PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2013-D38

PROVIDER –
Washington General Assistance Days Groups (See Appendix A)

Provider Nos.: Various (See Appendix A)

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ Noridian Administrative Services – WA/AK/Wisconsin Physicians Services

DATE OF HEARING -
May 15, 2013

Cost Reporting Periods Ended - Various (See Appendix A)

CASE NOs.: 00-3186G; 04-0361G; 05-0439G; 06-1812G; 08-1845G; 09-1503GC; 09-1581GC; 09-1743GC; 10-0088GC; 10-0129G and 10-0190GC

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ISSUE:

Should patient days associated with the Medically Indigent and General Assistance/Unemployable Programs in Washington State be included in the numerator of the Medicaid fraction of the Medicare Disproportionate Share Hospital ("DSH") payment calculation formula in accordance with 42 C.F.R. § 412.106(b)(4) and § 1886(d)(5)(F)(vi)(II)[1] of the Social Security Act ("Act")?[2]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services. The Medicare program was established under Title XVIII of the Act[3], as amended, to provide health insurance to the aged and disabled. The Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the U.S. Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[4] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[5]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[6] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues a Notice of Program Reimbursement ("NPR").[7] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of the NPR.[8]

Part A of the Medicare program covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("IPPS").[9] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[10]

The statutory provisions addressing the IPPS are located in § 1886 of the Act[11] and they contain a number of provisions that adjust payment based on hospital-specific factors.[12] This case

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[1] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).
[2] *See* Providers' Revised Final Position Paper at 2, MAC Final Position Paper at 1.
[3] Title XVIII of the Act was codified at 42 U.S.C. Ch. 7, Subch. XVIII.
[4] FIs and MACs are hereinafter referred to as intermediaries.
[5] *See* §§ 1816 and 1874A of the Act, 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[6] *See* 42 C.F.R. § 413.20.
[7] *See* 42 C.F.R. § 405.1803.
[8] *See* § 1878(a) of the Act, 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835 – 405.1837.
[9] *See* § 1886(d) of the Act, 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.
[10] *Id.*
[11] *See* 42 U.S.C. § 1395ww(d).
[12] *See* § 1886(d)(5) of the Act, 42 U.S.C. § 1395ww(d)(5).

involves the hospital-specific DSH adjustment specified in § 1886(d)(5)(F)(i)(I). This provision requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[13]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[14] The DPP is a proxy for utilization by low-income patients and determines a hospital's qualification as a DSH. It also determines the amount of the DSH payment to a qualifying hospital.[15]

The DPP is calculated as the sum of two fractions expressed as percentages.[16] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. The Medicare/SSI fraction is defined in § 1886(d)(5)(F)(vi)(I) as:

> [T]he 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 patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this title, ...

The Medicare/SSI fraction is computed annually by CMS, and intermediaries use CMS' calculation to compute the DSH payment adjustment as relevant for each hospital.[17]

Similarly, the Medicaid fraction (also referred to as the Medicaid proxy) is defined in § 1886(d)(5)(F)(vi)(II) as:

> [T]he fraction (expressed as a percentage), the numerator of which is 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*, 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's patient days for such period.[18]

The intermediary determines the number of the hospital's patient days of service for which patients were eligible for medical assistance under a State Plan approved under Title XIX of the

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[13] *See* 42 C.F.R. § 412.106.
[14] *See* §§ 1886(d)(5)(F)(i)(I) and (d)(5)(F)(v) of the Act, 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[15] *See* § 1886(d)(5)(F)(iv) and (d)(5)(F)(vii)-(xiv) of the Act, 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiv); 42 C.F.R. § 412.106(d).
[16] *See* § 1886(d)(5)(F)(vi) of the Act, 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[17] *See* 42 C.F.R. § 412.106(b)(2)-(3).
[18] (Emphasis added.)

Act[19] but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[20]

The Medicaid fraction is the only fraction at issue in this case. However, resolution of the Medicare DSH issue also involves the interpretation of a similar Medicaid DSH provision found in Title XIX of the Act and whether it applies to the Medicare DSH Medicaid fraction. The details of the Medicaid DSH provisions are discussed in more detail below.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case includes 11 group appeals, collectively known as the Washington General Assistance Days Groups ("Providers").[21] The Providers in these group appeals are all acute care hospitals located in the State of Washington that received payment under Medicare Part A for cost reporting periods from 1992 through 2006. The Providers participated in the Washington State Plan which provides medical assistance to uninsured low-income patients not eligible for other medical assistance programs, including the Medicaid program.[22]

During the years in question, the intermediaries were Noridian Administrative Services and Wisconsin Physicians Service ("WPS") (collectively referred to as the "Intermediary"). In the NPRs for the Providers' cost reporting periods at issue, the Intermediary excluded Washington Medically Indigent ("MI") and General Assistance/Unemployable ("GAU") program[23] days from the Medicaid fraction of the Providers' Medicare DSH calculations. The Providers timely appealed the Intermediary's determinations to the Board.

The Providers were represented by Teresa A. Sherman, Esq., of the Sherman Law Office, PLLC. The Intermediary was represented by Robin Sanders, Esq., of the Blue Cross and Blue Shield Association.

