CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Southwest Consulting 1999-2002 State of MA Uncompensated Days Group	**Reimbursement Determination for Cost Reporting Periods Care ending: 09/30/99 - 09/30/02**
Provider	
vs.	**Review of:**
Blue Cross Blue Shield Association/ Associated Hospital Services	**PRRB Dec. No. 2009-D38 Dated: August 28, 2009**
Intermediary	

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 submitted by the Intermediary 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.

ISSUES AND BOARD DECISION

The issue was whether the Intermediary improperly computed the numerator of the Medicaid fraction that were used to calculate the Providers' disproportionate share hospital (DSH) payments for fiscal years (FYs) 1999, 2000, 2001 and 2002 by excluding inpatient days attributable to individual who received assistance under the Massachusetts Uncompensated Care Pool (MA UCP) for such days.

The Board held that the Intermediary properly excluded MA UCP days from the numerator of the Providers' Medicaid proxy. In reviewing the Medicaid DSH statute at § 1923 of the Act, the Board found that the term "medical assistance under a State plan approved under [Title] XIX" excluded days funded only by the

state and charity care days even though those days may be counted for Medicaid DSH purposes. The Board reasoned that if Congress had intended the term "eligible for medical assistance under a State plan" (the only category of patients in the Medicaid utilization rate) to include the State funded hospital days and charity care days, the subsections adding those categories of days in the low income utilization rate would have been superfluous. Because the MA UCP days were funded by "state and local governments" and included in the low income utilization rate, not the Medicaid inpatient utilization rate, the Board found that the MA UCP patient days did not fall within the Medicaid statute definition of "eligible for medical assistance under a State plan" at § 1923 of the Act.

Finally, the Board referenced *Adena Regional Medical Center v. Leavitt*.[1] The Court of Appeals for the D.C. Circuit held that the phrase "eligible for medical assistance under a State plan approved under title XIX" referred to patients who are eligible for Medicaid. The Court rejected the argument that the days of patients who were counted toward a Medicaid DSH payment must be counted toward the Medicaid fraction of the Medicare DSH calculation.

COMMENTS

The Intermediary submitted comments requesting that the Administrator affirm the Board's decision. To support this position the Intermediary referenced *Adena Regional Medical Center v. Leavitt*.[2]

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

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[1] 527 F. 3d 176 (D.C. Cir. 2008).

[2] Id.

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

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 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,

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[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.
[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."

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 provides 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]

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[10] 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,[11] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[12] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[13] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[14] This

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[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 medical assistance under the State plan or have no health insurance (or other source of third part 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.

[10] Pub. Law No. 89-97.

[11] Section 1811-1821 of the Act.

[12] Section 1831-1848(j) of the Act.

[13] Under Medicare, Part A services are furnished by providers of services.

[14] Pub. L. No. 98-21.

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.[15]

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 reimburse 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…."[16] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[17] 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 terms "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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[15] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

[16] 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).

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

> (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 CFR § 412.106. The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 CFR § 412.106(b) (2). Relevant to this case, the second computation, the "Medicaid-low income proxy", or "Clause II", is set forth at 42 CFR § 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 CFR § 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 [P]lan 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 [S]tate [P]lan, 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 [P]lan, 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 [P]lan 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 [P]lan 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. [18] (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.[19]

In addition, for the relevant fiscal period 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

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[18] 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.

[19] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

be included in the Medicare DSH calculation.[20] 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.[21]

In 2001, CMS issued a Program Memorandum (PM) Transmittal A-01-13,[22] 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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[20] 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.")

[21] Id.

[22] 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)

> *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.)

Finally, in a recently enacted legislation, Congress clarified the meaning of the phrase "eligible for medical assistance under a State plan approved under title XIX" with respect to patients not Medicaid eligible, but who are regarded as such, because they receive benefits under a demonstration project approved under title XI. Congress added language to §1886(d)(5)(F)(vi)(II) of the Act which stating:

> 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.[23]

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 under title XI.

In sum, the Secretary has 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 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.

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[23] 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).

