PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D7

PROVIDER -
Mercy Medical Center
Des Moines, Iowa

Provider No.: 16-0083

vs.

INTERMEDIARY -
Wisconsin Physician Service

DATE OF HEARING -
March 16, 2009

Cost Reporting Periods Ended -
June 30, 1997 and June 30, 1996

CASE NOs.: 06-0301 and 06-0302

INDEX

ISSUE:

Whether the Intermediary improperly calculated the Provider's Medicare disproportionate share hospital (DSH) payment by excluding patient days attributable to hospital inpatients who were eligible for Medicaid and enrolled in Medicare Part A for all or a part of the period at issue.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and interpretive guidelines published by CMS. See 42 U.S.C. §1395h; 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the receipt of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). 42 U.S.C. §1395ww(d). The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. 42 U.S.C. §1395ww(d)(5). This case involves one of the hospital-specific adjustments, specifically the "disproportionate share hospital," or "DSH" adjustment. The Secretary is required to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. §1395ww(d)(5)(F)(i)(I).

Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage." 42 U.S.C. §1395ww(d)(5)(F)(v). The "disproportionate patient percentage" is the sum of two fractions, the "Medicare and Medicaid fractions," expressed as a percentage for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi). A provider whose DSH percentage meets certain thresholds receives an adjustment which results in increased PPS payment for inpatient hospital services. 42 U.S.C. §1395ww(d)(5)(F)(ii). The Medicare fraction's numerator is the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income (SSI), excluding patients receiving state supplementation only, and the denominator is

the number of hospital patient days for patients entitled to Medicare Part A. Id. See also, 42 C.F.R. §412.106(b)(2). The Medicare fraction is also referred to as the Medicare proxy or the SSI fraction. The Medicaid fraction's numerator is the number of hospital patient days for patients who were "eligible for medical assistance under a State plan approved under . . . [Title] XIX" for such period but not entitled to benefits under Medicare Part A, and the denominator is the total number of the hospital's patient days for such period. Id; See also, 42 C.F.R. §412.106(b)(4). The Medicaid fraction is also referred to as the Medicaid proxy.

The Medicaid fraction is the only fraction under the Title XVIII Medicare DSH statute at issue in this case.

Part A of the Medicare Act covers "inpatient hospital services." 42 U.S.C. §1395d(a)(1). This benefit includes the right to have Medicare payment made on the beneficiary's behalf for 90 days of inpatient hospital service, per spell of illness, plus 60 additional "lifetime reserve" days. Id. 42 C.F.R. §409.61. No payment may be made under Part A for inpatient hospital services furnished to a beneficiary after exhaustion of this benefit. 42 U.S.C. §1395d(b)(1).

The regulation provides that the fiscal intermediary determines . . . "[t]he 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." 42 C.F.R. §412.106(b)(4).

FACTS/BACKGROUND:

The parties' have stipulated to the following:

1. The issue in these two appeals is whether the Intermediary improperly calculated the Provider's Medicare disproportionate share hospital (DSH) payment by excluding patient days attributable to two hospital inpatients (referred to herein as Patient 1 and Patient 2) who were eligible for Medicaid. Patient 1 was enrolled in Medicare Part A for part of the period put in issue and was eligible for Medicaid only during another part specified below. Patient 2 was enrolled in Medicare Part A for all of the period at issue.

2. The Provider in these appeals is Mercy Medical Center, Medicare provider number 16-0083. The cost reporting periods at issue are the periods that ended on June 30, 1996 and June 30, 1997. Cahaba Government Benefit Administrators (Cahaba) previously served as the Provider's fiscal intermediary and issued the final payment determinations at issue in this case for those cost reporting periods. Wisconsin Physicians Service currently serves as the Provider's Medicare Administrative Contractor. The Blue Cross and Blue Shield Association is defending the final payment determinations at issue in this appeal. These three organizations are referred to herein individually and collectively as the "MAC."

