CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
QRS 96 DSH MediKan Days Group	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: June 30, 1996 and September 30, 1996**
Provider	
vs.	
Blue Cross /Blue Shield Association **Blue Cross & Blue Shield of Kansas**	**Review of:** **PRRB Dec. No. 2007-D24** **Dated: March 30, 2007**
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)). CMS' Center for Medicare Management (CMM) submitted comments, requesting reversal of the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from the Providers' requesting that the Administrator affirm the Board's decision. Finally, the Intermediary submitted comments requesting that the Administrator reverse the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Providers in this appeal are Via Christi Regional Medical Center (VCRMC), University of Kansas Hospital (UKH) and Stormont-Vail Regional Health Center (SVRHC) (hereafter "Providers"). The Providers are seeking to include MediKan or general assistance "eligible"

days in their disproportionate share computation. MediKan is a general assistance program operated by the Kansas Department of Social and Rehabilitation Services (SRS).[1] MediKan is 100 percent funded by the State of Kansas and is the State health program for people who are getting general assistance from SRS. MediKan covers disabled individuals who do not qualify for Medicaid, but who are eligible for benefits under a general assistance program.[2]

For the fiscal periods in dispute (FYE 6/30/96 and FYE 9/30/96), the Providers furnished services to persons eligible for MediKan who were included in the State of Kansas paid days total on the Medicaid Provider Summary Report (PSR) because the MediKan program paid the Providers for furnishing services to such persons. Such days are referred to in this case as "primary" MediKan paid days. For the same fiscal periods in dispute, the Providers also provided services to persons eligible for MediKan who were **not** included in the State of Kansas paid days total on the Medicaid PSR because the MediKan program did not pay the Providers for furnishing services to such persons. Such days are referred to in this case as "secondary" MediKan eligible days.[3]

In computing the Providers' Medicare disproportionate share adjustment (DSH) for the fiscal periods in dispute the Intermediary erroneously allowed "primary" MediKan paid days to be included in the Medicaid patient percentage. This occurred because the Intermediary was not aware that "primary" MediKan paid days were included in the State of Kansas Medicaid paid days total on the State's Medicaid Provider Statistical Report (PSR). The Intermediary did not, at any time, include "secondary" MediKan eligible days in the Medicare DSH adjustment because "secondary" MediKan eligible days were not included on the State of Kansas Medicaid paid days PSR that the Intermediary used as a basis for adjusting Medicaid days.

The point of contention between the parties is the fact that the Providers believe that the "secondary" MediKan eligible days should be included in the Medicaid patient percentage , as if the individual was eligible for Medicaid, in the calculation for the DSH payment.

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[1] Intermediary's Exhibit I-1.

[2] Id. The MediKan program currently provides the following benefits to recipients: (1) twelve physician office visits per year, (2) diagnostic lab and radiology services, (3) prescription drugs, (4) durable medial equipment other than prosthetics and orthotics, (5) outpatient hospital diagnostic and lab services, (6) limited community health and hospitalization services.

[3] "Secondary" MediKan eligible days are days where a commercial insurance company paid as the primary payer and MediKan was the secondary insurer (i.e. MediKan "eligible"), but did not make a payment on the claim.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustment excluding "secondary" MediKan eligible days from the Providers' Medicare DSH calculation was proper.[4]

A majority of the Board held that the Intermediary's adjustment improperly excluded MediKan patient days from the Providers' DSH calculation. The Board majority held that both primary and secondary MediKan patient days should be included in the calculation of the Medicaid proxy to determine the Providers' DSH adjustment. In reaching this determination, the Board majority concluded that the DSH statute was not limited to only Medicaid patients but included patients who qualify for "medical assistance" under a State Plan that was approved under Title XIX.

The Board majority disagreed with the Intermediary's argument that the statute, when read collectively with the implementing regulation, limited medical assistance to Medicaid. The Board majority held that the statute did not limit or qualify "eligible for medical assistance under a State Plan approved under Title XIX" as the Intermediary proposed. Rather, the statute applied to Medicaid patients and to patients eligible for medical assistance under a State Plan approved under Title XIX.

