

CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:

Hackensack University Medical Center;

Provider

vs.

**Blue Cross /Blue Shield Association
Riverbend Government Benefits Administrator**

Intermediary

Claim for:

**Provider Cost Reimbursement
Determination for Cost Reporting
Periods Ending: December 31, 2002**

**Review of:
PRRB Dec. No. 2008-D11
Dated: December 3, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The Center for Medicare Management (CMM) submitted comments, requesting reversal of the Board’s decision. Accordingly, the parties were notified of the Administrator’s intention to review the Board’s decision. Comments were also received from the Provider requesting that the Administrator affirm the Board’s decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD’S DECISION

The issue is whether the Intermediary erred by not including patient days attributable to certain patients, who were not eligible for Medicaid but who were given assistance under the New Jersey Charity Care Program (CCP), in the calculation of the “Medicaid proxy” to determine the Provider’s Medicare disproportionate share hospital (DSH) payment for fiscal year 2002.

The Board, relying on previous decisions¹ and a recently issued decision by the United State District Court for the District of Columbia,² held that the Intermediary's adjustment improperly excluded New Jersey's CCP patient days from the Provider's DSH calculation. The Board found that the Medicare DSH statute was not limited to only Medicaid-eligible patients, as the Intermediary argued, but included patients who qualified for "medical assistance" under a State Plan approved under Title XIX. Therefore, since the New Jersey CCP was approved under Title XIX, and the State received payment for these claims from CMS through the Medicaid DSH payment, the Board held that the New Jersey CCP days should be included in the Medicaid proxy to determine the Provider's DSH adjustment.

SUMMARY OF COMMENTS

CMM submitted comments requesting that the Administrator overturn the Board's decision. Specifically, CMM disagreed with the Board's determination that the plain language of the statute required the numerator of the Medicaid fraction to include patients who are not eligible for Medicaid, but instead receive State benefits under a general assistance or charity care program.

To support this position, CMM relied on Program Memorandum (PM) Transmittal A-01-13 which outlines which days are to be included in the Medicaid fraction of the Medicare DSH calculation. Program Memorandum A-01-13 identifies Medicaid DSH days as days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State. Furthermore, PM A-01-13 provides that: "These patients are not Medicaid-eligible. Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care or general assistance days. This, however, is not 'payment' for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicare formula."

¹ See, *Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey*, PRRB Dec. No. 99-D4, October 30, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,083, rev'd, CMS Administrator, January 4, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,153; *Ashtabula County Medical Center et al. v. Blue Cross Blue Shield Association/AdminiStar Federal, Inc.*, PRRB Dec. No 2005-D49, August 10, 2005, Medicare & Medicaid Guide (CCH) ¶ 81,442, rev'd, CMS Administrator, October 12, 2005; *Washington State Medicare DSH Croup II v. Blue Cross Blue Shield Association/Noridian Administrative Services*, PRRB Dec. No. 2007-D5, November 22, 2006, Medicare & Medicaid Guide (CCH) ¶ 81,620, rev'd, CMS Administrator, January 19, 2007, Medicare & Medicaid Guide (CCH) ¶ 81,684.

² *Adena Regional Medical Center v. Leavitt*, U.S. District Court for the District of Columbia 05-2422 (LFO) (June 21, 2007), Medicare & Medicaid GUIDE ¶ 302,186 (appeal pending).

Therefore, given the fact patients who receive assistance through the New Jersey CCP are not “eligible for medical assistance” under the New Jersey State Plan, days associated with the New Jersey CCP should not be included in the numerator of the Medicaid fraction of the Medicare DSH calculation.

The Provider commented requesting that the Administrator not review the Board’s decision and allow it to become the final agency decision or, in the alternative, affirm the Board’s decision because it is consistent with the applicable statutes, regulations and judicial precedent. The Provider argued that a plain reading of the Act requires that the New Jersey CCP days be included in the Provider’s DSH calculation, because CCP is part of New Jersey State plan approved under title XIX. The DSH statute does not limit the patients covered to “Medicaid” only, but includes patients who qualify for “medical assistance” under the New Jersey CCP, which is part of the New Jersey Medicaid State Plan that was approved by the Secretary under Title XIX.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board’s decision. All comments received timely are included in the record and have been considered.