The Administrator notes that this policy was recently upheld in *Adena.*[24] In *Aden*a, a group of Ohio Providers sought to have included, State-only charity care days (Ohio's Hospital Care Assurance Program (HCAP)) in their Medicare DSH calculation because such days were included in the State's Medicaid plan for purposes of setting the methodology by which Ohio calculated it Medicaid DSH adjustment. The Court held that the phrase "eligible for medical assistance under a State plan approved under title XIX" referred to patients who are eligible for Medicaid. The Court rejected the Providers' argument that days of patients who were counted toward a Medicaid DSH payment must be counted toward the Medicaid fraction of the Medicare DSH calculation.[25]

In this case, the Providers argued that the MA UCP days should be counted in the numerator of the Medicaid fraction for purposes of determining its Medicare DSH calculation because the MA UCP is part of the Medicaid DSH payment described in the CMS approved Medicaid State plan.[26] Because CMS paid Federal financial participation or FFP (Medicaid DSH) for MA UCP expenditures and because CMS has the authority to pay matching funds only for State expenditures on medical assistance under the State plan, Providers claim that the MA UCP qualifies as "medical assistance under the State Plan" in accordance with § 1886(d)(5)(F)(vi)(II) of the Act.

The Administrator does not agree. The Administrator finds that §1886(d)(5)(F)(vi)(II) of the Act requires, for purposes of determining the Providers' "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 assistance under a State plan approved under Title XIX," to mean "eligible for Medicaid."[27] 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

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[24] Supra, n 1.
[25] Id. at 179.
[26] Providers' Final Position Paper at 7.
[27] 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.")

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."[28] 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.[29] That is, the individual must be eligible for the Federal government program also referred to as Medicaid.

The Administrator finds that in Massachusetts, the State's Medicaid program is called MassHealth.[30] The record shows that the Massachusetts Uncompensated Care Pool or MA UCP is considered a last resort for people that do not qualify for any other assistance program such as MassHealth. MassHealth is the State

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

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

[30] Intermediary's Exhibit I-37 at 3. See § 114.6 Mass. Code Regs. § 10.02.

Medicaid program administrated by the Division of Medical Assistance in accordance with Title XIX (i.e., Medicaid).[31] The State Plan Amendment (SPA), Transmittal No (TN) 98-102 reflects the incorporation of, inter alia, the criteria for "Uncompensated Care Disproportionate Share Adjustments," effective October 1, 1998.[32]

The SPA Attachment 4.19(A)(1) shows a provision for Medicaid DSH payments for an "uncompensated care disproportionate share adjustment." Hospitals eligible for this adjustment are those acute facilities that incur "free care costs" as defined in the State regulations. Consistent with the State Plan, the State regulation at 114.1 CMR 36.07(5) defines the uncompensated care disproportionate share adjustment. Hospitals eligible for this adjustment are those that report "free care costs," as defined by 114.6 CMR 11.00 and who are participating in the free care pool. The uncompensated care pool's gross liability to a hospital is determined by the following calculation: total free care charges plus cost to charge ratio equals the allowable free care costs minus the shortfall allocation amount, equals the pool liability to hospitals.[33] The State regulation at 114.6 CMR 11.02 defines "free care" as "unpaid hospital or community health center charges for medically necessary services which are eligible for reimbursement from the uncompensated care pool pursuant to the criteria set forth in 114.6 CMR 10.00. The "hospital free care charges" are based on the uncompensated care charges filed with the Division in accordance with 114.6 CMR 11.03. Similarly, "charge" is defined as the uniform price for a specific service charged by a hospital or community health center."

The State regulation at 114.6 CMR 10.00 et. seq. sets forth standards and procedures for determining patients' eligibility for free care at acute care hospitals. The regulation explains that: "[i]f a patient is enrolled in MassHealth [Medicaid] on the date that service is provided, the Hospital or Community Health Center may not bill the UCP pool for that service. Therefore, for a patient requesting Free Care, Hospitals… must check Division of Medical Assistance eligibility verification

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[31] See Providers' Exhibit P-1 at 1. Healthpoint, Information from the State of Massachusetts Division of Health Care Finance Policy (Sept. 1996); See also Provider's Exhibit 2 at 2. "Free Care Reform," An update from the State of Massachusetts Division of Healthcare Finance and Policy on the Uncompensated Care Pool, (Sept. 1999). See also Intermediary's Exhibit 34.

