CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Good Samaritan Regional Medical Center/Banner Health 94, 96, 97, 98, 99 DSH Calculation Groups/Samaritan 95 DSH Calculation Group	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: Various**
Provider	
vs.	
Blue Cross /Blue Shield Association Blue Cross & Blue Shield of Arizona	**Review of: PRRB Dec. No. 2007-D35 Dated: May 17, 2007**
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 Management (CMM) submitted comments, requesting reversal of the Board's decision. Comments were received from the Providers'[1] requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

[1] The Providers in this appeal involves four non-profit hospitals: Good Samaritan, Desert Samaritan, Thunderbird Samaritan and Maryvale Samaritan. Each of the Providers was operated by Samaritan Health System until a 1999 merger. Stipulations ¶ 2. Since 1999, each of the Providers has been operated by Banner Health System. Id.

ISSUE AND BOARD'S DECISION

The issue is whether Arizona's State-funded general assistance days (here after referred to as MN/MI population days)[2] qualify as Medicaid days for purposes of determining the Providers' Medicare disproportionate share hospital (DHS) adjustments for the fiscal years in dispute.

The Board held that the Intermediary improperly excluded Arizona State funded MN/MI population inpatient days associated with the Arizona Health Care Cost Containment System (AHCCCS) program from the numerator of the Medicaid fraction of the Medicare DSH calculation.[3] Relying on Portland Adventist Medical Center v. Thomas, 399 F.3d 1091 (9th Cir. 2005)(Portland), the Board held that all patients eligible for medical assistance under a State Plan approved under Title XIX must be included in the DSH adjustment without regard to how they became eligible. The Board held that this included patients who became eligible for Medicaid as a result of the §1115 waiver provisions. The Board also held that all patients eligible for medical assistance under a State plan approved under Title XIX must be included in the DSH adjustment without regard to whether the State received direct Federal Financial Participation (FFP) for this low-income population.

The Board noted that Title XIX of the Act authorized the use of Federal funds to help States offset the costs of providing medical assistance to eligible low-income individuals.[4] The Board also noted that to receive these funds, a State must have a "State plan" approved by the Secretary (i.e., CMS) and administered according to the Medicaid requirements.[5] However, the Secretary, may waive the Medicaid requirements through §1115 (demonstration project waiver) of the Act, to approve "experimental, pilot, or demonstration projects" that go beyond the Medicaid requirements in order to promote innovative

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[2] See Providers' Post Hearing Brief at 17 § 3.2.1. The Providers' refer to the State-only general assistance groups as: Medically Indigent (MI); Medically Needy (MN); Eligible Low Income Children (ELIC); and Eligible Assistance to Children (EAC). The Board's decision and the parties have referred to all these categories as MI/MN days.

[3] The Administrator finds that the record indicates that, technically, the Intermediary did not "exclude" these days, but rather that the State followed CMS policy and forwarded data that did not include these days. See Providers' Post Hearing Brief at 23-24 § 3.3 ("[t]he Intermediary has always determined the numerator of the Medicaid fraction based upon data the Intermediary receives from AHCCCS….")

[4] 42 U.S.C. § 1396 et. seq

[5] Id.

approaches to meeting the health care needs of low-income individuals.[6] The Board noted that the State of Arizona did not have a traditional Medicaid program. Instead, the State of Arizona operated its Medicaid program as a §1115 waiver project that was approved by the Secretary on July 13, 1982. Therefore, the Board concluded that the AHCCCS program was the "State plan" approved by the Secretary. This approval included all the AHCCCS programs and sub-programs, irrespective of how they were funded, because §1115 of the Act, requires that all costs of the demonstration project be regarded as expenditures under the State plan. Therefore, since Arizona's §1115 waiver project is a State plan approved by the Secretary, the Board concluded that the MN/MI population days should be included in the Providers' Medicare DSH calculation.