The Board majority also disagreed with Intermediary's position that since the Kansas State Statute §39-708c(a) precluded patients who were eligible for medical assistance from participation in MediKan program, therefore, such preclusion applied to the DSH Medicaid proxy. The Board stated that, while the patients in question were not eligible for Medicaid, Congress nevertheless intended that medical services be provided to indigent patient population. Furthermore, it did not appear that the limitation in the Kansas statute was

[4] By letter dated August 26, 2003, the Intermediary challenged Board jurisdiction on Via Christi Medical Center. The Intermediary argued that the Board did not have jurisdiction over the issue of MediKan days because no audit adjustments were made to this issue in the Intermediary's determination. By letter dated November 7, 2003 the Board determined that it had jurisdiction over the Via Christi appeal based on Bethesda Hospital Association v. Bowen, 485 U.S. 399 (1988), which held that the Board had jurisdiction over costs that were unclaimed or self-disallowed by the Provider if the Intermediary would have been bound to disallow the costs by a methodology mandated by statute, regulation, rule or manual provision had the costs been claimed by the Provider.

intended to limit the Federal statute. Regardless, since the Federal statute is the controlling statute in this case, that authority does not contain the limitation on medical assistance that the Intermediary proposed. Therefore, MediKan patient days, both primary and secondary, should be included in the calculation of the Medicaid proxy to determine the Providers' DSH adjustment.

One member of the Board dissented holding that the Board did not have jurisdiction over the inclusion of "secondary" MediKan eligible days in the DSH payment computation with respect to the UKH appeal from a revised notice of program reimbursement (NPR). Specifically, the dissenting Board member held, that, since neither the revised NPR, nor the Intermediary made an adjustment to "secondary" MediKan eligible days, the Board did not have jurisdiction over the inclusion of these days in the DSH payment computation. The dissenting Board member noted that it was not until after the revised NPR was issued in 2003 that the UKH sought to have these "secondary" MediKan eligible days included in the Medicaid fraction. Therefore, the UKH should be dismissed from the group appeal.

In addition, the dissenter also found that UKH was not entitled to have these days included under the hold harmless provisions of Program Memorandum (PM) A-99-62, dated December 1999. A review of the record shows that the UKH did not have a valid DSH appeal pending before the Board as of the October 15, 1999 deadline established by PM A-99-62. Other than being listed on the Schedule of Providers in this case, all other documents in the record including the Stipulation of the Parties, the Providers' oral argument as contained in the transcript, and the Providers' Post Hearing Brief are silent with respect to the UKH appeal of DSH before the cutoff dated. Therefore, when all the facts are considered, even if the Board had jurisdiction, the UKH did not qualify for the relief afforded by the hold harmless provisions of PM A-99-62.

SUMMARY OF COMMENTS

CMM submitted comments requesting that the Administrator overturn the Board's majority decision. Specifically, CMM requested reversal of the Board's majority decision on grounds that the inpatient days associated with the State of Kansas MediKan program were not provided to Medicaid eligible patients. CMM noted that the statute required the inclusion in the Medicaid fraction of only those days for which a patient was eligible for assistance under an approved Medicaid State plan and did not reference or require the inclusion of patients who were not eligible for Medicaid but instead received State benefits under a general assistance program.

CMM agreed with the Board's majority statement that "the federal statute includes patients eligible for medical assistance under a State Plan approved under Title XIX, without exception/limitation." CMM stated however, that it did not follow that patients who received benefits under the MediKan program should also be included in the DSH fraction. CMM noted that the MediKan program was a State program with its own eligibility requirements that covered patients who, by definition, were not eligible for medical assistance under the State Plan.

In addition, the Secretary has addressed which days are to be included in the Medicaid fraction of the Medicare DSH calculation in Program Memorandum (PM) A-01-13. With regard to State-only general assistance patient days, which are the days at issue in the MediKan program, PM A-01-13 states that "these patients are not Medicaid-eligible" and while a hospital may receive Medicaid DSH payments based upon these days, "payment for these days does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicare formula." Therefore, given the fact that the Kansas Economic and Employment Manual specify that the MediKan program is a totally State-funded program and that it covers disabled individuals who do not qualify for Medicaid but are eligible for benefits under the general assistance program, the Intermediary correctly excluded "secondary" MediKan eligible days from the Medicare DSH calculation because they do not fall within the scope of the hold harmless provision stated in PM A-01-13.