3. On December 19, 2002, Cahaba issued revised notices of program reimbursement (NPR), reflecting the Provider's DSH payments for its fiscal years ending June 30, 1996 and June 30, 1997. The Provider appealed those determinations to the Board on the issue concerning the exclusion of the Provider's Medicaid-eligible patient days attributable to the two patients who had exhausted Medicare Part A benefits, and those appeals were assigned PRRB case numbers 03-0683 and 03-0684.

4. The Provider and Cahaba agreed to an Administrative Resolution for the above-referenced appeals, which agreement is included in Provider Exhibit P-3. In that agreement, Cahaba agreed to include a portion of the Part A exhausted days at issue in the Medicaid fraction for the 1996 and 1997 cost reporting periods. In particular, Cahaba agreed to add 730 Medicaid days (365 each for Patients 1 & 2) to the numerator of the Medicaid fraction for the 1996 cost reporting period and to add 377 Medicaid days (65 for Patient 1 and 312 for Patient 2) to the numerator of the Medicaid fraction for the 1997 cost reporting period. The Provider proposed, but Cahaba refused, to include all of these days in the DSH calculation for the 1997 cost reporting period, based on the patients' date of discharge in that period. In connection with this Agreement, Cahaba verified that the inpatient days for the two patients at issue were not included in CMS' calculation of the Provider's Medicare/SSI fraction for 1996 or 1997.

5. The Secretary issued a final rule on August 11, 2004 in which CMS stated (at 69 Fed. Reg. 49099):

> [W]e are adopting a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Part A hospital coverage. If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. We are revising our regulation at § 412.106(b)(2)(i) to include the days associated with dual-eligible beneficiaries in the Medicare fraction of the DSH calculation.

6. In June 2005, Cahaba issued notices of reopening for the 1996 and 1997 cost reporting periods (Provider Exhibit P-4) "to ensure patient days where the patients are dual eligible are properly excluded from the Medicare and Medicaid proxy in the Intermediary's calculation of DSH." Those notices stated that the reopenings were based "on a recent clarification received from CMS . . . that dual eligible days should not be included in either the Medicare or Medicaid proxy for periods prior to October 1, 2004."

7. Cahaba issued revised NPRs dated June 10, 2005 (Provider Exhibit P-5) that excluded the same Medicaid-eligible Part A exhausted days that had been included in the Medicaid fraction pursuant to the Administrative Resolution of the Provider's prior appeals in PRRB case numbers 03-0683 and 03-0684.

8. The Provider subsequently filed appeals from the June 2005 revised NPRs, and those appeals were assigned PRRB case numbers 06-0302 and 06-0301.

9. All of the days at issue in these appeals relate to two patients who were admitted to the hospital in 1992 and discharged in the 1997 cost reporting period. As reflected in Cahaba's workpaper (Provider Exhibit P-17), both patients were in areas of the hospital subject to the prospective payment system.

10. Patient 1 first became a patient of the Provider on September 18, 1992 and died in the hospital on September 4, 1996 and was a patient at all times in between. From the date of admission the patient was eligible for Medicaid. Effective May 1, 1994, Patient 1 also became enrolled in Medicare Part A. The duration of Patient 1's Medicaid only eligibility was 589 days (from September 18, 1992 until May 1, 1994). From May 1, through September 28, 1994, Medicare Part A covered benefits for the full 150 day spell of illness maximum. From September 29, 1994 to June 30 1995, Patient 1 was still eligible for Medicaid and enrolled in Medicare Part A (275 days). As noted in paragraph 4, Patient 1 remained a patient and remained eligible for Medicaid until September 4, 1996 (or 430 days).

11. Patient 2 was first admitted on May 7, 1992 and remained in the Provider until discharged on May 9, 1997. Patient 2 became eligible for Medicaid on July 1, 1995 (the first day of FYE June 30, 1996) and remained eligible for Medicaid through the date of discharge (678 days). While Patient 2 was enrolled in Medicare Part A during the Provider's 1996 and 1997 fiscal years, Medicare Part A coverage had been exhausted prior to the commencement of Medicaid eligibility.

