CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Covenant Health System 91, 93-97 DSH/Medicaid Proxy Group	**Provider Cost Reimbursement Determination for Cost Years**
Provider	**Ending: June 30, 1991; June 30, 1993 - June 30, 1997**
vs.	**Review of :**
Mutual of Omaha Insurance Company	**PRRB Dec. No. 2008-D13**
Intermediary	**Dated: January 11, 2008**

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 Intermediary submitted comments requesting review of the Board's decision. Comments were also received by the Provider requesting that the Administrator reverse, or remand in part, the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. The Providers subsequently submitted additional comments. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue before the Board was whether the Intermediary's calculation of the disproportionate share hospital (DSH) payment was proper.

The Board held that the Intermediary's exclusion of the Texas charity care days from the Providers' DSH calculations was proper, due to the failure of the Providers to submit adequate documentation. The Board observed that §1886(d)(5)(F)(vi)(II) of the Act governs the issue in this case. The Board relied on the Medicare statute, which states that the Medicaid proxy of the DSH calculation includes all "patient

days for such period which consists 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 [Medicare Part A benefits]."

The Board reasoned that the purpose of the DSH statute is to compensate hospitals for the additional costs associated with treating low-income patients. The plain language of the statute requires all days relating to patients eligible for medical assistance under a State plan approved under Title XIX to be included in the Medicaid proxy. The Board found no authority, or overriding rationale, to limit the term "eligible for medical assistance under a State plan approved under Title XIX" to the Intermediary's Medicaid-eligible definition. The Board noted that, although the patients in the charity care program did not qualify for Medicaid under §1901 of the Act, the patients did qualify for medical assistance under a State approved plan as these programs are included in the State approved plan.[1]

Despite the fact that the Providers did not receive payment for the days in question, the paid versus eligible days issue was resolved in prior cases[2] and the CMS issuance of Program Memorandum A-99-62. The Board found there was no evidence in the record of why the hospitals did not qualify to receive payment for the charity care services rendered. The Board, therefore, found consistent with the above referenced cases, that the Providers' failure to be paid for the services rendered to charity care patients was irrelevant, as the basis for their inclusion in the Medicaid proxy was based on their "eligibility" status.

The Board reasoned that, although the Providers established that charity care days for the period beginning September 1, 1993 and ending June 30, 1997 should be counted, the Providers failed to meet their burden of proof as an essential element of their case. The Board found that the Providers presented no evidence of the number of charity care days they were claiming, nor was there any evidence in the record of the Providers' attempt to resolve the specific days prior to the hearing. Therefore, the

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[1] See Ashtabula County Medical Center et al., PRRB Case No. 2005-D49 (August 10, 2005), and Washington State Medicare DSH Group II, PRRB Case No. 2007-D5 (November 22, 2006) and the recent decision from the United States District Court for the District of Columbia, Adena Regional Medical Center v. Michael A. Leavitt, United States District Court for the District of Columbia, Civil Action No. 05-2422 LFO), (June 21, 2007).

[2] See Jewish Hospital, Inc. v. Secretary of Health and Human Services, 19 F.3d 270, 272 (6th Cir. 1994); Deaconess Health Services, Corp. v. Shalala, 83 F.3d 1041 (8th Cir. 1996); Legacy Emanuel Hospital and Health Center v. Shalala, 97 F.3d 1261, 1266 (9th Cir. 1996).

Board found that the Providers failed to adequately support their claim to include the Texas charity care days in the DSH computation.

SUMMARY OF COMMENTS

The Providers commented, noting that the Board was correct in concluding that the charity care days at issue were included in the Texas Title XIX State plan for certain of the periods at issue and, therefore, should be counted for purposes of calculating the Providers' DSH payment. However, the Providers requested that the Administrator review and reverse the Board's finding that the Providers presented absolutely no evidence of the charity care days they are claiming and that there was no evidence in the record of the Providers' attempt to resolve the specific days prior to the hearing.

The Providers argued that the record shows that the Intermediary did receive documentation of the days claimed. While the Providers acknowledged that such documentation was received by the Intermediary only shortly before the hearing, they argued that the Intermediary had an opportunity post-hearing to review the information and reopen the record for additional documentation, cross-examination of the Providers' witness, or other evidence as necessary in response. The Providers noted that the issue presented to the Board was to resolve the "type" of days to be included for purposes of calculating the Providers' DSH payments. They did not request that the Board audit or count the number of days. They pointed out that it was appropriate to provide the information to the Intermediary to review, but that there was no need to provide the same information to the Board prior to the decision on the type of days to be included in the DSH payment calculations.

