CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
National DSH Dual Eligible Group Appeal **Provider** **vs.** **Blue Cross Blue Shield Association** **National Government Services** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: Various** **Review of:** **PRRB Dec. No. 2009-D26** **Dated: June 23, 2009**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review on own motion, 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)). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the CMS Center for Medicare Management (CMM) requesting reversal of 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 properly excluded dual eligible patient days from the Medicaid eligible days in determining the Medicaid percentages that were used for the disproportionate share hospital (DSH) adjustment payments.

The Board held that dual eligible days for Medicare Part A exhausted benefit days, Medicare secondary payer days and days denied for lack of medically necessity or custodial care should be included in the Medicaid percentage that is used to calculate the DSH adjustment payment.

SUMMARY OF COMMENTS

CMM submitted comments requesting that the Board's decision to include dual-eligible exhausted benefit and MSP days be reversed and that the Board's decision to include medically unnecessary days in the Medicaid percentage also be reversed. CMM stated that the Board improperly included these dual eligible days in the Medicaid fraction.

CMM explained that the issue involved whether the patient days associated with patients who were dually eligible for both Medicare and Medicaid, but for which Medicare did not "cover" nor make payment. These days include: (1) days of care furnished to patients after exhaustion of the patients' Medicare Part A benefits (exhausted day benefits); (2) days of care for which another party was the primary payer and for which Medicare was secondary in order of payment (Medicare secondary payer or MSP); and (3) days of care for which Medicare coverage was denied and no payment was made to the hospitals under Medicare Part A because the days were determined to be medically unnecessary or custodial care.

CMM stated that under current regulations both exhausted Medicare benefit days and MSP days are included in the Medicare fraction and such days have never been counted in the Medicaid fraction under the DSH regulations. With respect to medically necessary or custodial days, CMM notes that these types of days should not be included in either fraction of the DPP, because they are not considered valid "patient" days under the regulations.

Medically unnecessary or custodial care days are distinguished from other categories of days at issue in that medically unnecessary days are at no point considered "covered days" whereas exhausted benefit days are covered to the point that benefits exhaust and MSP days are covered to the extent that third party insurer does not cover, or pay for, an eligible service. Similarly, Medicaid does not generally cover, or view as eligible, a day that is determined to be medically unnecessary. Therefore, with respect dual eligible exhausted days and MSP days, CMM recommended that the Administrator overturn the Board's decision because such days are precluded from the inclusion in the Medicaid fraction. With respect to medically unnecessary days, CMM recommended that the Administrator reverse the Board's decision as these days may not be included in either the Medicare or Medicaid fraction.

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.

Since 1983, The Medicare program has paid most hospitals for the operating cost of inpatient hospital services under the prospective payment system (PPS).[1] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[2] Concerned with possible payment inequities for inpatient prospective payment system (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…."[3]

To be eligible for the additional DSH payment, a hospital must meet certain criteria concerning, inter alia, its disproportionate Patient percentage (DPP). Section 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 first fraction that is used to compute the DSH payment is commonly known as the "Medicare fraction." The statute defines the Medicare fraction as:

> 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.[4]

The second fraction that is used to compute the DSH payment is commonly known as the "Medicaid fraction." The statute defines the Medicaid fraction as:

> 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

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[1] Section 1886(d)(1)-(5) of the Social Security Act (Act); 42 C.F.R. § 412.106
[2] Id.
[3] See Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985; Pub. L. No. 99-272, § 9105. See also 51 Fed. Reg. 16772, 16773-16776 (1986).
[4] Section 1886(d)(5)(F)(vi)(I)

> under Part A of this title, and the denominator of which is the total number of the hospital patient days for such period.[5] (Emphasis added.)

The Secretary implemented the statutory provisions at 42 C.F.R. § 412.106 (1993) and explained that the hospital's DPP is determined by adding the results of two computations and expressing that sum as a percentage. The first computation, the "Medicare fraction" is set forth at 42 C.F.R. § 412.106(b)(2) (1993). The regulation at 42 C.F.R. § 412.106(b) provides that:

> (b) *Determination of a hospital's disproportionate patient percentage.*
> *(1) General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS-
> (i) Determines the number of covered patient days that-
> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation; …. (Emphasis added.)

The second computation, the "Medicaid fraction" is also set forth at 42 C.F.R. § 412.106(b)(2) (1993). The regulation at 42 C.F.R. § 412.106(b) provides that:

> (4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.…. (Emphasis added.)

Relevant to this case, in the May 6, 1986 final rule implementing the DSH adjustment the Secretary stated with respect to the calculation of the Medicare fraction that:

> [I]f a Medicare beneficiary is eligible for SSI benefits (excluding state supplementation only) during a month in which the beneficiary is a patient in the hospital, the covered Medicare Part A inpatient days of hospitalization in that month will be counted for the purpose of

[5] Section 1886(d)(5)(F)(vi)(II)

> determining the hospitals disproportionate patient percentage."[6] (Emphasis added.)