BACKGROUND ON INCLUSION OF WASHINGTON MI AND GAU DAYS IN THE MEDICAID PERCENTAGE OF THE MEDICARE DSH ADJUSTMENT:

The parties agree that resolution of the MI and GAU days issue before the Board hinges on the meaning of the phrase "patients who for such days were eligible for medical assistance under a State plan approved under [T]itle XIX" as used in § 1886(d)(5)(F)(vi)(II)[24] to describe the Medicaid fraction. This phrase identifies those days that are to be counted in the Medicaid proxy of the Medicare DSH adjustment.

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[19] Title XIX was codified at 42 U.S.C. Ch. 7, Subch. XIX.
[20] *See* 42 C.F.R. § 412.106(b)(4).
[21] *See* Appendix A for a summary of Providers by Group.
[22] *See* excerpts from the Washington State Plan Under Title XIX of the Social Security Act at Provider Exhibit P-1.
[23] GA days involve the uncompensated direct patient care provided by one or more hospitals in Washington. Hospitals may receive payments from the state for this care which may be reimbursed through disproportionate share payments by the federal Medi*caid* program.
[24] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

Title XIX of the Act[25] provides for federal sharing of state expenses for medical assistance for low-income individuals under the Medicaid program provided the state Medicaid program meets certain provisions contained in Title XIX. The state must submit a plan describing the state Medicaid program and seek approval from the Secretary.[26] If approved, the state may claim federal matching funds, known as federal financial participation ("FFP") under the Title XIX for the services provided and approved under the state Medicaid program.

PROVIDERS' CONTENTIONS:

The Providers contend that the Medicare statute and regulations require the inclusion of the Washington MI and GAU days in the Medicare DSH calculation because the MI and GAU programs were a part of the Washington State Plan and CMS reviewed and approved that plan. The Providers state that the MI and GAU programs are funded by Medicaid dollars for which the State receives federal matching funds. The Providers assert that the approved amendment to the Washington Medicaid State Plan in the early 1990s generates federal funding making MI and GAU patients eligible for medical assistance under a State plan approved under Title XIX.[27]

The Providers also argue that the term "medical assistance" is broad in scope and includes all services and payments for services made under the State Medicaid plan, including Medicaid DSH payments. Thus, the Washington MI and GAU programs must be considered "medical assistance under a State plan," and all days related to providing care for MI and GAU patients must be included in the Providers' DSH calculations.[28]

The Providers assert that, even though the case law on this issue generally does not support the Providers' position, the better reasoned decisions are those that do support their position. In this regard, the Providers rely on a number of decisions from the Ninth Circuit: *Portland Adventist Medical Center v. Thompson*, 399 F.3d 1091 (9th Cir. 2005) *("Portland Adventist")* and *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d. 1261, 1262 (9th Cir. 1996).[29]

The Providers recognize that the Ninth Circuit specifically addressed the inclusion of Washington State MI and GAU days in the Medicaid fraction in the 2011 decision in *University of Washington Med. Ctr. v. Sebelius*, 634 F.3d 1029 (9th Cir. 2011).[30] In that case, the Ninth Circuit concluded that such days were properly excluded because they did not fall within the traditional categories of Medicaid patients. However, the Court did not have the benefit of certain facts related to how federal funds paid for the MI and GAU programs[31]. The Providers assert, among other things, that the Ninth Circuit erred in its factual findings regarding the Washington State MI and GAU programs and erred in treating Medicaid DSH funding under § 1923 of the Act as separate and distinct from the funding of regular Medicaid patients.[32]

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[25] Title XIX of the Act is codified at 42 U.S.C. Ch. 7, Subch. XIX.
[26] *See* 42 U.S.C. § 1396a.
[27] *See* Providers' Revised Final Position Paper at 8-10.
[28] *See id.* at 14-16.
[29] *See id.* at 21-32.
[30] The Board notes that, pursuant to the Provider's request, this case was held in abeyance pending the outcome of the appeal in *University of Washington. See id.* at 1.
[31] See id. At 25
[32] *See id.* at 24-25, 29-30.

Further, the Providers assert that the *University of Washington* decision is in direct conflict with the Ninth Circuit's earlier 2005 decision in *Portland Adventist*. In this regard, the Providers assert that the Ninth Circuit decision in *Portland Adventist* supports the inclusion of expansion population patient days. While the Providers acknowledge that the Medicaid waiver expansion days under § 1115 of the Act that were at issue in *Portland Adventist* are different from a program included in a State Plan, the Providers assert that the results are the same – Title XIX funds are providing medical assistance to low-income patients.[33]

The Providers also argue that Program Memorandum ("PM") A-99-62[34] that was issued in December, 1999 permits inclusion of MI and GA days in the DSH calculation. The Providers contend that CMS arbitrarily allowed only the following providers to be "held harmless" and retain or obtain the additional funding: (1) providers that had previously received payment based upon what CMS considered to be the prior erroneous inclusion of strictly state funded programs; and (2) those providers which had appealed the exclusion of state-only programs prior to October 15, 1999. This policy results in similarly situated providers being treated in a dissimilar manner and is therefore arbitrary.[35]

Finally, the Providers disagree with the decision of the District of Columbia ("D.C.") Circuit in *Adena Reg'l Med. Ctr. v. Leavitt*, 527 F.3d 176 (D.C. Cir. 2008), *cert. denied*, 129 S. Ct. 1933 (2009) ("*Adena*"). The Providers argue that the facts in *Adena* are not present in the subject appeal. In *Adena*, the D.C. Circuit's holding was based on the fact that, under the Ohio Hospital Care Assurance Program, the State of Ohio did not reimburse hospitals for the cost of providing mandatory general assistance ("GA"), whereas under an approved Medicaid State plan, providers must be paid for the care of eligible patients. In contrast, the Washington State plan does provide payment to hospitals for inpatient services for individuals who qualify as MI or GAU.