CMM also disagreed with the Board's majority determination that it had jurisdiction over the UKH appeal. CMM concurred with the dissenting Board member opinion that the Board lacked jurisdiction over the appeal.

The Intermediary submitted comments requesting that the Administrator reverse the Board's majority decision. Specifically, the Intermediary concurred with CMM's analysis that jurisdiction was lacking and that the issue was decided incorrectly on the merits. Furthermore, the patient days at issue do not meet the statutory and regulatory definition of "eligible for Medicaid."[5]

The Providers commented requesting that the Administrator affirm both the jurisdictional and substantive decisions of the Board majority. With respect to the jurisdictional issue, the UKH acknowledged that it appealed MediKan days from a revised NPR date April 17, 2003. Nonetheless, the Board had jurisdiction because the revised NPR was issued in response to the UKH's reopening request dated September 14, 2001, that requested inclusion of MediKan days in the Provider's DSH adjustment. The UKH asserted that it had a right to appeal any matter considered by the Intermediary upon issuing the revised NPR.[6] Furthermore, the Intermediary's failed to fully comply with the requirements of HCFA Ruling 97-2 implemented in the revised NPR, i.e., although the Intermediary included Medicaid eligible but unpaid days and MediKan primary days, the Intermediary did not include MediKan secondary eligible days. Thus, the issue in dispute was specifically adjusted by the revised NPR. Accordingly, there should be no jurisdiction question since the revised NPR adjusted the DSH payment and the Provider remains dissatisfied with the DSH payment.

The Provider further argued that while the DSH adjustment contained a number of sub-components, the Intermediary did not issue a separate audit adjustment for each of the various DSH sub-components in UKH's revised NPR. The Intermediary made a single DSH adjustment. Thus, requiring the UKH to appeal from an explicit adjustment to one-subcomponent of the DSH adjustment, i.e., MediKan days, when the Intermediary did not issue a "component specific" audit adjustment report would be unreasonable.

With respect to jurisdiction over VCRMC and SVHC, the Providers maintained that the Board had jurisdiction because the Board properly applied the self disallowance principle of

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[5] See Washington State Group II v. Blue Cross Blue Shield Ass'n, PRRB Dec. 2007-D5, Nov. 22, 2006, Medicare and Medicaid Guide (CCH) ¶81,620, rev'd, CMS Admin, Jan. 19, 2007, Medicare and Medicaid Guide (CCH) ¶81,684; and Ashtabula County, Ohio v. BlueCross/Blue Shield Ass'n AdminiStar Federal, Inc., PRRB Dec. 2005-D49, Aug. 10, 05, Medicare and Medicaid Guide (CCH) ¶81,376, rev'd, CMS Admin, Oct. 12, 2005, Medicare and Medicaid Guide (CCH) ¶81422.

[6] See French Hospital Medical Center v. Shalala, (9th Cir. July 9, 1996) (Medicare and Medicaid Guide (CCH) ¶ 44,486.)

Bethesda Hospital Association v. Bowen, 485 U.S. 399 (1988). The Providers' maintained that it would have been unlawful for them to include a claim for any unpaid days, whether Medicaid, MediKan or otherwise. Furthermore, the Providers' contended that the Intermediary's response to VCRMC's reopening request, dated July 18, 2003, that "MeiKan days and general assistance days are not considered to be Medicaid eligible days by CMS (HCFA) policy and may not be included in the DSH computation demonstrates that *Bethesda* is controlling.[7]

With regard to the substantive issue, the Providers argued that a plain reading of the statute requires that the "secondary" MediKan eligible days be included in the Providers' Medicare DSH calculation because MediKan is included within the Kansas State Plan under Title XIX. The Providers contended that MediKan days constituted "medical assistance" for purposes of the Medicare DSH statute and therefore must be counted. The Providers' asserted that Congressional intent is clear: patient days for medical assistance under a State Plan approved under Title XIX must be counted. Furthermore, reference to "a medical plan" in the Kansas State statute in the singular is evidence that Kansas Medicaid and MediKan programs are part of the same Title XIX plan.[8]

Finally the Providers' maintained that the "secondary" MediKan eligible days fall within the hold harmless requirements of PM A-99-62 and should therefore be included the DSH adjustment computation. Specifically, just as HCFA Ruling 97-2 provided that there was no distinction between Medicaid "paid" and "unpaid" days, there should be no distinction between "paid" and "unpaid" MediKan days. The Providers' contended that having included the paid MediKan days, the Intermediary should have included "unpaid" MediKan days. These days were subject to the protection of the hold harmless provisions set forth in the PM A-99-62.