Relevant to the issue involved in this case, two Federal programs, Medicaid and Medicare involve the provision of health care services to certain distinct patient populations. The Medicaid program is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children.³ The program is jointly financed by the Federal and State governments and administered by the States according to Federal guidelines. Medicaid, under Title XIX of the Social Security Act, establishes two eligibility groups for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.⁴ The “categorically needy” are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) [42 USC 601 *et seq.*] and Supplemental Security Income or SSI [42 USC 1381, *et seq.*] Participating States may elect to provide for payments of medical services to those aged blind or disabled individuals known as “medically needy” whose incomes or resources, while exceeding the financial eligibility requirements for the categorically needy, (such as an SSI recipient) are insufficient to pay for necessary medical care.⁵

³ Section 1901 of the Social Security Act (Pub. Law 89-97).

⁴ Section 1902(a) (10) of the Act.

⁵ Section 1902(a) (1) (C) (i) of the Act.

In order to participate in the Medicaid program, a State must submit a plan for medical assistance to CMS for approval. The State plan must specify, *inter alia*, the categories of individuals who will receive medical assistance under the plan and the specific kinds of medical care and services that will be covered.⁶ If the State plan is approved by CMS, under §1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.

Within broad Federal rules, States enjoy a measure of flexibility to determine eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.⁷ However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for “medical assistance” under the State plan.

In particular, §1901 of the Social Security Act sets forth that appropriations under that title are “[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services....” Section 1902 sets forth the criteria for State plan approval.⁸ As part of a State plan, § 1902(a) (13) (A) (iv) requires that a State plan provide for a public process for determination of payment under the plan for, *inter alia*, hospital services which in the case of hospitals, take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs. Notably, § 1905(a) states that for purposes of this title, “the term ‘medical assistance’ means the payment of part or all of the costs” of the certain specified “care and medical services” and the identification of the individuals for whom such payment maybe made.

Section 1923 of the Act implements the requirements that a State plan under Title XIX provide for an adjustment in payment for inpatient hospital services furnished by a disproportionate share hospital. A hospital maybe deemed to be a Medicaid disproportionate share hospital pursuant to §1923(b) (1) (A), which addresses a hospital’s Medicaid inpatient utilization rate, or under paragraph (B), which addresses a hospital’s low-income utilization rate. The latter criterion

⁶ *Id.* §1902, *et. seq.*, of the Act.

⁷ *Id.*

⁸ 42 C.F.R. 200.203 defining a State plan as “a comprehensive written commitment by a Medicaid agency submitted under section 1902(a) of the Act to administer or supervise the administration of a Medicaid plan in accordance with Federal requirement.”

relies, *inter alia*, on the total amount of the hospital's charges for inpatient services, which are attributable to charity care.⁹

Congress recognized that the various conditions and requirements of Title XIX of the Act, under which a State may participate in the Medicaid program, created certain obstacles to potentially innovative and productive State health-care initiatives. Consequently, Title XI of the Act was amended to allow States to pursue such innovative programs.¹⁰ Under §1115 of subchapter XI of the Act, a State that wishes to conduct such an innovative program must submit an application to CMS for approval. CMS may approve the application, if, in their judgment, the demonstration project is likely to assist in promoting the objectives of certain programs established under the Act, including Medicaid.¹¹ To facilitate the operation of an approved demonstration project, CMS may waive compliance with specified requirements of Title XIX, to the extent necessary and for the period necessary to enable the State to carry out the demonstration project.¹² In addition, CMS may direct that costs of the demonstration project that would not "otherwise" qualify as section 1903 Medicaid expenditures, "be regarded as expenditures under the State plan approved under [Title XIX]."¹³

While Title XIX implemented medical assistance pursuant to a cooperative program with the States for certain low-income individuals, the Social Security Amendments of 1965¹⁴ established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,¹⁵ and Part B, which is a supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.¹⁶ At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to