The Board was also persuaded by two additional factors that supported the inclusion of the MN/MI population in the DSH calculation. First, even though AHCCCS did not receive direct FFP for its MN/MI population, the State funded its capitation and DSH payments to providers with all of the funds it received from the Federal, State and local governments. The Board held that this indirect funding, or the lack of direct FFP, did not prohibit a population from being considered part of the "State plan approved under Title XIX." Secondly, the fact that AHCCCS could have included the MN/MI population as an optional groups under a traditional Medicaid State plan (even without a waiver) and received direct FFP persuaded the Board that the MN/MI population should be included in the Providers' Medicare DSH calculation.

SUMMARY OF COMMENTS

CMM submitted comments requesting that the Administrator overturn the Board's decision.

The Providers commented requesting that the Administrator affirm the Board's decision. The Providers argued that the MN/MI population days should be included in the Medicaid fraction because these patients were eligible for medical assistance under the AHCCCS plan that was approved by the Secretary. The Providers stated that these MN/MI patients received the same benefits under the AHCCCS program as any other AHCCCS recipient and that the State received FFP for AHCCCS DSH payments made for hospital services furnished to the MN/MI patients. For these reasons alone the Providers maintained that the MN/MI population days should be included in the numerator of the Medicaid fraction, irrespective of whether the State received FFP for these particular patients, because these patients were eligible for medical assistance under the State plan.

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[6] 42 U.S.C. § 1395.

The Providers also asserted that, even if these MN/MI patients did not receive medical assistance under Arizona's AHCCCS plan, these patients were "eligible" for medical assistance under a State plan that could be approved under Title XIX of the Act by virtue of their low-income status. In additions, the Providers asserted that they are entitled to relief under the hold harmless provisions of Program Memorandum (PM) A-99-62, dated December 1999, because the Intermediary included MN/MI population days in the DSH calculation of the Medicaid fraction for prior cost reporting periods 1986 through 1989.[7]

Finally, the Providers argued that the deadline imposed by PM A-99-62 to qualify for the hold harmless under the second prong should be equitably tolled or waived because the Providers did not learn of the imposed deadline of October 15, 1999 until after it had passed.

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.[8] 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.[9] 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

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[7] Supra note 2 at 27 § IV. The Providers also argue with respect to Good Samaritan for fiscal years 1990 through 1992 that this provider's interim Medicare DSH payments included MN/MI population days in the numerator of the Medicaid fraction. Thus, at a minimum, for each cost reporting period at issue (1991 & 1993 through 1999) the MN/MI population days should be included in the numerator of Good Samaritan's Medicaid fraction.

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

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

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.[10]

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.[11] If the State plan is approved by CMS, under §1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.

Within broad Federal rules, States enjoy a measure of flexibility to determine "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.[12] However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for "medical assistance" under the State plan.

In particular, §1901 of the Social Security Act sets forth that appropriations under that title are "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services…." Section 1902 sets forth the criteria for State Plan approval.[13] As part of a State Plan, § 1902(a) (13) (A) (iv) requires that a State Plan provide for a public process for determination of payment under the plan for, inter alia, hospital services which in the case of hospitals, take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs. Notably, § 1905(a) states that for purposes of this title "the term 'medical assistance' means the payment of part or all of the costs" of the certain specified "care and medical services" and the identification of the individuals for whom such payment maybe made.

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[10] Section 1902(a) (1) (C) (i) of the Act.

[11] Id. §1902 et. seq. of the Act.

[12] Id.

[13] 42 CFR 200.203 defining a State Plan as "a comprehensive written commitment by a Medicaid agency submitted under section 1902(a) of the Act to administer or supervise the administration of a Medicaid plan in accordance with Federal requirement."

