**CENTERS FOR MEDICARE AND MEDICAID SERVICES**
Decision of the Administrator

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| **In the case of:**<br>**QRS UMHC 1991-1996**<br>**DSH/ Michigan**<br>**General Assistance Days Group** | **Claim for Payment**<br>**Determination for Cost**<br>**Reporting Period(s) Ending:**<br>**1991-1996 and 2003-2006** |
| **Provider**<br>**vs.** | |
| **Blue Cross Blue Shield Association/**<br>**Wisconsin Physicians Service** | **Review of:**<br>**PRRB Dec. No. 2013-D21**<br>**Dated: July 25, 2013** |
| **Intermediary** | |

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. This case is now before the Administrator for final agency review.

## ISSUE AND BOARD'S DECISION

The issue is whether days associated with patients covered under the Michigan Indigent/Charity Care Program (MICCP) should be included in the numerator of the Medicaid proxy of the Medicare disproportionate share hospital (DSH) calculation pursuant to § 1886(d)(5)(F)(vi)(II) of the Act, as amended.[1]

[1] The Provider argued that days for those patients not eligible for Medicaid, but involved in the calculation of the State Medicaid DSH payment under Title XIX, should be included in the calculation of the section 1886(d)(5(F) DSH payment under Title XVIII as they are "covered" under the State plan.

The Board held that the Intermediary properly excluded Michigan Indigent/Charity Care Program (MICCP) days from the numerator of the Provider's Medicaid proxy. The Board held that the charity care beneficiaries are not eligible for Medicaid and the services provided under the Charity Care program are not matched with Federal funds, except under the Medicaid DSH program. In reviewing the Medicaid DSH statute at §1923 of the Act, the Board found that the statute mandated that a State Medicaid plan under Title XIX include a provision for a payment adjustment to hospitals which serve a disproportionate number of low income patients, i.e., a Medicaid DSH adjustment for hospitals that's independent of the Medicare DSH adjustment at issue in this case. The Board found that, while the Medicaid DSH adjustment was eligible for Federal financial participation (FFP), the patient days are not directly eligible for FFP because they do not qualify as "traditional Medicaid" services described in §1905(a) of the Act.

In addition, upon further review and analysis of 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 MICCP 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 MICCP 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.[3]

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

[3] The Board also rejected the Provider's attempt to introduce late in the proceedings new arguments and evidence.

## 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.[4] 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.[5] 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.[6]

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.[7] 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

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

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

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

[7] Id. § 1902 et seq., of the Act.

operating procedures.[8] 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.[9] 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 §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 list the specific 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),[10] which addresses a

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[8] Id.

[9] 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."

[10] Section 1923(b) states that "Hospitals Deemed Disproportionate Share.— (1) For purposes of subsection (a)(1), a hospital which meets the requirements of subsection (d) is deemed to be a disproportionate share hospital if— (A) the hospital's Medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State" In addition, paragraph "(2) For purposes of paragraph (1)(A), the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under

hospital's Medicaid inpatient utilization rate, or under paragraph (B),[11] which addresses a hospital's low-income utilization rate or by other means and (e) which provides a special exception.[12] 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.[13]

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this title in a period (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere."

[11] Subsection (B) provides that for purposes of subsection (a)(1), a hospital which meets the requirements of subsection (d) is deemed to be a disproportionate share hospital if— "(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent." (3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—(A) the fraction (expressed as a percentage)— (i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this title (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and (ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and (B) a fraction (expressed as a percentage)— (i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and (ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period. The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this title).

[12] Paragraph (e) provides a "Special Rule."

[13] 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 medical assistance under the State plan or have no health

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[14] 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,[15] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[16] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[17] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[18] 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.[19]

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 diagnosis related groups or DRG subject to certain payment adjustments.

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insurance (or other source of third part coverage for services provided during the year.(The Medicaid DSH payments may not exceed the hospital Medicaid shortfall; that is the amount by which the costs of treating Medicaid patient exceeds hospital Medicaid payments plus the cost of treating the uninsured.)

