PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2014-D27

PROVIDER –
Cooper Hospital/University Medical Center
Camden, New Jersey

Provider No.: 31-0014

vs.

INTERMEDIARY -
Novitas Solutions, Inc./
Blue Cross and Blue Shield Association

DATE OF HEARING -
June 19, 2014

Cost Reporting Period Ended -
December 31, 2001

CASE NO: 05-0553

INDEX

ISSUE:

Whether days associated with patients covered under the New Jersey Charity Care Program should be included in the numerator of the Medicaid proxy of the Medicare disproportionate share hospital ("DSH") calculation pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

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 Social Security Act, as amended ("Act"), to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & 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[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant accounting period and the portion of those costs allocated to the Medicare program.[3] 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").[4] A provider dissatisfied with the intermediary's final determination of total reimbursement (*i.e.*, the NPR) may file an appeal with the Provider Reimbursement Review Board ("Board") provided it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[5]

Part A of the Medicare program covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[6] Under IPPS, the Medicare program pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The statutory provisions addressing the IPPS are located in 42 U.S.C. § 1395ww(d) and they contain a number of provisions that adjust payment based on hospital-specific factors.[8] This case

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[1] FIs and MACs will be collectively referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[3] *See* 42 C.F.R. § 413.20.
[4] *See* 42 C.F.R. § 405.1803.
[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1837.
[6] *See* 42 C.F.R. Part 412.
[7] *See id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).

involves the hospital-specific DSH adjustment specified in § 1395ww(d)(5)(F)(i)(I). This provision requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] 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.[11]

The DPP is defined as the sum of two fractions expressed as percentages.[12] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. The Medicare/SSI fraction is defined in § 1395ww(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 subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, 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 subchapter, ...

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.[13]

Similarly, the Medicaid fraction (also referred to as the Medicaid proxy) is defined in § 1395ww(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 subchapter XIX of this chapter*, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.[14]

The intermediary determines the number of the hospital's patient days of service for which patients were eligible for medical assistance under a State plan approved under Title XIX of the

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[9] *See also* 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (F)(vii)-(xiv); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] *See* 42 C.F.R. § 412.106(b)(2)-(3).
[14] (Emphasis added.)

Act (*i.e.*, 42 U.S.C. Chapter 7, Subchapter XIX) but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[15]

The Medicaid fraction is the only fraction at issue in this case. However, resolution of the Medicare DSH issue also involves the interpretation of a similar Medicaid DSH provision in Title XIX of the Act and its application 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:

Cooper Hospital/University Medical Center ("Provider") is located in New Jersey and participates in the New Jersey Charity Care Program ("NJCCP") which provides medical assistance to uninsured low-income patients not eligible for other medical assistance programs, including Medicaid. The Provider timely appealed from the NPR for fiscal year ("FY") 2001 dated January 14, 2005.

The Provider is challenging the Intermediary's refusal to include NJCCP days in the Medicaid fraction of the Provider's Medicare DSH calculation. The parties agree that resolution of this issue hinges on the meaning of the phrase "patients who for such days were eligible for medical assistance under a State plan approved under subchapter XIX [*i.e.*, Title XIX of the Act]" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) to describe the Medicaid fraction. This phrase identifies those days that are to be counted in the Medicaid proxy of the Medicare DSH adjustment.

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. 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.

The Provider was represented by James A. Robertson, Esq., of McElroy, Deutsch, Mulvany & Carpenter, LLP. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's exclusion of NJCCP days from the Provider's DSH calculation conflicts with the plain language of the Medicare DSH statute. 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."[16] Contrary to the Intermediary's position, the plain language describing this fraction does not refer more narrowly

[15] *See* 42 C.F.R. § 412.106(b)(4).
[16] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

to only days of persons "eligible for Medicaid," or to persons who are found to be categorically eligible or medically needy under 42 U.S.C. § 1396a(a)(10)(A).[17]

The Provider argues that the enabling State Plan authorizing medical assistance in New Jersey was approved under Title XIX of the Act as required by the statute, and contains provisions for payments to hospitals under the subject NJCCP as one form of federally matched medical assistance. Under Section II of the New Jersey State Plan, in one of the several Medicaid DSH payments implemented pursuant to 42 U.S.C. §§ 1396a(a)(13)(A)(iv) and 1396r-4, hospitals received qualifying medical assistance in FY 2001 in the form of a particular category of Medical DSH payments that correspond to "actual documented charity care" for that State fiscal year.[18]