Section 1923 of the Act implements the requirements that a State plan under Title XIX provide 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 §1923(b) (1) (A), which addresses a hospital's Medicaid inpatient utilization rate, or under paragraph (B), which addresses a hospital's low-income utilization rate. The latter criterion relies, inter alia, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.[14]

Congress recognized that the various conditions and requirements of Title XIX of the Act, under which a State may participate in the Medicaid program created certain obstacles to potentially innovative and productive State health-care initiatives. Consequently, Title XI of the Act was amended to allow States to pursue such innovative programs.[15] Under §1115 of subchapter XI of the Act, a State that wishes to conduct such an innovative program must submit an application to CMS for approval. CMS may approve the application, if, in their judgment the demonstration project is likely to assist in promoting the objectives of certain programs established under the Act, including Medicaid.[16] To facilitate the operation of an approved demonstration projects, CMS may waive compliance with specified requirements of Title XIX, to the extent necessary and for the period necessary to enable the State to carry out the demonstration project.[17] In addition, CMS may direct that costs of the demonstration project that otherwise would not "otherwise" qualify as section 1903 Medicaid expenditures, "be regarded as expenditures under the State plan approved under [Title XIX]."[18]

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[19] established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part

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[14] 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.

[15] Section 1115 of the Act.

[16] Id.

[17] Id.

[18] Id.

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

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,[20] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[21] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[22] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[23] This provision added §1886(d) of the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[24]

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimburse their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based on one of almost 500 diagnosis related groups (DRG) subject to certain payment adjustments.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to §1886(d) (5) (F) (i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…."[25] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[26] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage. Relevant to this case, with respect to the proxy method, §1886 (d)(5)(F)(vi) of the Act states that the terms

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[20] Section 1811-1821 of the Act.
[21] Section 1831-1848(j) of the Act.
[22] Under Medicare, Part A services are furnished by providers of services.
[23] Pub. Law No. 98.21.
[24] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).
[25] 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).
[26] The Pickle method is set forth at section 1886(d) (F) (i) (II) of the Act.

"disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" and the Medicaid low-income proxy", respectively, and are defined as follows:

> (I) the fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act and the denominator of which is the number of such hospital's patients day for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this title.
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> (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 C.F.R. § 412.106. The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 C.F.R. § 412.106(b) (2). Relevant to this case, the second computation, the "Medicaid-low income proxy", or "Clause II", is set forth at 42 C.F.R. § 412.106(b) (4) (1995) and provides that:

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

Although not at issue in this case, CMS revised 42 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 § 1886(d)(5)(vi)(II) of the Act. In conjunction with this revision, CMS issued a Memorandum dated June 12, 1997, which explained the counting of patient days under the Medicaid fraction, stating that:

> [I]n calculating the number of Medicaid days, fiscal intermediaries should ask themselves, "Was this person a Medicaid (Title XIX beneficiary on that day

> of service?' If the answer is "yes," the day counts in the Medicare disproportionate share adjustment calculation. This does not mean that title XIX had to be responsible for payment for any particular services. It means that the person had to have been determined by a State agency to be eligible for Federally-funded medical assistance for any one of the services covered under the State Medicaid Title XIX plan (even if no Medicaid payment is made for inpatient hospital services or any other covered service)….

In order to clarify the definition of eligible Medicaid days and to communicate a hold harmless position for cost reporting periods beginning before January 1, 2000, for certain providers, CMS issued Program Memorandum (PM) A-99-62, dated December 1999. The PM 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 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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> 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.
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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 document to substantiate the number of Medicaid days claimed. [27] (Emphasis added.)

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

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[27] An attachment to the PM describes the type of day, description of the day and whether the day is a Title XIX day for purposes of the Medicare DSH calculation. In particular, the attachment describes "general assistance patient days" as "days for patients covered under a State–only (or county only) general assistance program (whether or not any payment is viable for health care services under the program). These patients are not Medicaid–eligible under the State plan." The general assistance patient day is not considered an "eligible Title XIX day." "Other State-only health program patient days" are described as "days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State program." Likewise, State-only health program days are not eligible Title XIX days. Finally, charity care patient days are described as "days for patients not eligible for Medicaid or any other third-party payer and claimed as uncompensated care by a hospital. These patients are not Medicaid eligible under the State plan." Charity care patient days are not eligible Title XIX days.