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[7] The Administrator notes that the Intermediary's refusal to accept the reopening request was for FYE 9/30/98. A cost reporting period not at issue in this case.

[8] See also Kansas Administrative Regulations (K.A.R.) §§ 30-5-58 to 30-5-174. These provisions make frequent reference to "the Medicaid/MediKan program," demonstrating the existence of a program or plan with two parts rather than two distinct programs.

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.

Section 1878(a) of the Act and the regulations found at 42 C.F.R. § 405.1835 set forth the requirements for Board jurisdiction. A provider may obtain a hearing before the Board with respect to its fiscal intermediary's determination of its cost report, inter alia, only if: the provider is dissatisfied with a final determination of its fiscal intermediary as to the amount of reimbursement due the provider for the period covered by such report; there is $10,000 or more in controversy; and the provider filed a request for a hearing within 180 days after the notice of the intermediary's final determination.[9]

The regulation found at 42 C.F.R. § 405.1885(a) allow for a reopening of an intermediary determination or decision if "made within 3 years of the date of the notice of the intermediary determination." In addition, the regulation found at § 405.1889 provides that:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 405.1877 are applicable.

[9] The Board may also take jurisdiction of late-filed appeals "for good cause shown" (42 C.F.R. § 405.1841(b)).

This provision is also set forth in § 2932B of the Provider Reimbursement Manual (PRM). This section likewise refers to a revised NPR as a "separate and distinct determination" which gives a right to a hearing on the matters corrected by such determination. Thus, a revised NPR does not reopen the entire cost report to appeal. It merely reopens those specific matters adjusted by the revised NPR.

Relevant to the issue involved in this case, two Federal programs, Medicaid and Medicare involve the provision of health care services to certain distinct patient populations. The Medicaid program is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children.[10] 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.[11] 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.[12]

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.[13] If the State plan is approved by CMS, 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.[14] 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

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

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

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

[13] Id. § 1902 et. seq. of the Act.

[14] Id.

under the State plan. Individuals who do not meet the applicable requirements are not eligible for "medical assistance" under the State plan.

In particular, Section 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. As part of a State plan, Section 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 section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs. Notably, Section 1905(a) states that for purposes of this title "the term 'medical assistance' means the payment of part or all of the costs" of the certain specified "care and medical services" and the identification of the individuals for whom such payment maybe made.

Section 1923 of the Act implements the requirements that a State plan under Title XIX provide for an adjustment in payment for inpatient hospital services furnished by a disproportionate share hospital. A hospital maybe deemed to be a Medicaid disproportionate share hospital pursuant to Section 1923(b)(1)(A), which addresses a hospital's Medicaid inpatient utilization rate, or under paragraph (B), which addresses a hospital's low-income utilization rate. The latter criteria relies, inter alia, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.[15]

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[16] established title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part

[15] Congress has revisited the Medicaid DSH provision several times since its establishment. In 1993, Congress enacted further limits on DSH payments pursuant to section 13621 of Pub. Law 103-66 that took into consideration costs incurred for furnishing hospital services by the hospital to individuals who are either eligible for Medicare assistance under the state plan or have no health insurance (or other source of third part coverage for services provide during the year). The Medicaid DSH payments may not exceed the hospital's Medicaid shortfall; that is; the amount by which the costs of treating Medicaid patients exceeds hospital Medicaid payments plus the cost of treating the uninsured.

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

A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[17] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[18] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[19] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[20] 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.[21]

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

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to §1886(d) (5) (F) (i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…."[22] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[23] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage. Relevant to this case, with respect to the proxy method, § 1886 (d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the

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[17] Section 1811-1821 of the Act.

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

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

[20] Pub. Law No. 98.21.

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

[22] 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).

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

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

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

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 was in response to problems that occurred as a result 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 plan 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 patients 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 state plan, 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 plan, 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 plan 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.
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> 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 plan 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 document to substantiate the number of Medicaid days claimed. [24] (Emphasis added.)