12. The Provider did not receive reimbursement for DSH in the 1993 and 1994 cost reporting periods. The Provider claimed and received reimbursement for DSH in the 1995, 1996 and 1997 cost reporting periods. The Provider received DSH payments for the 1995, 1996 and 1997 cost reporting periods based upon the number of patient days in each cost reporting period (service date) instead of based upon the number of patient days of the stay when discharged (discharge date).

13. The Provider is contending all of the days identified for Patient 1 except for the 150 days paid by Medicare Part A, or a total of 1,297 days, should be added to the numerator of the Medicaid fraction for fiscal year ended June 30, 1997. In addition, the Provider is contending that 678 days for Patient 2 should be added to the numerator of the Medicaid fraction for the fiscal year ended June 30, 1997.

14. The Intermediary first contends that as a matter of law, the Medicaid fraction was correctly determined and no additional days should be added. If the final decision by the last administrative or judicial review is that the days in dispute meet the tests of inclusion in the Medicaid fraction, then the final decision should be to reverse the adjustments identified in paragraph 7 and not permit the Provider to change the method as to how days are accumulated in the Medicaid fraction as reflected in paragraph 12 above.

15. The Intermediary contends that if the final administrative or judicial decision is to require that all days be included in the year of discharge in the numerator of the Medicaid proxy, then the denominator of the Medicaid fraction should be adjusted to include all days.

16. None of the patient days at issue have been counted in the numerator of the Medicaid fraction for the Provider's 1996 and 1997 cost reporting periods or for any prior cost reporting period.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mercy Medical Center (Provider) is an acute care hospital located in Des Moines, Iowa. The Provider timely appealed that determination and met the jurisdictional requirements of 42 U.S.C. §1395oo and 42 C.F.R. §405.1835.

The Provider is represented by Christopher L. Keough, Esq., of King & Spalding, L.L.P. The Intermediary is represented by Bernard Talbert, Esq., of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the dispositive question presented in this case is whether the two patients at issue were "entitled to benefits under Part A" for the days at issue. If so, the days would have to be included in the Medicare/SSI fraction and could not be counted in the numerator of the Medicaid fraction. However, if these patients were not entitled to benefits under Part A for the days at issue, then all of those days would have to be counted in the numerator of the Medicaid fraction for the 1997 cost reporting period because each of these patients was discharged in that cost reporting period, they were in areas of the hospital subject to PPS, and they were eligible for Medicaid for the number of days in question.

The Provider contends that the Intermediary's application of CMS' 2004 policy change with respect to the Part A exhausted benefit days for the 1996 and 1997 cost reporting periods at issue is incorrect and must be reversed for the following two reasons.

First, the Intermediary's application of CMS' 2004 policy change is contrary to the DSH regulation that was in effect for the periods at issue. The regulation in effect at that time interpreted the statutory phrase "entitled to benefits under Part A" to mean "covered" by Medicare Part A, see, e.g., 42 C.F.R. §412.106(b)(2)(i) (1997), and the Part A coverage regulations define "covered" to mean "services for which the law and regulations authorize Medicare payment." 42 C.F.R. §409.3 (1997). Accordingly, under the regulation in effect for the periods at issue, Part A exhausted benefit days cannot be considered to be days for which a patient is "entitled to benefits under Part A" because these days are not "covered" days for which the patient is entitled to have Medicare Part A payment made. This is consistent with the Secretary's statements of intent at the time he adopted the DSH regulation in 1986, 51 Fed. Reg. at 31460-61 (Sept. 3, 1986), in subsequent litigation before several Federal courts of appeals,[1] and in the Administrator's decision in Presbyterian Med. Ctr. of Philadelphia v. Aetna Life Ins. Co., CMS Administrator, November 29, 1996, MEDICARE & MEDICAID GUIDE (CCH) ¶ 45,032 (Presbyterian). This is also consistent with CMS' calculation of the Medicare/SSI fraction for periods before the 2004 change in policy. As the agency itself has acknowledged, and as the stipulations in this case confirm, CMS never counted Part A exhausted benefit days in the Medicare/SSI fraction for periods before the 2004 change in policy because the regulation in effect before that change included only "covered" days in that fraction. 69 Fed. Reg. at 49098 (Aug. 11, 2004). In the brief in Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.C.C. 2008), (Baystate) the Secretary conceded that Part A exhausted benefit days were not, and should

