CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Castle Medical Center **Provider** **vs.** **Blue Cross /Blue Shield Association** **United Government Services, LLC-CA** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 12/31/94** **Review of:** **PRRB Dec. No. 2003-D36** **Dated: July 16, 2003**

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 Intermediary submitted comments, requesting reversal of the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from the Center for Medicare Management (CMM) requesting reversal or modification of the Board's decision. No comments were received from the Provider. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary adjustment to the disproportionate share hospital (DSH) payment was proper.

The Board first held that the Intermediary's refusal to include all Quest Days, including general assistance (GA) and State Health Insurance Program for children (SHIP) days in the calculation of the Provider's DSH payment beginning on and after August 1, 1994 was not proper. The Board determined that the Social Security Act and the implementing regulations require the inclusion of all Medicaid eligible patient days in the DSH payment calculation.

With the implementation of the Title XIX waiver, effective August 1, 1994, the Board concluded that all Quest days including GA and SHIP days should be included in the calculation of the Provider's DSH payment because they represent days of services furnished to patients who were eligible for medical assistance under a State plan approved under Title XIX. The fact that the regulation was amended effective January 20, 2000, to specify that Title XIX waiver days representing expanded Medicaid population should be included in the Medicaid percentage only confirmed the Board position that the regulation as it existed in 1994 required the same treatment. Finally, with regard to Quest days, the Board held that, under Program Memorandum (PM) A-99-62, issued December 1999, all Quest days, including GA days and SHIP days should be included in the calculation of the Provider's DSH payment because the Provider filed a jurisdictionally proper appeal requesting the inclusion of all GA days and all Title XIX waiver days in the calculation of the DSH payment prior to October 15, 1999. The Board determined that the Provider's reference to "GA Days" and all "Title XIX waiver days," specific enough to satisfy the hold harmless provision of PM A-99-62.

With respect to waitlist days, the Board held that the Intermediary's refusal to include these days in the Provider's Medicaid fraction was improper. The Board determined that since the waitlisted patients were not entitled to Medicare benefits during the time they were waitlisted and the fact that the days were not included in the SSI statistics there would be no duplication if the days were included in the Medicaid fraction. In addition, the Board held that it would be a violation of the Medicare statute if these were not included in the Medicaid proxy, since the Act requires Medicaid eligible days to be included in the Medicaid proxy.

With respect to no-pay days, the Board held that the Intermediary's refusal to include these days in the Provider's Medicaid fraction was improper. The Board determined the No-Pay Days represented Medicaid eligible days, and by law should be included in the calculation of the Provider's DSH payment for the fiscal year in question. In addition, the Board held that they should be included in the Medicaid fraction, because there was no evidence in the record that the days in question were for days in which the patient was also entitled to Medicare Part A benefits.

Finally, the Board found that the Provider should use the admission date in calculating days as the Intermediary instructed the Provider to use the admission date rather than the discharge date. The Board instructed the intermediary to use the days identified in the Provider's exhibits as a basis for the Intermediary to

revise its adjustments determining the appropriate number of days to be included in the Provider's DSH payment for the 1994 fiscal year.

SUMMARY OF COMMENTS

The Intermediary commented requesting that the Administrator reverse the Board's decision because it reflected an incorrect interpretation of the regulations and program instructions. Specifically, the Intermediary argued that, the Provider did not meet the hold-harmless provision of Program Memorandum (PM) A-99-62.

CMM commented requesting that the Administrator review the Board's decision with respect to the inclusion of all three categories of days in the Medicaid fraction of the Provider's DSH calculation. Specifically, CMS disagreed with the Board's determination that all Quest days, including GA and SHIP days should be included in the Medicaid fraction. CMS wrote that, under Medicare policy at the time, hospitals were to include in the Medicare DSH calculation only those days for population under the section 1115 waiver who were or could have been made eligible under a State plan. Patient days of the expanded eligibility groups, however, were not to be included in the Medicare DSH calculation.

