CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Alhambra Hospital **Provider** **vs.** **Blue Cross/ Blue Shield Association** **United Government Services, LLC-CA** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 06/30/99 and 06/30/2000** **Review of:** **PRRB Dec. No. 2005-D47** **Dated: July 29, 2005**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review on own motion, 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)). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Provider, 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

The Provider is a 144-bed acute hospital located in Alhambra, California. For the fiscal periods in dispute the Provider operated a 22-bed "sub-acute" unit that was located within an area of the hospital that was subject to the inpatient prospective payment system (IPPS) but was not part of a distinct Medicare certified skilled nursing facility (SNF).[1] On September 17, 2001, the Provider was issued an initial

[1] Provider's Position Paper at 3. Sub-acute units are classified under California's Medi-Cal program as units that provide less intensive care than acute care units, but more intensive nursing care than is typically provided in a skilled nursing facility. In

Notice of Program Reimbursement (NPR) for fiscal year ending (FYE) 6/30/99.[2] The Intermediary made an adjustment to the Provider's cost report to eliminate sub-acute unit Medicaid patient days from the calculation of the Provider's disproportionate share hospital (DSH) payment. By letter dated January 14, 2002, the Provider timely appealed.[3] Prior to the scheduled hearing date before the Board, the Intermediary reopened the Provider's FYE 6/30/99 cost report to comply with the court's holding on the sub-acute day issue in *Alhambra Hosp. v. Thompson*, 259 F.3d 1071 (9th Cir. 2001).[4]

In revising the DSH adjustment to recognize the sub-acute days, the Intermediary did not include sub-acute days associated with "dually eligible patients" i.e., patients qualified to receive Part A Medicare benefits and Medicaid benefits in the numerator or the denominator of the Medicaid percentage of the DSH calculation. A revised NPR was issued on November 24, 2003 to correct the number of sub-acute days used in the Provider's DSH adjustment.[5] The Provider appealed the Intermediary's adjustments to the Board.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustment excluding dual-eligible patient days associated with the Provider's sub-acute unit from the Provider's DSH percentage was proper.

The Board held that the Intermediary's adjustment improperly eliminated from the Provider's DSH calculation those sub-acute patient day for patients, who otherwise were entitled to both Medicare and Medicaid benefits but who had exhausted their Medicare Part A SNF benefits. The Board determined that these "dual-eligible" patient days associated with the Provider's sub-acute unit, should have been included in the calculation of the Medicaid proxy for DSH purposes. The Board relied on the *Alhambra* decision along with recent Medicare policy statements and recent revisions

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addition, to the sub-acute unit, the Provider also operated a separate and distinct Medicare certified SNF within the hospital, which was excluded from PPS.

[2] Provider's Position Paper at 7. An initial NPR for FYE 6/30/00 was issued on April 8, 2002.

[3] *Id.* at 8. For FYE 6/30/00 the Provider timely appealed by letter dated September 26, 2002.

[4] In *Alhambra*, the Court held that, because the Provider's sub-acute beds were not located in an area of the hospital that was exempt from payment under IPPS, the patient days attributable to those beds should have been included in the Medicaid proxy of the Provider's DSH calculation.

[5] A revised NPR was issued for FYE 6/30/00 on November 24, 2003.

to the Medicare DSH regulations to determine that the original intent of Congress was to include Part A exhausted days somewhere in the DSH calculation, whether it be in the Medicare fraction (SSI percentage) or the Medicaid proxy.

SUMMARY OF COMMENTS

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider argued that the Intermediary erred by eliminating from the Medicaid proxy, patients days associated with dually eligible sub-acute unit patients who had exhausted their Medicare Part A SNF benefits. The Provider contended that once a "dually eligible" patient's Part A benefits are exhausted, the patient is no longer "entitled" to Medicare Part A benefits. Therefore, the remaining days of the patient's stay should be included in the Medicaid proxy of the DSH adjustment.

Furthermore, the Provider argued that the proper treatment of sub-acute days was articulated by the United States Court of Appeals for the Ninth Circuit in its decision in *Alhambra*. In that case, the court held that, because the Provider's sub-acute unit was not located in the area of the Hospital that was exempt from payment under PPS, the patient days attributable to that unit should have been included in the Medicaid proxy of 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.

