CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of: **Washington General Assistance Days Groups**	**Claim for Payment Determination for Cost Reporting Period(s) Ending:** **Various**
Provider **vs.**	
Blue Cross Blue Shield Association/ Noridian Administrative Services - WA/AK/Wisconsin Physician Services	**Review of:** **PRRB Dec. No. 2013-D38** **Dated: September 12, 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 Providers submitted comments, requesting that the Administrator review and reverse the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Further comments were received from the Providers and comments were received from the Intermediary. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether patient days associated with the Medically Indigent (MI) and General Assistance/Unemployable (GAU) Programs in Washington State should be included in the numerator of the Medicaid fraction of the Medicare Disproportionate Share Hospital (DSH) payment calculation formula in accordance with 42 C.F.R. § 412.106(b)(4) and § 1886(d)(5)(F)(vi)(II) of the Act.

The Board held that the Intermediary properly excluded Washington State's MI and GAU Program days from the numerator of the Providers' Medicaid proxy. The Board held that the MI and GAU beneficiaries are not eligible for Medicaid and

that the services provided under the Washington State MI and GAU programs are not matched with Federal funds, except under the Medicaid DSH provisions. In reviewing the Medicaid DSH statute at § 1923 of the Act, the Board found that the statue mandated that a State Medicaid plan under Title XIX include a provision for 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 particular patient days counted for the Medicaid DSH adjustment are not directly eligible for FFP because they do not qualify as "traditional Medicaid" services described in § 1905(a) of the Act.

The Board stated that the only issue was whether the Washington MI and GAU programs, which is a State funded program, which is included in the Washington State Medicaid Plan solely for the purpose of calculating the Medicaid DSH, constitute "medical assistance under a State Plan approved under [T]itle XIX" for purposes of the Medicare DSH Adjustment specifically the Medicaid fraction component. The Board determined that, upon further review and analysis of the Medicaid DSH statute at § 1923 of the Act, the term "medical assistance under a State plan approved under [Title] XIX" excluded days funded only by the State and MI and GAU 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 Washington State's MI and GAU programs 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 Washington State's MI and GAU patient days did not fall within the Medicaid DSH statute definition of "eligible for medical assistance under a State plan" at § 1923(b)(2) of Act.

In addition, the Board noted that the Providers were located in the Ninth Circuit and that the Ninth Circuit's decision in the *University of Washington Medical Center v. Sebelius*,[1] was controlling.[2] In *University of Washington*,[3] the Court of Appeals reviewed the Washington State's MI and GAU programs and confirmed

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[1] 634 F.3d 1029 (9th Cir. 2011).

[2] See Board's Dec. No. 2013-D38 at 11, fn. 52.

[3] Id.

that MI and GAU days should be excluded from the Medicaid fraction of the Medicare DSH calculation.[4] The Board noted that the Ninth Circuit's decision in the *University of Washington* was consistent with the U.S. Court of Appeals for the District of Columbia decision in *Adena Regional Medical Center v. Leavitt*.[5]

Finally, the Board rejected the Providers' arguments that the hold harmless provisions in PM A-99-62 were arbitrary because it allegedly treated similarly situated providers in a dissimilar manner and was an impermissible substantive rule change subject to APA rulemaking. The Board explained that CMS had reasonably issued PM A-99-62 to provide further guidance to intermediaries on the retrospective and prospective treatment of the State-only days issue. Intermediaries in some States had historically and erroneously allowed providers to include State-only program days applicable to health programs not contained in the relevant Medicaid State plans in their DSH calculations, even though § 1886(d)(5)(F)(vi)(II) of the Act stated that only days attributable to individuals eligible for medical assistance *under a State plan approved under Title XIX* were to be included in the DSH calculation. [6]

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[4] 634 F.3d 1029, 1036.

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

[6] The Board, by letter dated August 13, 2013, denied the Providers' late submission in the proceedings of new arguments and evidence after the record had already closed on June 1, 2012 for the record hearings. The additional material was included in the Providers' "Supplemental Position Papers" dated July 23, 2012 and May 2, 2013, respectively. The Board determined that the Providers failed to properly petition the Board to reopen the record for the record hearing for the admission of additional arguments and evidence. The Board returned the material to the Providers and it was not made part of the administrative record. See Board's Dec. No. 2013-D38 at n. 49.