⁹ Congress has revisited the Medicaid DSH provision several times since its establishment. In 1993, Congress enacted further limits on DSH payments pursuant to section 13621 of Pub. Law 103-66 that took into consideration costs incurred for furnishing hospital services by the hospital to individuals who are either eligible for Medicare assistance under the state plan or have no health insurance (or other source of third part coverage for services provide during the year). The Medicaid DSH payments may not exceed the hospital's Medicaid shortfall; that is; the amount by which the costs of treating Medicaid patients exceeds hospital Medicaid payments plus the cost of treating the uninsured.

¹⁰ Section 1115 of the Act.

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ Pub. Law No. 89-97.

¹⁵ Section 1811-1821 of the Act.

¹⁶ Section 1831-1848(j) of the Act.

beneficiaries.¹⁷ However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.¹⁸ This provision added §1886(d) of the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.¹⁹

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based on one of almost 500 diagnosis related groups (DRG) subject to certain payment adjustments.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to §1886(d) (5) (F) (i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients...."²⁰ There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."²¹ To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, *inter alia*, its disproportionate patient percentage. Relevant to this case, with respect to the proxy method, §1886 (d)(5)(F)(vi) of the Act states that the term "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" and the "Medicaid low-income proxy", respectively, and are defined as follows:

(I) the 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

¹⁷ Under Medicare, Part A services are furnished by providers of services.

¹⁸ Pub. Law No. 98-21.

¹⁹ H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

²⁰ Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See also 51 Fed. Reg. 16772, 16773-16776 (1986).

²¹ The Pickle method is set forth at section 1886(d) (F) (i) (II) of the Act.

number of such hospital's patients day for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this title.

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consists 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 patient days for such period. (Emphasis added.)

CMS implemented the statutory provisions at 42 C.F.R. § 412.106. The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 C.F.R. § 412.106(b) (2). Relevant to this case, the second computation, the "Medicaid-low income proxy", or "Clause II", is set forth at 42 C.F.R. § 412.106(b) (4) (1995) and provides that:

Second computation. The fiscal intermediary determines, for the hospital's cost reporting period, the number of patient days furnished to patients entitled to Medicaid but not to Medicare Part A, and divides that number by the total number of patient days in the same period. (Emphasis added.)

Although not at issue in this case, CMS revised 42 C.F.R. § 412.106(b)(4) to conform to HCFA Ruling 97-2, which was issued in light of Federal Circuit Court decisions disagreeing with CMS' interpretation of a certain portion of § 1886(d)(5)(vi)(II) of the Act. In conjunction with this revision, CMS issued a Memorandum dated June 12, 1997, which explained the counting of patient days under the Medicaid fraction, stating that:

[I]n calculating the number of Medicaid days, fiscal intermediaries should ask themselves, "Was this person a Medicaid (Title XIX beneficiary on that day of service?" If the answer is "yes," the day counts in the Medicare disproportionate share adjustment calculation. This does not mean that title XIX had to be responsible for payment for any particular services. It means that the person had to have been determined by a State agency to be eligible for Federally-funded medical assistance for any one of the services covered under the State Medicaid Title XIX plan (even if no Medicaid payment is made for inpatient hospital services or any other covered service)....

In order to clarify the definition of eligible Medicaid days and to communicate a hold harmless position for cost reporting periods beginning before January 1, 2000, for certain providers, CMS issued Program Memorandum (PM) A-99-62, dated December 1999. The PM responded to problems that occurred as a result of hospitals and intermediaries relying on Medicaid State days data obtained from State Medicaid agencies to compute the DSH

payment that commingled the types of otherwise ineligible days listed with the Medicaid days.

In clarifying the type of days that were proper to include in the Medicaid proxy, the PM A-99-62 stated that the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. The PM explained that:

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for Medicaid days reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's eligibility for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX state plan, not the patient's eligibility for general assistance under a State-only program; Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, 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).

