CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
QRS 1991-2006 Colorado DSH/General Assistance Days Group	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 1993 - 2006**[1]
Provider	
vs.	
BlueCross BlueShield Association/ Trailblazer Health	**Review of: PRRB Dec. No. 2012-D23 Dated: September 6, 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. The Center for Medicare (CM) submitted comments requesting that the Administrator affirm the Board's determination. 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 Colorado Indigent Care Program (CICP) should be included in the numerator of the "Medicaid proxy" of the Medicare disproportionate share hospital (DSH) calculation pursuant to section 1886(d)(5)(F)(vi)(II) of the Social Security Act, as amended (Act).

[1] This case involves three providers for cost reporting periods 1993-2006. The Providers in this group appeal are acute care hospitals located in Colorado that received payment under Medicare part A for services to Medicare beneficiaries. *See* PRRB Dec. No. 2012-D23 Appendix A for a list of the participating providers. Parkview Medical Center, Provider No. 06-0020, for fiscal years 1991 and 1992 was excluded from this appeal.

The Board held that the Intermediary properly excluded CICP days from the numerator of the Providers' Medicaid proxy.In reviewing the Medicaid DSH statute at section 1923 of the Act, the Board found that the statute 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 is 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 section 1905(a) of the Act.

In addition, upon further review and analysis of the Medicaid DSH statute at section 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 CICP 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 CICP patient days did not fall within the Medicaid statute definition of "eligible for medical assistance under a State plan" at section 1923 of the Act.

Finally, the Board referenced *Adena Regional Medical Center v. Leavitt*.[2] 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 Center for Medicare (CM) submitted comments requesting that the Administrator affirm the Board's determination. CM agreed with the Board's determination that it would be inappropriate and inconsistent with CMS' policy to include these days, given the fact that the inpatient days associated with the CICP days are part of a "state-only" program and patients associated with the CICP are not eligible for Medicaid under a State Plan approved under Title XIX on the day of service. Therefore, since they do not qualify for "traditional Medicaid" services, they do not meet the DSH statutory or regulatory requirements for inclusion in the Medicare DSH calculation.

[2] 527 F. 3d 176 (D.C. Cir. 2008).

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, 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

---

[3] Section 1901 of the Social Security Act (Pub. Law 89-97).
[4] Section 1902(a) (10) of the Act.
[5] Section 1902(a) (1) (C) (i) of the Act.
[6] Id. Section 1902 et. seq. of the Act.
[7] Id.

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, section 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. As part of a State plan, section 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, Section 1905(a) states that for purposes of this title "the term 'medical assistance' means the payment of part or all of the costs" of the certain specified "care and medical services" and the identification of the individuals for whom such payment maybe made.

Section 1923 of the Act implements the requirements that a State plan under Title XIX and provides for an adjustment in payment for inpatient hospital services furnished by a disproportionate share hospital. A hospital maybe deemed to be a Medicaid disproportionate share hospital pursuant to Section 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 criteria relies, inter alia, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.[8]

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[9] 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,

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

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

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

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 lowincome patients, pursuant to section 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…."[15] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[16] 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, section 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:

---

[10] Section 1811-1821 of the Act.
[11] Section 1831-1848(j) of the Act.
[12] Under Medicare, Part A services are furnished by providers of services.
[13] Pub. Law No. 98-21.
[14] H.R. Rep. No. 25, 98 th Cong., 1 st Sess. 132 (1983).
[15] 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).
[16] The Pickle method is set forth at section 1886(d) (F) (i) (II) of the Act.

> (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.
>
> (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.

Relevant to 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 section 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:

> Consistent with the Courts of Appeals decisions on the issue of Medicaid days, the [CMS] Ruling 97-2 was meant to be inclusive, rather than exclusive. This means that, in 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). Any examples of days to be

counted given [CMS] Ruling or [CMS] instructions should not be construed as an all-inclusive list. We note that individuals who are eligible for payments under a demonstration project, but would not be eligible under the provisions of the underlying State plan, are not included in this definition. Demonstration projects often involve waivers of State plan provisions; individuals eligible only by virtue of those waivers are not eligible under the State plan itself. Thus, they would not meet the statutory definition of Medicaid days….

