CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Southwest Consulting 95-01 **Disproportionate Share Hospital** **Georgia Indigent Care Trust Fund** **Provider** **vs.** **Blue Cross Blue Shield Association/** **Blue Cross Blue Shield of Georgia** **Intermediary**	**Reimbursement Determination** **for Cost Reporting Periods** **Ending: Various** **Review of:** **PRRB Dec. No. 2009-D39** **Dated: September 21, 2009**

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. No comments were received. Accordingly, this case is now before the Administrator for final agency review.

ISSUES AND BOARD DECISION

The issue was whether the hospital days attributable to individuals who applied to the Providers for, and received, assistance under Georgia's Indigent Care Trust Fund (ICTF) should be counted in the number of Medicaid-eligible days in the numerator of the Medicaid fraction used to calculate the Medicare disproportionate share (DSH) payments to the Providers.[1]

[1] There are two Providers participating in this group appeal—Memorial Health University Medical Center (Provider No. 11-0036) and the Medical Center Provider No. 11-0064). For Memorial Health University Medical Center, the periods at issue are the Provider's fiscal years ending December 31, 1995-2001.

The Board held that the Intermediary's adjustment properly excluded Georgia's ICTF program patient days from the numerator of the Providers' DSH calculation. In reviewing the Medicaid DSH statute at § 1923 of the Act, the Board found that the term "medical assistance under a State plan approved under [Title] XIX" excluded days funded only by the state and charity care days even though those days may be counted for Medicaid DSH purposes.

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. Because the Georgia's ICTF days were funded by "state and local governments" and included in the low income utilization rate, not the Medicaid inpatient utilization rate, the Board found that the Georgia's ICTF patient days did not fall within the Medicaid statute definition of "eligible for medical assistance under a State plan" at § 1923 of the Act.

Finally, the Board referenced *Adena Regional Medical Center v. Leavitt.*[2] The Court of Appeals for the D.C. Circuit held that the phrase "eligible for medical assistance under a State plan approved under title XIX" referred to patients who are eligible for Medicaid. The Court rejected the argument that the days of patients who were counted toward a Medicaid DSH payment must be counted toward the Medicaid fraction of the Medicare 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.

Relevant to the issue involved in this case, two Federal programs, Medicaid and Medicare involve the provision of health care services to certain distinct patient populations. The Medicaid program is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children.[3] 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

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For the Medical Center, the period at issue is the fiscal year ending June 30, 2000. See Providers' Supplement Position Paper at 1 -2.

[2] 527 F. 3d 176 (D.C. Cir. 2008).

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

for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.[4] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) [42 USC 601 et seq.] and Supplemental Security Income or SSI [42 USC 1381, et seq.] Participating States may elect to provide for payments of medical services to those aged blind or disabled individuals known as "medically needy" whose incomes 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.[5]

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.[6] 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.[7] 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.[8] As part of a State plan, § 1902(a) (13) (A) (iv) requires that a State plan provide for a public process for determination of

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[4] Section 1902(a) (10) of the Act.
[5] Section 1902(a) (1) (C) (i) of the Act.
[6] Id. §1902 et seq., of the Act.
[7] Id.
[8] 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."

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 requirements that a State plan under Title XIX provides 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 or by other means. The low income criterion relies, inter alia, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.[9]

While Title XIX implemented medical assistance pursuant to a cooperative program with the States for certain low-income individuals, the Social Security Amendments of 1965[10] 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,[11] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[12] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[13] However, concerned with increasing costs,

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[9] 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 medical assistance under the State plan or have no health insurance (or other source of third part coverage for services provided 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.

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

[11] Section 1811-1821 of the Act.

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

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

Congress enacted Title VI of the Social Security Amendments of 1983.[14] 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.[15]

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

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to §1886(d) (5) (F) (i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…."[16] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[17] 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

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

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

[16] 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).

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

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

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

Although not at issue in this case, CMS revised 42 CFR § 412.106(b)(4) to conform to HCFA Ruling 97-2, which was issued in light of Federal Circuit Court decisions disagreeing with CMS' interpretation of a certain portion of § 1886(d)(5)(vi)(II) of the Act. In conjunction with this revision, CMS issued a Memorandum dated June 12, 1997, which explained the counting of patient days under the Medicaid fraction, stating that:

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

In order to clarify the definition of eligible Medicaid days and to communicate a hold harmless position for cost reporting periods beginning before January 1, 2000,

for certain providers, CMS issued Program Memorandum (PM) A-99-62, dated December 1999. The PM responded 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 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 [P]lan 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 [S]tate [P]lan, 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 [P]lan, 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 [P]lan 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. 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 [P]lan 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. [18] (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.[19]

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[18] 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.