The PM A-99-62 further instructed intermediaries to apply a hold harmless policy under certain limited circumstances. CMS stated:

> In accordance with the hold harmless position communicated by HCFA on October 15, 1999, for cost reporting periods beginning before January 1, 2000, you are not to disallow, within the parameters discussed below, the portion of

[24] 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.

> Medicare DSH adjustment payments previously made to hospitals attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days in the Medicaid days factor used in the Medicare DSH formula…. Although [CMS] has decided to allow the hospitals to be held harmless for receiving additional payments resulting from the erroneous inclusion of these types of otherwise ineligible days, this decision is not intended to hold hospitals harmless for any other aspect of the calculation of Medicare DSH payments or any other Medicare payments.

Regarding hospitals that received payments reflecting the erroneous inclusion of days at issue, CMS stated that:

> In practical terms this means that you are not to reopen any cost reports for periods beginning before January 1, 2000 to disallow the portions of Medicare DSH payments attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days if the hospital received payments for those days based on those cost reports.… Furthermore, on or after October 15, 1999, you are not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.
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> For cost reporting periods beginning before January 1, 2000, you are to continue to allow these types of days in the Medicare DSH calculation for all open cost reports only in accordance with the practice followed for the hospital at issue before October 15, 1999 (i.e., for open cost reports, you are to allow only those types of otherwise ineligible days that the hospital received payment for in previous cost reporting periods settled before October 15, 1999). For example, if, for a given hospital, a portion of Medicare DSH payment was attributable to the erroneous inclusion of general assistance days for only the out-of State or HMO population in cost reports settled before October 15, 1999, you are to include the ineligible waiver days for only that population when settling open cost reports for cost reporting periods beginning before January 1, 2000. However, the actual number of general assistance and other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration days, as well as Medicaid Title XIX

> days, that you allow for the open cost reports must be supported by auditable documentation provided by the hospital.

Regarding hospitals that did not receive payments reflecting the erroneous inclusion of days at issue, CMS stated that:

> If, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days… Where, for cost reporting periods beginning before January 1, 2000, a hospital filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula on or after October 15, 1999, reopen the settled cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, but only if the hospital appealed, before October 15, 1999, the denial of payment for the days in question in previous cost reporting periods. The actual number of these types of days that you use in this revision must be properly supported by adequate documentation provided by the hospital. Do not reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before PRRB on other Medicare DSH issues or other unrelated issues.
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> You are to continue paying the Medicare DSH adjustment reflecting the inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for all open cost reporting periods beginning before January 1, 2000, to any hospital that, before October 15, 1999, filed a jurisdictionally proper appeal to the PRRB specifically for this issue on previously settled cost reports.
>
> Finally, you are reminded that, if a hospital has filed a jurisdictionally proper appeal with respect to HCFA 97-2 ruling and the hospital has otherwise received payment for the portion of Medicare DSH adjustment attributable to the inclusion of general assistance or other State-only health programs, charity

> care, Medicaid DSH, and/or ineligible waiver or demonstration population days based on its paid Medicaid days, include these types of unpaid days in the Medicare DSH formula when revising the cost reports affected by the HCFA 97-2 appeal.

In the August 1, 2000 Federal Register, the Secretary reasserted his policy regarding general assistance days, State-only health program days and charity care days.

> General assistance days are days for patients covered under a State-only or county-only general assistance program, whether or not any payment is available for health care services under the program. Charity care days are those days that are utilized by patients who cannot afford to pay and whose care is not covered or paid by any health insurance program. While we recognize that these days may be included in the calculation of a State's Medicaid DSH payments, these patients are not Medicaid eligible under the State plan and are not considered Titled XIX beneficiaries.[25]

In 2001, CMS issue a Program Memorandum Transmittal A-01-13[26] which again stated, regarding 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. Sometime 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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> ****
>
> Days for patients covered under a State-only (or count-only) general assistance program (whether or not any payment is available for health care

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[25] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

[26] The PM, while restating certain longstanding interpretations in the background material, clarified certain other points for cost reporting periods beginning on or after January 1, 2000, with respect to the hold harmless policy. See Transmittal A-01-13; Change Request 1052 (January 25, 2001)

> services under the program). These patients are not Medicaid-eligible under the State plan.