In addition, CMM disagreed with the Board's determination that all Quest days, including GA days and SHIP days should be included in the Medicaid fraction because the Provider filed a jurisdictionally proper appeal with the Board requesting the inclusion of all Quest days. CMM noted that the Provider's request was not specific enough to include all Quest days. CMS stated that, under the PM A-99-62, the Provider's appeal documents only contain a reference to GA days. Accordingly, in 2002, the CMS San Francisco Regional Office advised the Intermediary that the Provider should be held harmless for the GA days, but not for all categories of Quest days. The PM A-99-62 is very specific in stating that hold harmless is not to be applied to all questionable days on a blanket basis but is to be applied to specific categories of days that have been properly appealed, which did not occurred in this case.

Regarding the waitlist days, CMM disagreed with the Board's determination that these days should be included in the Provider's DSH payment calculation. CMM noted that the Act specifically excludes days in which a patient is entitled to benefits under Part A from the Medicaid fraction. CMM stated that this position appears to be based on the incorrect assumption that Medicare does not provide benefits for waitlist patients. The Administrator's Decision in Edgewater Medical Center, PRRB Dec. No.2000-D44 (June 19, 2000) clarified this point. CMM stated that the statutory phrase "but who were not entitled to benefits under Part

A" cannot be read to mean that days for which Medicare is not paid should be included in the numerator of the Medicaid proxy for dually eligible patients. Furthermore, under Medicare, waitlisted days, or administrative days, are considered acute care days and payment for these days are included in the hospital inpatient prospective payment amount under Medicare.

Regarding the no-pay days, CMM stated that the issue was one of documentation. CMM stated that the no-pay Quest days should be included in the Provider's DSH calculation so long as the patient was eligible for Title XIX, effective for cost reporting periods not settled as of the date of Ruling 97-2, February 27, 1997. However, with regard to no-pay Quest days associated with § 1115 waivers, (i.e., GA days and SHIP days), these days are not eligible for Title XIX under the State plan, as noted above, and, thus, should not be included in the Provider's DSH calculation.

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 issues 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.[1] 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.[2] 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.]. [3] Participating States may elect to provide for payment of medical

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[1] Section 1901 of the Act (Pub. Law 89-97.)

[2] Section 1902(a)(10) (A) of the Act.

[3] Relevant to this case, eligibility for SSI generally confers automatic eligibility for Medicaid. However, Congress allows States to retain more restrictive pre-1972

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.[4]

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.[5] 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.[6] In particular, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for medical assistance under the State plan.

However, Congress recognized that the requirements of Title XIX under which a State may participate in the Medicaid program created certain obstacles to experimental State health-care initiatives. Congress amended Title XI of the Act to provide flexibility for States to pursue such experimental programs.[7] Under §1115 of the Act, a State that wants to conduct such an experimental program must submit an application to the Secretary for approval. The Secretary may approve the application, if, it is determined that the demonstration project is likely to assist in promoting the objectives of certain programs established under the Social Security Act, including Medicaid.[8] To facilitate the operation of an approved demonstration project, the Secretary may waive compliance with specified requirements of Title XIX, to the extent necessary and for the period

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eligibility standards for determining whether new SSI recipients qualified for Medicaid under the State plan.

[4] Section 1902(a)(10)(C)(i) of the Act.

[5] Id. § 1902 et seq. of the Act.
[6] Id.
[7] Section 1115 of the Act.
[8] Id.

necessary to enable the State to carry out the demonstration project.[9] In addition, the Secretary may direct that costs of the demonstration project that otherwise would not qualify as Medicaid expenditures, "be regarded as expenditures under the State Title XIX plan (i.e., receive Federal Financial Participation (FFP)). Thus, individuals who are not eligible for medical assistance under the State plan approved under Title XIX of the Act might be eligible for medical assistance under a §1115 demonstration project.

In addition to the medical assistance provided under Title XIX and Title XI, the Social Security Amendments of 1965[10] established Title XVIII of the Social Security Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[11] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[12] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[13] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[14] This provision added Section 1886(d) to the Act and established the prospective payment system (PPS) 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 PPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[15]

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under PPS, hospitals and other health care providers are reimbursed their inpatient operating costs on the basis of

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[9] Id.

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

[11] Section 1811-1821 of the Act.

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

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

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

[15] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

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 PPS hospitals that treat a disproportionate share of low-income 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 an additional payment amount for each subsection (d) [PPS] hospital" serving "a significantly disproportionate number of low-income patients ...."[16]

There are two methods to determine eligibility for a DSH adjustment: the "proxy method" and the "Pickle method."[17] To be eligible for the DSH payment under the proxy method, a PPS 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 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", respectively, and are defined as follows:

> (I) the fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act and the denominator of which is the number of such hospital's patients 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.
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> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patients 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

[16] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See also 51 Fed. Reg. 16772, 16773-16776 (1986).