The definition of Medicaid days for purposes of Medicare disproportionate share adjustment calculation includes all days that a beneficiary would have been eligible for Medicaid benefits, whether or not Medicaid paid for any services. This includes, but is not limited to, days that are determined to be medically necessary but for which payment is denied, days that are determined to be medically unnecessary and for which payment is denied, days that are utilized by a Medicaid beneficiary prior to an admission approval, days that are paid by a third party, and days that an alien is considered a Medicaid beneficiary, whether or not it is an emergency service. However, 42 CFR 412.106(b) (4) precludes the counting of any patient days furnished to patients entitled to both Medicare Part A and Medicaid.

Therefore, once the State has verified the eligibility of the hospital's patient data for Medicaid purposes, the intermediary must determine if any of these days are dual entitlement days and subtract them from the calculation.

While we do recognized days utilized by Medicaid beneficiaries through a Managed Care Organization (MCO) or Health Maintenance Organization (HMO), days that are utilized by State-only eligibility groups for which no Federal participation is available are not considered to be Medicaid beneficiaries under Title XIX. Many States operate programs which include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to recipients of Statefunded income support programs through the same administrative process as Medicaid. While providers may be unable to distinguish between State-only and Federal-State beneficiaries, States must be able to do so. Similarly, some States have a demonstration project which includes expanded eligibility populations who would not be eligible under a State plan under title XIX, or a State waiver which includes people who are not and would not have been Medicaid Title XIX beneficiaries. Inpatient hospital days for these non- Medicaid individuals would not be properly included in the calculation of Medicaid days. State records should distinguish between individuals eligible under the State plan and individuals who are only eligible under a demonstration project or waiver. (Emphasis added.)

In addition, according to CMS' Memorandum dated June 12, 1997, if a cost report was settled prior to February 27, 1997; the hospital filed a jurisdictionally proper appeal on this issue; and the hospital submitted documentation to support a recalculation of Medicaid days, the Medicaid days were to be recalculated according to the principles contained in HCFA Ruling 97-2. However, this memorandum also stated that no action was required unless and until the hospital submitted the necessary data with evidence of its jurisdictionally proper appeal.

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 was in response to problems that occurred as a result 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 patients 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 under Title XIX, and

> therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.
>
> In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under title XIX on that day, the day is not included in the Medicare DSH calculation.
>
> ****
>
> Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate document to substantiate the number of Medicaid days claimed.[17] (Emphasis added.)

The PM A-99-62 further instructed intermediaries to apply a hold harmless policy under certain limited circumstances. CMS stated:

> In accordance with the hold harmless position communicated by HCFA on October 15, 1999, for cost reporting periods beginning before January 1, 2000, you are not to disallow, within the parameters discussed below, the portion of Medicare DSH adjustment payments previously made to hospitals attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days in the Medicaid days factor used in the Medicare DSH formula…. Although [CMS] has decided to allow the hospitals

[17] 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 thirdparty 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.

> to be held harmless for receiving additional payments resulting from the erroneous inclusion of these types of otherwise ineligible days, this decision is not intended to hold hospitals harmless for any other aspect of the calculation of Medicare DSH payments or any other Medicare payments.