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

[15] Section 1811-1821 of the Act.

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

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

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

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

Concerned with possible payment inequities for Inpatient Prospective Payment System (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…."[20] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[21] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, *alia inter*, 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 <u>patients who (for such days) were eligible for medical assistance under a State Plan approved under title XIX</u>, 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.[22] The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 C.F.R. §412.106(b)(2). Relevant to this case, the second computation, the "Medicaid-low

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[20] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). <u>See also</u> 51 Fed. Reg. 16772, 16773-16776 (1986).

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

[22] The cost years in this case are cost years ending 1991 through 1996 and 2003 through 2006.

income proxy", or "Clause II", is set forth at 42 C.F.R. §412.106(b)(4)[23] and provides that:

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

[23] The main portion of the regulation has remained unchanged for the various cost reporting periods at issue. Effective October 1, 1995, the second computation, the Medicaid fraction, set forth at 42 C.F.R. §412.106(b)(4), provided 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.)

However, effective for discharges occurring on or after January 20, 2000 certain changes were made: "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 number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply: (i) A patient is deemed eligible for Medicaid on a given day if the patient is eligible for medical assistance under an approved State Medicaid plan on such day, regardless of whether particular items or services were covered or paid under the State plan. (ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act. (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." (2000) Sub-paragraph (i) was further clarified to state that: "(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for *inpatient hospital services under an approved State Medicaid plan* or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver." (2003) (This language was effective for the 2003-2006 cost years.)

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

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

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

In order to clarify the definition of eligible Medicaid days and to communicate a hold harmless position for cost reporting periods beginning before January 1, 2000, for certain providers, CMS issued Program Memorandum (PM) A-99-62, dated December 1999. 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. (Emphasis added.)

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.

In the August 1, 2000 Federal Register, the Secretary reasserted the 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.[24]

CMS issued a Program Memorandum (PM) Transmittal A-01-13,[25] 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 patient is eligible for Medicaid benefits or can be counted as such in the Medicaid formula.

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[24] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

[25] 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 a hold harmless policy. See Transmittal A-01-13; Change Request 1052 (January 25, 2001). The scope and basis for the hold harmless policy is set forth at length in the program memorandum. The Providers did not claim that the hold harmless policy was applicable to the facts under their appeals. See Provider's March 31, 2011 Position Paper, received April 1, 2011.

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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.)

In addition, prior to 2000, the Secretary's policy was to include in the Medicare DSH calculation, only those days for populations under the Title XI section 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.[26] 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 section 1115 waiver expansion populations from the DSH calculation was revisited by CMS and, effective with discharges occurring on, or after, January 20, 2000, certain section 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.[27]

Several courts have also analyzed the phrase "eligible for medical assistance under a State plan approved under title XIX" both for State-only general assistance days and charity care days and have concluded that the phrase "eligible for medical assistance under a State plan approved under title XIX" means patients who are eligible for Medicaid under a Federal statute. This would not include general assistance State- only funded days. These cases include *Adena Regional Medical Center v. Leavitt*, 527 F.3d 176 (D.C. Cir. 2008)*; Cooper University Hosp. v. Sebelius*, 686 F.Supp.2d 483 (D.N.J. Sep 28, 2009); *aff'd.* 636 F.3d 44 (3rd Cir. Oct 12, 2010) *University of Washington Medical Center v. Sebelius*, 634 F.3d 1029 (9th Cir 2011).

In *Cooper, supra*, the district court as adopted by the Court of Appeals for the Third Circuit, concluded that the phrase "eligible for medical assistance under a State plan approved under title XIX" referred to patients who are eligible for Medicaid. Therefore, the New Jersey Charity Care Program patient days could not be included in the numerator of the Provider's Medicaid proxy for purposes of determining the Provider's Medicare DSH adjustment. In *Phoenix Memorial Hospital v. Sebelius,* 622 F.3d 1219 (9th Cir. 2010), the Court of Appeals for the Ninth Circuit affirmed a district court's judgment concluding that state-only funded

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[26] 65 Fed. Reg. 3136 (Jan. 20, 2000).