Title VI of the Social Security Amendments of 1983[6], adding §1886(d) to the Act, 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. 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 reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding costs effective hospital practices.[7]

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[6] Pub. L. No. 98-21.

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

Pursuant to §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) hospital" serving "a significantly disproportionate number of low-income patients…."[8] To be eligible for the additional DSH payment for each prospective payment, a hospital must meet certain criteria concerning, *inter alia*, its disproportionate patient percentage. The Act states that the term "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage. The fractions are often referred to as the "Medicare low-income proxy" ("Clause I") and the "Medicaid low-income proxy" ("Clause II") and, respectively, are defined as follows at §1886(d) (5) (F) (i) (II) as:

> (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 patient days for such period which consist of patients who (for such days) *were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title*, and the denominator of which is the total number of the hospital's patient days for such period. (Emphasis added).

Consistent with the Act, the regulations further explains the DSH calculation at 42 C.R.R. §412.106:

> (a) *General considerations*. (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location.
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> (i) The number of beds in a hospital is determined in accordance with §412.105(b).

[8] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-2725). *See also* 51 Fed. Reg. 16772, 16773-19776-(1986).

> (ii) The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others….

CMS implemented the provisions of the Act involving 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)(2000), 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—
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> (A) Are associated with discharges occurring during each month; and
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> (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;
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> (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.

In addition, the second computation, the "Medicaid-low income proxy", or "Clause II", is set forth at 42 CFR 412.106(b)(4)(2000) and provides that:

> *Second computation*. The fiscal intermediary determines, for the hospital's cost reporting period used for the first computation, the number of hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.

As noted above, the DSH adjustment payment under 42 C.F.R. §412.106 is determined based on the number of patient days attributable to areas of the hospital that are subject to IPPS. As the Secretary explained:

> [W]e believe that, based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment. Congress clearly intended that a disproportionate share hospital be defined in terms of *subsection (d) hospital*, which is the only type of hospital subject to the prospective payment system. Section 1886(d) (1) (B) of the Act defines a subsection (d) hospital as a "hospital located in one of the fifty States or the District of Columbia *** and does not include a psychiatric or rehabilitation unit of a hospital which is a distinct part of the hospital." In providing for the disproportionate share adjustment, section 1886(d) (5) (F) of the Act specifically refers to a subsection (d) hospital. Thus, section 1886(d) (5) (F) (i) of the Act refers only to "an additional payment amount for each subsection (d) hospital ***." Other references in section 1886(d) (5) (F) of the Act are to "hospital" and "such hospital" However, since 1886(d) (5) (F) of the Act incorporates the definition of "hospital" by reference to "subsection (d)," all further references in that subparagraph, unless stated otherwise, are taken to mean a subsection (d) hospital….
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> Moreover, this reading of section 1886(d) (5) (f) of the Act produces the most consistent application of the disproportionate share adjustment, since only data from prospective payment hospitals, or from hospital units subject to prospective payment system are used in determining both the qualifications for and the amount of additional payment to hospitals that are eligible for a disproportionate share adjustment.[9]

[9] 53 Fed. Reg. 38476, 38480 (Sept. 30, 1988); *see also* 53 Fed. Reg. 9337 (March 22, 1988)

Thus, the Secretary's longstanding policy is to count only patient days attributable to beds in units or wards providing inpatient acute care that would generally be payable under as an inpatient hospital bed day.[10]

However, this policy was challenged by the Provider in another case arising from the Intermediary's calculation of its DSH reimbursement for fiscal year ending FYE 9/30/93. In *Alhambra*,[11] the Court held that, because the Provider's sub-acute beds were not located in an area of the hospital that was exempt from payment under PPS, the patient days attributable to those beds should have been included in the Medicaid proxy of the Provider's DSH calculation. To comply with this court ruling on the sub-acute day issue, the Intermediary issued a revised NPR, on November 24, 2003 to correct the number of sub-acute days used in the Provider's DSH adjustment payment.

