CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Sharp Coronado Hospital and HealthCare Center **Provider** **vs.** **Blue Cross /Blue Shield Association** **United Government Services, LLC - CA** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 09/30/2000 and 09/30/2001** **Review of:** **PRRB Dec. No. 2009-D32** **Dated: July 15, 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)). Comments were received from the Intermediary requesting reversal of the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. Comments were submitted by the Center for Medicare Management (CMM) requesting that the Administrator reverse the Board's decision. The Provider also submitted comments requesting that the Board's decision be affirmed. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUES AND BOARD'S DECISION

There are two issues in this case: (1) Whether the Intermediary's calculation of the Provider's disproportionate share hospital (DSH) payments, as it pertains to sub-acute unit days was proper; and (2) Whether the Intermediary's calculation of the Provider's DSH payments, as it pertains to Medicare Part A exhausted days for dual eligible patients was proper.

The Board held that the Provider's sub-acute and dual eligible exhausted days are properly included in the numerator of the Medicaid fraction of the Medicare disproportionate share hospital (DSH) computation. In reaching this conclusion the Board relied on the *Alhambra Hosp. v. Thompson*, 259 F.3d 1071, 1074 (9th Cir. 2004)[1] decision along with recent Medicare policy statements and recent revisions to the Medicare DSH regulations to determine that the original intent of CMS and Congress was to include sub-acute unit days and Medicare Part A exhausted days in the DSH calculation.

SUMMARY OF COMMENTS

The Intermediary submitted comments requesting that the Administrator reverse the Board's decision. With respect to the "sub-acute" days in the DSH calculation the Intermediary argued that *Alhambra*[2] did not apply because the sub-acute units located on the first floor were not adjacent to a routine inpatient unit of the hospital.

CMM commented requesting that the Administrator overturn the Board's decision. CMM disagreed that the days should be included in the Medicaid fraction and noted that under the current regulations, Medicare exhausted benefit days are included in the Medicare fraction. CMM noted that, while beneficiaries may have exhausted their Medicare Part A inpatient coverage, they may still be entitled to other Part A benefits. Furthermore, excluding exhausted benefit days from the Medicaid fraction is consistent with the language of § 1886(d)(5)(F)(vi)(II) of the Act, which specifies that patients entitled to benefits under Medicare Part A are excluded from the Medicaid fraction. Accordingly, such days are never counted in the Medicaid fraction under the Medicare DSH regulations.

CMM also disagreed with the Board's determination to include the patient days associated with sub-acute units because not all of the sub-acute units were located in an area subject to Inpatient Prospective Payment System (IPPS). CMM stated that *Alhambra* established a "geographic" criterion for counting a hospital's patient days based on whether an area of the hospital is subject to IPPS. The record shows that the two sub-acute units located on the first floor, are not adjacent to an inpatient acute care unit. Rather, they are located near the cafeteria, kitchen and storage areas, which are not areas that provide acute care services. Therefore, these two particular sub-acute units, and thus, the patient days provided in these units, do not meet the criteria under *Alhambra* that the sub-acute units must be located in areas generally used to provide inpatient acute care services.

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[1] The Provider is located in the judicial Circuit controlled by Ninth Circuit law.

[2] Id.

The Provider submitted comments requesting that the Administrator affirm or decline to review the Board's decision. The Provider disagreed with CMM comments that the Court in *Alhambra* established a "geographic" criterion for purposes of counting a hospital's patient days for purposes of determining a Provider's Medicare DSH computation. Furthermore, CMS cannot eviscerate the impact of the *Alhambra* decision through an informal memorandum that purports to interpret or limit a Federal Court of Appeals decision. The Provider contended that CMS is collaterally estopped from calculating DSH payments differently than that required by the *Alhambra c*ourt and from re-litigating issues already decided in the *Alhambra* case.

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.

Issue No. 1- - Sub-acute Unit Days

Title VI of the Social Security Amendments of 1983[3], adding § 1886(d) to the Act, 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. These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under PPS, hospitals and other health care providers are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. The purpose of PPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding costs effective hospital practices.[4]

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 …."[5] 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

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

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

[5] 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).

percentage. Relevant to this case is the second fraction, which is defined at § 1886(d)(5)(F)(i)(II) as:

> 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 explain 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).
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> (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….