Consistent with this explanation of days to be included in the Medicare DSH calculation, the PM stated regarding the exclusion of days, that:

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program.... These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of *Medicaid* DSH payments to the hospital, but the patient is not eligible for Medicaid under a State plan approved under title XIX on that day, the day is not included in the *Medicare* DSH calculation.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed.²² (Emphasis added.)

Regarding hospitals that did not receive payments in the cost year reflecting the erroneous inclusion of days at issue, CMS stated that:

If, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days.... Do not reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before PRRB on other Medicare DSH issues or other unrelated issues.

In the August 1, 2000 Federal Register, the Secretary reasserted his policy regarding general assistance days, State-only health program days, and charity care days.

General assistance days are days for patients covered under a State-only or county-only general assistance program, whether or not any payment is available for health care services under the program. Charity care days are those days that are utilized by patients who cannot afford to pay and whose

²² An attachment to the PM describes the type of day, description of the day and whether the day is a Title XIX day for purposes of the Medicare DSH calculation. In particular, the attachment describes "general assistance patient days" as "days for patients covered under a State-only (or county only) general assistance program (whether or not any payment is viable for health care services under the program). These patients are not Medicaid-eligible under the State plan." The general assistance patient day is not considered an "eligible Title XIX day." "Other State-only health program patient days" are described as "days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State program." Likewise, State-only health program days are not eligible Title XIX days. Finally, charity care patient days are described as "days for patients not eligible for Medicaid or any other third-party payer and claimed as uncompensated care by a hospital. These patients are not Medicaid eligible under the State plan." Charity care patient days are not eligible Title XIX days.

care is not covered or paid by any health insurance program. While we recognize that these days may be included in the calculation of a State's Medicaid DSH payments, these patients are not Medicaid eligible under the State plan and are not considered Titled XIX beneficiaries.²³

In addition, for the relevant fiscal periods in dispute, the Secretary's policy was to include in the Medicare DSH calculation, only those days for populations under the Title XI § 1115 waiver who were or could have been made eligible under a State plan. The patient days of the "expanded" eligibility groups, however, were not to be included in the Medicare DSH calculation.²⁴ This policy did not affect the longstanding policy of not counting general assistance or State-only days in the Medicare DSH calculation. The policy of excluding §1115 waiver expansion populations from the DSH calculation was revisited by CMS and, effective with discharges occurring on, or after, January 20, 2000, certain §1115 waiver expansion days were to be included in the Medicare DSH calculation in accordance with the specific instructions as specified in more detail in the January 20, 2000 Federal Register.²⁵

In 2001, CMS issued a Program Memorandum (PM) Transmittal A-01-13,²⁶ which again stated, regarding two specific types of Medicaid DSH days, that:

Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State. These patients are not Medicaid eligible. Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity

²³ 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

²⁴ 65 Fed. Reg. 3136 (Jan. 20, 2000). ("In some section 1115 waivers, a given population that otherwise could have been made eligible for Medicaid under section 1902(r)(2) or 1931(b) in a State plan amendment was made eligible under the section 1115 waiver. This population was referred to as hypothetical eligible, and is a specific, finite population identifiable in the budget neutrality agreements found in the Special Terms and Conditions for the demonstrations. The patient days utilized by that population are to be recognized for purposes of calculating the Medicare DSH adjustment. In addition, the section 1115 waiver may provide for medical assistance to expanded eligibility populations that could not otherwise be made eligible for Medicaid. Under current policy, hospitals were to include in the Medicare DSH calculation only those days for populations under the §1115 waiver who were or could have been made eligible under a state plan. Patient days of the expected eligibility groups however, were not to be included in the Medicare DSH calculation.")

²⁵ Id.

²⁶ The PM, while restating certain longstanding interpretations in the background material, clarified certain other points for cost reporting periods beginning on or after January 1, 2000, with respect to the hold harmless policy. See Transmittal A-01-13; Change Request 1052 (January 25, 2001)

care of general assistance days. This, however, is not “payment” for those days and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicaid formula.