The Providers argue that the *Adena* decision is flawed because, in that decision, the D.C. Circuit links the Medicaid and Medicare statutes together without Congressional authority to do so. Further, the Providers disagree with the D.C. Circuit's use of the Medicaid DSH statutory language as a basis for interpreting the Medicare DSH statute, simply because both provisions use the terms "medical assistance" and serve the same general purpose, *i.e.*, to compensate hospitals for rendering a disproportionate amount of care to low-income patients.[36]

INTERMEDIARY'S CONTENTIONS:

The Intermediary disputes the Providers' conclusion that the MI and GAU program amendments to the State plan provide "medical assistance" as used in § 1886(d)(5)(F)(vi)(II) of the Act to any of the MI or GAU enrollees. Under the State plan, the MI and GAU programs are for Medically-Indigent Disproportionate Share Hospitals ("MIDSH") and General Assistance Unemployable Disproportionate Share Hospitals ("GAUDSH") respectively. MI and GAU programs do provide additional funding to hospitals serving low income patients. However, these DSH

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[33] *See id.* at 25.
[34] CMS Pub. 60-A, Transmittal A-99-62 (Dec 1, 1999) (later re-issued as CMS Pub 60-A, Transmittal A-01-13 (Jan, 25, 2001)).
[35] *See* Providers' Revised Final Position Paper at 32-33.
[36] *See id.* at 21-23.

payments are not "medical assistance" payments on behalf of the patients but rather are DSH programs for the hospitals under § 1923(a)(1) of the Act.[37]

The Intermediary counters that days of care paid for by programs for low income patients who are not eligible for Medicaid – even if the programs are recited in the State plan approved by Medicaid – cannot be included. The Intermediary reasons that, because the Washington State Medicaid Plan provides that patients who are eligible for the Washington MI and GAU programs cannot be eligible for Medicaid, Washington MI and GAU days must be excluded from the Medicaid proxy of the Medicare DSH calculation. In support of its position, the Intermediary primarily relies on the decision of the Ninth Circuit in *University of Washington Med. Ctr. v. Sebelius*, 634 F.3d 1029 (9th Cir. 2011) ("*University of Washington*"). In that case, the Ninth Circuit affirmed the Intermediary's view of the statutory construction:

> Medicare does not define "medical assistance," but we may look to its definition under Medicaid. Nothing in the context of the Social Security Act overcomes the "natural presumption that identical words used in different parts of the same act are intended to have the same meaning." *Atl. Cleaners & Dyers v. United States*, 286 U.S. 427, 433 . . . (1932). Indeed, given that the Medicare DSH adjustment counts patients who are eligible for "medical assistance" under subchapter XIX of the Social Security Act, it is hard to imagine looking anywhere other than subchapter XIX for a definition of this critical term. *Cf. Phoenix Mem'l Hosp. v. Sebelius*, 622 F.3d 1219, 1226 (9th Cir. 2010).[38]

The Intermediary argues that the federal match payments of the State MI and GAU programs do not constitute Title XIX assistance to MI and GAU patients thus making those patients "eligible" for medical assistance. The MI and GAU programs allow hospitals to be eligible for and receive DSH payments but do not make patients eligible for Medicaid programs. Thus, MI and GAU programs are not programs under which patients could be eligible for medical assistance as required by the statute at §1886(d)(5)(F)(vi)(II) of the Act. That statutory provision is consistent with the Medicare DSH regulation at 42 CFR § 412.106(b)(4), HCFA Ruling No. 97-2, and PM A-99-62. In this regard, CMS stated the following in PM A-99-62:

> 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*.[39]

Finally, the Intermediary notes that, in *University of Washington*, the Ninth Circuited specifically reviewed the Washington State MI and GAU programs and found:

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[37] *See* Intermediary's Revised Final Position Paper at 13-14.
[38] Intermediary's Revised Final Position Paper at 9 (quoting *University of Washington*, 634 F.3d at 1034).
[39] *See id.* at 17 (quoting PM A-99-62 with bold emphasis in original and italics emphasis added.)

> First, substantial evidence supports the Secretary's finding that the GAU and MI populations do not fit within the enumerated classes of people under section 1396d(a). In large part, these classes share the characteristics of the categorically or medically needy. Compare 42 U.S.C. § 1396a(10) with id. § 1396d(a)(i)-(v), (vii)-(viii). The Hospital's own witnesses admitted during the administrative review process that the GAU and MI programs covered those who are not within these categories. Indeed, the Hospitals concede on appeal that the "MI and GAU programs cover low-income persons who do not meet the categorical or status requirements for the Categorically Needy and Medically Needy programs, and therefore are considered ineligible for 'Medicaid.'" Appellants' Opening Br. at 17. Because the Hospitals' GAU and MI patients did not fit within the statutory classes of people, the patients were not capable of receiving medical assistance as defined by Medicaid. *Cf. Adena Reg'l Med. Ctr.*, 527 F.3d at 180.[40]

Accordingly, the Ninth Circuit properly concluded "that Washington's GAU and MI patients were not eligible for medical assistance under Washington's Medicaid plan. They were, therefore, properly excluded from the calculation of the Hospitals' Medicare reimbursements."[41]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered the Medicare law and program instructions, the evidence presented and the parties' contentions. Set forth below are the Board's findings and conclusions.