Regarding hospitals that received payments reflecting the erroneous inclusion of days at issue, CMS stated that:

> In practical terms this means that you are not to reopen any cost reports for periods beginning before January 1, 2000 to disallow the portions of Medicare DSH payments attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days if the hospital received payments for those days based on those cost reports…. Furthermore, on or after October 15, 1999, you are not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.
>
> For cost reporting periods beginning before January 1, 2000, you are to continue to allow these types of days in the Medicare DSH calculation for all open cost reports only in accordance with the practice followed for the hospital at issue before October 15, 1999 (i.e., for open cost reports, you are to allow only those types of otherwise ineligible days that the hospital received payment for in previous cost reporting periods settled before October 15, 1999). For example, if, for a given hospital, a portion of Medicare DSH payment was attributable to the erroneous inclusion of general assistance days for only the out-of State or HMO population in cost reports settled before October 15, 1999, you are to include the ineligible waiver days for only that population when settling open cost reports for cost reporting periods beginning before January 1, 2000. However, the actual number of general assistance and other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration days, as well as Medicaid Title XIX days, that you allow for the open cost reports must be supported by auditable documentation provided by the hospital.

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

> If, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue

> of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days… Where, for cost reporting periods beginning before January 1, 2000, a hospital filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula on or after October 15, 1999, reopen the settled cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, but only if the hospital appealed, before October 15, 1999, the denial of payment for the days in question in previous cost reporting periods. The actual number of these types of days that you use in this revision must be properly supported by adequate documentation provided by the hospital. Do not reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before PRRB on other Medicare DSH issues or other unrelated issues.
>
> You are to continue paying the Medicare DSH adjustment reflecting the inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for all open cost reporting periods beginning before January 1, 2000, to any hospital that, before October 15, 1999, filed a jurisdictionally proper appeal to the PRRB specifically for this issue on previously settled cost reports.
>
> Finally, you are reminded that, if a hospital has filed a jurisdictionally proper appeal with respect to HCFA 97-2 ruling and the hospital has otherwise received payment for the portion of Medicare DSH adjustment attributable to the inclusion of general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days based on its paid Medicaid days, include these types of unpaid days in the Medicare DSH formula when revising the cost reports affected by the HCFA 97-2 appeal.

In the August 1, 2000 Federal Register, the Secretary reasserted this 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 Title XIX beneficiaries.[18]

The Program Memorandum Transmittal A-01-13[19], dated January 25, 2001, restated the principles and instructions originally set out in PM A-99-62, and stated regarding 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. Sometime 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.
>
> ****
>
> 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.

As a consequence, the regulation at 42 CFR 4412.106(b)(2006) was amended to clarify the foregoing principles, stating 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. For purposes of this second computation, the following requirements apply:
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether

[18] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

[19] 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)

> particular items or services were covered or paid under the State plan or the authorized waiver.
> (ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.
> (iii) 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.

Finally, Congress clarified the meaning of the phrase "eligible for medical assistance under a State plan approved under title XIX" by adding the following language to section 1886(d)(5(F) of the Act:

> 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.[20]

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. In sum, CMS policy has consistently required the exclusion of days relating to general assistance or State only days and distinguishes between days for individuals that receive medical assistance under a Title XIX State plan and days for individuals that are not in fact eligible for medical assistance, but may be a basis for Medicaid DSH payment under the State plan. These latter days are not counted for purposes of the Medicare DSH payment.

The Administrator finds that section 1886(d)(5)(F)(vi)(II) of the Act requires for purposes of determining a Provider's "disproportionate patient percentage" that the Secretary count patient days attributable to patients who were eligible for medical assistance under a State plan approved under Title XIX of the Act, but who were not also entitled to Medicare Part

[20] Deficit Reduction Act of 2005, 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)).

A. The Administrator finds that 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."[21] 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, than 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 section 1886(d)(5)(F)(vi)(II) 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 Sections 1901 and 1905 of the Social Security Act and the use of the term "medical assistance" at Section 1886(d)(5)(F)(vi)(II) of the Social Security 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."[22] Therefore, the Administrator finds the language at section 1886(d)(5)(F)(vi)(II) requires that for a day to be counted, the individual must be eligible for medical assistance under Title XIX. That is, the individual must be eligible for the Federal government program also referred to as Medicaid.

