaid matching funds for those payments.[6] The Providers argue that Section 1903 of the Social Security Act[7] provides CMS with no authority to pay Federal Medicaid matching funds to a state for anything other than "medical assistance" under the state plan. It follows therefore that the Medicaid DSH payments made by Georgia for the cost of inpatient hospital services furnished to individuals qualifying for assistance from the ICTF were for medical assistance under the state plan as defined in section 1905(a) of the Medicaid statute [8] and the inpatient days attributable to these patients should be included in the Medicaid proxy for purposes of calculating the hospital's DSH payment.

INTERMEDARY'S CONTENTIONS:

The Intermediary responds that although the ICTF is referenced in the Georgia Medicaid State plan, patients eligible for ICTF are not eligible for the traditional Medicaid program described in section 1901. Therefore, the individuals covered by the ICTF are not furnished "medical assistance" as described in Section 1901 et seq. of the Social Security Act, 42 U.S.C. §§1396 et seq. The Intermediary asserts that this distinction is critical to the issue under dispute and argues that the ICTF program must be covered under section 1901 of the Social Security Act to be included in the Medicaid proxy.

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

> [for] 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).

The ICTF is a safety net program for people who are uninsured, not eligible for other medical assistance programs, including Medicaid, and who have no access to health insurance coverage. Georgia included ICTF in the state plan consistent with the

[3] Adena, supra, at 3.
[4] Provider Exhibit P-1.
[5] Stipulations of the parties, ¶ 4.
[6] Id.
[7] 42 U.S.C. §1396b(a)(1).
[8] 42 U.S.C. §1396d(a).

requirement of Section 1923(b)(3) of the Social Security Act[9] to secure CMS's approval of the state plan.[10] That section requires the plan to include a description of how Medicaid DSH is calculated. The Intermediary asserts that ICTF's inclusion does not convert a person who benefits from ICTF to a patient eligible for "medical assistance" under the Title XIX State 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 evidence establishes that Georgia's ICTF program 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.

Similar to the Medicare DSH provisions, 42 U.S.C. §1396r-4(a) mandates that a Title XIX Medicaid state plan must include a provision for a payment adjustment to hospitals which serve a disproportionate number of low income patients; that is, it requires a Medicaid DSH adjustment for hospitals that is independent of the Medicare DSH adjustment. 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 42 U.S.C. §1395d(a) of the Medicaid statute.

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

In prior decisions on similar state programs, the Board has interpreted the Medicare statutory phrase "medical assistance under a State plan approved under [Title] XIX" to include any program identified in the approved state plan, i.e. it has not limited the days counted to traditional Medicaid days.[11] However, subsequent to the parties' hearing, the U.S. Court of Appeals for the District of Columbia issued its decision in Adena Regional Medical Center v. Leavitt, 527 F.3d 176, (D.C. Cir., 2008), 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.[12] Like the ICTF program, HCAP patients could not qualify for Medicaid but

[9] 42 U.S.C. §1396r-4(c)(3)(b).
[10] See Provider's Supplemental Position Paper, pp.10-11.
[11] See e.g., Ashtabula County Medical Center et al. v. BlueCross BlueShield Association/ AdminaStar Federal, Inc., (Ashtabula) PRRB Dec. No. 2005-D49 (August 10, 2005) rev'd CMS Adm. Dec., CCH Medicare Guide 81,442 (October 12, 2005) .
[12] The provider in Adena petitioned the U.S. Supreme Court to review the decision rendered by the U.S. Court of Appeals for the District of Columbia. On April 6, 2009 the Supreme Court denied review of that petition.

the HCAP days were included in the Medicaid DSH calculation. The D.C. Circuit pointed out that the federal Medicaid statute, 42 U.S.C. §1396r-4(c)(3)(B), allows for states to calculate Medicaid 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 HCAP."

Upon further analysis of the Medicaid DSH statute, 42 U.S.C. §1396r-4, the Board finds language persuades us that the term "medical assistance under a state plan approved under [Title] XIX" excludes days funded only by the state and charity care days even though those days may be counted for Medicaid DSH purposes.