[1] See Provider Exhibits P-12, P-13, and P-14.

not have been, counted in the Medicare/SSI fraction for the periods at issue because these days are not "covered", i.e., entitled to benefits under Part A.[2]
Second, even if CMS's 2004 policy change could properly be applied retroactively, the Provider contends that the 2004 change in policy is otherwise substantively and procedurally invalid.

The Provider believes the 2004 change in policy is substantively invalid in two respects. To begin with, CMS' new policy of counting Part A exhausted benefits days as days attributable to patients who are "entitled to benefits under Part A" is contrary to the plain meaning of the DSH statute. In a single sentence defining the Medicaid and Medicare/SSI fractions, the statute uses two different terms: "entitled" and "eligible." 42 U.S.C. §1395ww(d)(5)(F)(vi). In prior litigation as to the meaning of these terms, as used in that same sentence, three consecutive Federal appellate courts concluded that the Secretary cannot properly construe them to have the same meaning. Jewish Hosp. Inc., v. Sec'y of Health and Human Servs., 19 F.3d 270, 274-75 (6th Cir. 1994)(Jewish); Cabell Huntington Hosp. v. Shalala, 101 F.3d 984, 988 (4th Cir. 1996)(Cabell); Legacy Emanuel Hosp. and Health Ctr. v. Shalala, 97 F.3d 1261, 1265-66 (9th Cir. 1996) (Legacy). The Provider argues, now, as before, the Secretary is once again conflating the terms "eligible" and "entitled." CMS's new policy would count a Part A exhausted benefit day as a day for which the patient is "entitled to benefits under Part A" regardless of the fact that the beneficiary is not entitled to have any benefits paid under Part A for such days. In this regard, "entitled" to Medicare Part A is being given the same meaning as "eligible" for Medicaid, and such a construction of the DSH statute is clearly wrong.

Moreover, the benefit provided under Medicare Part A for inpatient hospital services is the right to have payment made on the beneficiaries' behalf. 42 U.S.C. §1395d(a)(1). This benefit is limited to a prescribed number of days per spell of illness. Id. §§1395(a)(1), (b)(1); 42 C.F.R. §409.61. After exhaustion of those days, the patient is not entitled to payment of further benefits under Part A for additional days in the same spell of illness. Id.

Additionally, while CMS's new policy would count Part A exhausted benefit days as days for which a beneficiary is "entitled to benefits under Part A" for purposes of the DSH statute, the same days are not counted as days for which a beneficiary is "entitled to benefits under Part A" for purposes of another Part A payment provision. In particular, the PPS statute establishes a special payment adjustment for a "Medicare dependent hospital," which is defined to mean a hospital that has not less than 60% of its inpatient days attributable to "inpatients entitled to benefits under Part A." 42 U.S.C. § 1395ww(d)(5)(G)(iv)(IV). For purposes of that provision, CMS construes the term "entitled to benefits under Part A" to exclude Part A exhausted days. 55 Fed. Reg. at 35996 (Sept. 4, 1990) ("Entitlement to payment under part A ceases after the beneficiary has used 90 days in a benefit period and has either exhausted the lifetime reserve days or elected not to use available lifetime reserve days.") And, as the D.C. Circuit recently ruled, we must presume that "identical words used in . . . the same act are intended to have the same meaning." Adena Reg'l Med. Ctr. v. Leavitt, 527 F.3d 176, 180 (D.C. Cir. 2008).