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.[6]

Thus, CMS' policy is to count only patient days attributable to units or wards providing inpatient acute care as the purpose of the DSH payment is to compensate hospitals for the general higher "inpatient" cost associated with low-income patients.[7]

The Ninth Circuit Court of Appeals issued a decision addressing the inclusion of certain sub-acute care bed days, which was unfavorable to CMS' position. After the Ninth Circuit Court of Appeals decision in *Alhambra*, CMS issued instructions to the intermediaries on how to treat sub-acute bed days for hospitals located within the Ninth Circuit. In Joint Signature Memorandum (JSM) -108,[8] CMS stated:

> Our policy on counting hospitals' patient days is stated in regulations at 42 C.F.R. § 412.106(a)(1)(ii). Generally, the number of patient days is

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[6] 53 Fed. Reg. 38476, 38480 (Sept. 30, 1988); See also 53 Fed. Reg. 9337 (March 22, 1988).

[7]This longstanding policy was clarified by setting forth specific language that addressed this situation in the regulation. FFY 2004 IPPS, Final Rule (68 FR 45417) August 1, 2003. See also *District Memorial Hosp. of Southwestern North Carolina, Inc. v. Thompson*, 369 F.3d 513 (4th Cir. 2004) affirming Administrator decision *Memorial Hosp. of Southwestern North Carolina*, PRRB Dec. No. 2001 D37. The Administrator herein incorporates by reference in this Administrative decision the general policy discussion explaining the bases for excluding non-inpatient days under this provision of the regulation in this Administrative decision.

[8] Provider's Exhibit PS-5.

determined by counting only those patient days attributable to areas, units, or wards that would be subject to the IPPS. Our longstanding policy is that patient days occurring in areas, units, or wards where the services provided are not inpatient acute care services at a level of care that is generally payable under the IPPS are not to be included in the count of a hospital's patient days. This policy applies regardless of whether the area, unit, or wards is separately certified by Medicare as being exempt from the IPPS. We clarified this longstanding policy in the August 1, 2003, Final Rule (68 FR 45417), which too, effect October 1, 2003. In that rule, we amended § 412.106(a)(1)(ii) to clarify our policy that the count of patient days includes only the patient days attributable to units or wards providing inpatient acute care services that would generally be payable under IPPS.

In *Alhambra,* two hospitals challenged the exclusion from their counts of patient days those patient days attributable to subacute care units that were not separately certified by Medicare as being excluded from the IPPS and were located in the same geographic area of the hospital as routine inpatient acute care units. At the time of the *Alhambra* decision, the codified regulations text specified that only the patient days attributable to "areas of the hospital that are subject to the prospective payment system" are to be included in the count of patient days. Despite our consistent and longstanding policy of excluding from a hospital's count of patient days those patient days attributable to subacute care units or wards where the level of care provided would not be payable under the IPPS, the court found that our regulations established a "geographic" criterion for counting a hospital's patient days based on whether an area of the hospital is subject to the IPPS. The court held that, because the subacute care units (which provided services that were not of a type or level that is subject to the IPPS) were located in the same "area" as inpatient acute care units (which did provide services that were of a type or level that is subject to the IPPS), our interpretation of the regulations to exclude the patient days attributable to the subacute care units was inconsistent with the plain language of our regulations and was, therefore, impermissible.

In light of the *Alhambra* decision, we are instructing you, for providers located within the Ninth Circuit and, as specified, further in the following paragraph, for discharges occurring before October 1, 2003, when hospitals operate subacute units that are located within areas of the hospital that are generally used to provide inpatient acute care services, the patient days attributable to the subacute care units should

> be included in the count of patient days under regulation at § 412.106(a)(1)(ii).

In sum, CMS' position is that for Providers located in the Ninth Circuit, only those sub-acute units that are located in an area generally used to provide inpatient acute care services should be included in the DSH calculation.

During the fiscal periods in dispute the Provider operated three sub-acute units: two on the first floor and one on the fourth floor.[9] The record showed that the sub-acute unit on the fourth floor was adjacent to an obstetrics and gynecology wing of the Provider. The two sub-acute units on the first floor were not adjacent to an acute care unit or wing of the Provider. Rather, they were located near the cafeteria, kitchen and storage areas which are not areas that provide acute care services. However, there was an intensive care unit (which provides acute care level services payable under the IPPS on the First Floor of the Provider).

