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

| **In the case of:** | **Claim for:** |
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| **Beverly Hospital** | **Reimbursement Determination for Cost Reporting Periods ending: Various** |
| **Provider** | |
| **vs.** | |
| **Blue Cross Blue Shield Association/ Associated Hospital Services** | **Review of: PRRB Dec. No. 2008-D37 Dated: Various** |
| **Intermediary** | |

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This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The Administrator notified the parties of his intent to review the Board's decision as to Issue Nos. 1, 2, 3 and 4. The Intermediary commented, requesting reversal of the Board's decision on Issue Nos. 2, 3, and 4. The Provider also commented, requesting that the Administrator affirm the Board's decision on Issue Nos. 2, 3 and 4 and reverse the Board on Issue No. 1. Comments were also received by the Center for Medicare Management (CMM), requesting the Administrator affirm the Board's decision on Issue No. 1 and reverse the Board on Issue Nos. 2 and 4. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

## ISSUES AND BOARD DECISION

**Issue No. 1 - Medicare+Choice Days.**

Issue No.1 is whether the Intermediary improperly computed the numerator of the Medicaid fractions that were used to calculate the Provider's disproportionate share

hospital (DSH) payments for fiscal years (FYs) 1999, 2000, 2001, and 2002 by excluding inpatient days attributable to individual who were both eligible for medical assistance under an approved Medicaid State plan and enrolled in a Medicare+Choice (M+C) plan for such days.

The Board held that the M+C days at issue in this case should be count in the Medicare fraction. In reaching this determination, the Board concluded that a beneficiary can only be eligible for Part C if "entitled to benefits" under Part A. Therefore, since the Medicaid fraction's numerator excludes patient days for patients who (for such days) 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, M+C days can only be counted in the Medicare fraction as they are specifically precluded from being included in the Medicaid fraction.

**Issue No. 2 – Massachusetts Uncompensated Care Pool.**

Issue No. 2 is whether the Intermediary improperly computed the numerators of the Medicaid fractions that were used to calculate the Provider's DSH payments for FYs 1999, 2000, 2001 and 2002 by excluding inpatient days attributable to individual who allegedly received assistance under the Massachusetts Uncompensated Care Pool (UCP) for such days.

The Board held that the UCP days at issue should be included in the numerator of the Medicaid fraction for DSH. The Board disagreed with the Intermediary's argument that "eligible for medical assistance" and "Medicaid" were interchangeable. The Board concluded that the plain language of the statute required all days relating to patients eligible for medical assistance under a State Plan approved under Title XIX to be included in the Medicaid proxy. In this case, since the State of Massachusetts made Medicaid DSH payments to hospitals to cover the costs of services furnished to individuals who qualified for assistance through the UCP, those individuals were eligible and received "medical assistance under a State plan for, such days. Accordingly, the UCP days should be included in the numerator of the Medicaid fraction for DSH.

**Issue No. 3 – Labor and Delivery Room.**

Issue No. 3 is whether the Intermediary improperly computed the Medicaid fraction that was used to calculate the Provider's DSH payment for fiscal year 2002 by 1) excluding from the numerator inpatient days attributable to individuals who were in a labor and delivery room (LDR) at the census-taking hour and who had not previously occupied a routine bed and 2) including such days in the denominator.

The Board held that the numerator and the denominator of the Medicaid fraction should be revised to include LDR days. The Board noted that the guidelines set forth at § 2205.2 of the Provider Reimbursement Manual (PRM), effective December 1991, did not specifically address how these days would be counted for DSH purposes, nor did CMS make any modification to the regulations, nor other guidelines that would change the treatment of these days for DSH purposes. Courts have found that the plain language of the regulation requires that all beds and bed days be included in the DSH calculation if the "area" of the hospital is subject to the inpatient patient payment system (IPPS), even when the services are not covered by IPPS. In this case, it is undisputed that the LDR units are located in areas subject to inpatient prospective payment system, or IPPS, therefore, the days at issue must be counted.

**Issue No. 4 – Recalculation of the SSI Ratio.**

Issue No. 4 is whether the Medicare/Supplemental Security Income (SSI) fraction that was used to calculate the Provider's DSH payment for FY 1999 should be recalculated or, in the alternative, whether the Medicare SSI fraction should be revised.

The Board, relying on its holding in *Baystate,* [1] held that the SSI ratio for FYE 1999 should be revised to 9.21 percent. The Board concluded that there was no statutory or regulatory impediment for recalculating the DSH percentage. Furthermore, the Medicare law required that the DSH calculation be accurate. Therefore, since the best available data was furnished by CMS itself, the 9.21 percent should used.

## COMMENTS

**Issue No. 1 - Medicare+Choice Days.**

The Provider commented requesting that the Administrator reverse the Board's decision for the reasons stated in the Provider's post hearing brief.

The Provider listed four reasons why Medicaid-eligible M+C days should be counted in the numerator for the Medicaid fraction. First, the plain language of the Medicare statute requires that Medicaid-eligible M+C days be counted in the

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[1] *Baystate Medical Center v. Mutual of Omaha Insurance, Co*., PRRB Dec. 2006-D20, March 17, 2006, (CCH) ¶81,468; modified, CMS, Administrator(CCH)¶81,506, (May 11, 2006); Civil Docket No. 1:06-cv-01263-JDB.

numerator of the Medicaid fraction. Second, the exclusion of these days from the Medicaid fraction is contrary to the intent of Congress. Third, CMS' policy and practice prior to 2004 shows that CMS did not consider these days to be entitled to payment under Medicare Part A, because M+C days were consistently excluded from the Medicare/SSI fraction for the periods at issue in this case. Fourth, it is arbitrary and capricious for CMS to treat M+C days as Medicare Part A days for DSH purposes, but for not other payment purposes, such as GME, for the periods at issue.

CMM submitted comments requesting that the Administrator affirm the Board's ruling on this issue, since the Medicare DSH statute expressly prohibits the inclusion of inpatient days associated with dual-eligible patient in the Medicaid fraction.

**Issue No. 2 – Massachusetts Uncompensated Care Pool.**

The Provider commented requesting that the Administrator affirm the Board's decision for the reasons stated in the Board's decision and in the Provider's post-hearing brief.

The Provider argued that the Intermediary improperly excluded from the numerator of the Medicaid fraction the days attributable to patients who received assistance under the Massachusetts UCP days for the fiscal years in dispute. To support its position, the Provider argued that since the Massachusetts UCP is part of the approved Medicaid DSH payment described in the approved Medicaid State plan, and since CMS paid Federal matching funds (FFP) for Massachusetts UCP DSH expenditures, the UCP days should be counted in the numerator of the Medicaid fraction. Furthermore, since the recipients of the Massachusetts UCP were eligible for, and received, assistance under the State plan that is indistinguishable from the assistance received by other Medicaid recipients under the State plan, the UCP days should be counted in the numerator of the Medicaid fraction.

CMM submitted comments requesting that the Administrator overturn the Board's decision. Specifically, CMM requested reversal of the Board's decision on grounds that the inpatient days associated with the Massachusetts UCP program were not provided to Medicaid eligible patients. To support this position, CMM relied on *Adena Regional Medical Center v. Leavitt*[2] and Program Memorandum (PM) A-99-62.

First, in *Adena*, CMM pointed out that the Court of Appeals for the D.C. Circuit held that the phrase "eligible for medical assistance under a State plan approved

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

under title XIX" referred to patients who are eligible for Medicaid. The Court rejected the argument that the days of patients who were counted toward a Medicaid DSH payment must be counted toward the Medicaid fraction of the Medicare DSH calculation.