The evidence before the Board establishes that Washington MI and GAU beneficiaries are not eligible for Medicaid and that the services provided under the Washington State MI and GAU programs are not matched with federal funds *except* under the Medicaid DSH provisions.

The Medicaid DSH provisions are similar to the Medicare DSH provisions. Section 1923(a) of the Act[42] mandates that a state Medicaid plan under Title XIX must include a provision for a payment adjustment to hospitals which serve a disproportionate number of low income patients, *i.e.*, it requires a Medi*caid* DSH adjustment for hospitals that is independent of the Medi*care* DSH adjustment at issue in this case. The Medicaid DSH adjustment is eligible for FFP even though the particular patient days counted for Medicaid DSH are not directly eligible for FFP because they do not qualify as "traditional Medicaid" services described in § 1905(a).

The question for the Board is whether the Washington MI and GAU programs as a state-funded program that is not otherwise eligible for Medicaid coverage and included in the Washington State Medicaid Plan solely for the purpose of calculating the Medi*caid* DSH payment constitutes

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[40] *See id.* at 17 (quoting *University of Washington*, 634 F.3d at 1035).
[41] *See id.* (quoting *University of Washington*, 634 F.3d at 1036).
[42] 42 U.S.C. § 1396r-4(a).

"medical assistance under a State plan approved under [T]itle XIX" for purposes of the Medi*care* DSH adjustment, specifically in the Medicaid fraction component.

In prior decisions on similar state-funded programs, the Board has interpreted the Medicare statutory phrase "medical assistance under a State plan approved under [T]itle XIX" to include any program identified in the approved state plan, *i.e.*, it has not limited the days counted to traditional Medicaid days.[43] Subsequent to those decisions, the D.C. Circuit issued its decision in *Adena Reg'l Med. Ctr. v. Leavitt*,[44] and concluded that the days related to beneficiaries eligible for the Ohio Hospital Care Assurance Program ("HCAP") should not be included in the Medicaid proxy of the Medicare DSH calculation.[45] Like the Washington MI and GAU programs, HCAP patients could not qualify for Medicaid but the HCAP days were included in the Medicaid DSH calculation. The D.C. Circuit pointed out that § 1923(c)(3)(B) of the Act[46] "permits the states to adjust DSH payments 'under a methodology that' considers *either* 'patients eligible for medical assistance under a State plan approved under [Medicaid] or ... low-income patients,' 42 U.S.C. § 1396r-4(c)(3)(B), such as those served under the HCAP."[47]

Upon further review and analysis of § 1923, the Board is persuaded and finds that the term "medical assistance under a state plan approved under [T]itle XIX" excludes days funded by only the state and MI and GAU days even though those days may be counted for Medicaid DSH purposes.

Title XIX describes how hospitals qualify for the Medicaid DSH adjustment. Specifically, § 1923(b) establishes two distinct categories of low-income patients that are used to calculate a Medicaid DSH payment. The two categories, identified as the "Medicaid inpatient utilization rate" and the "low-income utilization rate," are defined in subsection (b)(2) and (b)(3), in pertinent part, as follows:

> (b)(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were *eligible for medical assistance under a State plan approved under this title* [*i.e.*, Title XIX of the Act] in a period ... , and the denominator of which is the total number of the hospital's inpatient days in that period. ...
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> (b)(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of –
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> (A) the fraction (expressed as a percentage)-

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[43] *See, e.g., Ashtabula County Med. Ctr. v. Blue Cross Blue Shield Ass'n,* PRRB Dec. No. 2005-D49 (Aug. 10, 2005) *rev'd,* CMS Administrator Dec. (Oct. 12, 2005).
[44] 527 F 3d 176 (D.C. Cir. 2008), *cert. denied,* 129 S. Ct. 1933 (2009).
[45] *Adena,* 527 F.3d at 180.
[46] *See* 42 U.S.C. § 1396r-4(c)(3)(B).
[47] *Adena,* 527 at 180 (brackets, ellipses, and citation in original; footnote and italics emphasis added).

> (i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for *patient services under a State plan* under this title … and (II) the amount of the *cash subsidies for patient services received directly from State and local governments*, and
> (ii) the denominator of which is the total amount of revenues of the hospital for patient service (including the amount of such cash subsidies) in the period; and
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> (B) a fraction (expressed as a percentage)-
> (i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to GA in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and
> (ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.
> …[48]

Subsection (b)(2) specifically uses the term "eligible for medical assistance under a State plan," the exact language from the Medicare DSH statute at issue in this case. That phrase describes the days included in the definition of the "Medicaid inpatient utilization rate" for the Medicaid DSH adjustment.