The Medicaid DSH statute describes how hospitals qualify for the Medicaid DSH adjustment. It establishes two distinct categories of low-income patients that are used to calculate a Medicaid DSH payment. 42 U.S.C. 1396r-4(b). The two categories, identified as the "Medicaid inpatient utilization rate" and the "low-income utilization rate," are defined 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 subchapter* [Title] XIX in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. (emphasis added)
>
> (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 subchapter 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,

42 U.S.C. §1396r-4(b)(2)-(b)(3).

42 U.S.C. §1396r-4(b)(2)(i) specifically uses the term "eligible for medical assistance under a State plan," the exact language from the Medicare DSH statute at 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" description, that clarifies what is and what is not included in "medical assistance under a State plan." The components of the low-income utilization rate include "services rendered under a [Title] XIX State plan," the same category of patients described in the Medicaid utilization rate but then the statute adds as components subsidies for patient services received directly from State and local governments[13] and charity care.[14] 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 categories of days in the low income utilization rate would have been superfluous. As the ICTF program is funded by "state and local governments" and thus is included in the low income utilization rate, not the Medicaid inpatient utilization rate, ICTF patient days do not fall within the Medicaid statute definition of "eligible for medical assistance under a State plan" at 42 U.S.C. §1396r-4(b)(2)(i).

Statutory construction principles require us to apply the meaning Congress ascribed to the term "eligible for medical assistance under a [Title] XIX State plan" used in the Medicaid statute to the same phrase used in the Medicare statute. [15] ICTF patient days therefore cannot be included in the Medicare DSH statutory definition of "eligible for medical assistance under a State plan" at 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). Accordingly, the Intermediary's adjustments properly excluded Georgia ICTF program patient days from the Provider's Medicare DSH calculation.

With regard to Providers' assertion that CMS itself interpreted FFP for Medicaid DSH as "medical assistance" under a Title XIX state plan, we do not read CMS' 2000 letter[16]as supporting that premise. The letter analyzes whether state expenses for prisoner medical care can be included in the Medicaid DSH formula and concludes that they cannot. CMS points out the calculation is based on two formulas: costs for persons who are "*either* eligible for medical assistance under the State plan *or* have no health insurance or source of third party coverage for services . . ." (emphasis added) CMS reasons that the prisoner expenses cannot be included under the latter formula because the state is obligated to cover prisoners' basic economic needs including medical care; therefore, prisoners have a source of third party coverage. Further, prisoners cannot be included

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[13] Subsection (b)(3)(A)(i).
[14] Subsection (b)(3)(B)(i).
[15] Atlanta Cleaners & Dyers, Inc. v. U.S., 286 U.S. 427, 433 (1932).
[16] Provider Exhibit 1.

under the Medicaid formula comprised of those who receive medical assistance under the State plan because that statute and the regulations specifically prohibit FFP for services provided to inmates (i.e. even if prisoners were otherwise eligible for Medicaid, their prisoner status would disqualify them from eligibility). We see nothing inconsistent with CMS' rationale and our decision above or in CMS' positions. On the contrary, we read the 2000 letter as being entirely supportive. Even if such an inconsistency existed, the statutory distinctions we rely on are controlling.

DECISION AND ORDER:

The Intermediary's adjustment properly excluded Georgia's Indigent Care Trust Fund program patient days from the Provider's DSH calculation. The Intermediary's refusal to include these days in the numerator of the Provider's Medicaid proxy is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Brazanga, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran
Chairperson

DATE: September 21, 2009

Southwest Consulting Disproportionate Share Hospital
Georgia Indigent Care Trust Fund Group
Case Number 04-1799G

Schedule of Providers

Provider #	Provider Name	FYE	Original Case
11-0036	Memorial Health University Medical Center	12/31/95	99-1680
		12/31/96	00-0379
		12/31/97	01-1804
		12/31/98	02-1472
		12/31/99	03-0713
		12/31/00	04-1237
		12/31/01	05-1273
11-0064	The Medical Center	06/30/00	03-1020