Secondly, CMM noted that PM A-99-62 outlined which days are to be included in the Medicaid fraction of the Medicare DSH calculation. PM A-99-62 identifies Medicaid DSH days as day that are ineligible for inclusion in the Medicare DSH calculation. Such days are described as "[d]ays for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State." In addition, PM A-99-62 also provides that:

> *Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the States*. These patients are not Medicaid-eligible. Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care or 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 Medicare formula. (Emphasis added).

Therefore, CMM concluded that given that the State of Massachusetts regulations[3] indicate that in order to receive care under UCP, a patient must <u>not be</u> eligible for Medicaid, the Intermediary correctly excluded UCP inpatients days from the Medicaid fraction of the Medicare DSH calculation since such days were not attributable to Medicaid eligible patients.

The Intermediary commented requesting that the Administrator reverse the Board's decision for the reasons stated in the Intermediary's post-hearing brief. Specifically, the Intermediary stated that the Provider's claim must fail because the Provider cannot show that the individuals that it seeks to count were determined eligible for Medicaid by the relevant state agency.[4] Furthermore, Massachusetts' UCP program specifically excludes from coverage, those individuals participating in the Medicaid program. Finally, CMS PM A-99-62 provides no relief for the Provider because the Provider failed to file a jurisdictionally proper appeal to the Board on this issue before October 15, 1999. Here, the Provider filed an appeal, dated July 19, 2004, from a notice of program reimbursement (NPR) dated March 10, 2004; long after the passage of the deadline.

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[3] Intermediary's Exhibit I-10 at 7 (10.04(1)).

[4] Transcript (Tr.) at 161-62.

**Issue No. 3 – Labor and Delivery Room.**

The Provider commented requesting that the Administrator affirm the Board's decision for the reasons stated in the Board's decision and in the Provider's post-hearing brief. Alternatively, the Provider argued that, if the days are excluded from the numerator, they should also be excluded from the denominator. The Provider cited four reasons why LDR days should be included in numerator and the denominator of the Medicaid fraction.

First, the Provider explained that the exclusion of LDR days from the Medicaid fraction is inconsistent with the plain language of the DSH regulation at 42 C.F.R. § 412.106(a)(1)(ii). For periods prior to 2003, the DSH regulation included all days in the PPS areas of a hospital and drew no distinction between those patients who were in a routine service areas and those who were in an ancillary service area (lab, x-ray, cath lab, surgery, or even in the emergency room) at the census-taking hour.

Second, the Provider stated that the exclusion of LDR days from the Medicaid fraction is inconsistent with CMS' statement of intent at the time it adopted the DSH regulation and when it first adopted the Manual provision upon which CMS' new DSH rule purports to be based. The Provider noted that the DSH adjustment is calculated on Worksheet E, Part A at lines 4 through 4.04 and that the Medicaid fraction is listed on line 4.01, which describes this figure as the "[p]ercentage of Medicaid patient days to total days reported on Worksheet S-3, Part 1. Nothing on the face of Worksheet S-3 or the accompanying instructions for completion of the above-referenced lines provide for exclusion of inpatient days attributable to patients who are in an ancillary area at the census-taking hour.

Section 2205.2 of the PRM, which the Intermediary relied upon was not originally intended to count out LDR or labor, delivery, recover, or postpartum (LDRP) days from the number of inpatient days included in the cost report generally, or in the DSH calculation specifically. Section 2205.2 was created for the express limited purpose of conforming CMS' policy for the computation of a hospital's inpatient routine cost per diem, for cost apportionment purposes, to prior decisions that that had invalidated CMS' former policy of including LDR days in the computation. Accordingly, when CMS added § 2205.2, it did not amend other existing program guidance more generally defining what counts as an inpatient day with respect to maternity patients in particular or other patients.

Third, the exclusion of LDR days from the Medicaid fraction is invalid as applied to periods prior to the 2003 amendments to the regulation because CMS did not

follow the Administrative Procedure Act's (APA) notice and comment rulemaking procedure.

Fourth, the exclusion of LDR days from the Medicaid fraction is arbitrary and capricious, because it is inconsistent with CMS' treatment of other days attributable to patients in other ancillary service areas. The overarching purpose of the Medicaid fraction is to establish a proxy measure for utilization by low-income patients not to distinguish between low-income in routine areas and those in ancillary areas of a hospital subject to PPS. Finally, since CMS counts LDR days against a patient's Part A benefit for inpatient hospital services, such days should be counted as inpatient hospital days in the Medicare DSH calculation.

The Intermediary commented requesting that the Administrator reverse the Board's decision for the reasons stated in the Intermediary's post-hearing brief. Specifically, § 2205.2 of the PRM holds that a maternity patient in the LDR at midnight is included in the census of the inpatient routine care only if the patient has occupied an inpatient routine bed at some time since admission. In this case, for DSH calculators, the Provider seeks to include for 2002 the days of individual women in a LDR setting who have not occupied, or been admitted, to a routine bed as of the midnight census count. The Provider has presented no evidence to demonstrate that the patients whose days the Provider wishes to count occupied a routine bed at the midnight census hour. Furthermore, the Provider's witness conceded that its data was inadequate to determine whether the patients it seeks to count were in the LDR or a routine bed at the census-taking hour.[5]

**Issue No. 4 - Recalculation of the SSI Ratio.**

The Provider commented requesting that the Administrator affirm the Board's determination. The Provider argued that all SSI days must be included as long as the patient was entitled to both SSI and Medicare Part A. The statute does not afford the Secretary the discretion as to which SSI days should be included in the numerator of the SSI fraction. The law requires that the calculation be accurate.

CMM commented, requesting that the Administrator reverse the Board's decision. CMM argued that the Board erred in interpreting the regulations regarding recalculation of the Provider's DSH Disproportionate Patient Percentage (DPP). CMM noted that the regulation at issue permits a hospital to choose to have its DPP calculated based on the hospital's cost reporting period instead of the Federal fiscal year (FFY). However, if this request is made, CMS will perform this calculation "once per hospital per cost reporting period"[6] and that the resulting DPP will

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[5] Tr. at 218.
[6] 42 C.F.R. § 412.106(b) (3).

"become the hospital's official [DPP] for that period."[7] Thus, the regulation only permits CMS to recalculate a hospital's DPP based upon a different time period, i.e., the hospital's cost reporting period, rather than the FFY in which its cost reporting period began. CMM argued that there is no provision for re-computing the DPP based on updated or corrected data as the Board determined.

CMM noted that this policy of not performing redeterminations has also been applied in the context of outlier payment determinations. In fact, CMS' refusal to make redeterminations of outlier payments has been upheld in court. *Count of Los Angeles v. Shalala*, 192 F.3d 1005 (D.C. Cir. 1999) and *Rush-Presbyterian-St. Luke's Med. Ctr. v.* Thompson, No. 03-5375, 2003 WL 22019351 (N.D. Ill. Aug. 25, 2003).

The Intermediary commented requesting that the Administrator reverse the Board's decision for the reasons stated in the Administrator's decision in *Baystate*.[8]

## 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.

**Issue No. 1 - Medicare+Choice Days.**

To be eligible for the additional DSH payment, a hospital must meet certain criteria concerning, inter alia, its disproportionate Patient percentage (DPP). Section 1886(d)(5)(F)(vi) of the Act states that the term disproportionate patient percentage means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. Relevant to Issue No. 1 is the Medicaid portion of this fraction which is defined at § 1886(d)(5)(F)(vi)(II) as:

> the fraction (expressed as a percentage), the numerator of which is 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, 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's patient days for such period. (Emphasis added).