[17] The Pickle method is set forth at Section 1886(d)(5)(F)(i)(II).

> were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital patients days for such period. (Emphasis added.)

CMS implemented the provisions of the Act at 42 CFR 412.106. The regulation explains the proxy method at 42 CFR 412.106. Relevant to these cases, the first computation, the "Medicare proxy" or "Clause I" set forth at 42 CFR 412.106(b)(2)(1994) states:

> (2) *First computation*: *Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS
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> (i) Determines the number of covered patient days that—
> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;
> (ii) Adds the results for the whole period; and
> (ii) Divides the number determined under paragraph (b)(2)(ii) of is this section by the total number of patient days that –
> (A) Are associated with discharges that occur during that period; and
> (B) Are furnished to patients entitled to Medicare Part A. (Emphasis added.)

In addition, the second computation, the "Medicaid-low income proxy", or "Clause II", is set forth at 42 CFR 412.106(b)(4)(1994) and provides that:

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

Although not at issue in this case, CMS revised 42 CFR 412.106(b)(4) to conform to HCFA Ruling No. 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:

> [I]n calculating the number of Medicaid days, fiscal intermediaries should ask themselves, "Was this person a Medicaid (Title XIX) beneficiary on that day of service?" If the answer is "yes," the day counts in the Medicare disproportionate share adjustment calculation. This does not mean that Title XIX had to be responsible for payment for any particular services. It means that the person had to have been determined by a State agency to be eligible for Federally-funded medical assistance for any one of the services covered under the State Medicaid Title XIX plan (even if no Medicaid payment is made for inpatient hospital services or any other covered service)…..
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> 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….

In particular, concerning individuals eligible for payment under a demonstration project, CMS explained that:

> [S]ome 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.

However, while CMS assumed that State records would distinguish between individuals eligible under the State plan and those individuals who were eligible under a demonstration project or waiver, problems arose. In 1999, CMS observed certain practices and policies regarding Medicare DSH payment reflecting confusion regarding the counting of those State-only and waiver days for purposes of the DSH calculation. CMS determined that certain hospitals and intermediaries relied on Medicaid days data obtained from State Medicaid agencies to compute Medicare DSH payments and that some of those agencies commingled the types

of otherwise ineligible days listed above with Medicaid Title XIX days in the data transmitted to hospitals and/or intermediaries.

In order to again state 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. This program memorandum again explained that State-only and waiver days were not to be counted in the Medicaid proxy. With respect to included days, 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. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. 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) and does <u>not</u> include all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is <u>not</u> eligible for medical assistance benefits under an approved Title XIX State plan.

Consistent with this definition of days to be included, the PM-A-99-62 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 approved under Title XIX, and therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.
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> …..
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> Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed….

In addition, for those providers that were genuinely confused or held a genuine belief that, for example, certain "State-only" days and/or "waiver days were to be included in the DSH calculation, CMS announced a hold harmless policy for cost

reporting periods beginning before January 1, 2000. Pertinent to this case, CMS instructed intermediaries, pursuant to the PM A-99-62, to apply the hold harmless policy under certain limited circumstances. 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 ….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. (Emphasis added.)

In this case, relevant to the foregoing provisions of the law, Hawaii operated a fee-for-service Medicaid system for which it received Federal Financial Participation (FFP). Prior to the August 1, 1994, Hawaii also provided health insurance benefits to certain non-Medicaid beneficiaries, including general assistance (GA), and State Health Insurance Program (SHIP) patients, through separate State-only funded programs.

In April of 1993, Hawaii submitted a demonstration waiver application under §1115 of the Social Security Act, for review and approval to CMS. The Project was known as the Hawaii Health managed care project (hereafter referred to as the Quest program). CMS approved Hawaii's Quest program, for a period of five years, with an effective date of August 1, 1994. The Quest program included all current Medicaid eligible in the AFDC-related Program, and expanded eligibility for, what had been, the State-only funded general assistance (GA) and State hospital insurance program (SHIP).[18] Consequently, effective August 1, 1994,

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[18] When Medicare usually refers to GA days, it is referring to "State-only" days. That is, days for patients eligible for medical assistance under a State-only program. In this case, the parties continue to refer to certain days as GA days and SHIP days, although no longer State-only funded after August 1, 1994. These

those patients previously eligible for medical assistance under the State–only GA and SHIP programs were eligible for medical assistance under the Hawaii Quest program, a section 1115 waiver project.