It is the second category, the "low-income utilization rate," that clarifies what is and what is not included in "medical assistance under a State plan." Subsection (b)(3) defines the term "low-income utilization rate" to include three components. In paragraph (A)(i)(I) of this subsection, there is the first component consisting of "services [furnished] under a State plan under this title [XIX]," the same category of patients described in the Medicaid utilization rate. In paragraphs (A)(i)(II) and (B)(i), there are the second and third components consisting of "cash subsidies for patient services received directly from State and local governments" and "charity care" respectively. 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 types of days in the "low income utilization rate" would have been superfluous.

Based on the above, the Board concludes that, because the Washington MI and GAU programs are funded by "state and local governments" and, thus, are included in the low income utilization rate but not the Medicaid inpatient utilization rate, Washington MI and GAU patient days do not fall within the Medicaid DSH statute definition of "eligible for medical assistance under a State plan" at § 1923(b)(2) of the Act.[49] Statutory construction principles require the Board to apply the meaning

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[48] (Emphasis added.)

[49] 42 U.S.C. § 1396r-4(b)(2). On July 23, 2012, the Provider submitted a supplemental position paper to inform the Board of the following case involving a GA days DSH issue – *Nazareth Hosp. v. Sebelius*, Civ. Action No. 10 3513 (E.D. Pa.) ("*Nazareth*"). Subsequent to the Board receipt of this submission, a decision was issued in *Nazareth*. *See Nazareth*, Civ. Action No. 10-3513, 2013 WL 1401778 (E.D. Pa. Apr. 8, 2013). On May 2, 2013, the Provider

Congress ascribed to the term "eligible for medical assistance under a State plan" used in the Medicaid statute to the same phrase used in the Medicare statute.[50] Washington MI and GAU patient days, therefore, cannot be included in the Medicare DSH statutory definition of "eligible for medical assistance under a State plan" at § 1886(d)(5)(F)(vi)(II) of the Act.[51] Accordingly, the Intermediary's adjustments properly excluded Washington MI and GAU program patient days from the Providers' Medicare DSH calculations.

The Board notes that the Provider is located in the Ninth Circuit. The Ninth Circuit's decision in the *University of Washington* case is consistent with the D.C. Circuit's decision in *Adena*. These cases serve as controlling precedent as the Providers could bring suit in either the D.C. Circuit or the Ninth Circuit.[52] The Board agrees with the Intermediary that the *University of Washington* decision is especially relevant as the Ninth Circuit reviewed the Washington State MI and GAU programs and confirmed that MI and GAU days should be excluded from the Medicaid fraction of the Medicare DSH calculation. The Board decision is consistent with *University of Washington.*

Finally, the Board rejects the Providers' arguments that the hold harmless provisions in PM A-99-62 are arbitrary because they treat similarly situated providers in a dissimilar manner; and that the implementation of the "hold harmless" policy in the PM is an improper substantive rule change subject to the APA notice and comment requirements. CMS issued the PM to clarify

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submitted a second supplemental position paper updating its position for the *Nazareth* decision. However, concurrent with this decision, the Board sent a letter to the Provider Representative confirming that the Board would neither consider the *Nazareth* case nor enter into the record any additional arguments and evidence regarding *Nazareth* included or requested in those supplemental submissions because: (1) the *Nazareth* case presents new legal arguments under the Equal Protection Clause of the Constitution and Administrative Procedure Act (*see id.* at *2, *12 n.1) that were not raised by the Provider prior to the closing of the record on June 1, 2012 (indeed, none of these arguments would be ones that the Board would be authorized to consider pursuant to 42 C.F.R. § 405.1867 and the *Nazareth* case is not binding precedent on the Board); and (2) the Provider through the Provider Representative failed to properly preserve its right to make these arguments and evidence a part of the record for the record hearing because, in attempting to obtain Board consideration of new argument and evidence (as well as a request to admit yet more evidence) related to *Nazareth*, the Provider Representative failed to observe and comply with Board Rules 32.3(C) and 44 specifying the proper process and procedure to petition the Board by written motion to reopen the record for a record hearing for additional argument and evidence.

[50] *See Atlanta Cleaners & Dyers, Inc. v. U.S.*, 286 U.S. 427, 433 (1932).

[51] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

[52] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, CMS Administrator Dec. (Apr. 13, 2009), *affirming*, PRRB Dec. No. 2009-D11 (Feb. 27, 2009) (stating "as the *Alahambra* [*Hosp. v. Thompson*, 259 F.3d 1071 (9th Cir. 2001)] case is binding in the circuit in which the Providers are entitled to seek judicial review, the Administrator hereby affirms the Board's decision . . . with respect to the LDRP days. The Board's decision is affirmed only on the limited ground that there is binding law in the Ninth Circuit . . . . The decision does not affect the Secretary's ability to continue to defend this issue in other circuits . . . ."); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, CMS Administrator Dec. (Nov. 17, 2008), affirming in part and reversing in part, PRRB Dec. No. 2008-D35 (Sept. 15, 2008) (stating that "[i]n the absence of a controlling decision by the Supreme Court, the respective courts of appeals express the law of the circuit" with citation to *Hyatt v. Heckler*, 807 F.2d 376, 379 (4th Cir. 1986)). In recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also has applied as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.* CMS Administrator Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007) (stating in connection with a provider located in Plymouth, Massachusetts, that "under § 1878(f)(1), the District of Columbia is the judicial district in which this Provider may file suit and, thus, *St. Elizabeth's* [*Med. Ctr. of Boston v. Thompson*, 396 F.3d 1228 (D.C. Cir. 2005)] is binding case law here").