Further, CMS's 2004 policy change is also substantively invalid because it is an arbitrary and capricious departure from the agency's prior established interpretation of the DSH statute. In 2003, the Secretary published notice of a proposed rule in which he said that the agency was

[2] Provider Exhibit P-1.

proposing to amend the DSH regulation to permit hospitals to begin to count Medicaid-eligible days in the numerator of the Medicaid fraction after Medicare Part A benefits are exhausted. 68 Fed. Reg. at 27207 (May 19, 2003). The Secretary, however, did not address this issue in the final PPS rule that was adopted in 2003, 68 Fed. Reg. at 45421 (Aug. 1, 2003), and instead noted in the proposed rule published in 2004 that this issue would be addressed in the final PPS rule for Federal fiscal year 2005. 69 Fed. Reg. at 28286 (May 18, 2004). In the final PPS rule adopted in that year, though, the Secretary abruptly reversed course and revised the DSH regulation to begin counting these same days in the Medicare/SSI fraction. 69 Fed. Reg. at 49098-99 (Aug. 11, 2004).

In promulgating that final rule, the Secretary agreed with one commenter's suggestion that a beneficiary who exhausts Part A benefits for inpatient hospital services is entitled to other benefits under Part A, such as SNF services. However, this is clearly untrue. By definition, for days in which a beneficiary is a hospital inpatient, he or she cannot be entitled to have payment made on his or her behalf for "post-hospital extended care services" furnished to a patient admitted to a skilled nursing facility. See 42 U.S.C. §1395d(a)(2) (defining the scope of benefits covered under Part A to include "post-hospital extended care services"); 42 U.S.C. §1395x(i) (defining "post-hospital extended care services" to include services furnished "after transfer from a hospital"); see also 42 C.F.R. §409.20 (discussing Part A coverage for post-hospital services furnished to an inpatient of a skilled nursing facility). The only sense in which a hospital inpatient could be said to be "entitled" to other Part A benefits for a day of inpatient hospital care is in the sense that the beneficiary is enrolled in Medicare and therefore is eligible for Part A. But, here again, CMS is conflating the two different terms - "eligible" and "entitled." Thus, the Provider asserts CMS's 2004 policy change is arbitrary and capricious because the agency failed to provide a rational explanation for its departure from long-established precedent construing "entitled" to mean "covered" (or paid). *See, e.g.,* Mich. Pub. Power Agency v. FERC, 405 F.3d 8, 11 (D.C. Cir. 2005).

The Provider also contends that CMS's 2004 policy change is procedurally invalid because it violates the notice and comment rulemaking requirements prescribed by the Administrative Procedure Act, 5 U.S.C. §553.

The Provider contends that all of the days at issue must be counted in the numerator of its Medicaid fraction for the 1997 cost reporting period because each of these patients was discharged in that cost reporting period, they were in areas of the hospital subject to PPS, and they were eligible for Medicaid for these days. The denominator of the fraction should, however, remain unchanged in accordance with CMS policy letter dated April 23, 1991,[3] and to avoid double-counting for the days included in the denominator for prior periods. This method is consistent with the CMS Administrator's decision in the Castle Medical Center, CMS Administrator, Sep. 12, 2003, Medicare & Medicaid Guide (CCH) ¶ 81,085 (Castle).

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the DSH adjustment was made in accordance with the Medicare regulation at 42 C.F.R. §412.106(b)(4). It provides that the numerator of the Medicaid fraction is

[3] Provider Exhibit P-10.

"the number of hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A." The Intermediary also points out that the Medicare statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) concerning the Medicaid portion of the DSH fraction states that "the numerator of which is the number of 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." The Intermediary relies on CMS Administrator's decision in Edgewater Medical Center v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Illinois, CMS Administrator Decision 2000-D44 and 2000-D45, June 16, 2000, Medicare & Medicaid Guide (CCH) ¶ 80,525 (Edgewater), in which he found that:

> [t]he relevant language of the Medicaid proxy indicates that it is the status of the patients, as opposed to the payment of the day, which determines whether a patient day is included in the numerator of the Medicaid proxy. The phrase "but who were not entitled to benefits under Part A" cannot be read to mean that days for which Medicare is not paid should be included in the numerator of the of the Medicaid proxy.

And that:

> based on the plain language of the statute and the intent of Congress, the Administrator finds that days of dually eligible patients are not included in the DSH calculation regardless of whether these days include patients who have exhausted their Medicare Part A benefit.