[7] Id.

[8] Admr. Dec. 2006-D-20 (May 11, 2006).

Consistent with the statute the regulation at 42 C.F.R. § 412.106(b)(4)(1999) provides the following general guidance to determine the Medicaid percentage.

> (4) *Second Computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of services for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in that same period. For purposes of this second computation, the following requirements apply:
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> > (i) A patient is deemed eligible for Medicaid on a given day if the patient is eligible for medical assistance under an approved state Medicaid plan on such day, regardless of whether particular items or services were covered or paid under the State plan.
> > (ii) The hospital has the burden of furnishing data adequate to prove eligibility of each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Section 4001 of the Balanced Budget Act (BBA) of 1997, established the M+C program by adding a new Part C to Title XVIII of the Act. As enacted by § 4001 of the BBA of 97, § 1851 of the Act, provides that in order to be eligible to enroll in an M+C plan, an individual must be entitled to benefits under Medicare Part A.

In 2003, the Secretary proposed to change this policy, i.e., to include M+C days in the Medicaid fraction. In pertinent part, the Secretary stated that:

> We note that under § 422.50, an individuals is eligible to elect an M+C plan if he or she is entitle to Medicare Part A and enrolled in Part B. However, once a beneficiary has elected to join an M+C plan, that beneficiary benefits are no longer administered under Part A.
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> Therefore, we are proposing to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for

> Medicaid would be included in the numerator of the Medicaid fraction.[9]

In August, 2003, CMS announced that it was still reviewing comments.[10] However, in August of 2004, CMS announced in a final rule, that M+C days were to be included in the Medicare fraction of the DSH calculation. CMS stated:

> [W]e agree with the commentator that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as a final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction.[11]

In this case, the Board held that the M+C days should be counted in the Medicare fraction. The Board concluded that a beneficiary can only be eligible for Part C if "entitled to benefits" under Part A. Therefore, since the Medicaid fraction's numerator excludes patient days for patients who (for such days) 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, M+C days can only be counted in the Medicare fraction as they are specifically precluded from being included in the Medicaid fraction.

Applying the relevant law and program policy to the foregoing facts, the Administrator agrees with the Board's determination that the M+C days are properly included in the Medicare fraction. The Administrator agrees with the Board's determination that a beneficiary can only be eligible for M+C if "entitled to benefits" under Part A. Although the Medicare statute does not expressly address the treatment of M+C days, it is clear after reading the DSH statute and the implementing regulations, along with the M+C statute, that the M+C days can only be counted in the Medicare fraction as they are specifically precluded from being included in the Medicaid fraction.

Accordingly, based on the plain language of the statute the Administrator finds that the statutory phrase in the Medicaid proxy "but who were not entitled to benefits under Medicare Part A of this title" forecloses the inclusion of the days at issue in this case in the numerator of the Medicaid proxy.[12] Thus, the Intermediary's calculation of the Provider's DSH adjustment was proper.

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[9] 68 Fed Reg. 27208 (May 19, 2003).

[10] 68 Fed Reg. 45422 (August 1, 2003).

[11] 69 Fed Reg. 49099 (August 11, 2004).

[12] The Administrator notes that, even when a Medicare beneficiary exhausts their inpatient hospital benefits, these benefits will be renewed when the beneficiary has

**Issue No. 2 – Massachusetts Uncompensated Care Pool.**

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.[13] 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.[14] 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.[15]

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.[16] If the State plan is approved by CMS, under §1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.

Within broad Federal rules, States enjoy a measure of flexibility to determine "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.[17] However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet

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not been in a hospital or SNF for 60 days. Thus, while a Medicare beneficiary's benefit period may exhaust or expire, the entitlement for Medicare does not expire.

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

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

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

[16] Id. §1902 et seq., of the Act.

[17] Id.

the applicable requirements are not eligible for "medical assistance" under the State plan.

In particular, §1901 of the Social Security Act sets forth that appropriations under that title are "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services…." Section 1902 sets forth the criteria for State plan approval.[18] As part of a State plan, § 1902(a) (13) (A) (iv) requires that a State plan provide for a public process for determination of payment under the plan for, inter alia, hospital services which in the case of hospitals, take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs. Notably, § 1905(a) states that for purposes of this title "the term 'medical assistance' means the payment of part or all of the costs" of the certain specified "care and medical services" and the identification of the individuals for whom such payment may be made.

Section 1923 of the Act implements the requirements that a State plan under Title XIX provides for an adjustment in payment for inpatient hospital services furnished by a disproportionate share hospital. A hospital may be deemed to be a Medicaid disproportionate share hospital pursuant to §1923(b) (1) (A), which addresses a hospital's Medicaid inpatient utilization rate, or under paragraph (B), which addresses a hospital's low-income utilization rate. The latter criterion relies, inter alia, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.[19]

Congress recognized that the various conditions and requirements of Title XIX of the Act, under which a State may participate in the Medicaid program created

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[18] 42 C.F.R. § 200.203 defining a State plan as "a comprehensive written commitment by a Medicaid agency submitted under section 1902(a) of the Act to administer or supervise the administration of a Medicaid plan in accordance with Federal requirement."

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

certain obstacles to potentially innovative and productive State health-care initiatives. Consequently, Title XI of the Act was amended to allow States to pursue such innovative programs.[20] Under §1115 of subchapter XI of the Act, a State that wishes to conduct such an innovative program must submit an application to CMS for approval. CMS may approve the application, if, in their judgment the demonstration project is likely to assist in promoting the objectives of certain programs established under the Act, including Medicaid.[21] To facilitate the operation of an approved demonstration project, CMS may waive compliance with specified requirements of Title XIX, to the extent necessary and for the period necessary to enable the State to carry out the demonstration project.[22] In addition, CMS may direct that costs of the demonstration project that would not "otherwise" qualify as section 1903 Medicaid expenditures, "be regarded as expenditures under the State plan approved under [Title XIX]."[23]

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[24] established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[25] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[26] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[27] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[28] 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.[29]

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[20] Section 1115 of the Act.
[21] Id.
[22] Id.
[23] Id.
[24] Pub. Law No. 89-97.
[25] Section 1811-1821 of the Act.
[26] Section 1831-1848(j) of the Act.
[27] Under Medicare, Part A services are furnished by providers of services.
[28] Pub. L. No. 98-21.
[29] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

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…."[30] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[31] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage. Relevant to this case, with respect to the proxy method, §1886 (d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" and the Medicaid low-income proxy", respectively, and are defined as follows:

> (I) the fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act and the denominator of which is the number of such hospital's patients day for 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.)

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[30] 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).

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

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)(1999). 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) (1999) and provides that:

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

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

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

Problems were identified by CMS regarding the payment of the DSH adjustment to providers based on Medicaid data that commingled the days for ineligible Medicaid patients with the eligible Medicaid patients. Intense concerns regarding the recoupment of these improper payments were publicized and also shared with CMS by providers and their political representatives. In response to these concerns, CMS announced in a letter to the Chairman of the Senate Finance Committee, dated October 15, 1999, a "hold harmless" policy.

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

hospitals and intermediaries relying on Medicaid State days data obtained from State Medicaid Agencies to compute the DSH payment that commingled the types of otherwise ineligible days listed with the Medicaid days.

