CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of :	**Claim for :**
Connecticut 94-98 DSH Group **Provider** **vs.** **Blue Cross Blue Shield Association/ National Government Services** **Intermediary**	**Providers Cost Reimbursement Determination for Cost Reporting Period Ending: Various** **Review of: PRRB Dec. No. 2009-D25 Dated: June 17, 2009**

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. Comments were timely received from the Providers requesting that the Administrator reverse the Board's decision with respect to the Medicare disproportionate share hospital (DSH) calculation, and reverse the determination that the Board did not have jurisdiction over Waterbury Hospital. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue involves whether the Intermediary properly excluded Connecticut's State-Administered General Assistance (SAGA)[1] program days from the Medicare DSH calculation for the fiscal year ending (FYEs).[2]

[1] Connecticut's SAGA program is the same program identified in the State's plan, Provider's Exhibit P-2, as the "State's General Assistance Program." The change in terminology arises from the transfer of administration of this program from cities and towns to the Department of Social Services in April 1997.

[2] This group appeal for FYEs 1995 through 1998 involves four acute care hospitals located in Connecticut. The Schedule of Providers, dated January 26, 2006, identified five acute care

The Board found that the question before it dealt with whether the State paid program, not otherwise eligible for Medicaid coverage, and which is included in the State plan solely for the purpose of calculating the Medicaid DSH payment, constitutes "medical assistance under a State Plan approved under [Title] XIX" for purpose of the Medicare DSH adjustment, specifically the Medicaid fraction component. The Board referenced the U.S. Court of Appeals for the District of Columbia, which issued its decision in Adena Regional Medical Center v. Leavitt, 527 F.3d 176 (D.C. Cir., 2008) (hereinafter Adena Regional). The Court concluded that the days related to beneficiaries eligible for the Ohio Hospital Care Assurance Program (HCAP) should not be included in the Medicaid proxy of the Medicare DSH calculation. Like the SAGA program, HCAP patients could not qualify for Medicaid, but the HCAP days were included in the Medicaid DSH calculation.

Upon further analysis of the Medicaid DSH statute at §1923 of the Act, the Board found language that suggested the term "medical assistance under a state plan approved under [Title] XIX" excludes days funded only by the State and charity care days even though those days may be counted for Medicaid DSH purposes. The Medicaid DSH components of the low-income utilization rate include "services rendered under a [Title] XIX State plan," the same category of patients described in the Medicaid utilization rate. However, the statute adds as components subsidies for patient services received directly from State and local governments, and charity care.[3]

The Board reasoned that if Congress had intended the term "eligible for medical assistance under a State plan" (the only category of patients in the Medicaid utilization rate) to include the State funded hospital days and charity care days, the subsections adding those categories of days in the low income utilization rate would have been superfluous. The Board found that, because the SAGA program is funded by "State and local governments" and thus is included in the low income utilization rate, not the Medicaid inpatient utilization rate, SAGA patient days do not fall within the Medicaid statute definition of "eligible for medical assistance under a State plan" at Section 1923(b)(2)(i) of the Act. The Board found that since the SAGA patient days could not be included in the Medicare DSH statutory definition of "eligible for medical assistance under a State plan" at Section 1886(d)(5)(F)(vi)(II) of the

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hospitals and 14 FYEs. The Providers include: Waterbury Hospital (2 FYEs), Middlesex Hospitals (5 FYEs), William W. Backus Hospital (2FYEs), St. Vincent Medical Center (4 FYEs), and Danbury Hospital (1 FYE). Middlesex Hospital for FYE 1994 was withdrawn from this group. St. Vincent Medical Center was also subsequently withdrawn from this appeal. The remaining Schedule of Providers were Waterbury Hospital (FYE 9/30/1999), Middlesex Hospitals (FYEs 9/30/1996, 9/30/1997, 9/30/1998), William W. Backus Hospital (FYEs 9/30/1997, 9/30/1998), and Danbury Hospital (FYE 9/30/1995).