The Providers also argued that it was unnecessary and would have been inappropriate to provide documentation of actual patient days for the record, as such information would include confidential, protected health information. The Providers contended that the Board did not need this information in order to resolve the issue of the "type" of days that must be included in the calculation of the Providers' DSH payments. The Providers noted that they did not request, or expect, the Board to review detailed and voluminous reports containing the protected health information of the Providers in each of the fiscal years. The Providers expected that, upon the rendering of a decision by the Board regarding the type of days to be included, the Intermediary would cooperate in reviewing and auditing the documentation for the days claimed. The Providers noted that the Board instructions state that the Board is not the body for an initial detailed review of documentation and that such documentation should be timely submitted to the Intermediary. The Board instructions also strongly caution the parties not to submit documents containing patient names, health insurance or Social Security numbers, or other information that identifies individuals, since the record and Board proceedings may be disclosed to the public. Thus, the Providers argued it would have been inappropriate

and unduly burdensome upon the Board to have to review patient data to document the precise number of charity care days claimed by the Providers. Instead, the Board merely needed to determine the type of days to be included and, once the type of days to be included was resolved, the actual calculation of days and reimbursement impact could be resolved by the Intermediary and Providers.

The Providers submitted additional comments and argued that the Administrator affirm the Board's holding that the charity days should be counted for purposes of calculating the Providers' DSH payments. The Providers argued that the clear and unambiguous language of §1886(d)(F)(vi)(II) of the Act looks to the State plan approved under Title XIX for determining the low-income population count. The Providers noted that, in order for a State to participate in the Medicaid program to provide health care to indigent persons and qualify for Federal Financial participation, a State must submit a plan for medical assistance to CMS for approval. The Provider claimed that, although there are specific requirements, such as income and resource limitations, which must be complied with, the States still have broad discretion to specify the categories of individuals who will receive medical assistance under the Plan. The Providers further argued that, once the State plan is approved by CMS, the State is eligible to receive matching payments from the Federal government on behalf of the individuals receiving medical assistance under the State plan.

The Providers contended that the State of Texas implemented its Medicaid DSH Reimbursement Program as part of its Title XIX State plan as required by Federal law. The State recognized that it was necessary to design a way to measure low-income, indigent care that was not covered by traditional Medicaid and Medicare programs. The Providers requested that the Administrator affirm the Board's holding that the charity days should be counted for purposes of calculating the Providers' DSH payments, and cited a number of Board and Court decisions supporting their argument.

The Intermediary submitted comments and contended that the Board incorrectly assumed jurisdiction in this case. The Intermediary challenged the validity of the amount in controversy as simply a guess resulting from an unproven formula and that verification cannot be made without a listing of the patient days in dispute. The Intermediary argued that the Board erred in accepting the Providers' estimate when it found that the Providers failed to present any evidence of the charity care days they were claiming. The Intermediary reasoned that the regulations at 42 C.F.R. §405.1835 and §405.1837 do not allow for estimates. The Intermediary argued that the Providers' contentions are undocumented and, therefore, there is no amount in dispute. The Intermediary further argued that the Board mistakenly determined that the charity care days were allowable in the Medicaid proxy, as it was uncontested that the charity care days at issue in this case were attributable to patients who were not eligible for Medicaid.

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]

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

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[3] Section 1901 of the Social Security Act (Pub. Law No. 89-97).
[4] Section 1902(a) (10) of the Act.
[5] Section 1902(a) (1) (C) (i) of the Act.
[6] Id. §1902, *et seq*., of the Act.
[7] Id.

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 may be 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 may be 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 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.

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[8] 42 C.F.R. 200.203 defines 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."

[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 party coverage for services provided 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.

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 1965[14] 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 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]

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[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.
[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).

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 more than 700 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 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.
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> (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.)

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[20] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. Law 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.

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.
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> 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.
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> 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.)

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 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

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[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.

[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

longstanding policy of not counting general assistance charity care 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 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.
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> *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.)

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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)

In sum, for the cost years at issue, the Secretary has consistently required the exclusion of days relating to general assistance, charity care, or State-only days. The policy distinguishes 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; charity care days that may be 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 Providers alleged that the Intermediary improperly did not include the charity care days in the DSH calculation. The plan allowed for a Medicaid DSH payment to qualified hospitals for inpatient services provided to indigent or "charity care" patients.[27] The Providers asserted that the Texas Medicaid DSH program was thus part of the Texas State Medicaid Plan approved under Title XIX that provides Federal Financial Participation (FFP) for medical services provided to this defined group of low-income patients. The Providers claimed that the total numbers of days associated with the Medicaid DSH program were required to be included in the resulting DSH calculation. The Board held that charity care days should be included in the Medicaid fraction.[28] However, because the Providers failed to produce adequate documentation to support its claim to include the Texas charity care days in the DSH computation, the Intermediary's adjustment was proper.