[19] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

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.[20] This policy did not affect the longstanding policy of not counting general 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 days 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.[21]

In 2001, CMS issued a Program Memorandum (PM) Transmittal A-01-13,[22] which again stated, regarding two specific types of 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. Sometimes 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

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

[21] Id.

[22] 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)

> patient is eligible for Medicaid benefits or can be counted as such in the Medicaid formula.
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> *Days for patients covered under a State-only (or count-only) general assistance program (whether or not any payment is available for health care services under the program)*. These patients are not Medicaid-eligible under the State plan. (Emphasis added.)

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 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.[23]

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

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[23] 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).

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.

The Administrator notes that this policy was recently upheld in *Adena.*[24] In *Aden*a, a group of Ohio Providers sought to have included, State-only charity care days (Ohio's Hospital Care Assurance Program (HCAP)) in their Medicare DSH calculation because such days were included in the State's Medicaid plan for purposes of setting the methodology by which Ohio calculated it Medicaid DSH adjustment. The Court held that the phrase "eligible for medical assistance under a State plan approved under title XIX" referred to patients who are eligible for Medicaid. The Court rejected the Providers' argument that days of patients who were counted toward a Medicaid DSH payment must be counted toward the Medicaid fraction of the Medicare DSH calculation.[25]

In this case, the Providers argued that the days related to payments made under the State's ICTF days should be counted in the numerator of the Medicaid fraction for purposes of determining its Medicare DSH calculation.[26] Because CMS paid matching Federal financial participation or FFP for Georgia's ICTF expenditures, the Providers claim that the Georgia's ICTF expenditures for certain indigent patients at issue here, qualifies as "medical assistance under the State Plan" in accordance with § 1886(d)(5)(F)(vi)(II) of the Act.

The Administrator does not agree. The Administrator finds that §1886(d)(5)(F)(vi)(II) of the Act requires, for purposes of determining the Providers' "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."[27] The Administrator further finds that the term

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[24] Supra, n 1.
[25] Id. at 179.
[26] Providers' Supplemental Position Paper at 16.
[27] 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.")

"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, then the patient is not "eligible for medical assistance under a State plan approved under Title XIX."

The Administrator finds that the language set forth in §1886(d)(5)(F)(vi)(II) of the Act requires that the day be related to an individual eligible for "medical assistance under a State plan approved under Title XIX" also known as the Federal Program Medicaid. The use of the term "medical assistance" at §§1901 and 1905 of the Act and the use of the term "medical assistance" at §1886(d)(5)(F)(vi)(II) of the Act is reasonably concluded to have the same meaning. As noted by the courts, "the interrelationship and close proximity of these provisions of the statute presents a classic case for the application of the normal rule of statutory construction that identical words used in different parts of the same act are intended to have the same meaning."[28] Therefore, the Administrator finds that 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.[29] That is, the individual must be eligible for the Federal government program also referred to as Medicaid.

As stated above, the Secretary has interpreted the term "eligible for medical assistance under a State Plan approved under Title XIX" to mean eligible for the Federal government program also referred to as Medicaid. In this case, the

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

[29] Congress added language to §1886(d)(5)(F)(vi)(II) of the Act which stated: "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." 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). 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. This amendment left untouched CMS longstanding policy on general assistance days.

Georgia's ICTF specifically excludes individuals who are qualified for Medicaid. Section 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. The Administrator finds that the individuals related to the uncompensated care costs covered by the Georgia ICTF are not covered by "medical assistance" as described in Title XIX.[30]

Instead the Georgia Indigent Care Trust Fund (ICTF) is the State of Georgia's rather complex mechanism for administering Medicaid payments for disproportionate share designated hospitals. The ICTF was created in 1990 by Georgia General Assembly to compensate hospitals that provide free or reduced charge care to Medicaid recipients and also the medically indigent. Part of the funding of the ICTF is from Federal matching funds under the Medicaid DSH program. The Hospitals qualify for participation in the ICTF by satisfying Federal and State requirements.[31] The State plan provides that it annually designate enrolled Georgia hospitals as disproportionate share based upon meeting various criteria including criteria based on Medicaid utilization rate and low-income inpatient utilization rate.[32]