The Provider sought to include patient days relating to its three sub-acute units as part of its DSH calculation. In addition, the Provider contended that once a "dually eligible" i.e., crossover patient's Part A benefit are exhausted, the patient is no longer "entitled" to Medicare Part A benefits. The Provider contended 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 fraction.[10]

The Intermediary excluded all sub-acute patient days associated with the two sub-acute units on the first floor from the Provider's Medicare DSH computation as the Intermediary found that the ruling in *Alhambra* did not apply to these facts. However, the Intermediary agreed to include those days associated with the sub-acute unit on the fourth floor to the extent that they did not include cross over patients that had exhausted Medicare Part A benefits. The Intermediary excluded all dual eligible

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[9] See e.g., Provider's Exhibits P-1 and PS-6. Maps of hospital facility floor plans; Stipulations Provider Exhibit PS-9.

[10] For FYE 09/30/00, the parties agreed that the two sub-acute units on the first floor had 4,210 "Medicaid eligible days" and 4,654 dual eligible exhausted days. The parties agreed that the sub-acute unit on the fourth floor had 972 dual eligible exhausted days. For FYE 09/30/01 the parties agreed that the two sub-acute units on the first floor had 10,145 "Medicaid eligible days" and 9,191 dual eligible exhausted days. The Administrator notes that the parties did not stipulate as to the number of total sub-acute days which would be included in the denominator of the Medicaid fraction should the Provider prevails.

Medicare Part A exhausted patient days associated with all three sub-acute units from the Provider's DSH computation. The Provider timely appealed. 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 Court in *Alhambra* held that the regulation established a "geographic" criterion for counting a hospital's patient days based on whether an area of the hospital is subject to IPPS. As such, the Administrator finds that the sub-acute units on the first floor do not meet the requirements for an area that is generally used to provide inpatient care services. That is, they are not days attributable to areas of the hospital that are subject to the IPPS. The record shows, and the parties stipulated to, the fact that the geographical areas surrounding the first floor sub-acute units are non IPPS, non-patient care areas such as the cafeteria, kitchen, storage, none of which meet the requirements set forth by CMS in implementing the *Alhambra* decision for Ninth Circuit providers. The parties also agreed that each of the sub-acute care units provided a level of care that was less than that provided by inpatient acute care units and, thus, the Administrator concludes that these days are not otherwise includable as "inpatient" days. Thus, the Intermediary's disallowance of all sub-acute patient days associated with the two sub-acute units on the first floor in the Provider's Medicare DSH computation was proper.

Issue No. 2 - - Medicare Part A exhausted Days

To be eligible for the additional DSH payment, a hospital must meet certain criteria concerning, inter alia, its disproportionate Patient percentage (DPP). Section 1886(d)(5)(F)(vi) of the Act states that the term disproportionate patient percentage means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The first fraction that is used to compute the DSH payment is commonly known as the "Medicare fraction." The statute defines the Medicare fraction as:

> 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 patient 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.[11]

The second fraction that is used to compute the DSH payment is commonly known as the "Medicaid fraction." The statute defines the Medicaid fraction as:

> 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.[12] (Emphasis added.)

The Secretary implemented the statutory provisions at 42 C.F.R. § 412.106 (1993) and explained that the hospital's DPP is determined by adding the results of two computations and expressing that sum as a percentage. The first computation, the "Medicare fraction" is set forth at 42 C.F.R. § 412.106(b)(2) (1993). The regulation at 42 C.F.R. § 412.106(b) provides that:

> (b) *Determination of a hospital's disproportionate patient percentage.*
> *(1) General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
> (2) *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 patient days that-
> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation; …. (Emphasis added.)

The second computation, the "Medicaid fraction" is also set forth at 42 C.F.R. § 412.106(b)(2) (1993). The regulation at 42 C.F.R. § 412.106(b) provides that:

> (4) *Second computation.* The fiscal intermediary determines, for the 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

[11] Section 1886(d)(5)(F)(vi)(I)
[12] Section 1886(d)(5)(F)(vi)(II)

> number by the total number of patient days in the same period.….
> (Emphasis added.)

