CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Ober Kaler DSH Charity Care Groups	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 2000-2004**
Provider	
vs.	
Blue Cross/Blue Shield Association Highmark Medicare Services and Cahaba Government Benefits Administrators	**Review of: PRRB Dec. No. 2012-D17 Dated: June 20, 2012**
Intermediary	

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 parties were notified of the Administrator's intention to review the Board's decision. No comments were received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether days associated with patients covered under the New Jersey Charity Care Program (CCP), should be included in the numerator of the "Medicaid proxy" of the Medicare disproportionate share hospital (DSH) calculation pursuant to §1886(d)(5)(F)(vi)(II) of the Social Security Act, as amended (Act).[1]

[1] On April 26, 2010, the parties executed a joint stipulation of facts that the administrative record developed before the Board in Cooper University Hospital, PRRB Dec. No. 2008-D22 (hereinafter referred to as Cooper) be incorporated into this record and admitted as evidence in this case as though fully developed herein.

The Board held that the Intermediary properly excluded NJCCP days from the numerator of the Providers' Medicaid proxy.[2] In reviewing the Medicaid DSH statute at §1923 of the Act, the Board found that the statue mandated that a state Medicaid plan under Title XIX include a provision for a payment adjustment to hospitals which serve a disproportionate number of low income patients, i.e., a Medicaid DSH adjustment for hospitals that's independent of the Medicare DSH adjustment at issue in this case. The Board found that while the Medicaid DSH adjustment was eligible for Federal financial participation (FFP), the patient days at issue in this case are not directly eligible for FFP because they do not qualify as "traditional Medicaid" services described in §1905(a) of the Act.

In addition, upon further review and analysis of 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 NJCCP 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 NJCCP 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*, 527 F. 3d 176 (D.C. Cir. 2008). 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.

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[2] This case involves 43 individual group appeals, collectively known as the Ober Kaler DSH Charity Care Groups (Providers). The Providers in these group appeals are acute care hospitals located in New Jersey that participate in both the Medicare and Medicaid program for cost reporting periods from 2000 through 2004. A schedule of the Providers for each group appeal, containing a list of the Providers and their provider numbers, is attached at Providers' Exhibit P-23. For administrative efficiency, the Board issued one decision that would be applicable for all the respective groups as does the Administrator herein.

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. Pursuant to §1886(d)(5)(F)(i) of the Act, Congress directed the Secretary to provide a payment adjustment, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…."[3] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[4] Only the "proxy method" is at issue in this appeal. To be eligible for the DSH payment under the proxy method, an inpatient prospective payment system (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." The first fraction, the "Medicare low-income proxy" is not at issue in this case. The second fraction, the "Medicaid low-income proxy" or Medicaid patient percentage is defined as:

> [A] 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.)[5]

The dispute in this case is over the meaning of the phrase "a patient eligible for medical assistance under a State plan approved under Title XIX". Several courts have analyzed the phrase "eligible for medical assistance under a State plan approved under title XIX" and have unanimously concluded that the phrase "eligible for medical assistance under a State plan approved under title XIX" means patients who are eligible for Medicaid under a federal statute. These cases include *Adena Regional Medical Center*, supra; *Cooper University Hosp. v. Sebelius*, 686 F.Supp.2d 483 (D.N.J. Sep 28, 2009); *aff'd.* 636 F.3d 44 (3rd Cir. Oct 12, 2010) *University of Washington Medical Center v. Sebelius*, 674 F.Supp.2d 106 (W.D.

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[3] 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).
[4] The Pickle method is set forth at section 1886(d) (F) (i) (II) of the Act.
[5] See also 42 CFR 412.106 and the Administrator's decision in *Cooper University Hospital*, PRRB Dec. No. 2008-D22 regarding the full background on the DSH regulation and policy statements.

Wash Sep 30, 2009); and *Northeast Hosp. Corp. v. Sebelius*, 699 F.Supp.2d 81, (D.D.C. Mar 29, 2010).

Notably, in upholding the district court's decision in *Cooper*, the U.S. Court of Appeals for the Third Circuit stated that:

> We have paid particular attention to the patience and skill with which Judge Simandle has handled this case from its very inception until its conclusion, when he rendered an Opinion that thoughtfully, thoroughly, and articulately decided what had to be decided. We could not do it better, and we will not try. S uffice it to say, substantially for the reasons set forth in Judge Simandle's excellent Opinion of September 28, 2009, we will affirm.[6]

Relevant to this case, the district court in *Cooper*, supra, specifically addressed the issue of the treatment of NJCCP days and whether NJCCP days should be included in the numerator of the Medicaid patient percentage or proxy of the Medicare DSH calculation. The district court in *Cooper* concluded that the phrase "eligible for medical assistance under a State plan approved under title XIX" referred to patients who are eligible for Medicaid. Therefore, the NJCCP patient days could not be included in the numerator of the Provider's Medicaid proxy for purposes of determining the Provider's Medicare DSH adjustment. The district court stated, *inter alia*, that:

> There is clear statutory support for the CMS determination that NJCCP patients are not "eligible for medical assistance" under a State plan within the meaning of Section 1395ww(d)(5)(vi)(II). As discussed above, "medical assistance" is not defined in Title XVIII of the social Security Act, but Title XIX of that Act (the subchapter expressly referenced in the Medicaid proxy fraction) does define "medical assistance" as payment for certain designated services to either "categorically needy" or "medically needy" persons that fall within thirteen broader categories. 42 U.S.C. §1396(a); see 42 U.S.C. § 1396a(a)(10)(A)(i) & (ii), (C); Adena II, 527 F.3d at 180 ("[T]he federal Medicaid statute defines 'medical assistance' as 'payment of part or all of the cost' of medical 'care and services' for a defined set of individuals [.]"). Thus, patients "eligible for medical assistance" under Section 1396d(a) must be eligible for Medicaid. NJCCP patients, by their very nature, are not eligible for "medical assistance," and consequently NJCCP does not provide "medical assistance" as defined in Title XIX. NJCCP Fact sheet, AR 649 ("[NJCCP patients are] ineligible for any private or governmental sponsored covered (such as Medicaid)"); CMS Decision, AR 13014; See N.J. Admin. Code §10:52-11.5(c).