Notably, the days involved in this case are related to individuals that are not eligible for "medical assistance" as that term is used under Title XIX and, thus, are not properly included in the Medicaid patient percentage of Medicare DSH calculation under §1886(d)(5)(F)(vi)(II) of the Act. The record shows that the section of the Medicaid State Plan submitted by the Providers is for the Colorado Medicaid DSH formula.[23] This part of the State plan shows that the Colorado Indigent Care Program is used as part of the *Medicaid* DSH methodology. The Providers did not allege, nor did they provide evidence, that the individuals eligible for the Colorado Indigent Care Program are, in turn, individuals eligible for "medical assistance" as that term is defined at section 1905(a) of the Act and as those individuals are described in Title XIX. Instead, the Administrator finds that reference to the Colorado Indigent Care Program in the State Plan approved under Title XIX is limited to the Colorado Medicaid DSH adjustment and the amount of such Medicaid DSH payment. Notably, all State plans are required to provide for DSH payments. Thus, the Medicaid DSH methodology, may involve some indirect expenditure of Federal financial participation

---

[21] See Cabell Huntington Hosp. Inc., v. Shalala, 101 F.3d 984, 989 (4 th 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…").

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

[23] *See e.g.* Provider Exhibit 1.

(FFP) based on the care provided to Colorado Indigent Care program individuals by these hospitals. Regardless of the methodology used by this State to calculate its Medicaid DSH payments (whether it is by the Medicaid inpatient utilization rate, the low income utilization rate or under the special rule) these patient days cannot be included under section 1886(d)(5)(F) as a Medicaid patient day. The approval of the Colorado Medicaid DSH methodology under the State plan and the expenditure of Medicaid DSH FPP does not constitute "medical assistance" for the *individuals* at issue in this case as that term is used under Title XIX and Title XVIII. Therefore, the Administrator finds that the days relating to patients eligible for the Colorado Indigent care Program do not fall within the legal meaning of patient days attributable to *patients who were eligible for medical assistance under a State plan approved under Title XIX of the Act.* Consequently, these days are not properly included in the numerator of the Medicaid patient percentage fraction in calculating the Medicare DSH adjustment.

The Providers also challenged the application of CMS PM A-99-62, issued on December 1, 1999, which instructed intermediaries to hold harmless (i.e., not recoup overpayment) those providers that had been improperly allowed to included "general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days" in their calculation of the Medicaid fraction.
(Emphasis added). In addition, PM A-99-62 also advised intermediaries to hold harmless those providers that had filed a jurisdictionally proper appeal before October 15, 1999, on the precise issue of "general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days" even if the provider had not been erroneously reimbursed for the inclusion of otherwise ineligible days in their cost report. (Emphasis added). PM A-99-62 advised intermediaries to include "these types of unpaid days" in the Medicare DSH formula when revising cost reports affected by HCFA Ruling 97-2, if the Provider had filed a jurisdictionally proper appeal, with respect to HCFA Ruling 97-2 and the Provider otherwise had received payment for the portion of Medicare DSH adjustment attributed to the inclusion of general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days" based on its paid Medicaid days." (Emphasis added). The Providers claim that this policy "arbitrarily allowed only those providers who had previously received payment," based upon what CMS considered to be the prior erroneous inclusion of state-only programs prior to October 15, 1999 to be held harmless. The Providers argued that this policy is arbitrary and results in similarly situated providers being treated in a dissimilar manner and should be voided. As the Providers acknowledged, in this case, the record shows that Providers did not meet the criteria to have the days allowed under the "hold harmless" provisions. Further, contrary to the Providers' contentions, the PM was a reasonable and rationale exercise of the Program's authority. *See e.g.* United Hospital v. Thompson, 383 F.3d 728 (8th Cir.2004)(rejecting a hospital's claim that PM A-99-62 was illegal.)

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: 11/6/12

/s/

Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services