SUMMARY OF COMMENTS

The Providers submitted comments, requesting that the Administrator review and reverse the Board's determination. The Providers' disagreed with the Board's determination that Washington State's MI and GAU inpatient days are not to be included in the Medicaid Proxy Numerator of the Medicare DSH. The Providers' disagreed with the Board's determination that the State and local governments solely funded Washington State's MI and GAU days. The Providers asserted that the Board determination was based on confusion between "cash benefits" and "inpatient benefits made available to GA recipients and also ignored the controlling State Plan." The Providers noted that "cash benefits" for GA populations were solely State funded, while inpatient benefits under Washington's MI/GAU program were "federalized under the State Plan, effective December 1, 1991 (for MI) and October 1, 1992 (for GAU). Moreover, Washington's approved State Plan conspicuously includes and therefore provides matching Federal funding under Title XIX for claim-specific payments for inpatient care provided to MI/GAU recipients. The assumption that MI/GAU inpatient coverage is not provided for under the Washington State Plan approved by CMS is a clear factual error, which renders the Board decision unsustainable on a clear but narrow ground. The Providers also argued that the days at issue were not included in the low income utilization rate under the Medicaid DSH provision.

The Providers in their comments to the Administrator also requested that this matter be remanded to the Board so that the Board would have the opportunity to consider the relevance of the opinion of the United State District Court for the Eastern District of Pennsylvania in *Nazareth Hosp. v. Sebelius*, Case No. 10CV3513. The Providers argued that the Board erred in not considering this case or accepting its supplemental arguments after it was brought to its attention under the Board rules. The Providers contend that their supplemtnal position papers submitted dated July 23, 2012 and May 2, 2013, did not raise new issues or expand the legal arguments or evidence submitted for the records hearing pointing to its discussion of the case in *Portland Adventist Medical Center v Thompson*, 399 F. 3d 1091 (9th Cir. 2005) as proof. The Providers furthered argued in their comments to the Administrator, similarly, that the Board's reliance on *Adena* and the *University of Washington* is misplaced because of the underlying rationale the Providers put forth relating to the treatment of § 1115 demonstration projects and rulemaking, etc., and first raised in those same excluded Board submissions within the context of the *Nazareth* opinion.

The Providers' also requested that the Administrator reverse the Board's determinations that it did not have jurisdiction over several of the Providers in the respective Groups as set forth in the Board Notices dated February 21, 2013 (PRRB

Case No. 09-1743G March 15, 2013 (PRRB Case No. 00-3186G), April 15, 2013 (PRRB Case No. 09-1581G) and June 28, 2013 (PRRB Case No. 09-1503G).

The Intermediary submitted comments requesting that the Administrator affirm the Board's decision.[7] The Intermediary noted that because the Washington State's Medicaid Plan provides that patients who are eligible for the Washington MI and GAU programs cannot be eligible for Medicaid, Washington's MI and GAU days must be excluded from the Medicaid proxy of the Medicare DSH calculation. The Intermediary noted that the Board correctly concluded that because the MI and GAU programs are funded by state and local governments, and, thus, are included in the low income utilization rate but not the Medicaid inpatient utilization rate, Washington State's MI and GAU patient days do not fall within the Medicaid DSH statute definition of "eligible for medical assistance under a State plan" at § 1923(b)(2) of the Act. Furthermore, the jurisdiction where the Providers are located have already reviewed this particular issue and the Washington State MI and GAU programs and confirmed that MI and GAU days should be excluded from the Medicaid fraction of the Medicare DSH calculation.[8] Finally, the Board correctly rejected the Providers' attempts to supplement the record because the Providers failed to comply with the Board's rules regarding the manner in which a closed record may be reopened.

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

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[7] The Intermediary also requested that the Administrator affirm the Board's jurisdictional determination in its Notices dated February 21, 2013 (PRRB Case No. 09-1743G); March 15, 2013 (PRRB Case No. 00-3186G), April 15, 2013 (PRRB Case No. 09-1581G) and June 28, 2013 (PRRB Case No. 09-1503G) for several providers that was subsequently challenged by the Providers in their comments to the Administrator.