Finally, in a recently enacted statute, Congress clarified the meaning of the phrase "eligible for medical assistance under a State plan approved under title XIX" by adding the following language:

> In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.[27]

This amendment to §1886(d)(5)(F)(vi) of the Act specifically addressed the scope of the Secretary's authority to include (or exclude), in determining the numerator of the Medicaid fraction of the Medicare DSH calculation, patient days of patients not eligible for medical assistance under a State plan but who receive benefits under a demonstration project approved under Title XI of the Act. In sum, CMS policy has consistently required the exclusion of days relating to general assistant or State only days and distinguishes between days for individuals that receive medical assistance under a Title XIX State plan and days for individuals that are not in fact eligible for medical assistance, but may be a basis for Medicaid DSH payment under the State plan. These latter days are not counted for purposes of the Medicare DSH payment.

In this case a majority of the Board held that the Intermediary's adjustment improperly excluded MediKan patient days from the Providers' DSH calculation. The Board majority concluded that the DSH statute was not limited to only Medicaid patients but included patients who qualify for "medical assistance" under a State Plan that was approved under Title XIX. The Board determined that, while the patients in question were not eligible for Medicaid, Congress nevertheless intended that medical services be provided to indigent patient population.

The Administrator finds that Section 1886(d)(5)(F)(vi)(II) of the Act requires for purposes of determining a Provider's "disproportionate patient percentage" that the Secretary count

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[27] Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 5002, 120 Stat. 4, 31 (February 8, 2006) (codified in part at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

patient days attributable to patient 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 this statutory phrase "patients who (for such days) were eligible for medical assistance under a State Plan approved under title XIX," to mean "eligible for Medicaid."[28] The Administrator further finds that the term "Medicaid" refers to the joint State/Federal program of medical assistance authorized under Title XIX of the Act. If a patient is not eligible for Medicaid, than the patient is not eligible for medical assistance under a State plan approved under Title XIX.[29]

The Administrator finds that 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 a state plan approved under Title XIX" also known as the Federal program Medicaid. The use of the term "medical assistance" at Sections 1901 and 1905 of the Social Security Act and the use of the term "medical assistance" at Section 1886(d)(5)(F)(vi)(II) of the Social Security Act is reasonably concluded to have the same meaning. As noted by the courts, "the interrelationship and close proximity of these provisions of the statute presents a classic case for the application of the normal rule of statutory construction that "identical words used in different parts of the same act are intended to have the same meaning."[30] Therefore, the Administrator finds the language at section 1886(d)(5)(F)(vi)(II) 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.

Notably, the days involved in this case are related to individuals that are not eligible for medical assistance as that term is used under Title XIX and, thus, are not properly included in the Medicaid patient percentage of Medicare DSH calculation under §1886(d)(5)(F)(vi)(II) of the Act.[31] Rather, the Medicaid DSH formula includes Medi-Kan

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[28] See Cabell Huntington Hosp. Inc., v. Shalala, 101 F.3d 984, 989 (4th Cir. 1996) ("It is apparent that 'eligible for medical assistance under a State plan' refers to patients who meet the income, resource, and status qualifications specified by a particular state's Medicaid plan…").

[29] Stipulation of the Parties B (3) at p. 2.

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

[31] The Providers found the application of this rule of statutory construction made the word "approved" superfluous and that another rule of statutory construction requires that all words in a statute be given effect. The excerpt of Kansas State Statute section 39-708c(a) indicates approved and unapproved plans. The Providers noted that the MediKan program is derived from the State Secretary's "power to develop a State plan in regard to assistance and

patients in its utilization rate methodology.[32] The Administrator finds that reference to Medicaid/MediKan in the State Plan approved under Title XIX is limited to the criteria for determining if hospitals are eligible for the Kansas Medicaid DSH adjustment and the amount of such Medicaid DSH payment. All state plans are required to provided for DSH payments. The Kansas Medicaid DSH program includes the MediKan days in its Medicaid DSH methodology and, thus, may involve some expenditure of Federal financial participation (FFP) based on the care provided to MediKan individuals by these hospitals. However, the MediKan program is by definition for individuals not eligible for Medicaid.[33] The approval of the Kansas Medicaid DSH provision under the State plan and the expenditure of Medicaid DSH FPP does not constitute "medical assistance" for the *individuals* at issue in this case as that term is used under Title XIX and Title XVIII.[34] Therefore, the Administrator finds that the days relating to patients eligible for the MediKan program do not fall within the legal meaning of patient days attributable to *patients who were eligible for medical assistance under a State plan approved under Title XIX of the Act*. Consequently, these days are not properly included in the numerator of the Medicaid patient percentage fraction in calculating the Medicare DSH adjustment.