In addition, in the September 1, 1995, final IPPS rule, the Secretary stated that the numerator and denominator of the Medicare fraction included only Medicare covered days:

> Section 1886(d) (5) (F) of the Act provides for additional payments for hospitals that serve a disproportionate share of low income patients. A hospital's disproportionate share adjustment is determined by calculating two patient percentages (Medicare Part A/Supplemental Security Income (SSI) covered days to total Medicare covered days, and Medicaid but not Medicare Part A covered days to total inpatient hospital days), adding them together and comparing that total percentage to the hospital's qualifying criteria.[7]

In the proposed FFY 2004 IPPS rule,[8] the Secretary considered the option of changing its long-standing policy, and proposed to allow dual-eligible days where the patient has exhausted its Medicare A benefits to be included in the Medicaid Proxy. The Secretary stated that:

> As described above, the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits. If a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction. This is consistent with the language of section 1886(d)(5)(F)(vi)(II) of the Act, which specifies that patients entitled to benefits under Part A are excluded from the Medicaid fraction.
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> We are proposing to change our policy, to begin to count in the Medicaid fraction of the DSH patient percentage the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage has

[6] 51 Fed. Reg. 16772 at 16777 (May 6, 1986)
[7] 60 Fed. Red. 45778 at 45811 (September 1, 1995)
[8] 68 Fed. Reg. 27182, 27207 (May 19, 2003)

> expired. We note the statute referenced above stipulates that patient days attributable to patients entitled to benefits under Medicare Part A are to be excluded from the Medicaid fraction, while the statute specifies the Medicaid fraction is to include patients who are eligible for Medicaid.
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> Under this proposed change, before a hospital could count patient days attributable to dual-eligible beneficiaries in the Medicaid fraction, the hospital must submit documentation to the fiscal intermediary that justifies including the days in the Medicaid fraction after the Medicare Part A benefits have been exhausted….

However, due to strong opposition and the volume of comments received, the Secretary in the final rule, 69 Fed. Reg. 49098 (Aug. 11, 2004), decided not to adopt the May 19, 2003, proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. The Secretary explained with respect to the Medicare fraction that:

> It has come to our attention that we inadvertently misstated our current policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 (68 FR 27207). In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. Our policy has been that only covered patient days are included in the Medicare fraction (§412.106(b)(2)(ii)). A notice to this effect was posted on CMS's Web site (http://www.cms.hhs.gov/providers/hipps/dual.asp) on July 9, 2004.[9]
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However, with respect to the proposed inclusion of these days in the Medicaid fraction, the Secretary stated:

> However, we acknowledge the point raised by the commenter that

[9] 69 Fed. Reg. 48916 at 49098 (Aug. 11, 2004)

> beneficiaries who have exhausted their Medicare Part A inpatient coverage may still be entitled to other Part A benefits. We also agree with the commenter that including the days in the Medicare fraction has a greater impact on a hospital's DSH patient percentage than including the days in the Medicaid fraction. This is necessarily so because the denominator of the Medicare fraction (total Medicare inpatient days) is smaller than the denominator of the Medicaid fraction (total inpatient days). However, we note that we disagree with the commenter's assertion that including days in the Medicaid fraction instead of the Medicare fraction always results in a reduction in DSH payments. For instance, if a dual-eligible beneficiary has not exhausted Medicare Part A inpatient benefits, and is not entitled to SSI benefits, the patient days for that beneficiary are included in the Medicare fraction, but only in the denominator of the Medicare fraction (because the patient is not entitled to SSI benefits). The inclusion of such patient days in the Medicare fraction has the result of decreasing the Medicare fraction in the DSH patient percentage.
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> For these reasons, we have decided not to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, we are adopting a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage. If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual-eligible beneficiaries in the Medicare fraction of the DSH calculation.[10]

While continuing the procedure of excluding the exhausted days from the Medicaid fraction, the Secretary did adopt the prospective policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[11] Medicare Part A exhausted days are to be included in both the numerator and denominator for discharges occurring on or after October 1, 2004. Prior to October 1, 2004, CMS only included "covered" patient days in the Medicare fraction, which was not a criteria that either exhausted days or MSP days met.

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[10] 69 Fed. Reg. 48916 at 49098-49099 (Aug. 11, 2004)
[11] 69 Fed. Reg. 49099 (Aug. 11, 2004).

With respect to medically unnecessary or custodial days,[12] the Medicare Intermediary Manual (CMS Pub. 100-4) § 40.2 states "days on which the hospital furnished no covered part A services are not charged to utilization and are not counted as Medicare patient days." Medically unnecessary or custodial days are not treated as "hospital days."