> 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…. 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.

In the August 1, 2000 Federal Register, the Secretary reasserted his policy regarding general assistance days, State-only health program days and charity care days.

> General assistance days are days for patients covered under a State-only or county-only general assistance program, whether or not any payment is available for health care services under the program. Charity care days are those days that are utilized by patients who cannot afford to pay and whose care is not covered or paid by any health insurance program. While we recognize that these days may be included in the calculation of a State's Medicaid DSH payments, these patients are not Medicaid eligible under the State plan and are not considered Titled XIX beneficiaries.[28]

In addition, for the relevant fiscal periods in dispute, the Secretary's policy was to include in the Medicare DSH calculation only those days for populations under the Title XI § 1115 waiver who were or could have been made eligible under a State plan. The patient days of the "expanded" eligibility groups, however, were not to be included in the Medicare DSH calculation.[29] This policy did not affect the longstanding policy of not counting general

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[28] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

[29] 65 Fed. Reg. 3136 (Jan. 20, 2000). ("In some section 1115 waivers, a given population that otherwise could have been made eligible for Medicaid under section 1902(r)(2) or 1931(b) in a State Plan amendment was made eligible under the section 1115 waiver. This population was referred to as hypothetical eligible, and is a specific, finite population identifiable in the budget neutrality agreements found in the Special Terms and Conditions for the demonstrations. The patient days utilized by that population are to be recognized for purposes of calculating the Medicare DSH adjustment. In addition, the section 1115 waiver

assistance or State–only days in the Medicare DSH calculation. The policy of excluding §1115 waiver expansion populations from the DSH calculation was revisited by CMS and, effective with discharges occurring on, or after, January 20, 2000, certain §1115 waiver expansion were to be included in the Medicare DSH calculation in accordance with the specific instructions as specified in more detail in the January 20, 2000 Federal Register.[30]

In 2001, CMS issued a Program Memorandum (PM) Transmittal A-01-13[31] which again 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.
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> 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.

Finally, in a recently enacted legislation, Congress clarified the meaning of the phrase "eligible for medical assistance under a State plan approved under title XIX" with respect to patients not Medicaid eligible, but who are regarded as such, because they receive benefits

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may provide for medical assistance to expanded eligibility populations that could not otherwise be made eligible for Medicaid. Under current policy, hospitals were to include in the Medicare DSH calculation only those days for populations under the §1115 waiver who were or could have been made eligible under a state plan. Patient days of the expected eligibility groups however, were not to be included in the Medicare DSH calculation.")

[30] Id.

[31] 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)

under a demonstration project approved under title XI. Congress added language to §1886(d) (5) (F) (vi) (II) of the Act which stating:

> In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.[32]

This amendment to §1886(d) (5) (F) (vi) of the Act specifically addressed the scope of the Secretary's authority to include (or exclude), in determining the numerator of the Medicaid fraction of the Medicare DSH calculation, patient days of patients not eligible for medical assistance under a State plan but who receive benefits under a demonstration project approved under Title XI of the Act. This enactment makes clearly distinguishes those patients eligible to receive benefits under Medicaid from those patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.

In sum, for the cost years at issue, the Secretary has consistently required the exclusion of days relating to general assistance or State-only days. The policy distinguishes those days as for individuals that receive medical assistance under a Title XIX State plan that are to be counted and "other" days that are not to be counted. Examples of some of these other days include days for individuals that are not in fact eligible for medical assistance but may receive State assistance; days that maybe a basis for Medicaid DSH payment under the State plan only; or days related to individuals that may receive benefits under a Title XI plan. These other days are not counted for purposes of the Medicare DSH payment.