Edgewater at 201,702 and 201,703.

With respect to the method of counting days in the Medicare and Medicaid proxies, the Intermediary acknowledges that based on the CMS policy letter dated April 23, 1991 and the decision in Castle, supra, it appears that CMS' preference is to count days based on the discharge date for both Medicare and Medicaid.[4] The Intermediary points out that Medicare days can be counted based on the date of discharge because payment is based on it, thus, the days reported in both the numerator and denominator for the Medicare DSH fraction are consistent. For Medicaid, the total days reported in the denominator of the Medicaid DSH fraction is likely to be paid days during the period as reported by the State as opposed to being based on the discharge date.[5] While the CMS letter notes the inconsistency of reporting by discharge date in the numerator and total paid days in the denominator, it states that in most cases it would have little effect on total days because of the overlap of days associated with discharges at the beginning and end of a cost reporting period. In this case, due to the extremely long length of stays, a large number of days will cross cost reporting periods if all the days are counted in the Medicaid numerator based on discharge date. To rectify the distortion, the Intermediary contends that the denominator of the Medicaid fraction should be adjusted to include all days as well.[6]

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[4] Tr. at 128-130.
[5] Id.
[6] See Stipulation 15.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds that Medicare Part A exhausted benefits days should be included in the Medicaid percentage that is used to calculate the DSH adjustment payment.

The Board concludes that the Intermediary's exclusion of Medicaid-eligible days for patients who had exhausted Medicare Part A benefits (dual eligible exhausted days) violates the plain language of the Medicare statute. The Medicare DSH statute defines the numerator of the Medicaid fraction as the number of days for patients who were eligible for Medicaid but "not entitled to benefits under Part A" of Medicare. See 42 U.S.C. §1395ww(d)(5)(F)(vi)(II), 42 C.F.R. §412.106(b)(4). Thus, if the Medicaid eligible patients were not "entitled" to Medicare Part A for the days at issue, then the days should be included in the numerator of the Medicaid fraction. Conversely, if the patients are "entitled" to Medicare Part A benefits for the days at issue, then the days should not be included in the numerator of the Medicaid fraction.

The statutory definition of entitlement to benefits under Medicare Part A means the right to have payment made on the patient's behalf for covered services. See 42 U.S.C. §1395d(a); 42 U.S.C. §426(c)(1). The dual eligible days at issue here were not attributable to patients who were entitled to have payment made on their behalf for those days.

With respect to Part A exhausted benefit days, the Medicare statute provides that the Part A benefit for inpatient hospital services covers 90 days per spell of illness with a lifetime reserve of 60 days. 42 U.S.C. §1395d(a)(1) see also 42 C.F.R. §409.61(a). Therefore, an individual is entitled "to have payment made on his behalf" only for those days. 42 U.S.C. §1395d(a)(1). Payment "may not be made" for inpatient days in excess of those limits. 42 U.S.C. §1395d(b)(1). As articulated by CMS in the preamble to a 1990 Federal Register notice, "[e]ntitlement to payment under Part A ceases after the beneficiary has used 90 days in a benefit period and has either exhausted the lifetime reserve days or elected not to use available lifetime reserve days." 55 Fed. Reg. 35990, 35996 (Sept. 4, 1990) (emphasis added).

The Board finds that the Intermediary's exclusion of the days at issue from the Medicaid fraction is also inconsistent with the position of the Secretary of Health and Human Services (Secretary) in Baystate, supra.[7] The Secretary conceded that exhausted days are not Medicare "covered" days for which patients are "entitled to benefits under Part A" for purposes of the Medicare/SSI fraction of DSH calculation. [8] The Board agrees with the Providers' position that if the days are not "entitled" under Part A for purposes of the Medicare/SSI fraction, then they cannot be entitled for purposes of the Medicaid fraction. See, e.g., Adena Reg'l Med. Ctr. v. Leavitt, 527 F.3d 176, 180 (D.C. Cir. 2008) ("as the Supreme Court has instructed on countless occasions, we

[7] In that case, the hospital challenged the Secretary's calculation of its Medicare/SSI fractions for its fiscal years ending 1993, 1994, 1995, and 1996.