[3] Social Security Act §§ 1923(b)(3)(A)(i) and (B)(i).

Act, the Intermediary's adjustments properly excluded Connecticut SAGA program patient days from the Providers' Medicare DSH calculation.

Jurisdictional Challenges: The Intermediary challenged the Board's jurisdiction over six of the ten Provider FYEs included in this group appeal. The Board found that it had jurisdiction over Middlesex Hospital (FYE 1996), William W. Backus Hospital (FYE 1997), and Danbury Hospital (FYE 1995), as the Providers adequately documented that they had proper individual appeals pending when the SAGA issues were transferred to this group appeal. The Intermediary challenged jurisdiction of Middlesex Hospital (FYE 1995), as the Provider's appeal request of a revised NPR, dated February 23, 1998 did not revise the DSH percentages. The Intermediary argued that, since the revised NPR did not adjust the DSH calculation, the Board would not have jurisdiction over the SAGA days excluded from the DSH calculation. The Board found that it did not have jurisdiction over Middlesex Hospital for FYE 1995, as the only determination appealed was the revised NPR, which did not incorporate an adjustment relating to DSH, or more specifically, SAGA days. Finally, the Intermediary argued that the revised NPR for Waterbury Hospital (FYE 1996) did not address the specific issue of SAGA days, and thus, the Board lacked jurisdiction. The Board found that, since the Provider did not request SAGA days as part of the reopening for the revised NPR, and the Intermediary did not adjust the cost report for SAGA days, the Board did not have jurisdiction over the SAGA days issue for Waterbury Hospital (FYE 1996).

SUMMARY OF COMMENTS

The Providers submitted comments requesting that the Administrator reverse the Board's decision with respect to the Medicare DSH calculation. The Providers also requested that the Administrator affirm the Board's determination that it had jurisdiction over Middlesex Hospital, FYE 9/30/1996, William W. Backus Hospital, FYE 9/30/1997, and Danbury Hospital, FYE 9/30/1995 and reverse the determination that the Board did not have jurisdiction over Waterbury Hospital, FYE 9/30/1996.

The Providers argued that the State of Connecticut developed its Title XIX State plan in an effort to meet the health care needs of the people of the State, and comply with its own budget requirements. The SAGA program was designed for medically indigent people who do not meet the categorical requirements (blind, aged, disabled, pregnant, or members of families with dependent children) for traditional Medicaid programs. Nonetheless, the Providers argued that the SAGA patients are very low-income, whose income is approximately seventy percent of the Federal poverty level.

The Providers made reference to several errors in the Board's decision. First, the Providers noted that the Board held that SAGA patients were not "directly" eligible for FFP because they do not qualify as "traditional Medicaid" services described in the Medicaid statute. The Providers argued that it was impossible for the SAGA program to be considered as

days funded only by the State, when there is in fact direct FFP paid to the State under Title XIX for the specific medical benefits provided by the Hospitals to the SAGA patients. The Providers further stated that the fact that the Federal matching payment for the SAGA patients is authorized under the Medicaid DSH portion of the State plan, does not make the SAGA patients any less eligible for FFP under the State plan. The Providers also argued that SAGA cannot be considered as funded solely by the State, when the State plan provides federal matching funds specifically for the medical benefits provided to SAGA patients.

The Providers went on to argue that the Board's rationale related to analysis of the Medicaid DSH statute at Section 1923 of the Act is flawed, as the Board concluded that there are two distinct categories of low-income patients that are used to calculate the Medicaid DSH payment: the Medicaid inpatient utilization rate and the low-income utilization rate. The Providers argued that these two methods do not create two distinct categories of low-income patients, but instead provide two alternative methods for hospitals to qualify for a Medicaid DSH payment. The Providers noted that, contrary to the Board's interpretation, the low-income method does not describe what is and what is not included in "medical assistance under a State plan," as the Board has confused the terms "services" and "revenues" with respect to the method. The Providers argued that, because the low-income utilization rate is made up of fractions based on revenues and charges (instead of patient days), it does not create distinct categories of low-income patients, but instead provides an alternative method for hospitals to qualify for Medicaid DSH.