[8] *University of Washington Medical Center v. Sebelius*, 634 F.3d 1029 (9th Cir. 2011).

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.[9] 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.[10] 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.[11]

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.[12] 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.[13] 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.

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

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

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

[12] Id. § 1902 et seq., of the Act.

[13] Id.

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.[14] 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),[15] which addresses a

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[14] 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."

[15] 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 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."

hospital's Medicaid inpatient utilization rate, or under paragraph (B),[16] which addresses a hospital's low-income utilization rate or by other means and (e) which provides a special rule.[17]

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[18] established Title XVIII of the Act, which authorized the establishment of the

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[16] 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).

[17] 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 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.)

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

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,[19] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[20] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[21] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[22] 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.[23] 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.

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…."[24] There are two methods to determine eligibility for

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[19] Section 1811-1821 of the Act.

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

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

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

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

[24] 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).

a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[25] 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 patients who (for such days) were eligible for medical assistance under a State Plan approved under title XIX, but who were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital patient days for such period. (Emphasis added.)

CMS implemented the statutory provisions at 42 C.F.R. § 412.106.[26] 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 income proxy", or "Clause II", is set forth at 42 C.F.R. § 412.106(b)(4) 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 number by the total number of patient days in the same period…. (Emphasis added.)

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

[26] The cost years in this case are cost years ending 1992 through 2007.

The language for the relevant portion of the regulation has remained mostly unchanged for the various cost reporting periods at issue.[27] Effective for discharged occurring on or after January 20, 2000 certain clarifying and other changes were made and 42 C.F.R. §412.106(b)(4) stated that:

> *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:
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> 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,

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[27] Effective October 1, 1991, 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."

regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver." (2003)

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.[28]

CMS issued a Program Memorandum (PM) Transmittal A-01-13,[29] 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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[28] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

[29] 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 § 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.[30] 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.[31]

Several courts have also analyzed the phrase "eligible for medical assistance under a State plan approved under Title XIX" both for State general assistance days and charity care days and have concluded that the phrase "eligible for medical assistance under a State plan approved under [T]itle XIX" means patients who are eligible for Medicaid under a Federal statute. 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). Relevant to this case, the Court of Appeals for the Ninth Circuit in *University of Washington Medical Center v. Sebelius*,[32] specifically addressed the nature of Washington State's MI and GAU program and whether MI and GAU

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[30] 65 Fed. Reg. 3136 (Jan. 20, 2000). In addition, the Deficit Reduction Act of 2005 (DRA) clarified the treatment by the Secretary of §1115 wavier days, and added language to §1886(d)(5)(F)(vi) of the Act that: "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 received benefits under a demonstration project approved under Title XI."

[31] Id.

[32] Supra n. 8.

patient days should be included in the numerator of the "Medicaid proxy" of the Medicare DSH calculation. In its analysis, the Court state that the "inquiry turns not on the payment of a patient's medical bill but on eligibility for "medical assistance."[33] The Court concluded that the phrase "eligible for medical assistance under a State plan approved under subchapter XIX" was unambiguously limited to those eligible for traditional Medicaid."[34] The Court recognized that the definition of "medical assistance" had 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." Id. at 1034. Based on this determination the Court found that while federal Medicaid monies indirectly subsidized the medical treatment received by Washington's MI and GAU populations, their care didn't meet the definition of "medical assistance." The Court stated:

> First, substantial evidence supports the Secretary's finding that the GAU and MI populations do not fit within the enumerated classes of people under section 1396d(a). In large part, these classes share the characteristics of the categorically or medically needy. *Compare 42 U.S.C. § 1396a(10) with id. § 1396d(a)(i)-(v), (vii)-(viii).* The Hospital's own witnesses admitted during the administrative review process that the GAU and MI programs covered those who are not within these categories. Indeed, the Hospitals concede on appeal that the "MI and GAU programs cover low-income persons who do not meet the categorical or status requirements for the Categorically Needy and Medically Needy programs, and therefore are considered ineligible for 'Medicaid.' …. Because the Hospitals' GAU and MI patients did not fit within the statutory classes of people, the patients were not capable of receiving medical assistance as defined by Medicaid….[35]

The days at issue in this case similarly involve the States of Washington GAU and MI programs. The Medical Assistance Administration (MAA), Washington State Department of Social and Health Services (DSHS), operates that State's Medicaid

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[33] Id. at 1034.

