CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Washington State Medicare DSH Group II	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: Various**
Provider	
vs.	
Blue Cross /Blue Shield Association Noridian Administrative Services	**Review of: PRRB Dec. No. 2007-D5 Dated: November 22, 2006**
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 Intermediary and the Center for Medicare Management (CMM) 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 Providers' 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.

BACKGROUND

This is a group appeal brought by eighteen Providers located in the state of Washington. In total, there are 46 cost reporting periods from 1994 through 2000 under appeal.[1] The alleged amount in controversy is approximately $31,000,000.[2] During the fiscal periods in dispute,

[1] Intermediary's Exhibit I-15.

[2] Intermediary's Revised Final Position Paper at 1.

the Medical Assistance Administration (MAA), Washington State Department of Social and Health Services (DSHS) operated the State's Medicaid Program. MAA operates many programs, including the Medically Indigent (MI) and General Assistance – Unemployable (GAU) at issue in this appeal. The MAA considers these programs to be State-only programs.[3] The MI program is a State-funded program that provides temporary medical assistance to "persons with an emergency medical condition requiring hospital services, and who are not eligible for cash benefits or for any other medical program."[4] The GAU program is also a State-funded program that provides cash grants and medical assistance to persons meeting low income eligibility criteria who are physically and/or mentally incapacitated and unemployable for more than 90 days (but had not qualified for Social Security disability benefits).[5]

Effective December 1, 1991, the Medically Indigent Disproportionate Share Hospital (MIDSH) program was added to the Washington State's Medicaid State Plan approved under Title XIX pursuant to State Plan Amendment TN 91-30[6] for purposes of a disproportionate share hospital (DSH) payment to hospitals that provide services to low-income, MIDSH patients. Effective October 1, 1992, the General Assistance-Unemployable Disproportionate Share Hospital (GAUDSH) program was added to the Washington State Medicaid Plan approved under Title XIX pursuant to State Plan Amendment TN 92-25[7] for purposes of a DSH payment to hospital that provide services to low-income, GAU patients.

For the fiscal periods in dispute, the State of Washington used an electronic verification system to verify the number of Title XIX eligible patient days to be used in the Medicare DHS payment calculations. Patient days associated with the Washington State's MI and GAU programs were not counted in calculating the Providers' Medicare DSH payments.

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[3] Intermediary's Exhibit I-2. The Board in (PRRB-DEC, CCH, ¶81,194, *Empire 91-94 Medicaid Eligible Days Group (Spokane, Wash.) v. Mutual of Omaha Insurance Company*, PRRB Hearing Dec. No. 2004-D41 (Sept. 17, 2004) addressed the issue of where Washington State MI and GAU days should be included in the Medicare DSH calculation and determined that MI and GAU days were State-only days and not part of a plan approved under Title XIX.

[4] Intermediary's Exhibit I-2.

[5] Id. See also, Board Dec. No. 2007-D5 at 4, *Washington State Medicare DSH Group II*, November 22, 2006.

[6] Provider's Exhibit P-22. State Plan Amendment TN 91-31 was approved by CMS on November 30, 1992.

[7] Provider's Exhibit P-. State Plan Amendment TN 92-25 was approved by CMS on May 26, 1993.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustment excluding patient days related to two Washington State funded programs referred to as MI and GAU should be included in the Medicaid proxy in the Medicare DSH calculation.

The Board held that the Intermediary should have included MI and GAU patient days in the Medicaid fraction of the Medicare DSH calculation. The Board concluded that while the patients associated with the MI and GAU program did not qualify for Medicaid under section 1901 of the Act, the Board determined that the purpose of the Medicare DSH statute was to compensate hospitals for the additional costs associated with treating low-income patients. Furthermore, CMS' participation in the MIDSH and the GAUDSH "recognized that MI and GAU programs patients should qualify for medical assistance under a state approved plan as these programs are included in the state approved plan." Therefore, the Intermediary should have included MI and GAU patient days form the Providers' DSH calculation.