The Providers stated that the Board incorrectly assumed that the SAGA program is funded only by "State and local governments" and thus must be included in the low-income utilization rate. The Provider argued that there is nothing in the record to support this conclusion, and the SAGA program may be considered in both. It is the Providers' position that the SAGA patient days should be counted for purposes of determining eligibility for Medicaid DSH as well as for the purpose of determining the amount of Medicare DSH. The Providers contended that the provisions of the Medicaid DSH statute do not divide patient days into mutually exclusive categories of patients "eligible for medical assistance under a State plan" versus State funded hospital days and charity care days. Rather, it provides an alternative methods for hospitals to qualify for Medicaid DSH, based upon the percentage of low-income patient days or percentage of revenue or charges related to low-income patients. Therefore, the Providers argued that the Board's rationale is not persuasive and should be rejected.

The Providers noted that the Board's decision in this case departed from its prior interpretation of this portion of the DSH Statute, based upon Adena Regional Medical Center v. Leavitt, 527 F.3d 176 (D.C. Cir. 2008). The Providers argued that in previous cases, the Board consistently held that hospital patient days included in a Title XIX State plan approved by the Secretary must be counted in the DSH adjustment, whether or not

they are considered traditional "Medicaid" patient days.[4] The Providers claimed that, in this regard, the Board was following the Ninth Circuit's decision in Portland Adventist Medical Center v. Thompson, 399 F.3d 1091 (9th Cir. 2005). The Providers noted that the Board has now abandoned established Ninth Circuit law and instead is siding with the District of Columbia (D.C.) Circuit Court's recent opinion in Adena. The Providers argued that it is undisputed that the purpose of the DSH adjustment is to provide additional reimbursement to hospitals that serve a significantly disproportionate number of low income patients. The Providers contended that the court in Portland Adventist confirmed this concept and expressly stated that "[t]he text of the statute, the intent of Congress, and the decisions of this and other courts make it plain that the entire low-income population actually serviced by the hospitals…must be accounted for in the DSH Medicaid fraction."

The Providers further argued that the Board's reliance on the Adena Regional case was misplaced. The Providers pointed out that the D.C. Circuit Court reversed the judgment of the District Court (and the decision of the PRRB in Adena) for two reasons, which are not present in the SAGA program and should be rejected as a matter of law. First, the D.C. Circuit Court found that the Ohio Hospital Care Assurance Program (HCAP) was not part of a "State plan approved under [Medicaid]" because the hospitals were required to provide the care for indigent patients without payment. The Connecticut State statutes define "medical assistance" to specifically include medical assistance provided under the SAGA or Medicaid program. Unlike the Ohio HCAP in the Adena case, the SAGA programs are defined by State law as programs for medical assistance under Title XIX and are part of the Connecticut State plan, where the eligibility of patients for the SAGA program is determined by the State based upon low-income criteria. Second, the D.C. Circuit Court found that HCAP patients were not "eligible for medical assistance" within the meaning of the term in the Medicare DSH provisions. Since "medical assistance" is not defined in the Medicare Statute, the court determined it must have the same meaning as provided in the Federal Medicaid Statute, Title XIX of the Act. The court found that the Federal Medicaid Statute defined "medical assistance" as "payment of part or all of the cost" of medical "care and services" for a defined set of individuals, whereas the HCAP did not entail any payment. The Providers contend that the SAGA program differs from the HCAP in this regard as the hospitals receive payments that were directly related to individual health care services provided to the defined set of SAGA patients who must qualify based upon low-income status.