[34] Id.

[35] 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).

Program. In addition to the State Medicaid categorically and medically needy, the MAA operates other Stat based programs financing health services of low income population, including the Medically Indigent or MI and General Assitance-Unemployable or GAU programs. The MI program is a State program that provides temporary medical assistance to "persons with an emergency medical condition requiring hospital services, and who are not eligible for cash benefits or for any other medical program." The GAU program is also a State program that provides cash grants and medical assistance to persons meeting low income eligibility criteria who are physically and/or mentally incapacitated and unemployable for more than 90 days (but had not qualified for Social Security disability benefits).[36] The State regulation provides pursuant to WAC 388-100-005 that: "Limited Casualty Program- Medically Indigent: … the department …shall provide a limited casualty program of medical care administered through the medical assistance administration designed to meet the health care needs of persons not receiving cash assistance or eligible for any other medical services." Further, *WAC 388-438-0100(c)(10)* provides that "a client is not eligible for MI if they are eligible for or receiving any other cash or medical program." *WAC 388-400-0025* sets out that

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[36] For citation purposes, as this decision involves 11 groups and cases and 11 identical or closely identical position papers and revised final Position Papers, the reference to the Provider's Final Position Paper will be to the Position Paper submitted in PRRB Case No. 06-1821G and to the Intermediary Position Paper in PRRB Case No. 06-1812G unless otherwise noted. See, e.g., Providers' Final Position Paper (PRRB Case No. 06-1821G) Provider Exhibits P-13, P-14. Intermediary Position Paper, Intermediary Exhibits I-3 "*Washington Assistance Administration, Technical Report, "Our Programs*"), I-6 *("HSHS Eligibility A-Z Manual, Program Summary*" describing GAU eligibility), I-7 ("*HSHS Eligibility A-Z Manual, Program Summary*" describing MI eligibility)(PRRB Case No. 06-1812G). While not relevant to this appeal, at some point in time, the GAU State program became "Medical Care Services" (*WAC 182-508-0005* Eligibility for medical care services) ("The MCS program provides medical benefits to persons who are physically and/or mentally incapacitated and unemployable for more than 90 days. This program differs from ABD in that no disability application is pending with the Social Security Administration. Eligible persons receive limited medical care coverage under the state-funded Medical Care Services (MCS) program."

http://www.dshs.wa.gov/manuals/eaz/sections/MedicalAssistance/ps_medprogs.shtml# 182-508-0005

eligibility for "general assistance-unemployment benefits" and disqualifies a person eligible for SSI, TANF (i.e. Medicaid).[37]

However, effective December 1, 1991, the Medically Indigent *Disproportionate Share Hospital* (MIDSH) program was added to the Washington State's Medicaid State Plan approved under Title XIX pursuant to State Plan Amendment TN 91-30 for purposes of a Medicaid disproportionate share hospital (DSH) payment to hospitals that provide services to low-income, MIDSH patients. Effective October 1, 1992, the General Assistance-Unemployable *Disproportionate Share Hospital* (GAUDSH) program was added to the Washington State Medicaid Plan approved under Title XIX pursuant to State Plan Amendment TN 92-25[38] for purposes of a DSH payment to hospital that provide services to low-income, GAU patients.

The State Plan at Attachment 4.19A describes the "Disproportionate Share Payments" and explains that all DSH payments will not exceed the State's DSH allotment. "Cost" is defined "as the cost of services to Medicaid patients less the amount paid by the State under the non-DSH payment provisions of the state plan plus the cost of the services to indigent and uninsured patients less any cash payments made by them." This provision explains that "we will not exceed the DSH State-wide Allotment nor allow a hospital to exceed the DSH limit. The following clarification of our process explains our precautionary procedures." In addition, "All the Departments DSH programs payments are prospective payments and these programs are the …MIDSH, GAUDSH." I-8, P-4. That is, the DSH payments cannot exceed the State DSH allotment and they are prospective.

