# PROVIDER REIMBURSEMENT REVIEW BOARD
# DECISION

ON THE RECORD
2013-D21

**PROVIDER –**
QRS UMHC 1991-1996 DSH/Michigan General Assistance Days Group

Provider No.: 23-0046

**vs.**

**INTERMEDIARY –**
BlueCross BlueShield Association/ Wisconsin Physicians Service

**DATE OF HEARING -**
October 31, 2012

Cost Reporting Periods Ended -
1991-1996 and 2003-2006

**CASE NO.:** 07-2446G

## INDEX

ISSUE:

Whether days associated with patients covered under the Michigan Indigent/Charity Care Program 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 Act[2] 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 MACs[3] 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 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 Act[10] 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

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[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 calculated 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 Medicaid plan approved under Title

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[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)(l).
[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), 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[16] 42 C.F.R. § 412.106(b)(2)-(3).
[17] (Emphasis added.)

XIX of the Act[18] but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[19]

The Medicaid fraction is the only fraction at issue in this case. However, resolution of the Medicare DSH issue involves the interpretation of a similar Medicaid DSH provision found 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 case involves a single provider, the University of Michigan ("Provider"), for its cost reports for fiscal years ("FYs") 1991 through 1996 and 2003 through 2006.[20] The Provider is an acute care hospital located in Michigan that received payment under Medicare Part A for services to Medicare beneficiaries. The Provider participated in the Michigan State Plan 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 Provider's designated intermediary was National Government Services, Inc ("Intermediary").[21] The Intermediary issued NPRs for the cost reports at issue excluding Charity Care[22] days in the Medicaid fraction of the Provider's Medicare DSH calculations. The Provider timely appealed the Intermediary's determinations to the Board.

The Providers were represented by J.C. Ravindran, C.P.A., of Quality Reimbursement Services, Inc. The Intermediary was represented by Bernard M. Talbert, Esq., of the BlueCross BlueShield Association.

BACKGROUND ON INCLUSION OF CHARITY CARE 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.

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[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 A for a list of the Provider's fiscal years included in Case No. 07-2446G. Note that FY 1994 is not included as the Board dismissed that fiscal year from the group appeal on October 31, 2012 for lack of jurisdiction.
[21] In October 2012, the Provider's designated intermediary was changed to Wisconsin Physicians Service (MAC Jurisdiction 8).
[22] Charity care is the uncompensated direct patient care provided by one or more hospitals in Michigan. Hospitals may receive payments from the state for this care which may be reimbursed by the federal Medicaid program. *See* Michigan State Plan Under Title XIX of the Social Security Act, Attachment 4.19-A at III.H.2.g (excerpt quoted in Provider's Final Position Paper at 10).
[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 Provider contends that the Medicare statute and regulations required the inclusion of the General Assistance/Charity Care days in the Medicare DSH calculation because the charity care program was a part of the Michigan State Plan and CMS had reviewed and approved that plan. The Provider also contends that according to CMS Program Memorandum A-99-62 issued in December 1999,[25] state-only program days should be included in the DSH calculations. This memorandum allows program days that are solely state-funded to be included for cost reporting periods beginning on or before January 1, 2000. The Provider however disputes the policy's restriction to only those providers which had previously received payment for inclusion of these strictly state-funded programs or had a properly pending appeal for this issue that was requested prior to October 15, 1999.

The Provider asserts that the State of Michigan provides medical assistance on behalf of low-income, uninsured patients through the Medicaid disproportionate share program which is a part of the Michigan State Plan, and as such receives FFP. Therefore, Charity Care/General Assistance days should be similarly included in the Medicare DSH calculation.

The Intermediary counters that days of care paid for by programs for low income patients who are not eligible for Medicaid cannot be included, even if the programs are cited in the State plan approved by the Medicaid program. The Intermediary reasons that it is irrelevant whether payment is made for Medicaid DSH or indirect FFP; these days should not be included in the Medicare DSH Medicaid proxy. In order to be included in the Medicaid proxy, a state program must be defined, specifically, as "medical assistance" under § 1905(a) of the Act.[26] Thus, patient days must be Medicaid-eligible as defined by § 1905(a), not inpatient hospital days paid for by other programs for low income patients that CMS permits to be counted for the Medicaid DSH adjustment.

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.

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[24] Relevant sections of the Michigan Medicaid Plan are included in the Provider Exhibit P-2.
[25] CMS Pub. 60-A, Transmittal A-99-62 (Dec. 1, 1999) (later re-issued as CMS Pub 60-A, Transmittal A-01-13 (Jan. 25, 2001)).
[26] 42 U.S.C. § 1396d(a). The Intermediary characterizes the services and eligibility requirements set out in § 1905(a) of the Act as "traditional" Medicaid coverage.