The Provider further stated that the Board's decision and the D.C. Circuit's reading of the Medicare DSH statute should be rejected as a matter of law. First, the Providers argued that the Adena court's interpretation of the phrase "medical assistance under a State plan

[4] Jersey Shore Med. Ctr., PRRB Dec. No 2007-D29 (May 4, 2007); Ashtabula County Med. Ctr., PRRB Dec. No. 2005-D49 (Aug. 10, 2005); and Washington State Medicare DSH Group II, PRRB Dec. No. 2007-D5 (Nov. 22, 2006).

approved under Title XIX" as limited to only patient days attributable to individuals who are eligible for traditional Medicaid benefits is contrary to the plain language of the Medicare DSH statute. The Adena court's decision rests on the incorporation into the Title XVIII Medicare DSH statute, the specific definition of medical assistance eligibility found in Section 1905(a) of Title XIX. However, the Medicare DSH statute plainly refers to "medical assistance under a State plan approved under Title XIX." Second, nothing in the Title XIX Medicare DSH statute, or in the legislative history of that statute, has ever acknowledged the definition in Section 1905(a) of the Act or hints that it was to be incorporated by reference. The Providers concluded that if Congress intended that a specific term apply to all parts of the Act, it would have done so, and as a result the Adena court's position rests on an implied amendment of the Medicare DSH statute, incorporating the medical assistance definition, which is improper.

The Providers also noted that in an informal guidance to the States, SMDS #02-013, CMS construed the statutory definition of "medical assistance" in Section 1905 of the Act to mean that a State cannot include the cost of hospitals services furnished to prison inmates in the calculation of a Medicaid DSH payment because this would entail the provision of "medical assistance" to them (and Federal law prohibits the payment of Federal matching fund for medical assistance furnished to inmates). By the same token, the Providers argued that the Medicaid DSH payment made to the Hospitals through the SAGA program was medical assistance for those individuals who applied for, and received, that assistance.

Jurisdictional Comments:

The Providers requested that the Administrator reverse the Board's determination that it did not have jurisdiction over the SAGA days issue for Waterbury Hospital, for FYE 9/31/1996. Waterbury's participation in this group appeal arises from the appeal of a revised Notice of Program Reimbursement (revised NPR). The Providers argued that the Medicare regulation at 42 C.F.R. §405.1889 specifically establishes the basis for an appeal from a revised NPR. The Providers were persuaded that the regulation clearly contemplates and provides for an appeal to the PRRB to review disputes arising out of a revised NPR. The Providers noted that the scope of administrative review, when a provider appeals an initial NPR to the Board, has been determined to be quite broad under the statute. However, the scope of review for a revised NPR has been interpreted to be more narrowly limited to the issues addressed in the process of reopening. The Providers cited a number of cases where the courts have held that the Board has authority to review all matters the Intermediary has reconsidered upon re-opening the cost report, whether or not such item was specifically adjusted.

The Providers argued that Waterbury Hospital did not qualify for any Medicare DSH until its 1996 FYE was reopened and eligible days were included for the DSH calculation. The revised NPR provided for a DSH adjustment for the first time, and the Provider was

dissatisfied with the amount of that DSH adjustment. The DSH adjustment contains a number of subcomponents, but the Intermediary does not issue separate audit adjustments of several DSH adjustment subcomponents. Thus, the revised NPR providers for a total DSH adjustment and was the first opportunity to address any component of the DSH adjustment in this case. The Providers cited a number of cases, and argued that its position is consistent with the Board's decision in jurisdiction cases where the provider appeals from one component of an audit adjustment in a revised NPR.[5]

In conclusion, the Provider's argued that the Board has jurisdiction to hear the appeal from Waterbury Hospital's revised NPR based upon the Provider being dissatisfied with the amount of that DSH adjustment, which was provided for in the revised NPR for the first time, since the Provider did not qualify for a DSH adjustment until the revised NPR was issued.

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 that were timely received are included in the record and have been considered.