This particular case centers on whether Arizona's general assistance State-only funded days at issue qualify as Medicaid days for purposes of determining the Providers' Medicare DSH adjustments for the fiscal years in dispute. Prior to 1982, the State of Arizona did not have a Medicaid program under Title XIX.[33] In May of 1982, the State of Arizona submitted a §1115 demonstration project waiver proposal to CMS.[34] CMS approved the §1115

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[32] Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, § 5002, 120 Stat. 4, 31 (February 8, 2006) (codified in part at 42 U.S.C. § 1395ww (d) (5) (F) (vi) (II).
[33] Stipulation ¶ 4, Providers' Exhibit P-2.
[34] Providers' Exhibit P-3.

demonstration project waiver on July 13, 1982, and the §1115 demonstration project waiver was implemented on October 1, 1982.[35] The system under which Arizona operates is called the Arizona Health Care Cost Containment System (AHCCCS). The AHCCCS program is a Statewide managed care system which delivers acute care services based on a prepaid, capitated approach.[36] Under Arizona' §1115 demonstration project waiver as approved by CMS, only the categorically needy receive direct Federal Financial Participation (FFP).[37] These patients are called the Mandatory Eligible under Title XIX (Categorically Needy). The State has also decided to provide services to three other groups, for which no FFP is paid, each with different State eligibility requirements. The Providers refer to the groups as:

1. Medically Needy/Medically Indigent (MN/MI);
2. Eligible Low Income Children (ELIC); and
3. Eligible Assistance to Children (EAC).[38]

For the fiscal periods in dispute, the Intermediary computation only included those AHCCCS days in which the patient was eligible to receive Federal Title XIX funds (Mandatory Eligible under Title XIX-Categorically Needy) in determining the Medicaid days to be included in the Medicaid fraction. The Providers dispute this treatment. The Providers' contend that all days covered under the AHCCCS program including the MN/MI population days should be included in the DSH computation.

The Administrator finds that §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 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. The Administrator finds that, as reflected at 42 C.F.R. § 412.106, the Secretary has interpreted this statutory phrase "patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX," to mean "eligible for Medicaid."[39]

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[35] Id.

[36] Providers' Exhibit P-2.

[37] Stipulation ¶ 7, Tr. 270-71, 283-84; Declaration of Branch McNeal ¶ 5, Providers' Exhibit 13 & 28, Providers' Post Hearing Brief at 19.

[38] Id. These three categories, MN/MI, ELIC, and EAC populations are persons who do not qualify as categorically eligible for Medicaid. These categories are funded entirely with State and county funds.

[39] See e.g. Cabell Huntington Hosp. Inc., v. Shalala, 101 F.3d 984, 989 (4th Cir. 1996) ("It is apparent that 'eligible for medical assistance under a State plan' refers to patients who meet the income, resource, and status qualifications specified by a particular state's Medicaid

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 §1886(d) (5) (F) (vi) (II) of the Act requires that the day be related to an individual eligible for "medical assistance under a State plan approved under Title XIX" also known as the Federal Program Medicaid. The use of the term "medical assistance" at §§ 1901 and 1905 of the Act and the use of the term "medical assistance" at §1886(d) (5) (F) (vi) (II) of the Act is reasonably concluded to have the same meaning. As noted by the courts, "the interrelationship and close proximity of these provisions of the statute presents a classic case for the application of the normal rule of statutory construction that "identical words used in different parts of the same act are intended to have the same meaning."[40] Therefore, the Administrator finds the language at §1886(d) (5) (F) (vi) (II) of the Act requires that for a day to be counted, the individual must be eligible for "medical assistance" under Title XIX. That is, the individual must be eligible for the Federal government program also referred to as Medicaid.

In contrast, 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. Rather, the days in question are associated with the general assistance days. Arizona's AHCCCS oversees the Medicaid mandatory eligibles under the § 1115 demonstration project waiver approved under Title XI (not under a State Plan as defined under § 1902 of the Act and 42 C.F.R. § 400.203 under Title XIX) for which the State receives matching FFP and the general assistance eligibles for which the State receives no matching FFP. These latter days are not related to patients eligible for Medicaid and hence cannot be counted in the numerator of the Medicare DSH fraction.