This case involved a dispute over the inclusion in the Medicaid fraction of the following types of patient days:

1. Quest program days. The Quest program was implemented effective August 1, 1994. The Quest days at issue are described as State assistance program days approved under a Section 1115 demonstration waiver. These State assistance program days were, prior to August 1, 1994, State–only general assistance (GA) days and SHIP days.
2. SNF/ICF waitlist days. These days are described as days in which dually eligible patients received skilled nursing facility services or intermediate care services while the Provider was waiting to transfer the patients to another facility.
3. No-pay-Medicaid-as-secondary-payor-days. These days are described as days for which patients were eligible for Medicaid but which were not paid by Medicaid. Certain of these days involve Quest no pay days.

The Provider contends that all Quest days (including all State assistance program days approved for Medicaid under a §1115 demonstration waiver, effective August 1994), no-pay days and waitlist days should be included in the Medicaid fraction for purposes of determining the Provider's DSH patient day percentage.

QUEST DAYS

These days at issue in this case, as presented before the Board, is limited to Quest waiver days, that is, those days for individuals eligible for medical assistance under the Quest waiver program implemented August 1, 1994 and not otherwise eligible for Medicaid. The Board found that all Quest days, including those Quest days that represent patients in expanded waiver programs (which were previously the State-only GA and SHIP programs) must be counted in the Medicaid fraction because all days represent patients eligible for Medicaid under a State Plan approved by the Federal government, effective date August 1, 1994. The Board also found that these days must be counted in the Medicaid fraction because the Provider met the hold-harmless provisions of the Program Memorandum A-99-62.

"GA" and "SHIP" Quest days, after August 1, 1994, could also more properly be referred to as waiver days as they were included in the expanded wavier program.

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" counting patient days attributable to patient who were eligible for medical assistance under a State plan approved under Title XIX of the Act, but who were not also entitled to Medicare Part A. (Emphasis added). In this case, certain of the Quest days (i.e., the former GA Days and SHIP days) are attributable to patients who were eligible for medical assistance under Title XI of the Act, not Title XIX.
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From the initial implementation of the Medicare DSH provision through the fiscal period at issue in this case, CMS has consistently taken the position that the numerator of the Medicaid fraction includes patient days of patients who were eligible for medical assistance under a Medicaid State plan approved under Title XIX of the Act. While § 1115 demonstration waiver days are treated, as expenditures for payment purposes under Title XIX, the medical assistance provided on that day is not approved under Title XIX. The Administrator finds that the §1115 demonstration waiver project days for patients formerly eligible for medical assistance under the GA and SHIP are not days for patients eligible for medical assistance under a State plan approved under Title XIX. Thus, the Administrator finds that under the existing policy in effect these days are properly excluded from the calculation of the Provider's DSH payment.

However, while these days are not to be included under the policy in effect for these cost reporting period, CMS did provide a hold harmless provision under certain circumstances pursuant to PM-A-99. The record in this case shows that the Provider, by letter dated October 6, 1999, added the issue of the exclusion of "waiver" days from the DSH calculation prior to the October 15, 1999 deadline. That is, the record indicates that the Provider believed that it was entitled to the inclusion of waiver days (that is, those days formerly referred to as GA days and SHIP days) prior to the issuance of the October 15, 1999 CMS memorandum. Consequently, the Provider meets the criteria for inclusion of the "waiver" days (i.e., those GA and SHIP days that were subsumed effective August 1, 1994 in the Quest waiver program) for purposes of its DSH payment for the subject cost year.[19] In accordance with the PM, the actual number of these types of days that

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[19] Regarding the pre-August 1, 1994 State-only GA and SHIP days, at the hearing, the Intermediary agreed that the DSH calculation should be modified to include "GA days" based on the hold harmless provision. Transcript of Oral Hearing (Tr.) at 20, 89. See also CMM comments regarding the Regional Office ruling on inclusion of "GA days." Intermediary worksheet I-12 ("days prior to 8/1/94 should not be subject to GA reduction per miller/DHS ruling.") The record is not clear as to the treatment of State-only SHIP days, prior to August 1, 1994, (Tr. 99-100,

the Intermediary uses in this revision must be properly supported by adequate documentation provided by the hospital.[20]

NO PAY DAYS

As the Provider meets the criteria of the hold harmless provision for the waiver days, the Administrator finds that the Medicaid proxy should include no pay days for the expanded waiver population under Quest to the extent they do not include dually eligible days.