The Provider explains that the regulation at 42 C.F.R. § 412.106(b)(4)(i) supports the inclusion of NJCCP days in the DSH Medicaid proxy because the regulation provides that a patient is deemed eligible for Medicaid "if the patient is eligible for inpatient hospital services under an approved State Medicaid plan." Because persons eligible under the NJCCP receive "medical assistance" as part of New Jersey's "State Plan approved under Title XIX," NJCCP days, accordingly, must be included in the Medicare DSH calculation.[19]

The Provider contends that its position is consistent with and controlled by the Board's ruling in several prior cases. The Provider points to the Board's 1998 decision in *Jersey Shore Med. Ctr. v. Blue Cross and Blue Shield Ass'n*,[20] where the Board found that NJCCP days should be included in the Medicaid proxy 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 NJCCP patients were, in fact so eligible. 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 (Dec. 1, 1999), in its 2005 and 2007 decisions for *Ashtabula Cnty. Med. Ctr. v. BlueCross BlueShield Ass'n*[21] and *Washington State Medicare DSH Group II v. BlueCross BlueShield Ass'n* respectively.[22] In those cases,[23] 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 Plans] approved under Title XIX."[24]

The Provider further asserts that this case is controlled by the Board's more recent decision in the Provider's parallel appeal for FY 2000, *Cooper Univ. Hosp. v. BlueCross BlueShield Ass'n*.[25]

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[17] *See* Provider's Post Hearing Brief at 7.
[18] *Id.*, at 7-8.
[19] *Id.*, at 8.
[20] PRRB Dec. No. 1999-D04 (Oct. 30, 1998), *vacating and remanding for development of record*, CMS Administrator Dec. (Jan. 4, 1999).
[21] PRRB Dec. No. 2005-D49 (Aug. 10, 2005), *rev'd*, CMS Administrator Dec. (Oct. 11, 2005). The Administrator's decision was appealed to the District Court of the District of Columbia.
[22] PRRB Dec. No. 2007-D05 (Nov. 22, 2006), *rev'd*, CMS Administrator Dec. (Jan. 19, 2007).
[23] Those decisions do not relate to the NJCCP, but to medical assistance programs in the states of Ohio and Washington, respectively.
[24] Provider's Post Hearing Brief at 11-12.
[25] PRRB Dec. No. 2008-D22 (Mar. 28, 2008), *rev'd*, CMS Administrator Dec..(May 23, 2008).

There, the Board relevantly concluded that the longer phrase used in the Medicaid fraction in clause (d)(5)(F)(vi)(I) was not simply a "longhand description" for care for persons with "Medicaid" under 42 U.S.C. § 1396a(a)(10)(A).[26]

Finally, the Provider explains, the U.S. District Court for the District of Columbia in *Adena Reg'l Med. Ctr. v. Leavitt*,[27] agreed with all of the Board's decisions on this issue and agreed that the plain language of the statute could not be read as limiting inclusion of days in the numerator of the Medicaid fraction to only patients who qualified for Medicaid. The Court determined that the phrase "eligible for medical assistance under a state plan approved under Title XIX" is not long-hand for "eligible for Medicaid."[28] It also relied on the legislative intent underlying the DSH adjustment that these fractions were designed to capture indigent care, which is consistent with the right of hospitals to count days of uninsured individuals whose patient care is funded under an approved State Plan through Medicaid DSH payments.[29]

The Provider notes that the Intermediary relies on PM A-99-62 to support its exclusion of NJCCP days from the Provider's DSH computation. However, the Provider asserts, PM A-99-62 is not an authoritative source that requires any particular deference by the Board. A program memorandum is merely an informal instruction from CMS to intermediaries in applying the Medicare statute and reimbursement regulations. It does not have the binding effect of law or regulation or CMS Ruling.[30]

The Provider also argues that the legislative intent of the DSH statute is consistent with counting charity care days in the DSH computation. The purpose of the DSH adjustment – to provide additional reimbursement to hospitals serving a disproportionately large share of "low income patients" – can only be reasonably accomplished if NJCCP days are included in the Medicare DSH calculation. As the Ninth Circuit observed in *Portland Adventist Med. Ctr. v. Thompson*:

> Congress' "overarching intent" in passing the disproportionate share provision was to supplement the prospective payment system payments of hospitals serving "low income" persons. The DSH provision directs the Secretary to provide an additional payment to hospitals serving a disproportionate number of low-income patients.... Congress intended the Medicare and Medicaid fractions to serve as a proxy for all low-income patients.[31]

Patients eligible for medical assistance under the NJCCP do not cease to be low-income patients because they do meet the eligibility requirements for the Medicaid program.[32]

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[26] *Id.* at 7-8. *See also* Provider's Post Hearing Brief at 12.
[27] 524 F. Supp. 2d 1 (D.D.C. 2007), *rev'd*, 527 F.3d 176 (D.C. Cir. 2008), *cert. denied*, 556 U.S. 1165 (2009).
[28] *Adena*, 524 F. Supp. 2d at 4.
[29] *Id.* at 5. *See also* Provider's Post Hearing Brief at 13-14.
[30] *See* Provider's Post Hearing Brief at 15.
[31] 399 F.3d 1091,1095 (quoting *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996)).
[32] *See* Provider's Post Hearing Brief at 16-17.