The Board also found that, if the State had operated a traditional Medicaid program, the AHCCCS State funded MN/MI population days would be included in the traditional plan. The record does not show an analysis of the criteria for the State funded MN/MI population under the Medicaid optional eligibility criteria. Rather, the Providers' allege that certain

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plan.…"); Legacy Emanuel Hospital v. Secretary, 97 F.3d 1261, 1265 (9th Cir. 1996)("[T]he Medicaid proxy includes all patient days for which a person was eligible for Medicaid benefits whether or not Medicaid actually paid for those days of service.")

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

parts of the MN/MI population would be eligible for Medicaid if they were to apply.[41] Moreover, by virtue of their low-income statue, the MN/MI population was capable of receiving Medicaid under a State Plan that could be approved under Title XIX of the Act. However, the Administrator finds that there is no demonstration in the record that the criteria for these general assistance populations are identical to the Medicaid optional eligibility criteria. Therefore, the Board finding that the MN/MI population at issue would have been included under the Medicaid optional category of patients in a traditional State plan is not supported by the record.

Further, regarding the expenditure of FFP under a Medicaid DSH program, generally, the issue of whether costs are regarded as expenditures under a State Plan approved under Title XIX for purposes of calculating Federal matching payments to the State is different from the issue of whether patients are considered eligible for medical assistance under a State plan approved under Title XIX for purposes of calculating Medicare DSH payments to a hospital. The statute clearly states that the patients' Title XIX eligibility for that day is a requirement. Therefore, regardless of any possible Medicaid DSH payment and indirect FFP provided under Title XI, the general assistance population days operated and funded by the State of Arizona (not Title XIX) are not counted as Medicaid days.

The Board also found that its decision is supported by the Ninth Circuit's decision in Portland. The Administrator finds that the general assistance days at issue in this case are distinguished for several reasons from the days at issue in Portland. Among other things, no direct FFP was expended for individuals in this case under §1115(a) (2) (or Title XIX) and, similarly, the MN/MI population at issue is not referenced as an expanded eligibility group under the waiver. While Arizona may have operated under a §1115 waiver, these general assistance days were not approved by the Secretary and included for payment under the waiver.[42] Further, even if one were to assume, *arguendo,* that these days were like the

[41] Providers' Post Hearing Brief at 35.

[42] Despite the fact that no direct FFP was even paid for these individual, the Board agreed with the Providers' argument that, under a Portland analysis, the §1115 waiver enabling statute does not deem "Federal costs" alone to be expenditures under a State plan. The Board agreed that the statute in no way limits which "costs" are deemed expenditures under a State Plan. Thus, the Board found that expenditures under the §1115 waiver (whether Federal, State or county) are equivalent to and deemed to be costs expended under the Title XIX. However, the Administrator finds that §1115(a)(2) states that "the costs of such projects *which would not otherwise be included as expenditures under section….1903* … shall to the extent and for the period prescribed by the Secretary be regarded as expenditures under the state plan approved under such title." This phrase specifically refers

Portland days, the Administrator finds that Congress has intervened since Portland was issued. Section 5002 of DRA 2005 ratified CMS' policy of not counting patient days of the expanded eligibility groups in the Medicare DSH calculation prior to January 20, 2000.[43] Hence, the court's analysis of the statute under Portland has been since revisited by Congress.

However, because the Board found that these days could be included under its reading of the statute, the Board did not make any factual findings as to whether any of the Providers could otherwise be allowed to include these days in the DSH calculation under the "hold harmless" provisions of PM A-99-62. In this case the Providers assert that they are entitled to relief under the hold harmless provisions of PM A-99-62 because the Intermediary included MN/MI population days in the DSH adjustment for each of the Providers from 1986 through 1989.[44] Therefore, the Providers maintain that for open cost reports, the Providers should continue to receive payments for MN/MI population days.