WAITLIST DAYS

Waitlist days are "dual eligible Medicare Part A and Medicaid days." In this case, the Intermediary maintained at the hearing that "waitlist days" should be excluded from the Medicaid proxy of the DSH calculation.[21] In contrast, the Provider argued that the waitlist days should be included in the DSH numerator as the waitlist days were for patients not entitled to Medicare benefits for those services furnished during the time they were waitlisted, because Medicare does not provide benefits for such a level of care in a hospital. The Board agreed with the Provider, finding that: "the waitlist patients were not entitled to Medicare benefits for those services furnished during the time they were waitlisted. Since none of the waitlist days were actually paid by Medicare, these days are not included in the total number of Medicare days in the Medicare proxy and therefore they will not be duplicated if they are included in the total number of Medicaid days in the Medicaid proxy. If they are not included in the Medicaid proxy, they will be omitted altogether."

CMM commented that the Board's position appears to be based on the incorrect assumption that Medicare does not provide benefits for waitlist patients. However, CMM stated that, under Medicare, waitlist days, or administrative days, are considered acute care days and payment for these days are included in the hospital inpatient PPS amount. Moreover, CMM stated that, regardless of whether the day is paid under Medicare, the day is for a patient entitled to Medicare Part A.

157-159) by either the Provider or the Intermediary, but it was not raised at the hearing and the Provider's Exhibit-13 does not list any pre-August 1, 1994 SHIP State-only days at issue.

[20] This documentation has not yet been reviewed by the Intermediary in this case, as the Intermediary rejected the application of the hold harmless rule to these days for this period.

[21] Tr. 74-75, 146-147.

The Administrator finds that the statutory phrase in the Medicaid proxy requiring the exclusion of days for patients "who were not entitled to benefits under Medicare Part A of this title" forecloses the inclusion of these days at issue in the numerator of the Medicaid proxy. A review of the plain language of the statute reflects that the Medicare low-income proxy and the Medicaid low-income proxy are intended to capture distinct patient populations. The Medicare low-income proxy, because it uses SSI as the income indicator, includes Medicare/Medicaid dual eligible patients. Thus, because such patients are counted in the Medicare proxy, the Medicaid low-income proxy specifically excludes from its calculations patients entitled to Medicare Part A and limits its proxy to Medicaid-only eligible patients.

The relevant language of the Medicaid proxy indicates that it is the status of the patients, as opposed to the payment of the day, which determines whether a patient day is included in the numerator of the Medicaid proxy. The phrase “but who were not entitled to benefits under Part A” cannot be read to mean that days for which Medicare is not paid should be included in the numerator of the Medicaid proxy.

In addition, a review of the legislative history of the Medicare proxy and the Medicaid proxy supports the agency's interpretation. The Administrator finds instructive the legislative history related to the Medicare proxy in determining the scope of the Medicaid proxy.

The legislative history related to the Senate enactment reflects that, in introducing the bill,[22] and describing the Medicare proxy, Senator Dole stated that:

> First, hospitals larger than 100 beds serving a large portion of low-income individuals or those participating in Medicare, will be eligible to receive an adjustment on the basis of <u>the proportion of low-income elderly and the proportion of Medicaid patients they serve</u>. In order to qualify for a adjustment, a hospital must have a specified proportion of its days accounted for by <u>either</u> dually eligible Medicare and Medicaid patients [Medicare proxy] <u>or</u> nonage Medicaid patients [Medicaid proxy].[23][Emphasis added.]

As reflected in this statement, generally, the Medicare proxy was intended to capture the Medicare/Medicaid dual eligible, i.e. the aged low-income patient, as

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[22] (See S. 1606, 99th Cong., 1st Sess. (Aug 1, 1985).(text reproduced in 131 Cong. Rec. S10928, S10930 (daily ed. Aug.1, 1985).