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

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[27] See, State of Texas Disproportionate Share Hospital Reimbursement Program for Hospitals Other than State-Owned Teaching Hospitals, Provider's Position Paper, Exhibit P-1, pg. 3.

[28] The Provider submitted excerpts from the Texas State plan effective September 1, 1995 in Provider Exhibit P-1, which documented that the Medicaid DSH program was included in the Texas State plan and the evidence established that it remained in effect through September 1, 2001. The Provider's witness testified that the Texas State Medicaid plan was totally revamped as of 1993 and that the effective date was September 1, 1993. (Transcript pgs. 64-66, and 110). The Board found that the Providers' witness testimony to be credible that substantially the same plan was in effect starting September 1, 1993 through September 1, 2001. However, there was no evidence in the record that a Medicaid DSH program was in effect prior to that date, that used the same methodology.

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 assistance under a State plan approved under Title XIX," to mean "eligible for Medicaid."[29] The Administrator further finds that the term "Medicaid" refers to the joint Federal-State 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.' "[30] 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.[31] That is, the individual must be eligible for the Federal government program also referred to as Medicaid.

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[29] 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.")

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

[31] 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

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 the Medicare DSH calculation under §1886(d)(5)(F)(vi)(II) of the Act. The Administrator finds that the days in question are used to provide a Medicaid DSH payment and the days are related to individuals that are not eligible for medical assistance under a State plan approved under Title XIX. For example, the "State of Texas Disproportionate Share Hospital Reimbursement Program" describes the Medicaid DSH calculation that is based, in part, on inpatient charity charges, and states that:

> Total inpatient charity charges, excluding bad debt charges, means the total amount of the hospital's charges for inpatient hospital services attributed to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period.[32]

As stated above, the Secretary has interpreted the term "eligible for medical assistance under a State Plan approved under Title XIX" to mean that the individual is eligible for the Federal government program also referred to as 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 charity care days are specifically related to the charity charges and not to the individual's eligibility for "medical assistance" as described in Title XIX.

In addition, eligibility for "medical assistance" under Title XIX, e.g., Medicaid, is determined by the State based on Federal rules, not the hospital. In this case, it is the hospital that is eligible for the Medicaid DSH program, not a specific individual patient,

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

[32] See, State of Texas Disproportionate Share Hospital Reimbursement Program for Hospitals Other Than State-Owned Teaching Hospitals, Provider Position Paper, Exhibit P-1.

as reflected in the application process. [33] The application to be filed by the hospital specifically states:

> In order to receive Medicaid disproportionate share funds in State Fiscal Year 1999, a hospital's fiscal year 1997 total charity care charges must be equal to or greater than 25 percent of its net State Fiscal Year 1998 disproportionate share payments.[34]

In calculating the charity care charges, the application explains that the hospital is to use the following definition:

> Total Hospital Charges for services provided to patients who have no health insurance or other source of Third Party Payment, less the amount of payments made by or on behalf of these patients.... Charges for services delivered to patient eligible for Medicaid or Medicare must be excluded from the report.[35] (Emphasis added.)

Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly did not include the charity care days in the numerator of the Medicaid fraction. The Administrator agrees with that part of the Board's conclusion that the Provider failed to properly support their claim to include the Texas charity care days in the DSH calculation.[36] However, this conclusion is secondary to the finding that such charity care days should not be included in the calculation based on the foregoing legal analysis.

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[33] See, Provider Position Paper, Exhibit P-2.

[34] See, Provider Position Paper, Exhibit P-2, p. 1.

[35] See, Provider Position Paper, Exhibit P-2, p. 3. Apparently, in this case the Providers acknowledged that they did not meet the necessary threshold under the State plan to receive Medicaid DSH payments. Therefore, the Hospital was not "eligible" for a Medicaid DSH payment, making the Board's analogy to paid versus claimed days further flawed.

[36] The regulation at 42 C.F.R. §412.106(b) states that "the hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day…" The regulations establish specific guidelines for the maintenance of data and submission of cost reports in 42 C.F.R. §413.20(d). In the instant case, the record shows that the Provider failed to submit adequate documentation. While the Providers argued that such documentation involved private information and could not be included in the record, the Administrator notes that the Board has procedures for handling such documentation.

Thus, pursuant to the laws and regulations cited above, the Administrator finds that the Board is incorrect to state that charity care days used to calculate a Medicaid DSH payment may be included in the Medicare DSH calculation. The charity care 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 upholding the Intermediary is affirmed, in accordance with the foregoing opinion.

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

Date: **3/7/08** **/s/**

Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services