SUMMARY OF COMMENTS

The Intermediary submitted comments requesting that the Administrator reverse the Board's decision. The Intermediary argued that the Board's broad view of the Medicare DSH policy is overly simplistic and not as far reaching as the Board's decision implies. The Intermediary noted that section 1902(a) (10) of the Act delineates the groups of patients who are eligible for medical assistance under a State plan and "nothing in the Medicare DSH Medicaid proxy implies an intent to go reaching for any patient who for economic reasons may get some public financial support for inpatient care but not covered by the section 1902(a) (10) categories. Thus, when the enabling DSH statute and the implementing regulations found at 42 C.F.R. 412.106(b) (4) are read collectively, Medicaid eligibility is required to be included in the Medicaid proxy. Accordingly, since MI and GAU provide assistance to individuals who are not eligible for Medicaid they can not be included in the numerator for purposes of determining the Providers' DSH percentage.

CMM submitted comments requesting that the Administrator overturn the Board's decision. Specifically, CMM requested reversal of the Board's decision on grounds that the inpatient days associated with Washington's MI and GAU programs were not provided to Medicaid eligible patients. CMM argued that 42 C.F.R. 412.106(b) (4) only allows Medicaid eligible days to be included in the Medicaid fraction of the Medicare DSH calculation. Furthermore, Program Memorandum (PM) 01-13 makes clear that including non-Medicaid eligible patients in the Medicaid DSH calculation does not make a patient Medicaid eligible. Regarding Medicaid DSH days PM 01-13 states 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 Medicare formula."

Similarly, with regards to general assistance patient days, PM 01-13 states that: "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). These patients are not Medicaid-eligible under the State plan." Therefore, CMM argued that given the fact that the statute and the regulation make clear that only Medicaid eligible days are to be included in the Medicaid fraction of the Medicare DSH calculation, the Intermediary correctly did not include MI and GAU inpatients days from the Medicare DSH calculation that were not provided to Medicaid eligible patients.

The Providers commented requesting that the Administrator affirm the Board's decision. The Providers argued that a plain reading of the Act requires that MI and GAU days be included in the Provider's Medicare DSH calculation because the MIDSH and GAUDSH programs are part of the Washington State Medicaid Plan approved under Title XIX. The Providers contended that these amendments to the State Plan under Title XIX incorporated the MI and GAU programs, thus, taking them out of the "state only" category making MI and GAU clients eligible for medical assistance under Washington's Title XIX State Medicaid Plan.

Furthermore, the Providers argued that this case can be distinguished from *Ashtabula County Medical Center*.[8] In *Ashtabula*, the statutory definition of individuals who were eligible for benefits under the Ohio's Hospital Care Assurance Program (HCAP) expressly excluded recipients of medical assistance, whereas, the Washington State statutes expressly included the MI and GAU population within the definition of medical assistance. Therefore, the

[8] PRRB-DEC, Med-Guide, ¶81,422, Ashtabula County Medical Center (Ashtabula County, Ohio) v. Blue Cross/Blue Shield Association AdminiStar Federal, Inc., *CMS Administrator Decision* (Oct. 12, 2005)

Washington State framework lacked the limiting clause that was present in the Ohio HCAP statute, which was the basis for the Administrator's decision.

Finally, the Providers requested that the Administrator modify portions of the Board's decision with regard to the effective dates of the MIDSH and GAUDSH programs[9] and the method of payments to Hospitals who provided services to MI and GAU patients.[10]

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.[11] 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.[12] 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

[9] PRRB Dec. No., 2007-D5 at page 6 states that the MIDSH and GAUDSH program were included in the Washington Medicaid State Plan approved under Title XIX as of November 30, 1992 for the MIDSH program and May 26, 1993 for the GAUDSH program. The record shows that the effective date for the State Plan amendment adding the MIDSH program to the Washington State's Medicaid Plan approved under Title XIX is December 1, 1991and October 1, 1992 for the GAUDSH program.

[10] Stipulation 9 of the parties explains that the Providers were reimbursed on an individual claim-by-claim basis.

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

[12] 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.[13]

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.[14] 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.[15] 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.

Section 1901 of the Social Security Act sets forth that appropriations under that title are "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services...." Section 1902 sets forth the criteria for State plan approval. Section 1902(a)(10) explains the individuals for whom "medical assistance" must be provided under the state plan. As part of a State plan, Section 1902(a)(13)(A)(iv) requires that a State plan provide for a public process for determination of payment under the plan for, inter alia, hospital services which in the case of hospitals, take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs. Section 1905 defines the term "medical assistance" within the context of the payment of part or all of the costs of certain specified care and medical services and the identification of certain individuals for whom payment maybe made.

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

[14] Id. § 1902 et. seq. of the Act.