[8] See Defendants' Memorandum of Points and Authorities in Support of Defendant Leavitt's Motion for Summary Judgment and in Opposition to Plaintiff's Motion for Summary Judgment at 21, 24; see also Plaintiff's Reply Memorandum in Support of Its Motion for Summary Judgment and Memorandum in Opposition to Defendant Leavitt's Motion for Summary Judgment at 35, Baystate, 545 F. Supp. 2d 20 (D.D.C. 2008).

are to presume that identical words used in . . . the same act are intended to have the same meaning.")

By excluding the dual eligible exhausted days from the Medicaid fraction, the Intermediary is effectively equating the terms "eligible" and "entitled" in the DSH statute. Four circuit courts rejected CMS' prior attempts to equate these two terms. See Jewish, ; Cabell; Legacy; and Deaconess Health Servs. Corp. v. Shalala, 83 F.3d 1041 (8th Cir. 1996) (per curium). Moreover, in HCFA Ruling 97-2, the agency acquiesced in these court decisions. See HCFA Ruling 97-2 (Feb. 27, 1997); see also 63 Fed. Reg. at 40984, 40985 (July 31, 1998). Therefore, the statute's reference to an individual who is "entitled" to Medicare Part A must mean something more than a beneficiary who has met Medicare eligibility criteria for some covered Medicare services but who is not entitled to have Medicare payment made for particular days of inpatient hospital services. As the Sixth Circuit concluded in Jewish.

> The Secretary would have this Court conflate eligibility with entitlement. Adjacent provisions utilizing different terms, however, must connote different meanings. To be *entitled* to some benefit means that one possesses the *right* or *title* to that benefit. Thus, the Medicare proxy *fixes* the calculation upon the absolute right to receive an independent and readily defined payment.
>
> By way of contrast, the Medicaid proxy speaks solely of *eligibility*. While Congress intended to refer to the qualification for Medicaid benefits in the calculation of this proxy, Congress could not have intended to fix its calculation on the actual payment of benefits in the state administered program. Had Congress intended that result, it would have also defined the Medicaid proxy in terms of entitlement to state Medicaid payments. Rather, Congress defined the Medicaid proxy with respect to eligibility for and not actual payment of benefits.

Jewish at 275.

Under these authorities, the patients at issue here were not "entitled to benefits" under Medicare Part A because they did not have the right to have payment made on their behalf for the days at issue. The days at issue occurred after these patients had exhausted Part A benefits for inpatient hospital services. Accordingly, consistent with the plain meaning of the statute, the exhausted days for which the patients were not entitled to receive payment should be included in the numerator of the Medicaid fraction to the extent that the patients were eligible for Medicaid.

The Board also finds that for the period at issue (which is prior to the change in the regulations in 2004) that under CMS' regulation and its interpretation of the regulation, CMS considered Part A exhausted days to be not entitled to benefits under Medicare Part A.

For example, in 1996, the Secretary affirmed the Board's decision that days billed to, and paid by Medicaid, after patients had exhausted Medicare Part A benefits, may properly be included in the Medicaid fraction. See Presbyterian, supra. In 1998, the Board held that dual-eligible patient days should be included in the numerator of the Medicaid fraction after the patient has exhausted

Medicare Part A benefits. See Jersey Shore Med. Ctr v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Dec. No. 99-D4, MEDICARE & MEDICAID GUIDE (CCH) ¶ 80,083 (Aug. 26, 1998). The Administrator vacated the Board's decision and remanded the case for a different reason, without commenting on the Board's decision regarding Part A exhausted days. Jersey Shore Med. Ctr., CMS Adm'r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 80,153 (Jan. 4, 1999).