Days for patients covered under a State-only (or count-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan. (Emphasis added.)

In sum, for the cost years at issue, the Secretary has consistently required the exclusion of days relating to general assistance or State-only days. The policy distinguishes those days for individuals that receive medical assistance under a Title XIX State plan that are to be counted and “other” days that are not to be counted. Examples of some of these other days include days for individuals that are not in fact eligible for medical assistance but may receive State assistance; days that maybe a basis for Medicaid DSH payment under the State plan only; or days related to individuals that may receive benefits under a Title XI plan. These other days are not counted for purposes of the Medicare DSH payment.

In this case, the Provider alleged that the Intermediary improperly did not include the days of patients who received assistance through the New Jersey CCP in the number of days of patients who were allegedly eligible for medical assistance under an approved State Medicaid Plan. The New Jersey CCP is a safety net for people who are uninsured, ineligible for any private or governmental sponsored coverage (such as Medicaid), and meet both income and assets eligibility criteria.²⁷ The Board held that the Intermediary erred by not including CCP days in the Medicaid fraction to determine the Provider’s Medicare DSH payment for fiscal year 2002.

The Administrator finds that §1886(d)(5)(F)(vi)(II) of the Act requires, for purposes of determining a Provider’s “disproportionate patient percentage”, that the Secretary count patient days attributable to patients who were eligible for medical assistance under a State plan approved under Title XIX of the Act, but who were not also entitled to Medicare Part A. The Administrator finds that, as reflected at 42 C.F.R. § 412.106, the Secretary has interpreted this statutory phrase “patients who (for such days) were eligible for medical

²⁷ See, New Jersey Hospital Care Payment Assistance Fact Sheet, Intermediary Exhibit I-12. See also, New Jersey Hospital Services Manual, Charity Care Section, Sections 10:52-11.5(e) and (k), Intermediary Exhibit I-11.

assistance under a State plan approved under Title XIX,” to mean “eligible for Medicaid.”²⁸ The Administrator further finds that the term “Medicaid” refers to the joint State/Federal program of medical assistance authorized under title XIX of the Act. If a patient is not eligible for Medicaid, then the patient is not “eligible for medical assistance under a State plan approved under Title XIX.”

The Administrator finds that the language set forth in §1886(d) (5) (F) (vi) (II) of the Act requires that the day be related to an individual eligible for “medical assistance under a State plan approved under Title XIX” also known as the Federal Program Medicaid. The use of the term “medical assistance” at §§1901 and 1905 of the Act and the use of the term “medical assistance” at §1886(d) (5) (F) (vi) (II) of the Act is reasonably concluded to have the same meaning. As noted by the courts, “the interrelationship and close proximity of these provisions of the statute presents a classic case for the application of the normal rule of statutory construction that ‘identical words used in different parts of the same act are intended to have the same meaning.’”²⁹ Therefore, the Administrator finds that the language at §1886(d) (5) (F) (vi) (II) of the Act requires that for a day to be counted, the individual must be eligible for “medical assistance” under Title XIX.³⁰ That is, the individual must be eligible for the Federal government program also referred to as Medicaid.

²⁸ See e.g. Cabell Huntington Hosp. Inc., v. Shalala, 101 F.3d 984, 989 (4th Cir. 1996) (“It is apparent that ‘eligible for medical assistance under a State plan’ refers to patients who meet the income, resource, and status qualifications specified by a particular state’s Medicaid plan...”); Legacy Emanuel Hospital v. Secretary, 97 F.3d 1261, 1265 (9th Cir. 1996) (“[T]he Medicaid proxy includes all patient days for which a person was eligible for Medicaid benefits whether or not Medicaid actually paid for those days of service.”)

²⁹ Sullivan v. Stroop, 496 U.S. 478, 484 (1990); Commissioner v. Lundy, 516 U.S. 235, 250 (1996).