[15] Id.

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 Section 1923(b)(1)(A), which addresses a hospital's Medicaid inpatient utilization rate, or under paragraph (B), which addresses a hospital's low-income utilization rate.

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[16] established title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[17] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[18] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[19] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[20] This provision added § 1886(d) of 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.[21]

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 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.

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[16] Pub. Law No. 89-97.
[17] Section 1811-1821 of the Act.
[18] Section 1831-1848(j) of the Act.
[19] Under Medicare, Part A services are furnished by providers of services.
[20] Pub. Law No. 98.21.
[21] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

Concerned with possible payment inequities for PPS 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…."[22]

There are two methods to determine eligibility for a DSH adjustment: the "proxy method" and the "Pickle method."[23] 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, § 1886 (d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" and the Medicaid low-income proxy", respectively, and are defined as follows:

> (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 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 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 statutory provisions of at 42 CFR 412.106. The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 CFR 412.106(b)(2). Relevant to this case, the second computation, the "Medicaid-low income proxy" or "Clause II", is set forth at 42 CFR 412.106(b) (4) (1995) and provides that:

> *Second computation*. The fiscal intermediary determines, for the hospital's cost reporting period, the number of patient days furnished to patients entitled

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[22] 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).

[23] The Pickle method is set forth at § 1886(d) (F) (i) (II) of the Act.

> 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.[24] With respect to the days to be included 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

[24] The PM provided a hold harmless provision which was not raised as being applicable to the appeals at issue in this case.

> 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, 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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> …
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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. [25] (Emphasis added.)

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

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[25] 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.

> 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.[26]

Finally, in 2001, CMS issued a Program Memorandum Transmittal A-01-13[27] 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 Medicare formula.
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> ….
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> 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). These patients are not Medicaid-eligible under the State plan.

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

In this case, the Providers contend that a plain reading of the Act requires that MI and GAU days be included in the Providers' Medicare DSH calculation because the MIDSH and GAUDSH programs are part of the Washington State Medicaid Plan approved under Title XIX. To support this position that the MI and GAU programs are made a part of the

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[26] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

[27] 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)

Washington State Medicaid Plan approved under Title XIX, the Providers' make reference to a definition of MI and GAU on the plan.[28] The Providers contend that these amendments to the State Plan under Title XIX incorporated the MI and GAU programs, thus, taking those entitled individuals out of the "state only" category and making MI and GAU clients eligible for "medical assistance" under Washington's Title XIX State Medicaid Plan. The Board agreed and held that the Intermediary's adjustment improperly excluded MI and GAU patient days from the Medicaid fraction of the Medicare DSH calculation.

However, the Administrator does not agree with the above conclusion that the MIDSH and GAUDSH programs as referenced in the State plan provide Title XIX "medical assistance" to the MI or GAU enrollees as defined at section 1905 of the Act. The Administrator finds that the inclusion of the MIDSH and GAUDSH programs in the amended State Plan approved under Title XIX is in reference to providing additional funding to hospitals serving a disproportionate number of indigent patients under Section 1923 of the Act.[29]

Notably, Medicaid DSH payments to hospitals are not medical assistance payments on behalf of the individual patient under Title XIX and as defined by section 1905 of the Act. The Administrator finds that the individuals/enrollees under the MI and GAU programs do not fall within the legal meaning of "patients who (for such days) were eligible for medical assistance under a State Plan approved under Title XIX." In particular, the language set forth in section 1886(d)(5)(F)(vi)(II) requires that the day be related to an individual eligible for "medical assistance under Title XIX" also known as the Federal program Medicaid. The use of the term "medical assistance" at sections 1901, 1902(a)(10) and 1905 of the Social Security Act, for example, and the use of the term "medical assistance" at Section 1886(d)(5)(F)(vi)(II) of the Social Security Act are 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."[30] Therefore, the Administrator finds the language at section 1886(d)(5)(F)(vi)(II) that states that the numerator "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" requires that for a day to be

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[28] Exhibit I-9, page 2

[29] Intermediary's Exhibit I-8. The eligibility requirements discussed for the MIDSH and GAUDSH programs under the payment portion of the State plan concern the extent to which a hospital serves low-income patients and other considerations pertaining to hospitals as opposed to individuals.

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

counted, the individual must be eligible for medical assistance under Title XIX. That is, the individual must be eligible for the Federal government program also referred to as Medicaid.