[32] See Providers' Exhibit P-11 from Beverly Hospital; SPA Transmittal No. (TN) 98-102-concerning attachment 4.19(A)(1)(classification of DSH and Payment Adjustments); TN 99-102 (effective 10/01/99; TN 00-010 (effective 09/02/2000); TN 02-023 effective 10/01/02.

[33] See e.g. 114.6 CMR 11.04(2)).

system to determine the patients' MassHealth enrollment status."[34] Furthermore, "[i]f an Acute Hospital or Community Health Center determines that a patient is potentially eligible for Medicaid or another government program, said Acute Hospital or Community Health Center shall encourage the patient to apply for such program and shall assist the patient in applying for benefits under such program."[35] In addition, the record further shows that the Commonwealth of Massachusetts developed the UCP as a financing mechanism to distribute more equitably the financial burden of uncompensated care.[36] The revenue in the UCP is derived from hospital assessments, UCP surcharges, State appropriation of FFP funds, and other appropriations.[37] Thus, the record supports the Administrator's finding that the MA UCP provides medical assistance to individuals who are not eligible for medical assistance [MassHealth] under a State plan approved under Title XIX.[38] In its final Position Paper at page 8, the Providers' concedes that the patients whose days the Providers' seeks to count are not eligible for Medicaid. The Provider directly states that "the UCP patients were not … eligible for traditional Medicaid…." As the UCP individuals are not Medicaid patients, the State Plan does not otherwise refer to these patients except in reference to the Medicaid DSH payment.

As stated above, the Secretary has interpreted the term "eligible for medical assistance under a State Plan approved under Title XIX" to mean eligible for the Federal government program also referred to as Medicaid. In this case, the MA UCP 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 MA UCP are not covered by "medical assistance" as described in Title XIX. The individuals for whom the Providers seek to count towards their DSH payments must be eligible for Medicaid.[39]

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[34] See Intermediary's Exhibit I-37 at 7, for PRRB Case No. 06-0317G; (114.6 CMR § 10.04(1)).
[35] Id. at 7, 10.04(2).
[36] Supra, n 32.
[37] Intermediary's Exhibit I-37 at 21, § 114.6 CMR § 11.04(1)(a).
[38] Providers' Position Paper at 8 ("Even though the UCP patients were not otherwise eligible for traditional Medicaid,…).
[39] See also, *Adena,* 527 F.3d at 180, which held that the phrase "eligible for medical assistance under a State plan approved under title XIX" in § 1886(d)(5)(F)(vi) referred to patients eligible for "medical assistance" as it is defined in the Medicaid statute in § 1905(a) (42 U.S.C. § 1396d(a)). Patients receiving "medical assistance" as, it is defined in § 1905(a) (42 U.S.C. § 1396d(a)), under a State plan are those who are eligible for Medicaid.

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. Section 1886(d) clearly states that the patients' Title XIX eligibility for that day is a requirement for inclusion in the Medicare DSH calculation.

Therefore, regardless of any possible Medicaid payment and indirect FFP provided under Title XIX, the general assistance population days operated and funded by the State of Massachusetts (not title XIX) are not counted as Medicaid days for purposes of the Medicare DSH calculation. In addition, regardless of the methods used by the State to calculate its Medicaid DSH payments (Medicaid inpatient utilization rate or the low-income utilization rate or the "special rule" at § 1923(e)(1) of the Act), these patients cannot be included under § 1886(d)(5)(F)(vi)(II) of the Act as Medicaid patient day.[40]

Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly did not include the MA UCP days in the numerator of the Medicaid fraction. The Administrator finds that the MA UCP is a State-only program that specifically excludes individuals who are qualified for MassHealth [Medicaid]. Since the applicable statutes require an

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[40] Section 1923(e) *Special rule*
(1) A State plan shall be considered to meet the requirement of section 1902 [42 USC 1396a (a)(13)(A)(iv)] of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to the requirement of subsection (a) of this section if
(A)
(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, or
(ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital,
(B) the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection, and
(C) the plan meets the requirement of subsection (d)(3) of this section and such payment adjustments are made consistent with the last

individual's eligibility for Medicaid [MassHealth] in order for the patient days to be counted in the numerator of the Medicare DSH payment, the Administrator affirms the Board's decision, for the foregoing reason.

DECISION

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

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

Date: 10/19/09

/s/
Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services