PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D25

PROVIDER -
Connecticut 94-98 DSH Group

Provider No.: Various (See Attached)

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services

DATE OF HEARING -
April 24, 2007

Cost Reporting Periods Ended -
Various

CASE NO.: 00-3473G

INDEX

ISSUE:

Whether the intermediary properly excluded Connecticut's State-Administered General Assistance (SAGA) program days from the Medicare disproportionate share hospital (DSH) calculation for fiscal year-ends (FYEs) 1994 to 1998 for hospitals in this group appeal.

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. 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). 42 U.S.C. §1395ww(d). The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. 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." 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). A provider whose

DSH percentage meets certain thresholds receives an adjustment which results in increased PPS payment for inpatient hospital services. 42 U.S.C. §1395ww(d)(5)(F)(ii). The Medicare fraction's numerator is the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income (SSI), excluding patients receiving state supplementation only, and the denominator is the number of hospital patient days for patients entitled to Medicare Part A. Id. See also, 42 C.F.R. §412.106(b)(2). The Medicare fraction is also referred to as the Medicare proxy or the SSI fraction. 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 also referred to as the Medicaid proxy.

The Medicaid fraction is the only fraction under the Title XVIII Medicare DSH statute at issue in this case. However, resolution of the Medicare DSH issue also involves the interpretation of a similar DSH provision in the Title XIX Medicaid statute 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:

The Providers in this group appeal for FYEs 1995 through 1998[1] are four acute care hospitals[2] located in the Connecticut. The Providers participated in the State of Connecticut's General Assistance Program or State-Administered General Assistance program (SAGA)[3] which provides medical assistance to uninsured low-income patients not eligible for other medical assistance programs, including Medicaid.

Empire Medicare Services[4] (Intermediary) issued NPRs for the Providers' cost reporting periods at issue without including SAGA days in the Medicaid fraction of the Providers' Medicare DSH calculations. Except as set out below, the Providers in this case timely appealed the Intermediary's determinations to the Board.

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[1] Middlesex Hospital for FYE 1994 was withdrawn from this group in the Providers' response to jurisdictional challenge brief dated May 24, 2007. Therefore only FYEs 1995-1998 remain.

[2] The Schedule of Providers dated January 26, 2006 identified five acute care hospitals and 14 FYEs. The hospitals are Waterbury Hospital (2 FYEs), Middlesex Hospital (5 FYEs), William W. Backus Hospital (2 FYEs), St. Vincent Medical Center (4 FYEs) and Danbury Hospital (1 FYE). In a letter dated January 18, 2007, St. Vincents Medical Center for FYE 1997 was transferred out of this appeal and back into the individual appeal, PRRB Case #01-1434. Then, in the Provider letter dated July 30, 2008, the Provider notified the Board that no documentation would be submitted for all FYEs for St. Vincents Medical Center as the Provider and the FI were administratively resolving those years. Therefore, the Board considers the three FYEs which remained for St. Vincents (FYEs 1995, 1996 and 1998) as withdrawn from this appeal.

[3] Connecticut's State Administered General Assistance Program (SAGA) is the same program identified in the State's plan, Provider's Exhibit P-2, as the "State's General Assistance Program." The change in terminology arises from the transfer of administration of this program from cities and towns to the Department of Social Services in April 1997.

[4] Currently doing business as (d/b/a) National Government Services.

The Providers were represented by Teresa A. Sherman, of Sherman Law Office, PLLC. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of Blue Cross Blue Shield Association.

INCLUSION OF SAGA DAYS IN THE MEDICAID PERCENTAGE OF THE MEDICARE DSH ADJUSTMENT

The parties agree that resolution of the issue hinges on the meaning of the phrase "patients who for such days were eligible for medical assistance under a State plan approved under . . .[Title] XIX" as used in the Medicare statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). This phrase identifies what days are counted in the Medicaid proxy of the Medicare DSH adjustment.

Title XIX of the Social Security Act, 42 U.S.C. 1396a et. seq, known as the Medicaid statute, provides for federal sharing of state expenses for medical assistance for low-income individuals, provided the state program meets certain provisions contained in the Medicaid statute. The state must submit a plan describing the program and seek approval from the Secretary. If approved, the state may claim federal matching funds, known as federal financial participation (FFP), under the Title XIX Medicaid statute for the services provided and approved.

The evidence established that the patients who qualify for medical assistance under the SAGA program are not eligible for Medicaid. The SAGA program is state funded and, except as discussed below, the State of Connecticut does not receive FFP for the inpatient services furnished to SAGA patients.[5]

The dispute arises because the SAGA program is described in the Connecticut Medicaid State Plan under the section dealing with the Medicaid Disproportionate Share (Medicaid DSH) provisions.[6] The Medicaid DSH program is similar to the Medicare DSH program in that it requires states that participate in Medicaid to make a payment adjustment to hospitals that "serve a disproportionate number of low income patients." 42 U.S.C. 1396r-4(a). The state receives FFP for its Medicaid DSH expenditures. It is undisputed that the SAGA program days are permitted as part of the Medicaid DSH calculation on which Medicaid DSH FFP is based, but they are not Medicaid inpatient days and so do not qualify for FFP for the inpatient services furnished, i.e. what the Intermediary refers to as "traditional" Medicaid. The details of the state's Medicaid DSH program are required to be included in the Medicaid State Plan. Id.