A hospital may receive a disproportionate share hospital payment "if the hospital meets the eligibility requirements for that respective DSH payment component." The State plan provides for a low income disproportionate share hospital payment (LIDSH), which is based on the hospital's "low income utilization rate", as defined in section 1923(b)(2) of the Act, and explained by the Board as involving three distinct components "services furnished under a State plan (Medicaid), "cash subsidies for patient services received directly from the State and local government" and "charity care."[39]

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[37] Provider Exhibit P-21 at 9.

[38] *See e.g.*, Providers' Position Paper (PRRB Case No. 06-1812G) at p 8, 11. Provider Exhibits P-11, P-22.

[39] The Providers state that they are not including patients whose statistics are used in this LIDSH formula in the Medicare DSH payment at issue. The Providers also point to a March 2, 2012, Revised Position Paper, Exhibit P-8, to show that the

The State Plan Medicaid DSH provision states that: "Effective July 1, 1994, hospitals shall be deemed eligible for a MIDSH payment if: a. …The hospital provides services to low-income medically indigent patients. MI persons are low income individuals who are not eligible for any health care coverage and who are encountering an emergency medical condition…." The resulting payment "is directly related to a hospital's volume of services provided to low-income MI patients." Similarly the GAUDSH payment is for a hospital that "provides services to low-income General Assistance Unemployed (GAUDSH) patients. GAU persons are low income individuals who are not eligible for any health care coverage and who are encountering a medical condition."[40] The resulting payment "is directly related to a hospital's volume of services provided to low-income GAU patients."

In this case, the Providers argued that the Washington State's MI and GAU Program days was included in the methodology for calculating the Medicaid DSH payments under the Washington State Plan approved under Title XIX and, therefore, the MI and GAU patient days qualified for Federal financial participation under the Medicaid DSH program. Consequently, the Providers argued that, MI and GAU 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 Providers also argued that, PM 99-62 resulted in unequal treatment of Providers through CMS' application of the hold harmless policy.

Medicaid and GAU/MI program days are treated as the same type of day for medical assistance under DSH. Notably, this exhibit cannot transform non-Medicaid eligible patients to Medicaid eligible patients. Moreover, while not dispositive of the issue, Exhibit P-8 is a "DSH application" for all the DSH programs. The Providers points to the declaration and testimony of Mr. Johnson for support that these days were included in the Medicaid inpatient utilization rate (MIPUR). However, the State plan itself also does not show a separate "Medicaid inpatient utilization rate" DSH payment methodology authorized under section 1923(b)(1) to prove the Providers' point in isolation, while the MIPUR is part of the low income utilization rate, which is used in part under the MIDSH and GAUDSH.

[40] Provider Exhibits P-4 (Transmittal No. 98-7, effective 12/15/98 and Transmittal No. 05-006, effective date 7/1/05) and P-l1 (Transmittal No. 92-25, effective 10/1/1992), P-22 (Transmittal No. 91-30, effective date 12/1/1991). This latter transmittal was in effect prior to approval of the GAUDSH provision and shows the payment being made under section 1923(b)(3) under the low income utilization rate and the MIDSH provision effective 1991 only.)"

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."[41] Section 1905(a) of the Social Security Act defines "medical assistance" as payment of part or all of the costs of certain services and care for certain populations of individuals.[42]

The Administrator finds that the State Plan inclusion of the MIDSH and GAUDSH programs refers only to the additional funding provided to hospitals serving a disproportionate number of indigent patients under Section 1923 of the Act, and does not make the patients eligible for medical assistance under an approved State plan. Notably, regardless of the methodology used, Medicaid DSH payments to hospitals are not medical assistance payments on behalf of the individual patient

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[41] See e.g. *Cabell Huntington Hosp. Inc., v. Shalala*, 101 F.3d 984, 989 (4 th 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.")