HCFA Ruling 97-2 which addressed Medicaid days included in the Medicare DSH calculation. The language in Ruling 97-2 and the implementing instructions regarding which individuals qualify as "eligible for medical assistance under a State plan approved under Title XIX" needed clarification. Ruling 97-2 and the implementing instructions stated CMS' policy that days attributed to individuals eligible for GA and other State-only funded programs (collectively, State-only program days) should be *excluded* from the DSH calculation. Intermediaries in some states had historically allowed providers to include State-only program days applicable to health programs not contained in the relevant Medicaid State plans in their DSH calculations, even though § 1886(d)(5)(F)(vi)(II) of the Act[53] stated that only days attributable to individuals "eligible for medical assistance *under a State plan approved under Title XIX*"[54] were to be included in the DSH calculation. Based on the newly-issued Ruling and the implementing instructions, several of the intermediaries that previously had allowed inclusion of State-only program days in their providers' DSH calculations began amending their policies on this issue. Accordingly, CMS issued PM A-99-62 in December 1999 to provide further guidance to intermediaries on the retrospective and prospective treatment of the State-only days issue.

DECISION AND ORDER:

The Intermediary properly refused to include Washington MI and GA Program days in the numerator of the Providers' Medicaid proxy. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, CPA
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: SEP 12 2013

[53] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).
[54] (Emphasis added.)

APPENDIX A

SUMMARY OF PROVIDERS BY GROUP

Case No.: 00-3186GC
Group Name: WA State Medicare DSH Group I
Lead Intermediary: Noridian Administrative Services

	Provider No.	Provider Name	FYE
1		**Provider removed**[55]	
2		**Provider removed**	
3	50-0050	Southwest Washington Med Center	09/30/1996
4	50-0050	Southwest Washington Med Center	09/30/1997
5	50-0050	Southwest Washington Med Center	09/30/1998
6		**Provider removed**	
7		**Provider removed**	
8	50-0026	Stevens Memorial Hospital	12/31/1996
9	50-0026	Stevens Memorial Hospital	12/31/1997
10	50-0003	Skagit Valley united General Hospital	12/31/1995
11	50-0003	Skagit Valley united General Hospital	12/31/1996
12	50-0003	Skagit Valley united General Hospital	12/31/1997
13	50-0129	Tacoma General Hospital	12/31/1994
14	50-0129	Tacoma General Hospital	12/31/1997
15	50-0129	Tacoma General Hospital	12/31/1998
16		**Provider removed**	
17	50-0039	Harrison Memorial Hospital	04/30/1998
18	50-0058	Kadlec Medical Center	12/31/1998

[55] Participants #1, 2, 6, 7, and 16 were removed from CN 00-3186GC based on the Board's jurisdictional review dated March 15, 2013.

Case No.: 04-0361G
Group Name: WA State 2000-2001 Medicare DSH Group III
Lead Intermediary: Noridian Administrative Services

	Provider No.	Provider Name	FYE
1	50-0026	Stevens Memorial Hospital	12/31/2000
2	50-0026	Stevens Memorial Hospital	12/31/2001
3	50-0036	Yakima Valley Memorial Hospital	10/31/2000
4	50-0036	Yakima Valley Memorial Hospital	10/31/2001
5	50-0039	Harrison Memorial Hospital	04/30/2001
6	50-0050	Southwest Washington Med Center	09/30/2001
7	50-0058	Kadlec Medical Center	12/31/2000
8	50-0058	Kadlec Medical Center	12/31/2001
9	50-0079	Good Samaritan Hospital	09/30/2000
10	50-0079	Good Samaritan Hospital	09/30/2001
11	50-0129	Tacoma General Hospital	12/31/2000
12	50-0129	Tacoma General Hospital	12/31/2001

Case No.: 05-0439G
Group Name: WA State 2001 Medicare DSH Group IV
Lead Intermediary: Noridian Administrative Services

1	50-0036	Yakima Valley Memorial Hospital	10/31/2002
2	50-0039	Harrison Memorial Hospital	04/30/2002
3	50-0039	Harrison Memorial Hospital	04/30/2003
4	50-0050	Southwest Washington Med Center	09/30/2002
5	50-0050	Southwest Washington Med Center	09/30/2003
6	50-0058	Kadlec Medical Center	12/31/2002
7	50-0079	Good Samaritan Hospital	09/30/2002
8	50-0129	Tacoma General Hospital	12/31/2002

Case No.: 06-1812G
Group Name: WA State 2004 Medicare DSH Group V
Lead Intermediary: Noridian Administrative Services

	Provider No.	Provider Name	FYE
1	50-0026	Stevens Memorial Hospital	12/31/2003
2	50-0026	Stevens Memorial Hospital	12/31/2004
3	50-0036	Yakima Valley Memorial Hospital	10/31/2003
4	50-0039	Harrison Memorial Hospital	04/30/2004
5	50-0039	Harrison Memorial Hospital	04/30/2005
6	50-0050	Southwest Washington Med Center	09/30/2004
7	50-0058	Kadlec Medical Center	12/31/2003
8	50-0072	Olympic Medical Center	12/31/2004
9	50-0079	Good Samaritan Hospital	09/30/2003
10	50-0079	Good Samaritan Hospital	09/30/2004
11	50-0079	Good Samaritan Hospital	09/30/2005
12	50-T079	Good Samaritan Hospital	09/30/2004
13	50-T079	Good Samaritan Hospital	09/30/2005
14	50-0129	Tacoma General Hospital	12/31/2003