In a supplemental filing, the Provider presented a new legal argument based on the recent federal district court decision in *Nazareth Hosp. v. Sebelius*.[33] The new legal argument alleges that the Secretary violated the Equal Protection Clause of the Constitution by treating similarly situated hospitals differently, depending on whether they are located in a § 1115 waiver state and violates the Administrative Procedure Act ("APA")[34] by applying the law in an arbitrary and capricious manner.[35]

INTERMEDIARY'S CONTENTIONS[36]

The Intermediary asserts that, although NJCCP is referenced in the New Jersey Medicaid State plan, NJCCP-eligible patients are not eligible for the traditional Medicaid program under the New Jersey Medicaid State plan. Therefore, the individuals covered by the NJCCP are not covered by "medical assistance" as described in Title XIX of the Act. The Intermediary 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.

It is the Intermediary's position (as well as that of the CMS Administrator as reflected the her decision for *Ashtabula Cnty. Med. Ctr. v.BlueCross BlueShield Ass'n*[37]) that, while the enabling DSH statute, 42 U.S.C. § 1395ww(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 § 1395ww(d)(5)(F)(vi)(II) states:

> [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 subchapter XIX*, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.[38]

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

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[33] 938 F. Supp. 2d 521 (E.D. Pa. 2013), *rev'd*, 747 F.3d 172 (3d Cir. 2014).
[34] 5 U.S.C. Ch. 5.
[35] *See* Provider's Supplemental Position Paper at 10, 13, 18.
[36] As stated in the Intermediary's Post Hearing Brief at 1, the Intermediary's contentions are the same as those set forth in *Cooper Univ. Hosp. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2008-D22 (Mar. 28, 2008).
[37] CMS Administrator Dec. (Oct. 11, 2005), *rev'g*, PRRB Dec. No. 2005-D49 (Aug. 10, 2005).
[38] (Emphasis added).

> divides that number by the total number of patient days in the same period.[39]

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.[40]

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 NJCCP 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 NJCCP clearly indicate that patients otherwise insured or receiving medical assistance from other private or government resources are not eligible for NJCCP:

> 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. . . .[41]

The Manual also provides that "[t]he Charity Care Program shall be the payer of last resort . . . ."[42] The Intermediary contends that these provisions clearly establish that specific patients receiving assistance from the NJCCP 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:

The Board has considered Medicare law and guidelines, the parties' contentions and the evidence presented at the record hearing. Set forth below are the Board's findings and conclusions.

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[39] (Emphasis added).
[40] *Cooper Univ. Hosp. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2008-D22 at 5 (Mar. 28, 2008).
[41] Provider Exhibit 14 at 2 (Charity Care Section Hospital Services Manual, N.J.A.C. 10:52-11, 12, 13); N.J. ADMIN. CODE § 10:52-11.5(e).
[42] Provider Exhibit 14 at 4; N.J. ADMIN. CODE § 10:52-11.5(k).

The evidence establishes that charity care beneficiaries of the NJCCP are not eligible for Medicaid and that the services provided under the NJCCP are not matched with federal funds except under the Medicaid DSH provisions.
The Medicaid DSH provisions are similar to the Medicare DSH provisions. 42 U.S.C. § 1396r-4(a) mandates that a state Medicaid plan under Title XIX of the Act 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 42 U.S.C. § 1396c(a).