Relevant to the issue involved in this case are two Federal programs, Medicaid and Medicare, which cover 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, disabled, or members of families with dependent children.[6] 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.[7] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income or SSI. Participating States may elect to provide for payments of medical services to those aged, blind, or disabled individuals known as "medically needy" whose incomes or resources, while exceeding the financial eligibility requirements for the categorically needy (such as an SSI recipient), are insufficient to pay for necessary medical care.[8]

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[5] Community Hospital of Monterrey Peninsula, PRRB Decision No. 2006-D13, (January 19, 2006); St. Rita's Medical Center, PRRB Decision No. 2005-D41 (May 25, 2005); Rome Memorial Hospital, PRRB Decision No. 2005-D42 (April 6, 2005).

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

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

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

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.[9] 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.[10] 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.[11] 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 may be made.

Section 1923 of the Act implements the requirement 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 may be 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

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[9] Id. §1902 et seq. of the Act.

[10] Id.

[11] 42 C.F.R. §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."

relies, inter alia, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.[12]

While Title XIX implemented payments for medical care pursuant to a cooperative program with the States for certain low-income individuals, the Social Security Amendments of 1965[13] 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,[14] and Part B, which is a supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[15] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[16] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[17] 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.[18]

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. Thus, hospitals are paid based on a pre-determined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based on diagnosis related groups (DRG) subject to certain payment adjustments.

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[12] 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.

[13] Pub. L. No. 89-97.

[14] Section 1811-1821 of the Act.

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

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

[17] Pub. L. No. 98.21.

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

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 additional payments, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…."[19] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[20] 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 "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 (2000). The first computation, the "Medicare proxy" or "Clause I" set forth at 42 C.F.R. § 412.106(b)(2) states:

> *First computation*: *Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, [CMS] –
> (i) Determines the number of covered patients days that –
> A. Are associated with discharges occurring during each month; and

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[19] 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).

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

B. Area furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State Supplementations

(ii) Adds the results for the whole period; and

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patient days that –

A. Area associated with discharges that occur during that period; and

B. Are furnished to patients entitled to Medicare Part A.

The second computation, the "Medicaid-low income proxy", or "Clause II", is set forth at 42 C.F.R. § 412.106(b)(4) (2000) and provides that:

> *Second computation*. The fiscal intermediary determines, for the hospital's same cost reporting period used for the first computation, the number of the 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. (Emphasis added.)

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. [21] The PM was in response to problems that occurred as a result of hospitals and intermediaries relying on Medicaid State days data obtained from State Medicaid agencies to compute the

[21] The Providers did not raise the hold harmless provision as an alternative ground for supporting payment and, thus, the issue is not addressed in this decision.

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 patient's 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 documentation to substantiate the number of Medicaid days claimed. [22] (Emphasis added.)

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.[23]

In addition, for the relevant fiscal period 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.[24] This policy did not affect the longstanding policy of not counting general

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[22] 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.

[23] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

[24] 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

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.[25]

In 2001, CMS issued a Program Memorandum (PM) Transmittal A-01-13[26] 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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> ****
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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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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 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.")

[25] Id.

[26] 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.[27]

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 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, the Secretary has required the exclusion of days relating to general assistance or State-only days. The policy distinguishes those days 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 may be 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 patients receiving benefits or payments for medical care from the SAGA program were eligible for "medical assistance under a State Medicaid Plan" for the purpose of calculating the Medicare DSH adjustment, specifically the Medicaid fraction component. However, in order for a patient day to be counted towards a hospital's Medicare DSH payment, the patient must be eligible for Medicaid, a determination that must be made by the relevant State agency. Connecticut's SAGA program was set up as a safety net for individuals who were not insured, had no access to health insurance coverage, and who were not eligible for Medicaid.[28] This included low income or poor individuals who, within income limits, were parents of children under 19,

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[27] 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).