[5] It appears from the briefs filed before the hearing, both parties may have been confused about whether SAGA inpatient services were matched with federal funds. The Providers' witness, David Parilla, who was responsible for the Connecticut Medicaid program as well as SAGA and other state funded programs (Tr. 32-33) confirmed that SAGA was included under the Medicaid State Plan solely under the Medicaid DSH provisions and, therefore, FFP was claimed only in relation to Medicaid DSH payments. Tr. 46-60, 65, 71; See also Provider Exhibit 2.

[6] See Transcript, at 46; Exhibit P-2 and Provider's post hearing brief, page 4.

PARTIES' CONTENTIONS:

The Providers contend that because the SAGA program was included in the Connecticut State Plan approved under Title XIX and the SAGA program qualified for federal financial participation under the Medicaid DSH program, SAGA patients are therefore "eligible for medical assistance under a State plan approved under [Title] XIX" and must be counted in the Medicaid fraction of the Medicare DSH adjustment.

The Intermediary counters that "eligible for medical assistance under a State plan approved under [Title] XIX" is the statute's "longhand description of Medicaid" and, consistent with the Secretary's use of the term in the implementing regulation,[7] the terms "medical assistance" and "Medicaid" are interchangeable in the Title XIX Medicaid context. The Intermediary reasons that because the State plan provides that patients who are eligible for the SAGA program cannot be eligible for Medicaid, SAGA days must be excluded from the Medicaid proxy of the Medicare DSH calculation. The Intermediary asserts that this distinction is critical. The state program must be covered under 42 U.S.C. §1396d(a)[8] of the Medicaid statute; that is, the patient days must be Medicaid eligible, not merely low income days that Medicaid permits to be counted solely for the Medicaid DSH adjustment.

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 Connecticut's SAGA 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

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[7] In 42 C.F.R. 412.106(b)(4), the Secretary substitutes the term "eligible for Medicaid" for "eligible for medical assistance under a state plan approved under Title XIX."

[8] Section 1396d(a) sets out services and eligibility requirements that the Intermediary characterizes as "traditional" Medicaid coverage.

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.[9] 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.[10] Like the SAGA 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 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."[11]

Upon further analysis of the Medicaid DSH statute, 42 U.S.C. §1396r-4, the Board finds language that 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)

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[9] 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) .

[10] 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.

[11] Although Adena involves HCAP days, and not Connecticut SAGA days, the Board found enough similarities in the two cases to request supplemental briefs from the parties regarding the application of that decision to the present case. Both parties submitted supplemental briefs.

> (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 in 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[12] and charity care.[13] 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 SAGA program is funded by "state and local governments" and thus is included in the low income utilization rate, not the Medicaid inpatient utilization rate, SAGA 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).

[12] Subsection (b)(3)(A)(i).
[13] Subsection (b)(3)(B)(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. [14] SAGA 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 Connecticut SAGA program patient days from the Provider's Medicare DSH calculation.

JURISDICTIONAL CHALLENGE

On April 13, 2007, the Intermediary challenged the Board's jurisdiction over six of the ten Provider FYEs included in this group appeal. The Providers/FYEs contested were:

Waterbury Hospital, Provider # 07-0005, FYE 9/30/1996
Middlesex Hospital, Provider # 07-0020, FYE 9/30/1994[15]
Middlesex Hospital, Provider # 07-0020, FYE 9/30/1995
Middlesex Hospital, Provider # 07-0020, FYE 9/30/1996
The William W. Backus Hospital, Provider # 07-0024, FYE 9/30/1997
Danbury Hospital, Provider # 07-0033, FYE 9/30/1995

The hearing for this case was held on April 24, 2007. The Board allowed the Provider 45 days to respond to the Intermediary's jurisdictional challenge. The Provider submitted its responsive jurisdictional brief on May 24, 2007. The Provider, in its jurisdictional brief, withdrew Middlesex Hospital, Provider # 07-0020, FYE 9/30/1994 from the group appeal.

The Board has reviewed the parties' jurisdictional briefs and other documents in the record. Its jurisdictional determinations are set out below:

Middlesex Hospital, Provider # 07-0020, FYE 9/30/1996
The William W. Backus Hospital, Provider # 07-0024, FYE 9/30/1997
Danbury Hospital, Provider # 07-0033, FYE 9/30/1995;

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of the NPR. The Intermediary challenged jurisdiction for Middlesex Hospital, FYE 9/30/1996, the William W. Backus Hospital, FYE 9/30/1997, and Danbury Hospital, FYE 9/30/1995, on the basis that the Providers could not demonstrate that the SAGA issue was properly added to an individual appeal and transferred to this group appeal prior to the individual appeal being closed. The Providers responded to the Intermediary's challenge by submitting additional documentation to

[14] Atlanta Cleaners & Dyers, Inc. v. U.S., 286 U.S. 427, 433 (1932).
[15] This Provider was withdrawn from the group appeal. See the Provider's Response to Jurisdictional Challenge Brief.

show that the SAGA issue was properly added to the individual appeals prior to the individual appeals being closed, and then transferred to the group appeal.