In the May 19, 2003 notice of the proposed inpatient PPS rule for Federal fiscal year 2004, CMS stated incorrectly that all dual-eligible patient days "are counted" in the *SSI fraction* as Part A "entitled" days even after a Medicare beneficiary exhausts Part A benefits. 68 Fed. Reg. 27154, 27207 (May 19, 2003). The following year, in the preamble to the final inpatient PPS rule for fiscal year 2005, CMS admitted that this statement in the May 19, 2003 proposed rule was incorrect. In the final PPS rule for fiscal year 2005, CMS stated:

> It has come to our attention that we inadvertently misstated our current policy with regard to the treatment of certain inpatient days for dual-eligible in the proposed rule of May 19, 2003 (68 FR 27207). In that proposed rule, we indicated that a dual eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. Our policy has been that only covered patient days are included in the Medicare fraction.

69 Fed. Reg. at 49098 (Aug. 11, 2004). This clarification contradicts the rationale given by the Administrator in other rulings where he has said that the Medicaid fraction should not include dual eligible exhausted days because those days were included in the SSI fraction. *See, e.g.*, Edgewater, supra and Castle, supra.

In the final rule, adopted in August 2004, CMS stated that it was "revising" the DSH regulation in order to begin counting all dual eligible days in the SSI fraction beginning with discharges on or after October 1, 2004. 69 Fed. Reg. 49099. CMS made clear that this revision to the regulation implemented the policy to be applied prospectively:

> *[W]e are adopting a policy* to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage . . . . This policy *will be effective for discharges occurring on or after October 1, 2004*. (emphasis added)[9]

Id.

[9] Likewise, in its final rule implementing section 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173 (2003), CMS explained that the "policy change" with respect to dual eligible MSP days applies to "FY 2005 and subsequent years." 670 Fed. Reg. 47278, 47441 (Aug. 12, 2005).

For periods prior to the October 1, 2004 effective date of the new rule, CMS's policy and practice was that dual eligible days were not considered to be "entitled" to benefits under Medicare Part A, and thus were excluded from the SSI fraction. Id. at 49098-99.[10]

The change in the regulation in 2004 to count dual eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Part A hospital coverage, was effective for discharges occurring on or after October 1, 2004. Since the days at issue in this case are not affected by the new regulation, the Board has based its decision in this case on its interpretation of the law and regulations that existed prior to the change in the regulation and has not addressed the Provider's arguments that CMS' changes in the regulation are otherwise invalid.

The Intermediary has conceded that Part A exhausted days were not included in the denominator of the SSI fraction described in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. §412.106(b), that includes days for which CMS has determined that the patients were entitled to benefits under Medicare Part A.[11] Since the days at issue in this case were not included in the DSH Medicare/SSI fraction no adjustment to that fraction is needed.

Finally, with respect to the issue of which year or years to count the exhausted days in the Medicare and Medicaid proxies, the Board relies on the CMS policy letter dated April 23, 1991[12] and the decision in Castle, supra, in which CMS expresses a preference to count days based on the discharge date for both Medicare and Medicaid. The Board notes that the CMS letter acknowledges that there will be an inconsistency of reporting by discharge date in the numerator and total paid days in the denominator for Medicaid but accepts that in most cases it would have little effect on total days because of the overlap of days associated with discharges at the beginning and end of a cost reporting period. While the effect in this case will be more pronounced due to the extremely long length of stays, the Board finds that the Intermediary should utilize the stated policy.

DECISION AND ORDER:

The Intermediary improperly excluded the Medicaid-eligible days at issue from the Provider's DSH calculation. The Intermediary is directed to revise its calculation by adding 1,975 Medicaid days to the numerator of the Medicaid fraction for the Provider's fiscal year ended June 30, 1997.

[10] The Provider points out that despite the clear language indicating that the policy change is prospective, the Administrator has continued to issue, but has not defended, rulings that Part A exhausted days should be excluded from the Medicaid fraction for periods prior to the October 1, 2004 effective date for CMS' change in policy. See Provider's Supplemental Position Paper, n. 8.

[11] See Stipulation 4.

[12] Provider Exhibit 10.

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Chairperson

DATE: DECEMBER 4, 2009