[42] Contrary to the Providers Position Paper, it is reasonable to assume Congress has consistently used the term "medical assistance" in the Social Security Act at sections 1901, 1902(a)(10), 1905 and 1923 of the Act and section 1886(d)(5)(vi)(II) of the Act. In addition, the Board's statement that the days were used in the "low income utilization" methodology is harmless error. In this particular case, the types of days/or costs for the MI/GAU patients are referenced for use in the Medicaid DSH payment methodology under the "special rule" of section 1923(e) and not under the low income utilization methodology at section 1923(b)(2) (as in *Ashtubula*). This does not negate the consistent use of the term "medical assistance" under Title XIX and Title XVIII. Moreover, as exemplified in this case, regardless of the statutory authority for the Medicaid DSH methodology, the MI/GAU patients are not eligible for "medical assistance" under section 1905 of the Act as they do not belong to the category of people so determined eligible for Medicaid.

under Title XIX and as defined by section 1905 of the Act. The Administrator finds that the individuals/enrollees under the MI and GAU programs do not fall within the legal meaning of "patients who (for such days) were eligible for medical assistance under a State Plan approved under Title XIX." In particular, the language set forth in section 1886(d)(5)(F)(vi)(II) requires that the day be related to an individual eligible for "medical assistance under Title XIX" also known as the Federal program Medicaid. The use of the term "medical assistance" at sections 1901, 1902(a)(10) and 1905 of the Social Security Act, for example, and the use of the term "medical assistance" at Section 1886(d)(5)(F)(vi)(II) of the Social Security Act are 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."[43] Therefore, the Administrator finds the language at section 1886(d)(5)(F)(vi)(II) that states that the numerator "is the number of the hospital's patients 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" requires that for a day to be counted, the individual must be eligible for medical assistance under Title XIX. That is, the individual must be eligible for the Federal government program also referred to as Medicaid. The 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, the statistic for which is also used for the Medicaid DSH payment.[44]

Moreover, while not dispositive, the record shows that the State of Washington also considers these programs to be State-only programs, not federally authorize programs under Title XIX.[45] The State of Washington used an electronic verification system to verify the number of Title XIX eligible patient days to be used in the Medicare DSH payment calculations. Patient days associated with the

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

[44] See Intermediary's Exhibit I-2. On its website, The Medical Assistance Administration (MAA), Washington State Department of Social and Health Service (DSHS) who administers these two programs describe these programs as State entitlement programs authorized under State law.

[45] See Intermediary's Exhibits I-14, pp. 11, 13; Exhibit I-14, pp. 16, 17, 30, 32. The transcripts of the DSHS personnel deposed by the Providers' legal representative also discussed these as State entitlement programs authorized under State law.

Washington State's MI and GAU programs were not counted in calculating the Providers' Medicare DSH payments. With respect to MI and GAU days, the State reported:

> *Counting on MI/GAU hospital as Title XIX days*: DSHS' review included an analysis of the identification of Medically Indigent (MI) and General Assistance (GAU) clients. DSHS has been asked whether or not inpatient hospital days for these clients should be included in Title XIX eligible days counts. An * on a Remittance Advice identifies a MI/GAU client. While some federal matching funds were at one time provided to states for MI/GAU client hospital services, these funds came in the form of a grant for uncompensated care, but did not make a client Title XIX eligible. MI/GA clients are not included in the count of Title XIX eligible days.[46]

Furthermore, in response to an Intermediary question regarding the treatment of GAU days, the Director of the Health and Recover Service Administration at Washington State DSHS stated:

> Your question is whether the Department considers GAU inpatient hospital days as attributable to patients who are eligible for Medical Assistance under the Medicaid State Plan. The Department does not consider these days as attributable to patients who are eligible for Medical Assistance under the State Plan. We have not counted these days as Medicaid days for several years in our calculations. Patients who are eligible for the GAU program are eligible for state medical assistance program, but they are not eligible for Medicaid [Title XIX] (TXIX). Payment for the GAU program are funded using DSH funds as a financing mechanism, but the program is a state entitlement authorized in state laws.[47]

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 MI and GAU Program specifically exclude 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 as interpreted and

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[46] See Intermediary's Exhibit I-1, p. 3.

[47] *See* Intermediary's Exhibit I-4.