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services in which the Federal government not participate" (i.e. a plan that is not approved under Medicaid).

[32] See, e.g., Provider Post-Hearing Brief Exhibit 1 (State assurances letter explaining that Attachment 4.19A describes the methodology under 42 CFR 447.253(b)(1)(ii)(A) to be used to determine disproportionate share hospitals and payments); Exhibit 2 (Medicaid State Plan Attachment 4.19-A describing method of determining Medicaid DSH payment which includes references to MediKan).

[33] See e.g. Section 2600 of the The Kansas Economic and Employment Support Manual ("MediKan is a totally state regulated and funded program and covers disabled individuals who do not qualify for Medicaid but are eligible for cash benefits under the general assistance program.")

[34] Furthermore, even assuming arguendo, that the expenditure of FFP were relevant, it was not demonstrated that these days were in fact included in the calculation of the State Medicaid DSH. The Provider argued that these days should be included under the Medicare DSH calculation because the MediKan is referenced under the Medicaid DSH program and, therefore, they are included under the State plan. However, the unpaid days were not included on the State's PSR and it is indicated these are days in which the patient was not uninsured and, therefore, MediKan was the secondary payer. Thus, not only are the Medi-Kan patients not Medicaid eligible, but it is not clear that these unpaid secondary MediKan days are even included under the State plan DSH program and, therefore, maybe different in that respect from the paid Medi-Kan days.

However, because the Board found that these days could be included under its reading of the statute, the Board did not make any factual findings as to whether the Providers could otherwise be allowed to include these days in the DSH calculation under the "hold harmless" provisions of PM-A-99-62. The PM –A-99-62 provided several different scenarios under which a provider may be allowed to include these otherwise not includable days in the Medicaid fraction of its DSH calculation.

For example, PM A-99-62 advised intermediaries to hold harmless (i.e., not recoup overpayment) those providers that had been improperly allowed to included "general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days" in their calculation of the Medicaid fraction. In addition, PM A-99-62 also advised intermediaries to hold harmless those providers that had filed a jurisdictionally proper appeal before October 15, 1999, on the precise issue of "general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days" even if the provider had not been erroneously reimbursed for the inclusion of otherwise ineligible days in their cost report.

The PM A-99-62 also addressed circumstances where the Provider had not filed appeals on or before October 15, 1999, but had raised the precise issue in earlier appeals. The PM also advised intermediaries that if the provider had filed a jurisdictionally proper appeal, with respect to HCFA Ruling 97-2 and the provider otherwise had received payment for the portion of Medicare DSH adjustment attributed to the inclusion of general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days" based on its paid Medicaid days to include these types of unpaid days in the Medicare DSH formula when revising cost reports affected by HCFA Ruling 97-2.

The Providers in this case argued that the "secondary" MediKan eligible days at issue satisfied the "hold harmless" provision of PM A-99-62 as the Intermediary should have allowed primary and secondary MediKan days. Two of the Providers also noted that they filed a jurisdictionally proper appeal to the Board on the issue before October 15, 1999. The Providers also argued that, just as HCFA Ruling 97-2 provided that there was no distinction between Medicaid "paid" and "unpaid" days, there should be no distinction between "paid" and "unpaid" MediKan days under the hold harmless provision. The Providers contended that having included the paid MediKan days, the Intermediary should have included "unpaid" MediKan days. Therefore, the Providers contended that these days ("secondary"

MediKan eligible days) are subject to the protection of the hold harmless provisions set forth in the PM A-99-62.