The question for the Board is whether the NJCCP as a state funded program not otherwise eligible for Medicaid coverage and included in the New Jersey State Medicaid 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).[43] Subsequent to those decisions, the U.S. Court of Appeals for the District of Columbia ("D.C. Circuit") issued its decision in *Adena Reg'l Med. Ctr. v. Leavitt*,[44] and concluded that the days related to charity care beneficiaries eligible for the Ohio Hospital Care Assurance Program ("HCAP") should not be included in the Medicaid proxy of the Medi*care* DSH calculation.[45] Like the NJCCP, HCAP patients could not qualify for Medicaid but the HCAP days were included in the Medicaid DSH calculation. The D.C. Circuit pointed out that 42 U.S.C. § 1396r-4(c)(3)(B) "permits the states to adjust DSH payments 'under a methodology that' considers *either* 'patients eligible for medical assistance under a State plan approved under [Medicaid] or ... low-income patients,' 42 U.S.C. § 1396r-4(c)(3)(B), such as those served under the HCAP."[46]

Upon further review and analysis of § 1396r-4, the Board continues to find 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, § 1396r-4(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 rate" and the "low-income utilization rate," are defined in subsection (b)(2) and (b)(3), in pertinent part, as follows:

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[43] *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 Administrator Dec. (Oct. 11, 2005).
[44] 527 F.3d 176, (D.C. Cir., 2008), *cert. denied,* 556 U.S. 1165 (2009).
[45] *Adena*, 527 F.3d at 180.
[46] *Adena*, 527 F.3d at 180 (brackets, ellipses, and citation in original; footnote and italics emphasis added).

> (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* [*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 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, 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.[47]

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 "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 Medicaid utilization rate. 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

[47] (Emphasis added).

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 NJCCP is funded by "state and local governments" and, thus, is included in the low income utilization rate but not the Medicaid inpatient utilization rate, NJCCP patient days do not fall within the Medicaid DSH statute definition of "eligible for medical assistance under a State plan" at 42 U.S.C. § 1396r-4(b)(2). 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.[48] NJCCP 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 NJCCP patient days from the Provider's Medicare DSH calculation for FY 2001.

Finally, the Board recognizes that, by letter dated June 27, 2013, the Provider filed a request to reopen the record for the on-the-record hearing in order to "present . . . new legal theory" based on the following case in federal district court: *Nazareth Hosp. v. Sebelius*, 938 F. Supp. 2d 521 (E.D. PA 2013) (*"Nazareth"*). The new legal argument alleges that the Secretary violated the Equal Protection Clause of the Constitution by treating similarly situated hospitals differently, depending on whether they are located in a §1115 waiver state and violated the APA by applying the law in an arbitrary and capricious manner. By email dated June 28, 2013, the Board gave the Provider until August 15, 2013 in which to supplement the record with this new legal argument.

On August 15, 2013, the Provider filed the Provider's Supplemental Position Paper with five exhibits marked P-1 to P-5 for Case No. 05-0553 to develop the record on the new legal argument. Concurrently, the Provider also filed a witness list that included the Provider's Vice-President of Revenue Cycle ("VP") as a "fact witness" and the Director in Health Sciences and Government Practice at Deloitte & Touche, LLP ("D&T") as an "expert witness." Provider Exhibit P-5 is an "expert report" from D&T and attached to that report as "Appendix B" is a certified statement from the Provider's VP with Exhibits A and B. Provider Exhibit P-2 is a report prepared on behalf of the providers in the *Nazareth* case and submitted to the CMS Administrator in response to the federal court's remand order and related to the Pennsylvania GA Program for 2002. In particular, the report states that it "focuses on the second question" posed by the court.

At the outset, the Board notes that the Provider never requested leave of the Board to allow the Provider to have witnesses for the on-the-record hearing. Leave was only granted to develop the legal theories. This is an on-the-record hearing and generally these types of hearings do not involve witnesses as this type of hearing is not conducive to allow for examination of the witness whether by the Board or the opposing party. Further, the Board notes that, while the Provider included a document identified as the *Cirriculum Vitae* ("C.V.") of the D&T Director in compliance with Board Rule 34, this document does not qualify as a C.V. pursuant to that Rule because it is only a one-page summary of his experience and does not include either a listing of his employment history and experience by employer or a listing of any publications and/or presentations. Similarly, the Board notes that the content of the report at Provider Exhibit P-2

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

suggests it is being submitted as an expert report and the Provider's Supplemental Position Paper refers to it as an "expert report"; however, the author of the report was not included on the witness list and no C.V. was submitted.

The Board has determined that it will accept the Provider's P-2 Report and P-5 Reports into the record for this case (hereinafter the "Provider P-2 Report" and "Provider P-5 Report" respectively); however, the Board refuses to recognize either as a report prepared by an "expert" due to the noncompliance with Board Rules 34 and 44 and will only give them the weight they are due as relevant[49] without further inquiry.[50] The Board also will accept the certified statement of the Provider's VP into the record as it is narrowly focused on establishing how many NJCCP days are at issue.