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. Therefore, the Administrator finds that the individuals covered by the Washington's MI and GAU programs are not covered by "medical assistance" as described in Title XIX. The fact that the costs or days for the patients qualified under these State only programs may be used in the computation of the Medicaid DSH payment does not quality the patients for Medicaid. Therefore, regardless of the fact that hospital may receive indirect FFP through a Medicaid DSH payment, based on a Medicaid DSH methodology, which relies upon MI/GUA statistics, the patients themselves are not are not Medicaid patient days.[48]

The Providers in this case also argued with respect to "waiver days" that the "recent decision in the Portland Adventist case … supports the inclusion of expansion population patient days from the effective date of the section 1115 waiver which preceded January 20, 2000. Other cases support the inclusion of expansion population patient days as well. *While an 1115 waiver is different* than a State plan amendment, the results are the same— Title XIX funds are providing medical assistance to low-income populations."[49]

The Providers did not challenge the validity of the regulation allowing for certain section 1115 days after January 20, 2000 or the constitutionality. Rather the providers specifically argued, using a "minted" State/Federal quarter analogy, that: "per the *Portland Adventist* decision in the Ninth Circuit, the Oregon quarters, or 1115 waiver population days are to be included in the Medicare DSH calculation effective with the minting of the coins -not January 20, 2000…. The Secretary

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[48] The record shows that the Board rejected the Providers' attempt to supplement the record with additional constitutional arguments as the documents and arguments were plainly not filed in accordance with the Board Rules 32.3(c) and 44. The Board Rules in effect specifically address the manner in which record hearings are to proceed and those Rules include the necessary steps for supplementing closed records. There is no dispute that at the time these supplemental papers were filed, the record had closed. Therefore, the Providers were bound to follow Rule 32.3(c), when they sought to supplement the closed record. The Administrator finds that the Board acted within its statutory right under section 1878(e) of the Act to enforce these Rules which are necessary and appropriate to carry out its functions and did so properly under the facts in this case. Accordingly, the Administrator affirms the Board's rejection of the Providers' supplemental arguments.

[49] Providers Final Position Paper at 34.

began providing Federal financial participation paying inpatient hospital healthcare costs effective December 1, 1991 and October 1992 for the MI and GAU patient population, respectively….In our analogy those equates to authorizing and minting of Washington quarters with a Washington image on the back side of the coin. This is federal financial participation on the front and back of the coin and State participation in the middle." The patients/quarters with State images on their backs represent medical assistance to expand eligibility population that could not otherwise be made eligible for Medicaid; however through the approval of an 1115 waiver or SPA, they were created authorized/minted and are eligible for and in fact received medical assistance under a state plan approved under Title XIX….. There should be no differentiation between the [State] coins. They were all accepted, approved and authorized by the Secretary and created to assist low-income populations. Federal financial participation dollars have been used in each State to provide medical assistance to these low-income populations. Equal treatment is fully consistent with Congressional goals calling for inclusion of these populations." (Providers' Final Position paper at p.52 (PRRB Case no. 06-1812G)

The foregoing argument is distinguishable from those presented in the Providers Supplemental arguments and does not contain a challenge to the section 1115 rulemaking nor raise an equal protection argument to the post- January 20, 2000 treatment. The provider wants the reasoning used in *Portland* applied under these facts. Regarding the application of *Portland* to the facts of this case, as the providers acknowledge, the days at issue are not the same type and are distinguishable from the days in this case. In addition, Portland was issued prior to the DEFRA statutory clarification and, finally, the Providers are not located in that circuit.

The Board also correctly rejected the Providers' argument that the "hold harmless" provision in the PM A-99-62 are arbitrary because it treats similarly situated providers in a dissimilar manner and that the implementation of the "hold harmless" policy is an improper substantive rule change. The Providers argued that there was no equality between providers in CMS' application of the PM-A-99-62 "hold harmless" provisions and the October 15, 1999 deadline. However, the Secretary reasonably set forth the scope of the hold harmless policy, which the Providers never argue allow for relief in this case. The Administrator notes that these arguments have also been addressed in several court holdings. As explained by the court in *United Hospital v Thompson*:[50]

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[50] *See e.g. United Hospital v Thompson*, N. Civ.02-3479 (DWF/SRN) (June 9, 2003) 2003 WL 21356086 (D. Minn.) (court found the Secretary's hold harmless policy and its application in PM-A-99-62 reasonable).