[28] See Intermediary's Position Paper, Exhibit I-5.

caretakers of young children, pregnant, chronically unemployed, disabled, or HIV positive. Moreover, the record shows that the program is funded by the State. The Provider's witness, David Parrella, who works at the Connecticut Department of Social Services in the Medical Care Administration Division, made it clear that the SAGA program was not part of the Medicaid Program, and completely State Funded.[29] He went on to state that the SAGA is modeled on Medicaid, but it does not have extensive coverage as the full Medicaid benefit package.[30] For instance, it does not include coverage for long term care facilities, home health care, or the non-emergency medical transportation benefit. It does cover inpatient/outpatient hospital services, pharmacy services, and physician services.[31] The program is designed to provide benefits to low income persons who do not qualify for, or are awaiting an eligibility determination, for other state or Federal programs like Medicaid.[32] It provides a safety net for those in need of health benefits without significant resources who do not qualify for Medicaid.

Section 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 patients 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."[33] 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 Medicaid Program. 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

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[29] See Tr. p. 32.
[30] See Tr. p. 36.
[31] See Tr. p. 36-37.
[32] See Intermediary's Position Paper, Exhibit I-5, and Tr. at 36-38.
[33] 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 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.")

same meaning. As noted by the courts, "the inter-relationship and close proximity of these provisions of the statute" presents a classic case for the application of the rule of statutory construction that "identical words used in different parts of the same act are intended to have the same meaning."[34] 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.

The Providers argued that, since the SAGA program is referenced in Connecticut's Medicaid Plan, these patients must be "eligible" for medical assistance under a State Plan approved under Title XIX" and therefore, the days can be counted. The Administrator finds that the Providers failed to include Connecticut's full SAGA program in the record, and instead only included one single page of the State Plan in its Position Paper.[35] However, additional documents supplied by the parties support the finding that the days were not for Medicaid eligible patients. The record supports the finding that SAGA patients that are not eligible for Medicaid under a State Plan should not be counted in the Medicare DSH payment. Several letters from the State of Connecticut Department of Social Services address the issue, and offer its view on the content of its own State plan. Specifically, one letter stated that if an "individual patient is not eligible for Medicaid under the State Plan…these inpatient days should not qualify for a Medicare DSH payment adjustment."[36] Further evidence is found throughout the record in the available literature.[37] Moreover, the Connecticut State statute for the SAGA program provides that, "No person eligible for Medicaid shall be eligible to receive medical care through the state-administered general assistance program."[38] Thus, the Administrator finds that, not only does the record fail to demonstrate that the groups at issue were eligible for Medicaid, but rather conversely supports a finding that these patients were specifically excluded from Medicaid.

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

[35] See Providers' Revised Final Position Paper, Exhibit P-2. Notably, the Providers as the proponent of the rule have the burden of proof under a preponderance of evidence standard.

[36] See Intermediary Position Paper, Exhibit I-2, and I-4.

[37] See Intermediary Position Paper, Exhibit I-5 ("The SAGA program provides medical assistance to low income persons who do not qualify for, or who are awaiting an eligibility determination, for other state and federal program."); Exhibit I-6 ('the state… will pay for medical care for its SAGA population, those ineligible for Medicare and Medicaid."); Exhibit I-7 ("SAGA provides… medical assistance to indigent individuals and families… who do not qualify for Medicaid."); Exhibit I-8 (GA assistance provides assistance to individuals not eligible for other state or federal programs.").

[38] See Providers' Revised Final Position Paper, Exhibit P-1.

The Providers further argued that, because Federal funds allegedly match SAGA payments, the patients receiving SAGA payments must be eligible to be counted towards the Providers' DSH payment. Even if the Providers receive Medicaid DSH payment and thus, indirectly FFP based on SAGA days or revenue, this does not mean that the patient receiving SAGA assistance is eligible for Medicaid or receiving medical assistance within the meaning of Medicaid. Regarding the expenditure of FFP under a Medicaid DSH program under section 1927 of the Act, 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. Section 1886(d)(5)(F)(vi)(II) 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 XIX, the general assistance population days operated and funded by the State of Connecticut (not Title XIX) are not counted as Medicaid days. Thus, regardless of the methods used by the State to calculate its Medicaid DSH payments (Medicaid inpatient utilization rate or the low-income utilization rate), these patients can not be included under §1886(d)(5)(F) as a Medicaid patient day.[39]