As the new legal arguments in the Provider's Supplemental Position Paper concern violations of the Constitution, the Board does not have the legal authority to rule on them pursuant to 42 C.F.R. § 405.1867. Moreover, the Federal Court of Appeals for the Third Circuit reversed the district court decision in *Nazareth* and this reversal is binding precedent on the Board as the Provider is located in the Third Circuit.[51] Notwithstanding, Board hearings are where the record is developed and set for any subsequent review on appeal and the Board must review the sufficiency of that record and make findings as relevant.

In reviewing the record for the additional legal argument, the Board notes that the Provider P-2 Report specifically identifies New Jersey as having a § 1115 waiver program that was approved on April 14, 2011 and expired on December 31, 2013 and covered childless adults up to 24 percent of the federal poverty limit ("FPL").[52] Further, the only description from the NJCCP in the record of the benefits furnished under the NJCCP is included at Provider Exhibit P-3 of the Provider's Supplemental Position Paper which describes certain medical assistance using a sliding scale up to 300 percent of the FPL. However, that description is dated March 2013 which coincides with the existence of the New Jersey § 1115 waiver program identified in the Provider P-2 Report and is more than ten years subsequent to the time period at issue (*i.e.*, the Provider's FY 2001). Further, the Board notes that the Provider's Supplemental Position Paper asserts that "[t]he provisions setting forth approved payments for DSH hospitals, explained at §4.19A (pages I-260 through 1-300 of P-4 [of Provider's Supplemental Position Paper]), include a detailed description of the NJCCP (pages 1-262 through 1-263 of P-4 [of Provider's Supplemental Position Paper])."[53] However, the cited materials for the "detailed description of the NJCCP" are

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[49] The Provider P-2 Report appears to have been accepted into the *Nazareth* record on remand from the *Nazareth* court to the CMS Administrator to answer one of the three questions. *See* 938 F. Supp. 2d at 527. The Board notes that the Board was not involved in this remand and that the *Nazareth* court did not refer to the report as an expert report in its decision. *See generally* 938 F. Supp. 2d at 521-542. Further, while the report itself "summarized" the "credentials and expertise" of the preparer, neither was the report formally proffered to the Board as an expert report nor was it submitted in accordance the process and procedure for expert reports delineated in Board Rules 28 and 34.

[50] Again, the Board notes that this is a on-the-record hearing and, as stated as recently in the Provider's June 27, 2013 request to supplement the record, "we [the Provider] . . . have already agreed to waive a formal hearing."

[51] 747 F.3d 172 (3rd Cir. 2014).

[52] It is unclear whether New Jersey implemented this §1115 waiver program and, if so, how that program related to the NJCCP that also appears to have been in place at the same time.

[53] Provider's Supplemental Position Paper at 5.

excerpts from the New Jersey State Plan that have a CMS-approval date of December 6, 2012 and an effective date of July 1, 2011 and, thus, were not in effect during the time at issue.

Finally, the Board notes that the Provider P-5 Report also includes descriptions of the NJCCP; however, it suffers similar issues as the Provider P-3 Report. The Provider P-5 Report represents that the D&T Director reviewed certain Iowa "fact sheets" and certain New Jersey materials that included for example the "New Jersey State Plan under Title XIX of the Social Security Act – Attachment 4.19A," the "New Jersey Care – Special Medicaid Program (Medically Needy Segment)," and the "New Jersey Hospital Care Payment Assistance Fact Sheet." However, the report neither identifies when *any* of these Iowa and New Jersey documents were published/issued nor to what time period its purported comparison of the Iowa and New Jersey programs is supposed to pertain. As a result, the Board cannot determine from the record whether the Provider P-5 report is relevant to the time period at issue (*i.e.*, the Provider's FY 2001).

Based on these gaps in the record, the Board concludes that Provider Exhibits P-2, P-3, and P-5 have no evidentiary value relative to determining whether the costs of inpatient services arising from the NJCCP were the same or different from those incurred in § 1115 demonstration projects in other states during the time period at issue, namely the Provider's FY 2001.[54]

DECISION AND ORDER:

The Intermediary's adjustments to exclude New Jersey Charity Care Program days from the numerator of the Provider's Medicaid proxy as used in the cost reports for FY 2001 comply with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and, accordingly, are affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: SEP 23 2014

[54] The Board's treatment of the Provider's Supplemental Position Paper and exhibits is consistent with virtually the same scenario in the Board's decision involving the same provider for FYs 2003 and 2004. *See Cooper Hosp. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2014-D11 (June 18, 2014), *declined review*, CMS Administrator (Aug. 20, 2014).