[23]131 Cong. Rec. at S10930 (Statement of Senator Dole).

the low-income proxy. The Medicaid proxy was intended to capture the "non-aged" , i.e. non-Medicare, Medicaid patient as the low-income proxy. Thus, the Medicare proxy and Medicaid proxy, together, include Medicaid/Medicare "dual eligible" patients and Medicaid patients in the DSH patient percentage.[24]

The courts have similarly recognized that the two "proxies" serve different purposes:

> Within the Medicare proxy, the language "entitled to benefits under [Medicare]" does not serve to define Medicare patients that are low income. Instead the language only limits the Medicare proxy to Medicare patients. This language does not determine the low-income status of Medicare patients-- that status is determined by their entitlement to SSI.
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> Within the Medicaid proxy, in contrast, the language "eligible for medical assistance under [Medicaid]" defines the low-income status of Medicaid patients. The Medicaid proxy covers patients "not entitled to benefits under [Medicare]" (thereby preventing Medicaid-eligible patients from being counted twice). The Medicaid proxy thus uses eligibility for Medicaid as the indicator.
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> In short, the clauses [proxies] serve different purposes within each proxy.[25] [Emphasis added.]

Accordingly, based on the plain language of the statute and the intent of Congress, the Administrator finds that waitlist days are properly not included in the Medicaid days of the DSH Medicaid proxy.[26]

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[24] The prohibition of counting Medicare patients in the Medicaid proxy could be considered a prophylactic rule to prevent double counting of patients (and, thus, days) in both the Medicare and Medicaid proxy.

[25] Legacy Emanuel Hospital and Health Center v. Shalala, 97 F.3d 1261, 1265-1266 (9th Cir. 1996).

[26] CMS requested comments in the proposed inpatient hospital PPS FY 2004 rule on modifying the policy where Part A benefits have been exhausted. 68 Fed. Reg. 27208 (May 19, 2003). CMS noted that "we recognize that it is often difficult for fiscal intermediaries to differentiate the days for dual eligible patient whose Part A coverage has been exhausted…Some States identify all dual-eligible beneficiaries in their lists of Medicaid patient days…, while in other States, the fiscal intermediary must identify patient days attributable to dual eligible[s]…by

DISCHARGES VERSUS ADMISSIONS

In addition to the foregoing differences between the Provider and Intermediary in calculating the DSH patient percentage, the Administrator also notes that the respective parties positions differed because the Provider used admissions to calculate the subject patient days, while the Intermediary used discharges to calculate the DSH adjustment. The Administrator finds that the regulation at 42 CFR 412.106, with respect to the Medicare proxy, generally refers to patient days relating to "discharges" occurring during the applicable period. While the Medicaid computation does not similarly explicitly refer to "discharges", it is reasonable to conclude that both computations would calculate patient percentage using the same statistic methodology of discharges.[27]

This conclusion is further supported by Section 2805 of the Provider Reimbursement Manual (HIM-15) which explains that, prior to PPS, providers were required to use cost apportionment data (charges and days) for the actual services rendered during the cost reporting period. That is, days and charges for patients remaining in the provider at the end of the cost reporting period were accrued through the last day of the period. However, in hospitals subject to PPS, payment for Medicare inpatients is based on discharges. Therefore, hospitals under PPS use utilization statistics for services (i.e., days and charges) related to discharges occurring during the cost reporting period as the Medicare apportionment statistic. Accordingly, the Administrator concludes that the patient days are to be calculated using discharges, not admissions.

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matching Medicare Part A bills with lists of Medicaid patients provided by the State. The latter case is problematic … because no Medicare Part A bill may be submitted for these patients." Due to the volume and nature of the comments received on the proposed policy, CMS decided to address them in a separate document. 68 Fed. Reg. 45421 (August 1, 2003).

[27] That the Medicaid computation requires the calculation of patient days based on discharges (like the Medicare computation) is also evident from 42 CFR 412.106(a)(4)(ii) (2002) which incorporates the prospective change to the waiver day policy based on "discharges", not admissions, "occurring on or after January 20, 2000" in calculating the Medicaid fraction.

DECISION

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

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

Date: 9/12/03

/s/

Leslie V. Norwalk, Esq.
Acting Deputy Administrator
Centers for Medicare and Medicaid Services