The Providers participating in each group appeal operated acute care facilities subject to "Inpatient Prospective Payment System" (IPPS). For the fiscal periods in dispute, the Intermediary audited the cost reports and made calculations of the Providers' "disproportionate patient percentages" (DPP) in order to determine whether each Provider qualified for "disproportionate share hospital" (DSH) adjustment payments, and if so, the amount of such payments. With regard to the Medicaid percentage component, the Intermediary made a determination of the number of Medicaid days to be included. As part of its review, the Intermediary excluded days attributable to patients eligible for Medicaid and entitled to Medicare Part A from the number of Medicaid eligible days included in the Providers' Medicaid percentages. In this case there are three categories of dual eligible patient days at issue: (1) exhausted benefits days; (2) Medicare secondary payer (MSP) days; and (3) medically unnecessary or custodial care days.

Applying the relevant law and program policy to the foregoing facts, the Administrator finds that the statutory phrase in the Medicaid fraction "but who were not entitled to benefits under Medicare Part A of this title" forecloses the inclusion of the days at issue in this case in the Medicaid fraction.

The Social Security Act and the regulations at Title 42 of the Code of Federal Regulations recognizes the distinctive use of the term "eligible" in conjunction with Medicaid recipients and "entitled" in conjunction with Medicare beneficiaries. The distinctive use of these terms is consistent with the differences in the respective programs. As a general matter, Medicare is a social insurance program, in contrast to Medicaid, which is a needs-based program. With respect to Medicare, certain populations are entitled (or have a legal right to) Medicare automatically[13] and others are "entitled" to Medicare once they have filed an application and are enrolled.[14]

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[12] See e.g., 42 C.F.R. §§ 411.15(g), 415.15(k); §§ 1814 and 1862(a) of the Act.

[13] For example, under the Medicare statute, an individual who is at least 65 years of age is "entitled" to Medicare Part A benefits if he or she currently receives Social Security or Railroad Retirement Board Benefits. 42 U.S.C. §426(a). Such an individual is automatically entitled to Part A benefits and does not have to file an application for coverage. 42 C.F.R. §406.6(a).

[14] For example, an individual who is at least 65 years of age and who is eligible for, but does not currently receive, Social Security or Railroad Retirement Board benefits,

With respect to Medicaid, certain low-income individuals and families are "eligible" who fit into an "eligibility" group that is recognized by Federal and State law.[15] Because Medicaid is a needs-based program, the Medicaid program generally requires a determination of an individual's eligibility and also periodic re-determinations of "eligibility." Therefore the distinctive use of the term "entitled" in section 1886(d)(5)(F)(vi)(I) and (II) when referencing Medicare, as opposed to eligible, is not in reference to the right of payment of a benefit, but rather the legal status of the individual as a Medicare beneficiary under the law. As noted by CMM, even when a Medicare beneficiary exhaust his/her inpatient hospital benefits, these benefits will be renewed when the beneficiary has not been in a hospital or SNF for 60 days. Thus, while a Medicare beneficiary's benefit period may exhaust or expire, the entitlement for Medicare does not expire. Similarly, with respect to the MSP claim, the Medicare beneficiary claim will be paid to the extent the primary payor does not pay the claim in full. Thus, CMS policy has been to consider the status of the patient as a Medicare beneficiary with respect to the exclusion from the Medicaid fraction. However, with respect to the Medicare fraction CMS has, prior to 2004, interpreted "such days" to require that the day be a covered day in order to be included in the Medicare fraction.

In addition, more fundamental to the issue of medically unnecessary or custodial care days, the Administrator finds that these types of days should not be included in the calculation of the DPP because they not only are related to Medicare beneficiaries and are not "covered" days but they are not even considered to be valid patient days. Medically unnecessary days are days that were determined to not be "reasonable and necessary" or were determined to be custodial in nature. In general, these days may not be charged to the Medicare beneficiaries' utilization as they are not inpatient days. Notably, § 1886(d)(5)(F) of the Act specifies that under both the Medicare and Medicaid fraction, the days to be counted are "hospital patient days." With respect to medically unnecessary or custodial days a determination has been made that these days do not meet the definition of hospital patient days.

Thus, the Administrator reverses the Board's determination that the days at issue should be included in the Medicaid fraction and affirms the Intermediary's exclusion of these days from the DPP calculation.

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is not entitled to Part A benefits *until* he or she files an application for Social Security or Railroad benefits. 42 U.S.C. §426(a) and 42 C.F.R. §406.6(c).

[15] See, e.g., Section 1905(a) and 42 C.F.R. §435.2 et seq.

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: 8/24/2009

/s/

Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services