In clarifying the type of days that were proper to include in the Medicaid proxy, the PM A-99-62 stated that the hospital must determine whether the patient was eligible for Medicaid under a State Plan approved under Title XIX on the day of service. The PM explained that:

> In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State [P]lan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for Medicaid days reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's eligibility for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX [S]tate [P]lan, not the patient's eligibility for general assistance under a State-only program; Third, the focus is on eligibility for medical assistance under an approved Title XIX State [P]lan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal–State cooperative program known as Medicaid (under an approved Title XIX State plan).

Consistent with this explanation of days to be included in the Medicare DSH calculation, the PM stated regarding the exclusion of days, that:

> Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program…. These beneficiaries, however, are not eligible for Medicaid under a State [P]lan approved under Title XIX, and therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so. In addition, if a given patient day affects the level of *Medicaid* DSH payments to the hospital, but the patient is not eligible for Medicaid under a State [P]lan approved under Title XIX on that day, the day is not included in the *Medicare* DSH calculation.

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> Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. [32] (Emphasis added.)

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

> General assistance days are days for patients covered under a State-only or county-only general assistance program, whether or not any payment is available for health care services under the program. Charity care days are those days that are utilized by patients who cannot afford to pay and whose care is not covered or paid by any health insurance program. While we recognize that these days may be included in the calculation of a State's Medicaid DSH payments, these patients are not Medicaid eligible under the State plan and are not considered Titled XIX beneficiaries.[33]

In addition, for the relevant fiscal period in dispute, the Secretary's policy was to include in the Medicare DSH calculation, only those days for populations under the Title XI § 1115 waiver who were or could have been made eligible under a State plan. The patient days of the "expanded" eligibility groups, however, were not to

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[32] 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.

[33] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

be included in the Medicare DSH calculation.[34] This policy did not affect the longstanding policy of not counting general assistance or State–only days in the Medicare DSH calculation. The policy of excluding §1115 waiver expansion populations from the DSH calculation was revisited by CMS and, effective with discharges occurring on, or after, January 20, 2000, certain §1115 waiver expansion days were to be included in the Medicare DSH calculation in accordance with the specific instructions as specified in more detail in the January 20, 2000 Federal Register.[35]

In 2001, CMS issued a Program Memorandum (PM) Transmittal A-01-13,[36] which again stated, regarding two specific types of Medicaid DSH days, that:

> *Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State.* These patients are not Medicaid eligible. Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care of general assistance days. This, however, is not "payment" for those days and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicaid formula.
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[34] 65 Fed. Reg. 3136 (Jan. 20, 2000). ("In some section 1115 waivers, a given population that otherwise could have been made eligible for Medicaid under section 1902(r)(2) or 1931(b) in a State plan amendment was made eligible under the section 1115 waiver. This population was referred to as hypothetical eligible, and is a specific, finite population identifiable in the budget neutrality agreements found in the Special Terms and Conditions for the demonstrations. The patient days utilized by that population are to be recognized for purposes of calculating the Medicare DSH adjustment. In addition, the section 1115 waiver may provide for medical assistance to expanded eligibility populations that could not otherwise be made eligible for Medicaid. Under current policy, hospitals were to include in the Medicare DSH calculation only those days for populations under the §1115 waiver who were or could have been made eligible under a state plan. Patient days of the expected eligibility groups however, were not to be included in the Medicare DSH calculation.")

[35] Id.

[36] 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)

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

In sum, for the cost years at issue, the Secretary has consistently required the exclusion of days relating to general assistance or State-only days. The policy distinguishes those days for individuals that receive medical assistance under a Title XIX State plan that are to be counted and "other" days that are not to be counted. Examples of some of these other days include days for individuals that are not in fact eligible for medical assistance, but may receive State assistance; days that maybe a basis for Medicaid DSH payment under the State plan only; or days related to individuals that may receive benefits under a Title XI plan. These other days are not counted for purposes of the Medicare DSH payment.

The Administrator notes that this policy was recently upheld in *Adena.*[37] In *Adena*, a group of Ohio Providers sought to have included, State-only charity care days (Ohio's Hospital Care Assurance Program (HCAP)) in their Medicare DSH calculation because such days were included in the State's Medicaid plan for purposes of setting the methodology by which Ohio calculated it Medicaid DSH adjustment. The Court held that the phrase "eligible for medical assistance under a State plan approved under title XIX" referred to patients who are eligible for Medicaid. The Court rejected the Providers' argument that days of patients who were counted toward a Medicaid DSH payment must be counted toward the Medicaid fraction of the Medicare DSH calculation.[38]

In this case, the Provider argued that the Massachusetts UCP days should be counted in the numerator of the Medicaid fraction for purposes of determining its Medicare DSH calculation because the Massachusetts UCP is part of the Medicaid DSH payment described in the CMS approved Medicaid State plan.[39] Because CMS paid FFP (Medicaid DSH) for UCP expenditures and because CMS has the authority to pay matching funds only for State expenditures on medical assistance under the State plan, the Massachusetts UCP qualifies as "medical assistance under the Stat Plan" in accordance with § 1886(d)(5)(F)(vi)(II) of the Act.

The Administrator does not agree. The Administrator finds that §1886(d)(5)(F)(vi)(II) of the Act requires, for purposes of determining Provider's

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[37] Supra, n 2.

[38] Id. at 179

[39] Provider's Exhibit 11. Massachusetts State Medicaid Plan, Transmittal Numbers (TN) TN 98-12 at 3; TN 99-12 at 6; TN 00-010 at 35; TN 00-14 at 47; TN 02-023 at 78. See also Provider's Exhibit 12, Mass. Gen. Laws Ch. 118G § 18.

"disproportionate patient percentage", that the Secretary count patient days attributable to patients who were eligible for medical assistance under a State plan approved under Title XIX of the Act, but who were not also entitled to Medicare Part A. The Administrator finds that, as reflected at 42 C.F.R. § 412.106, the Secretary has interpreted this statutory phrase "patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX," to mean "eligible for Medicaid."[40] 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, then the patient is not "eligible for medical assistance under a State plan approved under Title XIX."

The Administrator finds that the language set forth in §1886(d)(5)(F)(vi)(II) of the Act requires that the day be related to an individual eligible for "medical assistance under a State plan approved under Title XIX" also known as the Federal Program Medicaid. The use of the term "medical assistance" at §§1901 and 1905 of the Act and the use of the term "medical assistance" at §1886(d)(5)(F)(vi)(II) of the Act is reasonably concluded to have the same meaning. As noted by the courts, "the interrelationship and close proximity of these provisions of the statute presents a classic case for the application of the normal rule of statutory construction that identical words used in different parts of the same act are intended to have the same meaning."[41] Therefore, the Administrator finds that the language at §1886(d)(5)(F)(vi)(II) of the Act requires that for a day to be counted, the <u>individual</u> must be eligible for "medical assistance" under Title XIX.[42] That is, the <u>individual</u> must be eligible for the Federal government program also referred to as Medicaid.

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[40] <u>See</u> e.g. *Cabell Huntington Hosp. Inc., v. Shalala*, 101 F.3d 984, 989 (4th Cir. 1996) ("It is apparent that 'eligible for medical assistance under a State plan' refers to patients who meet the income, resource, and status qualifications specified by a particular state's Medicaid plan…."); *Legacy Emanuel Hospital v. Secretary*, 97 F.3d 1261, 1265 (9th Cir. 1996)("[T]he Medicaid proxy includes all patient days for which a person was eligible for Medicaid benefits whether or not Medicaid actually paid for those days of service.")