Relevant to this case, in the May 6, 1986, final rule implementing the DSH adjustment the Secretary stated with respect to the calculation of the Medicare fraction that:

> [I]f a Medicare beneficiary is eligible for SSI benefits (excluding State supplementation only) during a month in which the beneficiary is a patient in the hospital, the covered Medicare Part A inpatient days of hospitalization in that month will be counted for the purpose of determining the hospitals disproportionate patient percentage."[13]
> (Emphasis added.)

In addition, in the September 1, 1995, final IPPS rule, the Secretary stated that the numerator and denominator of the Medicare fraction included only Medicare covered days:

> Section 1886(d) (5) (F) of the Act provides for additional payments for hospitals that serve a disproportionate share of low income patients. A hospital's disproportionate share adjustment is determined by calculating two patient percentages (Medicare Part A/Supplemental Security Income (SSI) covered days to total Medicare covered days, and Medicaid but not Medicare Part A covered days to total inpatient hospital days), adding them together and comparing that total percentage to the hospital's qualifying criteria.[14]

In the proposed FFY 2004 IPPS rule,[15] the Secretary considered the option of changing the long-standing policy, and proposed to allow dual-eligible days where the patient has exhausted its Medicare A benefits to be included in the Medicaid Proxy. The Secretary stated that:

> As described above, the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits. If a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered

[13] 51 Fed. Reg. 16772 at 16777 (May 6, 1986)
[14] 60 Fed. Red. 45778 at 45811 (September 1, 1995)
[15] 68 Fed. Reg. 27182, 27207 (May 19, 2003)

> dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction. This is consistent with the language of section 1886(d)(5)(F)(vi)(II) of the Act, which specifies that patients entitled to benefits under Part A are excluded from the Medicaid fraction.
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> We are proposing to change our policy, to begin to count in the Medicaid fraction of the DSH patient percentage the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage has expired. We note the statute referenced above stipulates that patient days attributable to patients entitled to benefits under Medicare Part A are to be excluded from the Medicaid fraction, while the statute specifies the Medicaid fraction is to include patients who are eligible for Medicaid.
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> Under this proposed change, before a hospital could count patient days attributable to dual-eligible beneficiaries in the Medicaid fraction, the hospital must submit documentation to the fiscal intermediary that justifies including the days in the Medicaid fraction after the Medicare Part A benefits have been exhausted….

However, due to strong opposition and the volume of comments received, the Secretary in the final rule, 69 Fed. Reg. 49098 (Aug. 11, 2004), decided not to adopt the May 19, 2003, proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. The Secretary explained with respect to the Medicare fraction that:

> It has come to our attention that we inadvertently misstated our current policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 (68 FR 27207). In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. Our policy has been that only covered patient days are included in the Medicare fraction (§412.106(b)(2)(ii)). A notice to this effect was posted on CMS' Web site

(http://www.cms.hhs.gov/providers/hipps/dual.asp) on July 9, 2004.[16]

However, with respect to the proposed inclusion of these days in the Medicaid fraction, the Secretary stated:

> However, we acknowledge the point raised by the commenter that beneficiaries who have exhausted their Medicare Part A inpatient coverage may still be entitled to other Part A benefits. We also agree with the commenter that including the days in the Medicare fraction has a greater impact on a hospital's DSH patient percentage than including the days in the Medicaid fraction. This is necessarily so because the denominator of the Medicare fraction (total Medicare inpatient days) is smaller than the denominator of the Medicaid fraction (total inpatient days). However, we note that we disagree with the commenter's assertion that including days in the Medicaid fraction instead of the Medicare fraction always results in a reduction in DSH payments. For instance, if a dual-eligible beneficiary has not exhausted Medicare Part A inpatient benefits, and is not entitled to SSI benefits, the patient days for that beneficiary are included in the Medicare fraction, but only in the denominator of the Medicare fraction (because the patient is not entitled to SSI benefits). The inclusion of such patient days in the Medicare fraction has the result of decreasing the Medicare fraction in the DSH patient percentage.
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> For these reasons, we have decided not to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, we are adopting a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage. If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual-eligible beneficiaries in the Medicare fraction of the DSH calculation.[17]

While continuing the procedure of excluding the exhausted days from the Medicaid fraction, the Secretary did adopt the prospective policy to "include the days

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[16] 69 Fed. Reg. 48916 at 49098 (Aug. 11, 2004)

[17] 69 Fed. Reg. 48916 at 49098-49099 (Aug. 11, 2004)

associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[18] Medicare Part A exhausted days are to be included in both the numerator and denominator for discharges occurring on or after October 1, 2004. Prior to October 1, 2004, CMS only included "covered" patient days in the Medicare fraction, which was not a criteria that either exhausted days or MSP days met.