However, regardless of the criteria under which a hospital is qualified, with respect to the payment, the State makes an adjustment to a hospital's Medicaid DSH payment based on calculations involving uncompensated care and bad debts.[33] In ensuring that the State plan meets the Federal hospital-specific DSH limit, the State explained in a July 11, 1997 letter to the CMS that: "we believe that a hospital's bad debts for services to individuals with no insurance and its charity care have a relationship to services rendered to low-income individuals with special needs. Therefore, this element of the formula assists us in measuring the volume of DSH services rendered by a hospital."

In addition to affecting the payment, the uncompensated care costs affect the determination of the upper limits of a hospital's Medicaid DSH payment. The Medicaid DSH payment was explained as being the lesser of the hospital–specific DSH limit or the formula calculated amount. The hospital-specific DSH limit is

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[30] See also, *Adena*, 527 F.3d at 180, which held that the phrase "eligible for medical assistance under a State plan approved under title XIX" in § 1886(d)(5)(F)(vi) referred to patients eligible for "medical assistance" as it is defined in the Medicaid statute in § 1905(a) (42 U.S.C. § 1396d(a)). Patients receiving "medical assistance" as, it is defined in § 1905(a) (42 U.S.C. § 1396d(a)), under a State plan are those who are eligible for Medicaid.

[31] Provider Exhibit P-9.

[32] *See*, e.g., Provider Exhibit P-7, pp.64-81, pp.84-85, pp.168-170.

[33] See, e.g., Provider Exhibit P-8, p. 142.

calculated as the Medicaid shortfall (costs of Medicaid services less Medicaid non-DSH payments) plus the net costs of providing services to individuals with no insurance or other third party payment source. Therefore, for the Providers in this case, the patient days at issue are related to the costs for uncompensated care that was included in the calculation of the Medicaid DSH payment for the Providers and not for days of patients eligible for Medicaid.[34] Notably the Provider does not allege that the patients are in fact Medicaid patients, nor does the record demonstrate that the days are for patients eligible for "medical assistance" as that term is used at sections 1901 and 1905 of the Act.

Finally, regarding the expenditure of Federal financial participation or FFP under a Medicaid DSH program, generally, the issue of whether costs are regarded as expenditures under a State plan approved under Title XIX for purposes of calculating Federal matching payments to the State is different from the issue of whether patients are considered eligible for medical assistance under a State plan approved under Title XIX for purposes of calculating Medicare DSH payments to a hospital. Section 1886(d) clearly states that the patients' Title XIX eligibility for that day is a requirement for inclusion in the Medicare DSH calculation.

Therefore, regardless of any possible Medicaid DSH payment and indirect FFP provided under Title XIX, by the State of Georgia for the cost of certain patients, the related days are not counted as Medicaid days for purposes of the Medicare DSH calculation. Regardless of the methods used by the State to calculate its Medicaid DSH payments (Medicaid inpatient utilization rate or the low-income utilization rate or other), these patients days cannot be included under § 1886(d)(5)(F)(vi)(II) of the Act as Medicaid patient day.

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[34] *See* e.g. Provider Exhibit 12, p.256, lines 9 and 20, *see also* e.g. Tab D at pp 259-268 line 9. *See also* the Stipulation of the parties "The calculation of these Medicaid DSH amount paid to qualifying hospital considers *the costs of services* furnished to indigent patients who qualify for assistance from the ICTF." (Emphasis added.) The Georgia State regulation provides the criteria for qualifying for assistance which the hospitals use to determine the uncompensated /charity care costs which may be included in the uncompensated care portion of the DSH calculation, all of which is made to determine the amount of the payment under the ICFT. The Hospitals submits a "Program-Specific Indigent Care Addendum" and "Hospital Care Survey" which includes, inter alia, financial data related to indigent and charity care which the hospital must confirm conforms to accompanying instructions and submit copies of formal indigent/charity care policy. *See* e.g. Provider Exhibit P-13. The Survey does not identify individual patients or days but rather it, *inter alia*, captures the costs of the uncompensated care.

Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly did not include the days related to costs included in the payment determination of the State's ICTF program in the numerator of the Medicaid fraction. 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.

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: 11/13/09

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