[27] Id.

health care program population were ineligible for inclusion in DHS adjustment calculation and hospitals were ineligible for hold harmless relief.

In the *University of Washington Medical Center v. Sebelius*, 634 F.3d 1029 (9th Cir. 2011) the court recognized that: "Thus, the definition of "medical assistance" has four key elements: (1) federal funds; (2) to be spent in "payment of part or all of the cost"; (3) of certain services; (4) for or to "[p]atients meeting the statutory requirements for Medicaid". The court concluded that: "Because the Secretary has not granted Washington a waiver for its GAU and MI populations under section 1315, this provision does not operate to make these patients "eligible for medical assistance" under subchapter XIX of the Social Security Act. *See Phoenix Memorial Hospital*, 622 F.3d at 1226–27."[28]

In this case, the Provider argued that MICCP days were included in the methodology for calculating the Medicaid DSH payments under the Michigan State Plan approved under Title XIX and, therefore, the MICCP qualified for Federal financial participation under the Medicaid DSH program. Consequently, The Provider argued that, MICCP patients are "eligible for medical assistance under a State plan approved under [Title] XIX" and must be counted in the Medicaid fraction of the Medicare DSH adjustment.

The Administrator finds that § 1886(d)(5)(F)(vi)(II) of the Act requires, for purposes of determining the 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 the Secretary has interpreted the 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."[29] Section 1905(a) of the Social Security Act defines

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[28] See also, *Adena Regional Medical Center v. Leavitt,* 527 F.3d 176 (2008) 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 defined in the Medicaid statute in §1905(a).

[29] 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

"medical assistance" as payment of part or all of the costs of certain services and care for certain populations of individuals.

The Administrator finds that the days at issue are for patients who are not eligible for Medicaid but rather are only eligible for State-only general assistance or charity care. The provision of the State plan submitted in the record only shows the methodology for Medicaid DSH payments and not that these patients are eligible for the Federal Medicaid under section 1905(a) of the Act.[30]

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 as interpreted and applied by the Secretary pursuant to her discretion. That is, the individual must be eligible for the Federal government program also referred to as Medicaid.

Regarding the expenditure of Federal financial participation or FFP for Medicaid DSH under the Medicaid 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. The statute clearly states that the patients' Title XIX eligibility for that day is a requirement. Therefore, regardless of any possible indirect FFP through a Medicaid DSH payment, the days related to the State only general assistance program, operated and funded by the State of Michigan (not Title XIX), or charity care days, are not counted as Medicaid days.

In this case, the days at issue involve Michigan's general assistance and charity care patients. The Administrator finds that the individuals covered by the MICCP are not eligible for "medical assistance" as described in Title XIX which requires

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which a person was eligible for Medicaid benefits whether or not Medicaid actually paid for those days of service.")

[30] Provider's Exhibit P-2 (showing portion of Michigan State Plan that addresses Medicaid DSH payment eligibility and methodology for various types of health providers including acute care hospitals and does not demonstrate that the patient days are for patients eligible for Medicaid. See e.g. "Calculation of DSH Ceiling" at Attachment 4-19-A p.p. 25-26, "Uninsured Charges: Charges for services provided to patients who do not have any insurance coverage, or for services not covered by the patient's insurance coverage. Services covered by Medicare and/or Medicaid may not be included as uninsured charges.")

entitlement for payment of part or all of a service under an approved State plan.[31] Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly did not include these days in the numerator of the Medicaid fraction. The applicable statute requires an individual be eligible for Medicaid, in order for the patient day to be counted in the numerator of the Medicare DSH payment.[32]

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[31] *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.

[32] The Administrator affirms and adopts the Board's rejection of the Provider's attempt to introduce late in the process new arguments and evidence. See QRS UMHC 1991-1996 DSG/Michigan General Assistance Days Group, PRRB Dec. No. 2013-D21 n. 35. (07/25/13).

## 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: 9/25/13

/s/
Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services