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

[42] Congress added language to §1886(d)(5)(F)(vi)(II) of the Act which stated: "In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI." Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, § 5002, 120 Stat. 4, 31 (February 8,

The Administrator finds that in Massachusetts, the State's Medicaid program is called MassHealth.[43] In contrast, the Administrator finds that the Massachusetts UCP days in question, provide medical care to individuals who are not eligible for "medical assistance under a State plan approved under Title XIX, i.e. Medicaid.[44] The record shows that the Massachusetts UCP is considered a last resort for people that do not qualify for any other assistance program such as MassHealth (i.e., Medicaid). "If a patient is enrolled in MassHealth [Medicaid] on the date that service is provided, the Hospital or Community Health Center may not bill the UCP pool for that service."[45] Furthermore, "[i]f an Acute Hospital or Community Health Center determines that a patient is potentially eligible for Medicaid or another government program, said Acute Hospital or Community Health Center shall encourage the patient to apply for such program and shall assist the patient in applying for benefits under such program."[46] In addition, the record further shows that the Commonwealth of Massachusetts developed the UCP as a financing mechanism to distribute more equitably the financial burden of uncompensated care, i.e., medical care not covered by insurance programs such as Medicaid.[47] Finally, the record shows that the revenue in the UCP is derived from hospital assessments, UCP surcharges, State appropriation of FFP funds, and other appropriations and that the UCP individuals do not receive any direct FFP for payment of medical care.[48]

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2006) (codified in part at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(II). This amendment to §1886(d)(5)(F)(vi) of the Act specifically addressed the scope of the Secretary's authority to include (or exclude), in determining the numerator of the Medicaid fraction of the Medicare DSH calculation, patient days of patients not eligible for medical assistance under a State plan but who receive benefits under a demonstration project approved under Title XI of the Act. This enactment clearly distinguishes those patients eligible to receive benefits under Medicaid from those patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI. This amendment left untouched CMS longstanding policy on general assistance days.

[43] Provider's Exhibit 15 at 4, § 114.6 Mass. Code Regs. § 10.02.

[44] Intermediary's Exhibit I-6 at § 4.1. The implementing State statute requires hospital and community health centers to screen free care applicants for other health insurance benefits and public assistance programs that might pay for health care before qualifying people for free care.

[45] Intermediary's Exhibit I-10 at 7 (10.04(1)).

[46] Id. at 7, 10.04(2).

[47] Provider's Exhibit 9 at 1. Healthpoint, Information from the Division of Health Care Finance Policy (Sept. 1996); See also Provider's Exhibit 10 at 2. Provider Free Care Reform, An update from the Massachusetts Division of Healthcare Finance and Policy on the Uncompensated Care Pool, (Sept. 1999).

[48] Provider's Exhibit 8 at 4, § 114.6 Mass. Code Regs. § 11.04(1)(a).

As stated above, the Secretary has interpreted the term "eligible for medical assistance under a State Plan approved under Title XIX" to mean eligible for the Federal government program also referred to as Medicaid. In this case, the Massachusetts UCP specifically excludes individuals who are qualified for Medicaid. Section 1886(d)(5)(F)(vi) (II) of the Act requires that for a day to be counted, the individual must be eligible for "medical assistance" under Title XIX. Therefore, the Administrator finds that the individuals covered by the Massachusetts UCP are not covered by "medical assistance" as described in Title XIX. The individuals for whom the Provider seeks to count towards its DSH payment must be eligible for Medicaid.[49]

Finally, regarding the expenditure of Federal financial participation or FFP under a Medicaid DSH program, generally, the issue of whether costs are regarded as expenditures under a State plan approved under Title XIX for purposes of calculating Federal matching payments to the State is different from the issue of whether patients are considered eligible for medical assistance under a State plan approved under Title XIX for purposes of calculating Medicare DSH payments to a hospital. Section 1886(d) clearly states that the patients' Title XIX eligibility for that day is a requirement for inclusion in the Medicare DSH calculation. Therefore, regardless of any possible indirect FFP through a Medicaid DSH payment, the Massachusetts UCP days operated and funded by the State of Massachusetts (not Title XIX) are not counted as Medicaid days under § 1886(d)(5)(F)(vi)(II) of the Act.

Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly did not include the Massachusetts UCP days in the numerator of the Medicaid fraction. The Massachusetts UCP days involve individuals who are not eligible for medical assistance under a State plan approved under Title XIX and, therefore, cannot be included in the numerator of the Medicaid fraction for purposes of the Medicare DSH calculation.

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

**Issue No. 3 – Labor and Delivery Room.**

Relevant to this case, from the beginning of the program, under reasonable cost hospital inpatient reimbursement, the average cost per day for reimbursement purposes was calculated by dividing the total costs in the inpatient routine cost center by the "total number of inpatient days."[50] Generally, Medicare reimbursement for routine inpatient services was based on an average cost per day as reflected in the inpatient routine cost center multiplied by the total number of Medicare inpatient days.[51] Consequently, the inclusion or exclusion of a bed day in the per diem calculation would impact the Medicare per diem payment.

However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[52] This provision added §1886(d) to the Act and established the inpatient prospective payment system, or 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.[53]

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 reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Notably, while IPPS was implemented to replace the reasonable cost method of reimbursing hospitals for the operating costs of inpatient hospital services, it continues to require cost reporting consistent with that required under the reasonable cost methodology including the principles guiding the inpatient routine per diem methodology.

As noted in Issue No 2, 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, an additional payment per patient discharge,

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[50] *See e.g.* 42 CFR 413.53(b); 42 CFR 413.53(e)(1) ("Departmental Method: Cost reporting periods beginning on or after October 1, 1982.")

[51] *Id.* *See also* Section 2815 PRM-Part II, "Worksheet D-1 Computation of Inpatient Operating costs" sets forth definitions to apply to days used on Worksheet D-1 which ahs been in place since 1975. 60 Fed. Reg. 45778, 45810 (1995).

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

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

"for hospitals serving a significantly disproportionate number of low-income patients…."[54] Consistent with the section 1886(d)(5)(F) of the Act, noted above, the governing regulation at 42 C.F.R. § 412.106, which addresses the DSH adjustment, states that:

> (a) *General considerations.* (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location.
>
> (i) The number of beds in a hospital is determined in accordance with § 412.105(b).
>
> (ii) The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others.

The Secretary explained in the preamble promulgating the regulation that:

> [W] e believe that, based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment. Congress clearly intended that a disproportionate share hospital be defined in terms of subsection (d) hospital, which is the only type of hospital subject to the prospective payment system….
>
> Moreover, this reading of section 1886(d)(5)(F) of the Act produces the most consistent application of the disproportionate share adjustment, since only data from prospective payment hospitals or from hospital units subject to the prospective payment system are used in determining both the qualifications for and the amount of additional payment to hospitals that are eligible for a disproportionate share adjustment.[55] (Emphasis added.)

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[54] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. Law No. 99-272). *See also* 51 Fed. Reg. 16772, 16773-16776 (1986).

[55] 53 Fed. Reg. 38480 (Sept. 30, 1988); *See also* 53 Fed. Reg. 9337 (March 22, 1988).

Similarly, the Secretary stated in discussing the counting of bed days used to determine the related DSH bed size issue at 42 CFR 412.105, that:

> Our current position regarding the treatment of these beds is unchanged from the time when cost limits established under section 1861(v)(1)(A) of the Act were in effect and is consistent with the way we treat beds in other hospital areas. *That is, if the bed days are allowable in the calculation of Medicare's share of inpatient costs, the beds within the unit are included as well*.[56] (Emphasis added.)