Case No.: 08-1845G
Group Name: QRS 2004-2006 WA State General Assistance Days Group VI
Lead Intermediary: Noridian Administrative Services

	Provider No.	Provider Name	FYE
1	50-0016	Central Washington Hospital	12/31/2006
2	50-0026	Stevens Memorial Hospital	12/31/2005
3	50-0026	Stevens Memorial Hospital	12/31/2006
4	50-0039	Harrison Memorial Hospital	04/30/2006
5	50-0050	Southwest Washington Med Center	09/30/2005
6	50-0058	Kadlec Medical Center	12/31/2004
7	50-0058	Kadlec Medical Center	12/31/2005
8	50-0058	Kadlec Medical Center	12/31/2006
9	50-0072	Olympic Medical Center	12/31/2005
10	50-0079	Good Samaritan Hospital	09/30/2006
11	50-T079	Good Samaritan Hospital	09/30/2006

12	50-0079	Good Samaritan Hospital	12/31/2006[56]
13	50-0129	Tacoma General Hospital	12/31/2004
14	50-0129	Tacoma General Hospital	12/31/2005

Case No.: 09-1503GC
Group Name: QRS Univ of WA Medicine 1992-2006 WA State General Assistance Days CIRP Group
Lead Intermediary: Noridian Administrative Services

	Provider No.	Provider Name	FYE
1		**Provider Removed**[57]	
2		**Provider Removed**	
3	50-0064	Harborview Medical Center	06/30/2001
4	50-0064	Harborview Medical Center	06/30/2002
5	50-0064	Harborview Medical Center	06/30/2003
6	05-0064	Harborview Medical Center	06/30/2004
7	50-0064	Harborview Medical Center	06/30/2005
8	50-0008	University of Washington	06/30/2001
9	50-0008	University of Washington	06/30/2002
10	50-0008	University of Washington	06/30/2003
11	50-0064	Harborview Medical Center	06/30/2006
12	50-0008	University of Washington	06/30/2006

Case No.: 09-1581GC
Group Name: QRS Swedish Health Services 1994-2006 WA State General Assistance Days CIRP Group
Lead Intermediary: Noridian Administrative Services

	Provider No.	Provider Name	FYE
1		**Provider Removed**[58]	
2		**Provider Removed**	

[56] The Provider representative requested that this provider be transferred to Case No. 09-2108GC on May 2, 2013. The Board granted this request on August 27, 2013.
[57] Participants #1and 2 were removed from Case No. 09-1503GC based on the Board's jurisdictional review dated June 28, 2013.
[58] Participants #1, 2, 3, 4, 5, 11, 12, 13, and 14 were removed from Case No. 09-1581GC based on the Board's jurisdictional review dated April 15, 2013.

3		**Provider Removed**	
4		**Provider Removed**	
5		**Provider Removed**	
6	50-0027	Swedish Medical Center	12/31/2000
7	50-0027	Swedish Medical Center	12/31/2001
8	50-0027	Swedish Medical Center	12/31/2002
9	50-0027	Swedish Medical Center	12/31/2003
10	50-0027	Swedish Medical Center	12/31/2004
11		**Provider Removed**	
12		**Provider Removed**	
13		**Provider Removed**	
14		**Provider Removed**	
15	50-0025	Swedish Medical Center - Prov	12/31/1999
16	50-0025	Swedish Medical Center - Prov	06/30/2000
17	50-0025	Swedish Medical Center - Prov	12/31/2001
18	50-0025	Swedish Medical Center - Prov	12/31/2002
19	50-0025	Swedish Medical Center - Prov	12/31/2006
20	50-0027	Swedish Medical Center	12/31/2005
21	50-0027	Swedish Medical Center	12/31/2006

Case No.: 09-1743GC
Group Name: QRS Providence Health 1994-2005 WA State General Assistance Days CIRP Group
Lead Intermediary: Noridian Administrative Services

	Provider No.	Provider Name	FYE
1		**Provider Removed**[59]	
2		**Provider Removed**	
3	50-0077	Holy Family Hospital	07/31/1996
4	50-0077	Holy Family Hospital	07/31/1997
5	50-0077	Holy Family Hospital	12/31/1997
6	50-0077	Holy Family Hospital	12/31/1998
7	50-0077	Holy Family Hospital	12/31/2000

[59] Participants #1, 2, and 15 were removed from Case No. 09-1743GC based on the Board's jurisdictional review dated February 21, 2013.