In this case the Provider argued that the DSH statute required the inclusion of Medicare Part A exhausted days for dual eligible sub-acute patients in the Medicaid fraction. The Board held that dual eligible days for Medicare Part A exhausted benefit days should be included in the Medicaid percentage that is used to calculate the DSH adjustment payment with respect to those sub-acute care days in the IPPS areas of the hospital.

The Administrator finds that the statutory phrase in the Medicaid fraction "but who were not entitled to benefits under Medicare Part A of this title" forecloses the inclusion of the days at issue in this case in the Medicaid fraction. The Social Security Act and the regulations at Title 42 of the Code of Federal Regulations recognizes the distinctive use of the term "eligible" in conjunction with Medicaid recipients and "entitled" in conjunction with Medicare beneficiaries. The distinctive use of these terms is consistent with the differences in the respective programs. As a general matter, Medicare is a social insurance program, in contrast to Medicaid, which is a needs-based program. With respect to Medicare, certain populations are entitled (or have a legal right to) Medicare automatically[19] and others are "entitled" to Medicare once they have filed an application and are enrolled.[20]

With respect to Medicaid, certain low-income individuals and families are "eligible" who fit into an "eligibility" group that is recognized by Federal and State law.[21] Because Medicaid is a needs-based program, the Medicaid program generally requires a determination of an individual's eligibility and also periodic re-

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[18] 69 Fed. Reg. 49099 (Aug. 11, 2004).

[19] For example, under the Medicare statute, an individual who is at least 65 years of age is "entitled" to Medicare Part A benefits if he or she currently receives Social Security or Railroad Retirement Board Benefits. 42 U.S.C. §426(a). Such an individual is automatically entitled to Part A benefits and does not have to file an application for coverage. 42 C.F.R. §406.6(a).

[20] For example, an individual who is at least 65 years of age and who is eligible for, but does not currently receive, Social Security or Railroad Retirement Board benefits, is not entitled to Part A benefits *until* he or she files an application for Social Security or Railroad benefits. 42 U.S.C. §426(a) and 42 C.F.R. §406.6(c).

[21] See, e.g., Section 1905(a) and 42 C.F.R. §435.2 et seq.

determinations of "eligibility." Therefore the distinctive use of the term "entitled" in section 1886(d)(5)(F)(vi)(I) and (II) when referencing Medicare, as opposed to eligible, is not in reference to the right of payment of a benefit, but rather the legal status of the individual as a Medicare beneficiary under the law.

As noted by CMM, even when a Medicare beneficiary exhaust his/her inpatient hospital benefits, these benefits will be renewed when the beneficiary has not been in a hospital or SNF for 60 days. Thus, while a Medicare beneficiary's benefit period may exhaust or expire, the entitlement for Medicare does not expire. Thus, CMS policy has been to consider the status of the patient as a Medicare beneficiary with respect to the exclusion from the Medicaid fraction. However, with respect to the Medicare fraction CMS has, prior to 2004, interpreted "such days" to require that the day be a covered day in order to be included in the Medicare fraction.

In conclusion regarding the sub-acute care days, these days are only allowable that are attributable to the IPPS area of the hospital and, thus, would not include days related to the two sub-acute care units on the first floor. Moreover, of those sub-acute care days that may be allowed, such days associated with Medicare entitled/Medicaid eligible patients exhausted days may not be included in either the Medicare or the Medicaid fraction for the cost years in this case.

Thus, the Administrator reverses the Board's determination that the days at issue should be included in the Medicaid fraction and affirms the Intermediary's exclusion of these days from the DPP calculation.

DECISION

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

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

Date: 9/9/09

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