The general policy for counting bed days for purposes of inpatient services has remained unchanged from prior to the establishment of IPPS, except to account for adverse case law. From the beginning of the program, under reasonable cost hospital inpatient reimbursement, the average cost per day for reimbursement purposes is calculated by dividing the total costs in the inpatient routine cost center by the "total number of inpatient days." Early in the program, an inpatient day was defined as a day of care rendered to any inpatient except a newborn. Medicare reimbursement for routine services was based on an average cost per day as reflected in the inpatient routine cost center multiplied by the total number of Medicare inpatient days. Consequently, a bed day included in either the total number of Medicare days (for example, if for a Medicare hospital inpatient) or the total number of inpatient days (including both Medicare and non-Medicare hospital inpatients) would impact the Medicare per diem payment. Notably, IPPS was implemented to replace the reasonable cost method of reimbursing hospitals for the operating costs of inpatient hospital services, but continues to require cost reporting consistent with that required under the reasonable cost methodology. Moreover, certain payments for IPPS hospitals continued to be made under a pass-through reasonable cost methodology.

With respect to adverse case law affecting the counting of bed days, Medicare's policy on counting days for maternity patients was to count an inpatient day for an admitted maternity patient in the LDR at the census taking hour prior to December 1991, Generally, § 2205 of the PRM provides that:

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[56] 59 Fed. Reg. 45330, 45373 (1994). *See also Id.* at 45374 (with respect to the inclusion of neonatal beds in the count: "We disagree with the position that neonatal intensive care beds should be excluded based on the degree of Medicare utilization. Rather, we believe it is appropriate to include these beds because the costs and the days of these beds are recognized in the determination of Medicare costs (nursery costs and days, on the other hand, are excluded from this determination)…."

> Only a full patient day must be used to apportion inpatient routine care services … to the Medicare program. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method must be used even if you use a different definition of patient day for your statistic or other purposes.
>
> An inpatient at midnight is included in the census of your inpatient *routine* (general or intensive) *care area* regardless of the patient's location at midnight (whether in a routine bed, an ancillary area, etc.) including a patient who has yet occupied a routine care bed since admission (see exception in section 2205.2 regarding maternity patients.). (Emphasis added.)[57]

This is consistent with Medicare policy for counting days for admitted patients in any other ancillary department at the census-taking hour. However, based on decisions adverse to the government regarding this policy in a number of Federal courts of appeal, including the United States Court of Appeals for the District of Columbia Circuit, the policy regarding the counting of inpatient days for maternity patients was revised to reflect our current policy.

Reflecting that adverse case, the Secretary's current policy regarding the treatment of labor and delivery bed days is described in § 2205.2 of the PRM. Section 2205.2 provides that:

> A maternity inpatient in the labor/delivery room at midnight is included in the census of *inpatient routine* (general or intensive) *care area* if the patient has occupied an inpatient routine bed at some time since admission. No days of inpatient routine care are counted for maternity inpatient who is discharged (or dies) without ever occupying an inpatient routine bed. However, once a maternity patient has occupied an inpatient routine bed, at each subsequent census, the patient is included in the census of the routine care area to which it is assigned even if the patient is located in an ancillary area (labor/delivery room or another ancillary area) at midnight. In some case, a maternity patient may occupy an inpatient bed only on the day of discharge, where the day of discharge differs from the day of admission. For purposes of apportioning the cost of routine care, this single day of routine care is counted as the day of admission (to

[57] Adopted by Tans. No. 155 (June 1976), amended Trans. No. 293 (July 1983), Trans. No. 317 (Dec. 1984, effective for cost reporting periods beginning after September 1983 for hospitals under IPPS) and by Trans. No. 365 (December 1991).

> routine care) and discharge and therefore is counted as one day of inpatient routine care.

Therefore, for purposes of the DSH calculation, if a Medicaid patient is in the labor room at the census and has not yet occupied a routine inpatient bed, the bed day is not counted as a routine bed day of care in Medicaid or total days and, therefore, is not included in the counts under the regulation at 42 C.F.R. § 412.103(a)(1)(ii). If the patient is in the labor room at the census but had first occupied a routine bed, a routine inpatient bed day is counted, in Medicaid and total days, for DSH purposes and for apportioning the cost of routine care on the cost report consistent with the Secretary's longstanding policy to treat days, cost, and beds similarly.

In addition, as a result of changes in the delivery of health care, hospitals have been redesigning their maternity areas from the separate labor/delivery rooms and postpartum rooms, to single multipurpose labor, deliver, recovery and postpartum (LDRP) rooms. The Secretary noted that, as a result of these changes in the provision of health care, further clarification was required. The Secretary stated that:

> In order to appropriately track the days and costs associated with [Labor Delivery Postpartum ]LDP rooms, it is necessary to apportion them between the labor and delivery cost center, which is an ancillary cost center and the routine adults and pediatrics cost center. This is done under our policy by determining the proportion of the patient's stay in the LDP room that the patient was receiving ancillary services (labor and delivery) as opposed to routine adult and pediatric services (postpartum). 68 Fed. Reg. 45346, 45419-45420 (Aug 1, 2003).[58]

In response to comments concerning the counting of labor/delivery bed days, the Secretary stated that:

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[58] 68 Fed. Reg. 45346, 45419-45420 (Aug 1, 2003). The Secretary further explained that: "An example of this would be if 25 percent of the patient's time in the LDP room was for labor/delivery services and 75 percent for routine care, over the course of a 4-day stay in the LDP room. In that case, 75 percent of the time the patient spent in the LDP room is applied to the routine inpatient bed days and costs (resulting in 3 routine adults and pediatrics bed days for this patient, 75 percent of 4 total days)…… Alternatively, the hospital could calculate an average percentage of time patients receive ancillary services, as opposed to routine inpatient care in the LDP room(s) during a typical month, and apply that percentage through the rest of the year." Id.

> As we previously stated above and in the proposed rule, initially, Medicare's policy did count and inpatient day for an admitted maternity patient even if the patient was in the labor/delivery room at the census-taking hour. However, based on adverse court decisions, the policy was revised to state that the patient must first occupy an inpatient routine bed before being counted as an inpatient. With the development of LDP rooms, we found it necessary to apply this policy consistently in those settings, in order to appropriately apportion the costs between labor and delivery ancillary services and routine inpatient care.
>
> Although we have not previously formally specified in guidance or regulations the methodology for applying this policy the LDP rooms, this is not a new policy…[W]e believe this policy may not have been applied consistently. Therefore, we believe it is important to clarify the policy as part of our discussion of our policies pertaining to counting patient bed days.
>
> We continue to believe the LDP apportionment described above is an appropriate policy and does not, in fact, impose a significant additional burden because hospitals are already required to allocate cost on the cost report between ancillary and routine costs. In addition, this allocation is already required to be consistent with our treatment of costs, days, and bed and is consistent with our other patient bed day policies. Therefore, this policy will be applied to all currently open and future cost reports. However, it is not necessary to reopen previously settled cost reports to apply this policy.[59]

The Secretary also recognized adverse case law in the Ninth Circuit Court of Appeals reflected in *Alhambra v. Thompson*.[60] The court ruled that days attributable to groups of beds that are not separately certified as distinct part non-acute care beds and the care is provided at a level below the level of routine inpatient acute care, but are adjacent to or in an acute care "area" are included in the areas of the hospital that are subject to the prospective payment system and should be counted in calculating the Medicare DSH patient percentage. The Secretary stated that:

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[59] 68 Fed. Reg. 45346, 45419-45420(Aug 1, 2003).