Notably, the days involved in this case are related to individuals that are not eligible for medical assistance as that term is used under Title XIX, but rather are part of two programs used for purposes of the Medicaid DSH payment.[31] In particular, the record shows that the State of Washington considers these programs to be State-only programs.[32] The State reported:

> *Counting on MI/GAU hospital as Title XIX days:* DSHS' review included an analysis of the identification of Medically Indigent (MI) and General Assistance (GAU) clients. DSHS has been asked whether or not inpatient hospital days for these clients should be included in Title XIX eligible day counts. An * on a Remittance Advice identifies a MI'GAU client. While some federal matching funds were at one time provided to states for MI'GAU client hospital services, these funds came in the form of a grant for uncompensated care, but did not make a client Title XIX eligible. MI/GAU clients are not included in the count of Title XIX eligible days."[33]

Furthermore, in response to an Intermediary question regarding the treatment of GAU days, the Washington State DSHS stated

> Your question is whether the Department considers GAU inpatient hospital days as attributable to patients who are eligible for Medical Assistance under the Medicaid State Plan. The Department does not consider these days as attributable to patients who are eligible for Medical Assistance under the State Plan. We have not counted these days as Medicaid days for several years in our calculations. Patients who are eligible for the GAU program are eligible for a state medical assistance program, but they are not eligible for Medicaid [Title XIX] (TXIX). Payment for the GAU program are funded using DSH

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[31] The Medicaid DSH program and the Medicare DSH program are separate and distinct programs. In 1993, Congress placed restrictions on the Medicaid DSH payments in that a hospital's Medicaid DSH payment may not exceed the hospital's Medicaid shortfall (the amount by which the costs of treating Medicaid patients exceeds hospital's Medicaid payments) plus the costs of treating the uninsured. (Pub. Law No. 103-66)

[32] Intermediary's Exhibit I-3 is from the Washington State website in which the State describes its programs. In its description, the State divides its programs into two categories; Medicaid/Title XIX and State Funded Programs.

[33] Intermediary's Exhibit I-6.

> funds as a financing mechanism, but the program is a state entitlement authorized in state law.[34]

In conclusion, the Administrator finds that the MI and GAU days at issue in this case are State-only days and do not involved days for individuals that are eligible for medical assistance under a State plan approved under Title XIX.[35] Applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary was proper not to include the MI and GAU days in the numerator of the Medicaid fraction since MI and GAU days are related to individuals who are not eligible for medical assistance under a State plan approved under Title XIX.[36]

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[34] *See* e-mail from to Susan Lucas, Director of the Health and Recover Service Administration at Washington State DSHS to Intermediary. Intermediary Exhibit I-4.

[35] In *Empire 91-94 Medicaid Eligible Days Group (Spokane, Wash.) v. Mutual of Omaha Insurance Company*, PRRB Dec. NO. 2004-D41, September 17, 2004, Medicare and Medicaid Guide (CCH) ¶81,194, decl'd. rev. CMS Admin. November 16, 2004, the Board addressed the issue of the Washington State's MI and GAU days and whether they should be included in Medicare DSH calculation. The Board held that the MI and GAU days were State-only days, not approved under title XIX.

[36] The Administrator also finds problematic the documentation provided to support Board jurisdiction where approximately 19 cost years were appealed within 180 days of the revised Notice of Program Reimbursement (NPR). Intermediary Exhibit I-2. As set forth in 42 CFR 405.1889, a revised NPR is separate and distinct determination to which the appeal rights of 405.1835 attach. To the extent the issue of these days was not the subject of the revised NPR, there would be not right to appeal that issue using that vehicle. The record does not demonstrate that jurisdiction is proper over those appeals made pursuant to the revised NPR. The revised NPRs do have adjustment reports attached that show a specific adjustment with respect to the days at issue in this case and, where alleged, the provider(s) do not include the request for reopening showing that these days were clearly the subject of the reopening and revised NPR. See e.g. Schedule A, Schedule of Providers, Jurisdictional Documentation for the following: University of Washington, FYE 7/30/94; University of Washington, FYE 6/30/95, etc. The Administrator finds that there is no Board jurisdiction over these cost reports for this issue.

DECISION

The Administrator reverse the decision of the Board in accordance with the foregoing opinion.

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

Date: 1/19/07

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