The evidence establishes that Charity Care 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 Act[27] 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 Medi*caid* DSH adjustment for hospitals that is independent of the Medi*care* 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).[28]

The question for the Board is whether the Charity Care Program as a state-funded program that is not otherwise eligible for Medicaid coverage and included in the Michigan State Plan solely for the purpose of calculating the Medi*caid* DSH payment constitutes "medical assistance under a State plan approved under [T]itle XIX" for purposes of the Medi*care* DSH adjustment, specifically in the Medicaid fraction component.

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.[29] Subsequent to those decisions, in 2008, the U.S. Court of Appeals for the District of Columbia ("D.C. Circuit") issued its decision in *Adena Regional Medical Center v. Leavitt* ("*Adena*"),[30] 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.[31] Like the Michigan Charity 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 in *Adena* that § 1923(c)(3)(B) of the Act[32] "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."[33]

Upon further review and analysis of § 1923, the Board is persuaded 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

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[27] 42 U.S.C. § 1396r-4(a).
[28] *See* 42 U.S.C. § 1396r-4(c)(3).
[29] *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 Adm. Dec. (Oct. 12, 2005).
[30] 527 F.3d 176, (D.C. Cir., 2008), *cert. denied,* 129 S. Ct. 1933 (2009).
[31] *Adena,* 527 F.3d at 180.
[32] 42 U.S.C. § 1396r-4(c)(3)(B).
[33] *Id.* (emphasis added).

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* 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. . . .[34]

Subsection (b)(2) 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 definition of 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 definition of the Medicaid utilization rate.

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[34] (Emphasis added.)

In paragraphs (A)(i)(II) and (B)(i), there are the second and third components consisting of "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 Michigan Charity Care Program is funded by "state and local governments" and, thus, is included in the low income utilization rate but not the Medicaid inpatient utilization rate, Charity Care 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.[35] 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.[36] Michigan Charity Care patient days, therefore, cannot be included in the Medicare DSH statutory definition of "eligible for medical assistance under a State plan" at § 1886(d)(5)(F)(vi)(II) of the Act.[37] Accordingly, the Intermediary's adjustments properly excluded Michigan Charity Care Program patient days from the Provider's Medicare DSH calculations.

DECISION AND ORDER:

The Intermediary properly refused to include Michigan Charity Care Program days in the numerator of the Providers' Medicaid proxy. The Intermediary's adjustments are affirmed.

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[35] 42 U.S.C. § 1396r-4(b)(2). On April 19, 2012, as part of a Board submission for this case, the Provider Representative informed the Board of the following case involving a GA days DSH issue – *Nazareth Hosp. v. Sebelius*, Civ. Action No. 10 3513 (E.D. Pa.) ("*Nazareth*"). Subsequent to the Board receipt of this submission, a decision was issued in *Nazareth*. *See Nazareth*, Civ. Action No. 10-3513, 2013 WL 1401778 (E.D. Pa. Apr. 8, 2013). However, concurrent with this decision, the Board sent a letter to the Provider Representative confirming that the Board would neither consider the *Nazareth* case nor enter into the record any additional arguments and evidence regarding *Nazareth* included or requested in that submission because: (1) the *Nazareth* case presents new legal arguments under the Equal Protection Clause of the Constitution and Administrative Procedure Act (*see id.* at *2, *12 n.1) that were not raised by the Provider prior to the closing of the record on August 12, 2011 (indeed, none of these arguments would be ones that the Board would be authorized to consider pursuant to 42 C.F.R. § 405.1867 and the *Nazareth* case is not binding precedent on the Board); and (2) the Provider through the Provider Representative failed to properly preserve its right to make these arguments and evidence a part of the record for the record hearing because, in attempting to obtain Board consideration of new argument and evidence (as well as a request to admit yet more evidence) related to *Nazareth*, the Provider Representative failed to observe and comply with Board Rules 32.3(C) and 44.1-44.3 specifying the duty to confer with the other party and the proper process and procedure to petition the Board by written motion to reopen the record for a record hearing for additional argument and evidence.

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

[37] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

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Michael W. Harty
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DATE: JUL 25 2013

## APPENDIX A

## Summary of the Provider's Fiscal Years included in Case No. 07-2446G

| | Provider No. | Provider Name | Fiscal Year End ("FYE") |
|---|---|---|---|
| 1 | 23-0046 | University of Michigan | 06/30/1991 |
| 2 | 23-0046 | University of Michigan | 06/30/1992 |
| 3 | 23-0046 | University of Michigan | 06/30/1993 |
| 4[38] | n/a | n/a | n/a |
| 5 | 23-0046 | University of Michigan | 06/30/1995 |
| 6 | 23-0046 | University of Michigan | 06/30/1996 |
| 7 | 23-0046 | University of Michigan | 06/30/2003 |
| 8 | 23-0046 | University of Michigan | 06/30/2004 |
| 9 | 23-0046 | University of Michigan | 06/30/2005 |
| 10 | 23-0046 | University of Michigan | 06/30/2006 |

[38] University of Michigan, Provider No. 23-0046, FYE 06/30/1994 was removed from Case No. 07-2446G based on the Board's jurisdictional decision dated October 31, 2012.