The basis for the Providers claim is a letter from Bonnie Irwin, Audit Manager at the Intermediary from Eugene Chinn at CMS, dated January 30, 1992.[45] This letter discusses the commingling of types of days not eligible as Title XIX days in the State's AHCCCS report. The Administrator notes however, that the problem of commingling involved cost reports ending prior to 12/31/90 and that from 1990 forward, the State of Arizona (i.e., AHCCCS) excluded MN/MI population days from the data reported to the Intermediary.[46] The Providers argue that the October 15, 1999 appeal deadline for qualification under the second prong of the hold harmless provision in PM A-99-62 should be equitably tolled or

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to section 1903 (FFP) expenditures, not State or local government expenditures as the Board and Providers contend. Therefore, even under a Portland analysis, the fact that a State with a section 1115 waiver, has decided to expend State funds for general assistance population, is not a basis for including the related days of such a population in the numerator of the Medicaid fraction of the Medicare DSH calculation.

[43] Cookeville Regional Medical Center v. Leavitt, 2006 Lexis 68961 (D.D.C. Sept. 26, 2006). "whether as a clarification or ratification, the DRA's expression of the DSH formula must be retroactively applied to still-pending cases."

[44] See, Stipulations 10.

[45] Provider's Exhibit P-11.

[46] Providers Post Hearing Brief at 41. The Providers argued that this problem continued for Good Samaritan through the interim payments for FYs 1990, 1991, and 1992.

waived because the Providers were not aware that these days were excluded and that they only became aware that these days were excluded after the issuance of PM A-99-62.[47]

Based on the record the Administrator finds that the Providers had no expectation of being paid for the MN/MI population days at issue. The Administrator finds that the intent of continuing the payments for the incorrect inclusion of general assistance days was to prevent hardship on hospitals that were relying on the payment based on prior treatment and receipt of these funds. This finding is supported by question 16 to "Questions and Answers Related to Program Memorandum A-99-62" that states:

> Q16. How are the open cost reports for fiscal years beginning prior to 1-1-00 to be handled in a situation where the intermediary disallowed the ineligible days during the audit of the latest settled cost report (e.g., FYE 12-31-97) but allowed them in the preceding cost reports(s) (e.g., FYE 12-31-96 or FYE 12-31-96 and several prior fiscal years)?
>
> A. If before October 15, 1999 the hospital filed a jurisdictionally proper appeal on the issue of exclusion of these types of days for FYE 12-31-97 cost report the intermediary should reopen that cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days. Since the hospital established an expectation that these types of days should be included in the computation of the Medicare DSH payments, the intermediary should also continue to include these type of ineligible days in the computation of the Medicare DSH payment in the open cost reports for FYE 12-31-98 and FYE 12-31-99 as long as the hospital included these days in the "as submitted" cost reports for those years thus continuing this expectation. <u>If the hospital abandoned its expectation of receiving payment in those open cost reports (FYE 12-31-98 and FYE 12-31-99) and did not even include this issue on the "protected amount" line, the intermediary should not continue paying the Medicare DSH adjustment reflecting the inclusion of these types of days for those years</u>. (Emphasis added).

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[47] <u>Id</u>. ("The Hospitals had no way of knowing before October 15, 1999 that a deadline for appealing this issue (or adding it to already pending appeals) was going to be established as of that date. There is no dispute that the Hospitals absolutely would have added this issue to their pending appeals, as they are entitled to do, prior toe October 15, 1999 deadline if they had been given fair notice of the significance of date before it already passed.")

In this case, the record shows that the Providers had abandoned their expectation of receiving payment before the Program Memorandum had been issued. Moreover, while for some cost years some of the Providers had appeals pending prior to October 15, 1999, the appeals did not raise the specific issue of the inclusion of State-only days. The record shows that the Providers did not add the issue regarding the inclusion of State-only funded days in the DSH calculation prior to the October 15, 1999 date set forth in the Program Memorandum and, therefore, they cannot find relief under its terms.

In sum, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly did not count the State funded general assistance days at issue in this case in the numerator of the Medicaid fraction of the Medicare DSH calculation.

DECISION

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

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

Date: 7/13/07

/s/
Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services