[60] 259 F.3d 1071, 2001 U.S. App. for the Ninth Circuit No. 99-57009, Aug. 7, 2001, (CCH) ¶300,785

In particular, we proposed to revise our regulations to clarify that the beds and patient days attributable to a nonacute care unit or ward should not be included in the calculations at .. § 412.106(a)(1)(ii), even if the unit is not separately certified by Medicare as a distinct-part unit and even if the unit or ward is within the same general location of the hospital as areas that are subject to the IPPS (that is, a unit that provides and IPPS level of care is on the same floor of the hospital as a subacute care unit that does not provide an IPPS level of care).

Exceptions to this policy to use the level of care generally provided in a unit or ward as proxy for the level of care provided to a particular patient on a particular day are outpatient observation bed days and swing-bed days, which are excluded from the count of available bed days even if the care is provided in an acute care unit. Our policies pertaining to these beds and days are discussed further below.

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We also proposed to revise the DSH regulations at § 412.106(a)(1)(ii) to clarify that the number of patient days includes only those attributable to patients that receive care in units or wards that generally furnish a level of care that would generally be payable under the IPPS.

We note the proposed revision were clarifications of our regulations to reflect our longstanding interpretation of the statutory intent, especially relating to the calculation of the Medicare DSH patient percentage.[61]

Pursuant to the FFY 2004 rates, the Secretary revised the regulation to clarify, consistent with longstanding policy, the rule with respect to the days for non-acute and non-routine care provided in the hospital to state that .

§412.106 -- Special treatment: Hospitals that serve a disproportionate share of low-income patients.
(a) General considerations. (1) * * *
(ii) For purposes of this section, the <u>number of patient days in a hospital includes only those days attributable to units or wards of the hospital providing acute care services generally payable under the</u>

[61] 68 Fed. Reg., at 45417-45418.

> prospective payment system and excludes patient days associated with-
> (A) Beds in excluded distinct part hospital units;
> (B) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services; and
> (C) Beds in any other units or wards where the level of care provided would not be payable under the acute care hospital inpatient prospective payment system...[62] (Emphasis added.)

However, relevant to this case, the Court of Appeals for the Fourth Circuit in found *District Memorial Hospital v. Thompson*, 364 F.3d 513, (4th Cir. 2004) the Secetary's interpretation of the term "areas" as a sphere or scope of operation or activity reasonble. The Court stated that:

> The Secretary, on the other hand, presses a non-geographical reading of the term "areas," arguing that the term refers to the scope of activity; in this case, the provision of acute care; rather than to all beds geographically located in a hospital wing licensed to provide acute care. ….We find that neither party's interpretation of regulation § 412.106 is clearly beyond the plain meaning of the regulation's text and that the term "areas" is ambiguous. We therefore conclude that the Secretary's interpretation is at least a reasonable construction of the regulatory language. The word "area" may refer to a physical space, a geographical area, as found by the district court, or it may refer to "the sphere or scope of operation or action." Webster's Third New International Dictionary 115 (1993). Thus, employing this alternative definition, someone may say, "I practice in the area of Medicare law." Under this alternative definition, "areas of the hospital that are subject to the prospective payment system" would encompass activities that are defined by whether they are reimbursed under the prospective payment system, regardless of where the activities geographically took place. In other words, "days attributable to areas of the hospital that are subject to the prospective payment system" would mean "days attributable to hospital activities that involve acute care and therefore are reimbursed under the prospective payment system." While it is true that this interpretation relies on an alternative definition of "area," an agency's interpretation "need not be the best or most natural one by grammatical or other standards." Pauley, 501 U.S. at 702. Rather, it

[62] 68 Fed. Reg. 45346 at 45470 (Aug 1, 2003).

> need only be a reasonable construction. *Thomas Jefferson Univ*., 512 U.S. at 506, 114 S.Ct. 2381

The Administrator recognizes that, under the statute, the DSH adjustment is intended to be an additional payment to account for a "higher Medicare payment per case" for IPPS hospitals that serve a disproportionate number of low-income patients. The Administrator finds that the policy to only include bed days that are recognized as part of hospital's inpatient operating costs is consistent with that overarching statutory intent. Likewise, the application of the term "areas" as a "scope of activities or operation" is consistent from the perspective .of Medicare financing, which is focused on a hospital's cost finding and, how activities and operation are captured on a cost report, as opposed to the hospital as physical, geographical, bricks and mortar.

Applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly did not include bed days in the DSH calculation related to patients in labor who had not yet occupied a routine inpatient bed. The bed days relating to patients in labor who had not yet occupied a routine inpatient bed are not recognized under IPPS as part of the inpatient operating costs of a hospital and must be excluded from the inpatient day count for purposes of the DSH adjustment. As established by the above law and manual instructions, generally, CMS has excluded from the bed day count those bed days not paid as part of the inpatient operating cost of the hospital, that is, days not recognized as an inpatient operating cost under IPPS. When implementing IPPS, CMS has reasonably required the application of the same fundamental cost reporting and statistical methods and principles for identifying inpatient operating costs as applied under the prior reasonable cost methodology.

Further, section 2205.2 of the PRM is consistent with the regulation at 42 C.F.R. § 412.106(a)(iii) and the further clarifications set forth at 42 C.F.R. § 412.106(a)(iii)(B) and (C). Like the regulation, the § 2205.2 of the PRM uses the specific term "area" in discussing the counting of patient days as a scope of operation and distinguishes that from the location of the patient. While the regulation generally refers to patient days in "areas" of the hospitals that are subject to IPPS, § 2205.2 of the PRM specifically explains that a maternity patient in a labor delivery room bed at midnight is not to be included in census of "the inpatient routine [i.e., IPPS] care area" of the hospital if the patient has not occupied an inpatient routine bed at some time since admission. Similarly, the program guidance set forth in the PRM states that:: "An inpatient at midnight is included in the census of your inpatient *routine* (general or intensive) *care area* regardless of

the patient's *location* at midnight (whether in a routine bed, an ancillary area, etc.) including a patient who has yet occupied a routine care bed since admission." [63]

Moreover, the Administrator finds that regardless of whether the term "area" is referring to a "physical or geographical space" or whether it is referring to a "sphere or scope of operation or action"[64], the PRM instructions specify when days for admitted patients are, or are not, to be included in the routine patient "area" for purposes of counting inpatient days under the Medicare program.[65] Under the PRM interpretative guidelines, routine inpatients, <u>even if</u> "located" in the ancillary area of the hospital at census time, are to be counted in the routine "area". The exception is set out for the labor delivery patient bed days who are not to be counted in the routine "area" before the birth of their babies if they have not yet occupied a routine bed.

Consistent with this policy, CMS has continued to exclude the bed days related to labor delivery patients from the count of inpatient IPPS bed days for patients in LDRP units, where there is a mix of ancillary labor delivery room bed days and inpatient routine bed days. The Secretary has reasonably responded to changes in the provision of health care services and clarified this policy, while remaining consistent with the prior policy of not including bed days related to labor delivery

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[63] Section 2205 of the PRM.

[64] The Administrator continues to maintain, however, that the term "area" is referring to a "sphere or scope of operation or action."