> [T]he agency intended to hold harmless hospitals that had reasonably relied upon a false belief that they were entitled to compensation for general assistance days….. A hospital that did not file an appeal on this issue [of GA days] prior to October 15, 1999 - the date on which CMS announced the resolution to the confusion over inclusion of general assistance days-did not manifest belief independent of the Program Memo—that it was entitled to such payment and presumably would not have made budget decisions based on a belief in such entitlements. United seeks to characterize the Program memo as a change or reversal of CMS's policy of which hospitals should have been given notice. Yet the Program Memo is on its face a clarification of existing policy. The record indicates that CMS's policy has consistently been that general assistance days are not relevant to the Medicaid fraction, and the program memo simply reiterates that position. The fact that hospitals other than United misunderstood the policy and acted in reliance upon that misunderstanding and the fact CMS decided to provide those hospitals with relief from their own mistake did not lead to the conclusion that CMS had some obligation to extend additional benefits to other hospitals." *Id.* at 5.

In this case, the days at issue involve the Washington MI/GUA days. The Administrator finds that those patients are not eligible for "medical assistance" as described in Title XIX which requires entitlement for payment of part or all of a service under an approved State plan just because their statistics were included in the computation of the Medicaid DSH formula. 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 to be eligible for Medicaid, in order for the patient day to be counted in the numerator of the Medicare DSH payment. In addition, the Secretary's application of a hold harmless policy was reasonable and created no obligation to extend benefits for other providers and cost years beyond the scope of the PM.[51]

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[51] *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.

The Providers also requested that the Administrator review and reverse the Board's jurisdictional determinations.[52] The regulations at 42 C.F.R. §405.1885(a)(1) states that:

> A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in §405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in §405.1885(c) of this subpart).

The regulations at 42 C.F.R. §405.1887(d) states that:

> A reopening by itself does not extend appeal rights. Any matter that is reconsidered during the course of a reopening, but is not revised, is not within the proper scope of an appeal of a revised determination or decision (as described in §405.1889 of this subpart).

In addition, the regulations at 42 C.F.R. §405.1889 states that:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
> (b) (1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision are within the scope of any appeal of the revised determination or decision.
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

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[52] The Administrator notes that CMS issued clarifying language with respect to reopening and revised final determinations at 73 Fed. Reg. 30190, 30230-30234 (May 23, 2008). The clarifying language did not substantively change the relevant original language.

Federal courts have held that the above-cited regulations have the effect of limiting the scope of Board appeals arising from revised reimbursement determinations, giving such appeal rights an "issue specific" nature. For example, the Court *HCA Health Services Oklahoma v. Shalala*,[53] held that, "when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive from the federal government under the Medicare program …, a provider's appeal of that reopening to the Provider Reimbursement Review Board, is limited to the specific issues revisited on reopening and may not extend further to all determinations underlying the original reimbursement decision for that financial year."[54]

In this case, the Providers argued with respect to the Board jurisdictional determinations dated February 21, 2013 (PRRB Case No. 09-1743G) and March 15, 2013 (PRRB Case No. 00-3186G) that, while MI and GAU days were not specifically adjusted by the Intermediary on the revised Notice of Program Reimbursement (NPRs), their respective DSH calculation was revised. The record shows that the MI and GAU days were not adjusted by the Intermediary in the jurisdictionally dispute revised NPRs. The Administrator affirms the Board determination that it lacked jurisdiction over certain Providers' MI/GAU appeal issue as the matter being appealed was not the subject of the revised NPRs.[55]

With respect to the Board's denial of jurisdiction in the April 15, 2013 (PRRB Case No. 09-1581GC) and June 28, 2013 (PRRB Case No. 09-1503GC) determinations, the Administrator affirms the Board's denials in those cases. The Board acted within its authorities as provided under section 1878 (e) of the Act and 42 CFR 405.1801, et seq. The record supports the Board's findings that the matter, which the Providers were seeking to transfer were never properly and timely added to the original single appeals and thus those providers/cost years were properly dismissed.

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[53] 27 F.3d 614 (D.C. Cir. 1994).

[54] Id.

[55] The Administrator recognizes that the Washington court reversed the Administrator on the jurisdictional determinations in that case. However, jurisdictional determinations are fact specific and the Providers may also seek review in the United States Court of Appeals for the District of Columbia in this case. Moreover, even if the Providers were successful on that matter the days would not be includable in the numerator of the Medicaid fraction.

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: 11/27/13 /s/

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services