8	50-0077	Holy Family Hospital	12/31/2001
9	50-0077	Holy Family Hospital	12/31/2002
10	50-0077	Holy Family Hospital	12/31/2003
11	50-0077	Holy Family Hospital	12/31/2004
12	50-0077	Holy Family Hospital	12/31/2005
13	50-0014	Providence General Medical Center	12/31/1996
14	50-0014	Providence General Medical Center	12/31/1997
15		**Provider Removed**	
16	50-0014	Providence General Medical Center	12/31/2000
17	50-0014	Providence General Medical Center	12/31/2001
18	50-0014	Providence General Medical Center	12/31/2002
19	50-0014	Providence General Medical Center	12/31/2003
20	50-0014	Providence General Medical Center	12/31/2004
21	50-0019	Providence Hospital Centralia	12/31/2000
22	50-0024	Providence St Peter Hospital	12/31/1994
23	50-0024	Providence St Peter Hospital	12/31/1995
24	50-0024	Providence St Peter Hospital	12/31/1996
25	50-0024	Providence St Peter Hospital	12/31/1997
26	50-0024	Providence St Peter Hospital	12/31/1998
27	50-0024	Providence St Peter Hospital	12/31/2000
28	50-0024	Providence St Peter Hospital	12/31/2001
29	50-0024	Providence St Peter Hospital	12/31/2002
30	50-0024	Providence St Peter Hospital	12/31/2003
31	50-0024	Providence St Peter Hospital	12/31/2004
32	50-0012	Providence Yakima Medical Center	12/31/1996
33	50-0012	Providence Yakima Medical Center	12/31/1997
34	50-0012	Providence Yakima Medical Center	12/31/1998
35	50-0012	Providence Yakima Medical Center	12/31/2000
36	50-0012	Providence Yakima Medical Center	12/31/2001
37	50-0012	Providence Yakima Medical Center	12/31/2002
38	50-0012	Providence Yakima Medical Center	08/15/2003
39	50-0054	Sacred Heart Medical Center	12/31/1995
40	50-0054	Sacred Heart Medical Center	12/31/1996
41	50-0054	Sacred Heart Medical Center	12/31/1998
42	50-0054	Sacred Heart Medical Center	12/31/2000
43	50-0054	Sacred Heart Medical Center	12/31/2001
44	50-0054	Sacred Heart Medical Center	12/31/2002

45	50-0054	Sacred Heart Medical Center	12/31/2003
46	50-0054	Sacred Heart Medical Center	12/31/2004
47	50-0002	St. Mary Medical Center	12/31/2005
48	50-0077	Holy Family Hospital	12/31/2006
49	50-0014	Providence General Medical Center	12/31/2005
50	50-0024	Providence St Peter Hospital	12/31/2005
51	50-0024	Providence St Peter Hospital	12/31/2006
52	50-0054	Sacred Heart Medical Center	12/31/2005
53	50-0054	Sacred Heart Medical Center	12/31/2006

Case No.: 10-0088GC
Group Name: QRS Franciscan Health 1996-2006 WA State General Assistance Days CIRP Group
Lead Intermediary: Noridian Administrative Services

	Provider No.	**Provider Name**	**FYE**
1	50-0021	St. Clare Hospital	06/30/2001
2	50-0021	St. Clare Hospital	06/30/2003
3	50-0021	St. Clare Hospital	06/30/2004
4	50-0021	St. Clare Hospital	06/30/2005
5	50-0021	St. Clare Hospital	06/30/2006
6	50-0021	St. Clare Hospital	06/30/2007
7	50-0141	St. Francis Hospital	06/30/1997
8	50-0141	St. Francis Hospital	06/30/1998
9	50-0141	St. Francis Hospital	06/30/1999
10	50-0141	St. Francis Hospital	06/30/2001
11	50-0141	St. Francis Hospital	06/30/2002
12	50-0141	St. Francis Hospital	06/30/2003
13	50-0141	St. Francis Hospital	06/30/2004
14	50-0141	St. Francis Hospital	06/30/2005
15	50-0141	St. Francis Hospital	06/30/2006
16	50-0108	St. Joseph Hospital & Medical Center	06/30/1996
17	50-0108	St. Joseph Hospital & Medical Center	06/30/1997
18	50-0108	St. Joseph Hospital & Medical Center	06/30/1998
19	50-0108	St. Joseph Hospital & Medical Center	06/30/1999
20	50-0108	St. Joseph Hospital & Medical Center	06/30/2001

21	50-0108	St. Joseph Hospital & Medical Center	06/30/2002
22	50-0108	St. Joseph Hospital & Medical Center	06/30/2003
23	50-0108	St. Joseph Hospital & Medical Center	06/30/2004
24	50-0108	St. Joseph Hospital & Medical Center	06/30/2005

Case No.: 10-0129GC
Group Name: QRS 2006-2007 WA State General Assistance Days Group VII
Lead Intermediary: Noridian Administrative Services

	Provider No.	Provider Name	FYE
1	50-0050	Southwest Washington Medical Center	09/30/2006
2	50-0039	Harrison Medical Center	04/30/2007

Case No.: 10-0190GC
Group Name: QRS Empire 1992-2004 WA State General Assistance Days Group
Lead Intermediary: Noridian Administrative Services

	Provider No.	Provider Name	FYE
1		**Provider removed**[60]	
2		**Provider removed**	
3	50-0044	Deaconess Medical Center	12/31/1999
4	50-0044	Deaconess Medical Center	12/31/2000
5	50-0044	Deaconess Medical Center	12/31/2004
6		**Provider removed**	
7		**Provider removed**	
8	50-0119	Valley Hospital Medical Center	12/31/2002
9	50-0119	Valley Hospital Medical Center	12/31/2003
10	50-0119	Valley Hospital Medical Center	12/31/2004

[60] Participants #1, 2, 6, and 7 were removed from Case No. 10-0190GC based on the Board's jurisdictional review dated August 30, 2012.