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[6] *Cooper University Hosp. v. Sebelius*, 636 F.3d. 44, 45 (3rd Cir. Oct. 12, 2010).

> That NJCCP does not provider "medical assistance" under Medicaid Section 1396(a) is fatal to Plaintiff's claim, because CMS reasonably determined that Medicaid proxy fraction at issue here incorporates the definition of "medical assistance" from the Medicaid statute. *Adena II*, 527 F.3e at 179-80; see *Sullivan v. Stroop*, 496 U.S. 478, 484, 110 S.Ct. 2499, 110 L.ED.2d 438 (1990) (holding that "cross-references" indicate two administrative programs within Social Security Act "operate together"); Sorenson v. Secretary of Treasury, 475 U.S. 851, 860, 106 S.Ct. 1600, 89 L.Ed.2w 855 (1985) (observing that "the normal rule of statutory construction assumes that identical words used in different parts of the same act are intended to have the same meaning") (internal citation omitted). As the Court of Appeals for the District of Columbia recently held, Congress' cross-reference to the Medicaid statute in the Medicaid fraction of the Medicare DSH provision,[] as well as the use of nearly identical language-"patients eligible for medical assistance under a State plan approved under this subchapter"[] in the Medicaid DSH provision designed for the same purpose (to adjust the rate of payment to hospitals based on a proxy for low-income patients), 42 U.S.C. §1396r-4(c)(3)(B), suggest that Congress intended "medical assistance" to have the same meaning in the Medicare and Medicaid DSH provisions. *Adena II*, 527 f.3d at 179-80 []; see *Cabell, Huntington Hosp., Inc. v. Shalala*, 101 F.3d 984, 990 (4 th Cir. 1996) ("Section 1396d defines 'medical assistance' to include twenty-five medical services. If Congress had wanted 'medical assistance' to take on a completely different meaning in the context of this Medicaid proxy provision of the DSG calculation, Congress could easily have so indicated.") The context of the two statutes thus justifies application of "[t]he normal rule of statutory construction" which presumes " 'identical words used in different parts of the same act are intended to have the same meaning.' " Sorenson, 475 U.S. at 860, 106 S.Ct. 1600 (quoting *Helvering v. Stockholms Enskilda Bank*, 293 U.S. 84, 87, 88 S.Ct. 50, 79 L.Ed. 211 (1934)); *see Stroop*, 496 U.S. at 484, 110 S.Ct 2499 (cross-reference between two parts of the Social Security Act illustrate Congress' intent that the programs work together and that a term used in both have the same meaning).[7]

In this case, the Providers alleged that the Intermediary improperly excluded the days of patients who received assistance through the NJCCP from the count of the number of days of patients who were eligible for medical assistance under an approved State Medicaid Plan for purposes of calculating the DSH payment. The Board held that the Intermediary properly excluded NJCCP days from the numerator of the Providers' Medicaid patient percentage.

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[7] *Cooper University Hosp. v. Sebelius*, 686 F. Supp.2d 483,491-92 (D.N.J. Sept. 28, 2009).

The record shows that NJCCP specifically excludes individuals who are qualified for Medicaid.[8] Thus, by definition the NJCCP inpatient days are days for patients that are not eligible for medical assistance under Title XIX, that is, the program otherwise 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. The Administrator finds that the individuals covered by the NJCCP are not covered by "medical assistance" as described under Title XIX.[9] Both the United States Court of Appeals for the Third Circuit[10] and the United States Court of Appeals for the District of Columbia agree that the term "eligible for medical assistance under a State Plan approved under Title XIX" means eligible for the Federal government program also referred to as Medicaid.

Further, 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 DSH calculation. Therefore, regardless of any possible indirect FFP through a Medicaid DSH payment (regardless of the Medicaid DSH method in which the day is included), the NJCCP days operated and funded by the State of New Jersey (not Title XIX) are not counted as Medicaid days for purposes of the Medicare DSH payment.

In sum, the applicable statute requires an individual to be eligible for Medicaid in order for the patient day to be counted in the numerator of the Medicaid patient percentage portion of the Medicare DSH payment. The NJCCP days at issue are related to patients not eligible for medical assistance under a State plan approved under Title XIX. The Administrator therefore affirms the Board's decision for the foregoing reasons and as set forth in the controlling case law in the Third Circuit and the District of Columbia.[11]

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[8] *See*, e.g., n. 1, discussing the stipulation of the facts incorporating the administrative record and facts set forth in *Cooper*.

[9] *See*, e.g., section 1905(a) of the Act.

[10] The State in which the Providers are located, New Jersey, is in the Third Federal Judicial Circuit.

[11] The Administrator also incorporates by reference the Administrator's findings and decision in *Cooper University Hospital*, PRRB Dec. No. 2008-D22.

DECISION

The decision of the Board is affirmed with respect to each group appeal in accordance with the foregoing opinion.

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

Date: 8/15/12

/s/
Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services