The Administrator finds that the facts support the Intermediary's refusal to include Connecticut SAGA days in the numerator of the Providers' Medicaid proxy. The Administrator finds that SAGA is a State-only program that specifically excludes individuals who are qualified for Medicaid. Since the applicable statutes require an individual's eligibility for Medicaid in order for the patient days to be counted in the numerator of the Medicare DSH payment, the Administrator affirms the Board's decision, for the foregoing reasons.[40]

Finally, the Administrator affirms the Board's decision that it did not have jurisdiction over two Providers in the group: Waterbury Hospital for FYE 9/30/1996 and Middlesex Hospital for FYE 9/30/1995. The Providers accepted the Board's determination that it did not have jurisdiction with respect to this issue for Middlesex Hospital, FYE 9/30/1995.

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[39] The Court decision in Adena Regional adopted CMS' long held position regarding the exclusion in the Medicare DSH calculation of days of care provided to low income individuals pursuant to State funded programs for individuals not eligible for Medicaid.

[40] The Administrator does not find that the Providers argument regarding the SMDL #02-013 and the denial of FFP for prisoners supports a contrary finding here. The Secretary did not state that unless denied, it "would result in the payment of Federal Medicaid matching funds for 'medical assistance' furnished to inmates of correctional facilities." CMS only states that FFP cannot be paid as the State is obligated to cover a prisoner's basic needs and, therefore, the prisoner has a source for third party coverage and is not uninsured. That is not the same as stating, as the Providers attempt to suggest, that FFP for Medicaid DSH is "medical assistance."

The regulation at 42 C.F.R. §405.1885(a) allows for the reopening of a determination or decision if "made within 3 years of the date of the notice of the intermediary determination [i.e., the NPR]...." When a reopening pursuant to 42 C.F.R. §405.1885 results in the issuance of a revised NPR, the regulation at 42 C.F.R. §405.1889 (1991) controls the scope of the Board jurisdiction with respect to the revised NPR. The regulation provides that:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§405.1811, 405.1835, 405.1875, 405.1877 are applicable.

This provision is also set forth in §2932B of the Provider Reimbursement Manual. This section likewise refers to a revised NPR as a "separate and distinct determination" which gives a right to a hearing on the matters corrected by such determination. Thus, a revised NPR does not reopen the entire cost report to appeal, but rather, reopens those specific matters adjusted by the revised NPR.

The Administrator finds that 42 C.F.R. §405.1889 bars these particular Providers from using the revised NPR as a basis for appeal for the SAGA days. The regulation at 42 C.F.R. §405.1889 provides that "such revision shall be considered a separate and distinct determination" for purposes of appeal. In this case, Waterbury Hospital specifically requested a reopening to include only Medicaid eligible days.[41] The Provider's reopening request did not refer to SAGA days or State only days. Thus, the Intermediary made a determination in the revised NPR addressing only Medicaid eligible days as defined by HCFA Ruling 97-2, and not the specific issue of SAGA days. Therefore, the only Medicare DSH issue decided pursuant to the revised NPR and thus open for appeal was the issue of Medicaid eligible days. The Provider's reopening request which triggered the revised NPR showed that although the Provider's reopening request identified numerous sub-categories of Medicaid eligible days for which it was request payment, the Provider did not specifically request SAGA days as part of the reopening.[42] Since the Provider did not request SAGA days as part of the reopening for the revised NPR, and the Intermediary did not adjust the cost report for SAGA days, the Board properly found that it did not have jurisdiction over the SAGA days issue for Waterbury Hospital, for FY 9/30/1996.

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[41] See, Providers' response to Intermediary's Jurisdictional Challenge Brief at Exhibit I.A.
[42] Id.

DECISION

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

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

Date: 8/13/2009

/s/
Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services