In this case, the Provider sought to include patient days in its sub-acute unit as part of its DSH calculation. The Provider contended that once a "dually eligible" patient's Part A benefit are exhausted, the patient is no longer "entitled" to Medicare Party A benefits. To support this position the Provider relied on *Jewish Hospital v. Secretary of Health & Human Services*, 19 F.3d 270, 275-276 (6th Cir. 1994), *Cabell Huntington Hosp., Inc. v. Shalala*, 101 F.3d 984, 990-91 (4th Cir. 1996) and *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1266 (9th Cir. 1996) which hold that all Medicaid eligible days should be incorporated into the DSH calculation. Therefore, with respect to both FYE 6/30/99 and 6/30/00, the Provider contends that all sub-acute patient days for patients that remained in the Provider's sub-acute unit after they have exhausted their Part A Medicare SNF benefits should have been included in the calculation of the Provider's DSH payment adjustment through the Medicaid proxy. The Board held that the Intermediary's adjustment improperly eliminated sub-acute patient days for patients, who otherwise were entitled to both Medicare and Medicaid benefits but who had exhausted their Medicare Part A SNF benefits from the Provider's DSH calculation. The Board determined that these "dual-eligible" patient days associated with the Provider's sub-acute unit, should have been included in the calculation of the Medicaid proxy for DSH purposes.

The Administrator finds that the statutory phrase in the Medicaid proxy "but who were not entitled to benefits under Medicare Part A of this title" can reasonably be interpreted to prevent the inclusion of the days at issue in the numerator of the Medicaid proxy. The Medicaid low-income proxy specifically excludes from its calculations patients entitled to Medicare Part A and limits its proxy to Medicaid-

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[10] This longstanding policy was clarified in the August 1, 2003, IPPS Final Rule (68 FR 45417).

[11] *Alhambra v. Thompson*, 259 F.3d 1071(9th Cir. 2001).

only eligible patients. The relevant language of the Medicaid proxy indicates that it is the status of the Medicare patient, as opposed to the coverage of the day under Medicare, 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" does not indicate that days for which Medicare is not paid should be included in the numerator of the Medicaid proxy.[12] Consequently, it is reasonable to conclude that the phrase "entitled to benefits under Part A", as used in this Clause II phrase, refers to the status of the patient, as a Medicare beneficiary, rather than whether the patient was entitled to coverage by Medicare for the day at issue.[13]

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.[14]

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[12] Courts have addressed the meaning of the inclusion of the parenthetical phrase "(for such days)" within the context of the phrase "patients who (for such days) were eligible for Medical assistance under a State plan approved under title XIX…." See, e.g., *Cabel Huntington v. Shalala*, 101 F.3d 984, 990 (4th Cir. 1996). Courts have not addressed the phrase regarding patients "who were not entitled to benefits under part A."

[13] Such a policy also serves as a prophylactic rule to prevent double counting of days in both fractions. CMS has noted that intermediaries frequently must rely on hospitals to identify days attributable to dual-eligible patients whose Medicare Part A hospitalization benefits have expired. In addition, such patients may still be entitled to other Part A benefits.

[14] *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1265-1266 (9th Cir. 1996)

Accordingly, the Administrator finds a reasonable interpretation of the statutory phrase in the Medicaid proxy "but who were not entitled to benefits under Medicare Part A of this title" requires the exclusion of the days at issue in this case from the numerator of the Medicaid proxy. Thus, the Intermediary's calculation of the Provider's DSH adjustment was proper.[15]

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: 9/30/05

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services

[15] The Administrator notes that this policy was addressed in the proposed rule for the Inpatient Prospective Payment System (IPPS) for FFY 2004 at 68 Fed. Reg. 27207 (May 19, 2003) and the final rule for IPPS for FFY 2005 at 69 Fed. Reg. 48916)(August 11, 2004). In addition, CMS issued a clarification at *http://www.cms.hhs.gov/providers/hipps/dual.asp* regarding statements set forth in the May 19, 2003 *Federal Register*. Effective with discharges occurring on or after October 1, 2004, CMS revised the regulation at 42 CFR 412.106(b)(2)(i) to allow the inclusion of the days associated with dual eligible beneficiaries whether or not the beneficiary has exhausted Medicare Part A coverage in the Medicare fraction of the DSH calculation. (69 Fed Reg. 49099.) That part of the regulation was revised to remove the word "covered" from the introductory text at (2)(i). ("Determines the number of [] patient days that—")(69 Fed Reg. 49246)