³⁰ Congress added language to §1886(d) (5) (F) (vi) (II) of the Act which stated: “In determining under subclause (II) 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, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.” Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, § 5002, 120 Stat. 4, 31 (February 8, 2006) (codified in part at 42 U.S.C. § 1395ww (d) (5) (F) (vi) (II). This amendment to §1886(d)(5)(F)(vi) of the Act specifically addressed the scope of the Secretary’s authority to include (or exclude), in determining the numerator of the Medicaid fraction of the Medicare DSH calculation, patient days of patients not eligible for medical assistance under a State plan but who receive benefits under a demonstration project approved under Title XI of the Act. This enactment clearly distinguishes those patients eligible to receive benefits under Medicaid from those patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved

In contrast, the days involved in this case are related to individuals that are not eligible for “medical assistance” as that term is used under Title XIX and, thus, are not properly included in the Medicaid patient percentage of Medicare DSH calculation under §1886(d)(5)(F)(vi)(II) of the Act. The Administrator finds that the CCP days in question provide medical assistance to individuals who are not eligible for medical assistance under a State plan approved under Title XIX. The Administrator finds that New Jersey’s CCP is a safety net for people who are uninsured, not eligible for other medical assistance programs including New Jersey Medicaid, and have no access to health insurance coverage. The implementing State statutes and New Jersey’s Hospital Services Manual provisions for CCP unambiguously sets forth that patients otherwise insured or receiving other medical assistance from other private or government resources are not eligible for CCP. For example, the New Jersey Hospital Services Manual sets forth that:

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 services to charity care....³¹

As stated above, the Secretary has interpreted the term “eligible for medical assistance under a State Plan approved under Title XIX” means eligible for the Federal government program also referred to as Medicaid. In this case, the New Jersey CCP specifically excludes individuals who are qualified for Medicaid. Section 1886(d)(5)(F)(vi) (II) of the Act requires that for a day to be counted, the individual must be eligible for “medical assistance” under Title XIX. Therefore, the Administrator finds that the individuals covered by the CCP are not covered by “medical assistance” as described in Title XIX. Individuals for whom the Provider seeks to count towards its DSH payment must be eligible for Medicaid.

In addition, eligibility for “medical assistance” under Title XIX, e.g., Medicaid, is determined by the State, not the hospital. Here, eligibility for CCP is determined by the Provider, pursuant to an application process.³² A review of the record shows that the Provider is not evaluating CCP applicants on the core criteria for eligibility for Medicaid, e.g., age, blindness, disability, or parent of dependent children. Nothing in the record shows that, for each patient receiving CCP, whom the Provider seeks to count towards its DSH payment is, in fact, eligible for Medicaid. The

under title XI. This amendment left untouched CMS longstanding policy on general assistance days.

³¹ See, Hospital Service Manual, Charity Care Section, Sections 10:52-11.5 (e) through (l) Provider’s Exhibit P-18 and Intermediary’s Exhibit I-11. (Certain exceptions are set forth that are not involved here.)

³² Intermediary Exhibit I-2 at 2.

receipt of CCP benefits does not transform the patient into one eligible for “medical assistance under a State plan approved under Title XIX.”

Finally, regarding the expenditure of Federal financial participation or FFP under a Medicaid DSH program, generally, the issue of whether costs are regarded as expenditures under a State plan approved under Title XIX for purposes of calculating Federal matching payments to the State is different from the issue of whether patients are considered eligible for medical assistance under a State plan approved under Title XIX for purposes of calculating Medicare DSH payments to a hospital. The statute clearly states that the patients’ Title XIX eligibility for that day is a requirement. Therefore, regardless of any possible indirect FFP through a Medicaid DSH payment, the CCP days operated and funded by the State of New Jersey (not Title XIX) are not counted as Medicaid days.

Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly did not include the New Jersey CCP days in the numerator of the Medicaid fraction. The New Jersey CCP days involve individuals who are not eligible for medical assistance under a State plan approved under Title XIX and, therefore, cannot be included in the numerator of the Medicaid fraction for purposes of the Medicare DSH calculation..

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

**THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE
SECRETARY OF HEALTH AND HUMAN SERVICES**

Date: 1/31/08 /s/
Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services