The Intermediary argued that the PM A-99-62 instructs intermediaries to not accept reopening requests for previously settled cost reports or amendments to previously submitted cost report pertaining to the inclusion of these types of days in the Medicare DSH formula for these cost years. The PM A-99-62 instructs intermediaries to include these types of days (secondary" MediKan eligible days) only if these days had been erroneous included in the provider's Medicare DSH calculation in the past. The Intermediary argues that the record shows that these Providers' never received payment for these "types" of days (i.e. "secondary" MediKan eligible days) because such days were not included in the State of Kansas Medicaid paid day total on the Medicaid PSR. Furthermore, the Intermediary argued that the Providers precisely requested, after the October 15, 1999 deadline, that "secondary" MediKan eligible days be added to the list of issues pending before the Board.

A review of the record shows that the Group appeal for Stormont Vail Regional Center, Via Christi, and UKH was the result of the transfer of the issue from Case Nos. 99-2858, 99-1186, 03-1461 and 03-1462 to the group appeal. The original requests for a hearing received by the Board are not included in the record along with other pertinent documentation such as the related Notices of Program Reimbursement or NPRs, intermediary adjustment reports and work papers that are usually filed with the requests for hearings.[35] The determination of whether any aspect of the hold harmless provision applies to these Providers requires, inter alia, that several findings be made including when the appeal was filed with the Board, the nature of the requests for hearing, whether these "types" of days had been paid in earlier cost years or appealed in earlier cost years and whether these "types" of days are included under the hold harmless provision. Consequently, the Administrator finds that remand is appropriate for further record development and findings as to whether any aspect of the hold harmless provisions applies to these Providers.

[35] The Administrator recognizes that the Provider has submitted certain of these documents as Exhibits. However, for the Provider Via Christi, the first filed appeal has no date, while the subsequent filed appeal does not show the date of receipt by the PRRB. In addition, while NPRs are supplied, the relevant intermediary work papers, etc., are not included.

Further, as a preliminary jurisdictional matter, with respect to University of Kansas Hospital or UKH, the Administrator finds that the UKH appealed the issue of "secondary" MediKan eligible days from a revised NPR. The revised NPR showed that it was issued to implement the settlement of a court case. This issue was transferred and added to the Group appeal from PRRB Case Nos. 03-1461 and 03-1462. The original requests for hearing were not included in the record. The regulation at 42 C.F.R. § 405.1889 limits an appeal of a revised NPR to matters at issue on the revised NPR. In this case, the basis for the revised NPR was the effectuation of the court settlement.

Despite the Provider's allegations otherwise, the request for reopening does not appear to be related to this revised NPR or the court settlement. Moreover, the relevant reopening and court settlement are not a part of the record and, therefore, the underlying basis for the reopening is not set forth in the record. Consequently, in order to make an jurisdictional determination, the record needs to be further developed [36] to include the underlying basis for the revised NPR (e.g., the court settlement and the reopening notice) in the UKH appeal.

[36] Depending upon the terms of the settlement, the Board may decide it is appropriate that the settlement document be included in the record as a sealed document.

Accordingly, the Administrator orders:

That the Board's decision be vacated and remanded for further proceedings consistent with the foregoing opinion; and

That the Board will further develop and supplement the administrative record with respect to the matters at issue in the revised NPR for University of Kansas; and

That based on the supplemented record the Board will determine jurisdiction for the University of Kansas provider appeal of its revised NPR consistent with 42 CFR 405,1889, and

That, for the Provider appeals in the Group for which there is Board jurisdiction, the Board will further develop and supplement the record and make findings with respect to the applicability, if any, of the PM A-99-66 and A-01-13 "hold harmless" provisions to the Providers' claims; and

That the Board will issue a new decision addressing, inter alia, the jurisdiction issue and the hold harmless issue; and

That Board decision will be subject to the provisions of section 1878(f) of the Act and 42 CFR 405.1875.

Date: 5/25/07 /s/

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services

Accordingly, the Administrator orders:

That the Board's decision be vacated and remanded for further proceedings consistent with the foregoing opinion; and

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That, for the Provider appeals in the Group for which there is Board jurisdiction, the Board will further develop and supplement the record and make findings with respect to the applicability, if any, of the PM A-99-66 and A-01-13 "hold harmless" provisions to the Providers' claims; and

That the Board will issue a new decision addressing, inter alia, the jurisdiction issue and the hold harmless issue; and

That Board decision will be subject to the provisions of section 1878(f) of the Act and 42 CFR 405.1875.

Date: _____ _____

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services