The Board finds that it has jurisdiction over Middlesex Hospital, FYE 9/30/1996, the William W. Backus Hospital, FYE 9/30/1997, and Danbury Hospital, FYE 9/30/1995. For those three Providers/FYEs, the Board finds that the Providers have adequately documented that they had proper individual appeals pending when the SAGA issues were transferred to this group appeal.

Middlesex Hospital, Provider # 07-0020, FYE 9/30/1995

42 C.F.R. §405.1889 identifies that when a revision is made in a determination or a decision on the amount of program reimbursement after the determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§405.1811, 405.1835, 405.1875 and 405.1877 are applicable. The Intermediary challenges jurisdiction for this Provider's appeal request dated April 2, 1998 of a revised NPR (RNPR) dated February 23, 1998 which did not revise the DSH percentages. The Intermediary argues that the Board lacks jurisdiction over this issue as it is from a revised NPR which is a separate and distinct determination, and the Board's jurisdiction would cover only issues specifically revised in the RNPR. Therefore, as the RNPR did not adjust DSH, the Board would not have jurisdiction over the SAGA days excluded from the DSH calculation.

The Provider argues that the appeal request dated April 2, 1998 was from an original NPR dated September 23, 1997 in which the hospital did not qualify for DSH and, in addition, by letter dated September 24, 1999, the Provider claims it added the DSH issue to its pending appeal from the original NPR. The Provider also argues that the Board would have jurisdiction over the issue under Bethesda Hospital Ass'n v. Bowen, 485 U.S. 399, 405-06 (1988) as DSH is an issue covered by the cost report and does not need to be expressly claimed for the Board to take jurisdiction.

The Board finds that it does not have jurisdiction over Middlesex Hospital for FYE 9/30/1995 as the only determination appealed was the revised NPR dated February 23, 1998 which did not incorporate an adjustment relating to DSH, or more specifically, SAGA days. The copy of the appeal request included by the Provider in its jurisdictional brief at Exhibit III.B included only the first page which did not specify if the NPR being appealed was the original or the revised, but did reference an NPR date of February 26, 1998. The Board located the original appeal request for Middlesex Hospital for FYE 9/30/1995 from the individual case no. 98-2499 and found that the original appeal request was for the RNPR dated February 26, 1998. Therefore, it is clear to the Board that it was the RNPR that was appealed by the Provider, and not the original NPR as the Provider has asserted in its brief.[16] In addition, had the Provider appealed the original NPR dated September 23, 1997 in its appeal request dated April 2, 1998, the appeal request would

[16] As the appeal request was from a revised NPR, the Provider's argument relating to Bethesda are deemed moot as Bethesda was based on an original NPR appeal.

have been untimely as it was received more than 180 days after the original NPR was issued.

Waterbury Hospital, Provider # 07-0005, FYE 9/30/1996

The Intermediary argues that the Provider's appeal is from an RNPR which is a separate and distinct determination, and the Board's jurisdiction would cover only issues specifically revised in the RNPR. The Intermediary argues that the RNPR for Waterbury Hospital, FYE 9/30/1996, addressed only Medicaid eligible days as defined by HCFA Ruling 97-2, and not the specific issue of SAGA days; therefore, the Board lacks jurisdiction over this issue. The Provider argues that the RNPR was the first NPR in which the Provider qualified to receive a DSH payment, and therefore all aspects of the DSH adjustment should be under the Board's jurisdiction. The Provider also notes that the Board has found in previous decisions that it has jurisdiction over all components of an issue (e.g. Medicaid eligible days) from a RNPR where the RNPR is adjusted for that component.

The Board requested and received a copy of the Provider's reopening request which triggered the RNPR and found that, although the Provider's reopening request identified numerous sub-categories of Medicaid eligible days for which it was requesting payment, the Provider did not specifically request SAGA days as part of the reopening.[17] The Board finds that, pursuant to 42 C.F.R. §405.1889, the RNPR is a distinct determination and only the specific areas addressed as part of that revised NPR fall under the Board's jurisdiction. Since the Provider did not request SAGA days as part of the reopening for the revised NPR, and the Intermediary did not adjust the cost report for SAGA days, the Board concludes that the Board does not have jurisdiction over the SAGA days issue for Waterbury Hospital, for FY 9/30/1996.

DECISION AND ORDER:

The Board does not have jurisdiction over two Providers in the group: Waterbury Hospital for FYE 9/30/1996 and Middlesex Hospital for FYE 9/30/1995. The Intermediary properly refused to include Connecticut SAGA days in the numerator of the Providers' Medicaid proxy. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

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

[17] See: Provider's response to Intermediary's Jurisdictional Challenge Brief at Exhibit I.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: June 17, 2009