[65] <u>See</u> <u>also</u> the analysis of the term "area" as geographical in *District Memorial Hospital v. Thompson* , 364 F.3d 513, 519-520 (4th Cir. 2004)("Even if one were to insist that the word "area," as used in regulation § 412.106, be read to carry its geographical connotation, the Secretary's interpretation would remain a reasonable construction of the regulatory language. The word "area" would then refer to the location of any bed used to provide *acute care* when such services were being provided, and the disproportionate share adjustment would apply to that location at such times. Similarly, the word "area" would not refer to the location of a bed when *skilled nursing services* were being provided at that bed because such services were not "subject to the prospective payment system." Under this interpretation, the word "areas" in a geographical sense would be referring to the locations of individual beds, as opposed to wings or units of the hospital. Use of this meaning would result in the same interpretation advanced by the Secretary, who counted "patient days" when beds were actually being used for acute care. Although the reimbursement status of each swing bed might thus change daily, as the use of the bed shifted between acute care and skilled nursing care, such a daily reassessment would be consistent with the regulatory language, which refers to "*days* attributable to areas of the hospital that are subject to the prospective payment system." 42 C.F.R. § 412.106(a)(1)(ii) (1988).")

days in the DSH calculation.[66] Accordingly, based upon the foregoing reasoning, the Board's decision on this issue is reversed.

**Issue No. 4 – Recalculation of the SSI Ratio.**

The regulations at 42 C.F.R. § 412.106(b)(1999) provide that CMS will calculate a hospital's Medicare fraction based on its discharge data for a Federal fiscal year (FFY). The regulations at 42 C.F.R. § 412.106(b)(3) permits a hospital to choose to have its disproportionate patient percentage (DPP) calculated based upon the hospital's cost reporting period rather than the FFY. If a hospital requests for this to be done, the calculation is "performed once per hospital per cost reporting period" and the resulting DPP "becomes the hospital's official [DPP] for that period." Read together with other regulatory provision at 42 C.F.R. § 412.106, the regulation clearly indicates that CMS' calculations of hospitals' Medicare fractions are fixed when performed and that no change to the Medicare fraction, either higher or lower is allowed based on updated or later data. There is no provision for doing re-computations based on updated or later data and, thus, one should not be implied. Generally, CMS only performs a recalculation of an IPPS payment determination based on updated or later data where the regulations explicitly provide for such recalculation. In contrast, where the regulations have not provided explicitly for re-determinations, CMS or its designees do not perform them.

In this case, the Provider challenged the calculation of its Medicare fraction in determining its DSH adjustment payment.[67] The Board concluded that the regulation did not preclude the recalculation of the Medicare fraction.

The Administrator does not agree. The Administrator finds that, the regulation does not provide for a recalculation of the SSI ration based upon updated or later data once it is completed by CMS. A review of the applicable law and regulations show that the Secretary did not intend for the DSH calculations to be recomputed or recalculated based upon later, or corrected, data.

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[66] *National Cable & Telcomm Ass'n v. Brand X Internet Serv*., 125 S.Ct. 2688, 2699-2700 (2005)(" 'An initial agency interpretation is not instantly carved in stone. On the contrary, the agency…must consider varying interpretations and the wisdom of it policy on a continuing basis', **** for example, in response to changed factual circumstances or a change in administrations,…")

[67] Under the Administrative Procedure Act, the proponent of the rule has the burden of proof. 5 USC 556(d). Thus, a provider has the burden to establish its claim for reimbursement before the Board. In this instance, the Provider has the burden of proof to support its claim for additional DSH payments by a preponderance of the evidence. (*Fairfax Hospital Association v. Califano*, 585 F. 2d 602 (4th Cir. 1978) CMS/HCFA Ruling79-60c.)

On its face, the regulation does not allow for further recalculations of a provider's SSI ratio beyond that explicitly prescribed in the regulation. As the regulation shows, only a limited exception for recalculation of the Medicare fraction based upon a provider's cost reporting period is allowed. Notably, this limited exception was based on the explicit time period (a provider's cost reporting period) which was set forth in the statute. In contrast, no such explicit provision for recalculation of the Medicare fraction based on later, or corrected data, is set forth in the statute, nor in the regulation.

The Secretary has consistently recognized the administrative burdens involved in calculating the Medicare fraction and has made policy decisions balancing the need to reduce administrative burdens and the need for timely, accurate data. The policy to consider the CMS calculated Medicare fraction not subject to updating is consistent with the sometimes competing interests of finality, timeliness, efficiency and accuracy in the administration of a large Federal program.

In arriving at this policy, the Secretary considered the administrative burdens associated with the calculation of the Medicare fraction. The Secretary necessarily examined these problems within the context of administering the entire Medicare program and not within the singular context of calculating a single hospital's DSH Medicare fraction. In implementing DSH provisions in 1986, the Secretary found that to match SSI eligibility records to Medicare bills on a Federal fiscal year on an annual basis was the most efficient approach given the scope of the program. Noting the 11 million billing records and 5 million SSI records, the Secretary specifically limited any calculations to a *yearly basis* stating that:

> The data source for computation of the SSI/Medicare percentage include the Medicare inpatient discharge file which is compiled on a Federal fiscal year basis and includes approximately 11 million billing records (this compilation is done about three or four months after the close of the Federal fiscal year and is then updated periodically as additional discharge data are received) and the SSI file that lists all SSI recipients for a 3 year period denotes the month during the period in which the recipient was eligible for SSI benefits (the SSI file includes over 5 million records.) In order to compute the SSI /Medicare percentage, the 11 million records from the discharge file must be individually matched by beneficiary number and month of hospitalization with the SSI recipient records. On a Federal fiscal year basis, this match would be performed <u>on a yearly basis</u>. (Emphasis added.) [68]

[68] 51 Fed. Reg. 31454, 31459-60 (Sept 1986).

In balancing administrative efficiency and accuracy, the Secretary noted that:

> We do not believe that there are likely to be significant fluctuations from one year to the next in the percentage of patients served by hospitals that are dually entitled to Medicare Part A and SSI. Consequently, the percentage for a hospital's own experience during the Federal fiscal year should be reasonably close to the percentage specific to the hospital's cost reporting period.[69]

The Secretary, subsequently, compared the Medicare fraction based on a provider's cost reporting period and the Federal fiscal year and concluded, as predicated, that these two periods resulted in reasonably close percentages. The Secretary subsequently determined that he would afford hospitals the option to determine the number of patient days of those dually entitled to Medicare Part A and SSI for their own cost reporting periods. The Secretary concluded that:

> We do not believe Congress intended to impose cumbersome and costly administrative burden as that described above in implementing this provision. The Secretary has general rulemaking authority under section 1102 and 1871 of the Act to deal with problems of implementing and administering the Act in an efficient manner. Based on the above discussion, we believe that using the Federal fiscal year instead of a hospital's own cost reporting period is the most feasible approach to implementing provision terms of accuracy, timeliness and cost efficiency. In addition, we believe we have complied with the law by affording hospitals the option of having their SSI/Medicare percentages computed based on … the cost reporting period.[70]

In allowing for this provision, the Secretary noted that:

> [I]f a hospital has its SSI/Medicare percentage recomputed based on its own cost reporting period, this percentage will be used for purpose

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(The 2002 MEDPAR file contains over 12 million records. See, e.g., http://www.cms.gov/IdentifiableDataFiles/05_MedicareProviderAnalysisandReviewFile.asp .)

[69] 51 Fed. Reg. 16777.

[70] 51 Fed Reg. 31459-60. (See also "[I]n the interim final rule we proposed matching SSI eligibility records to the Medicare bills on a Federal fiscal year basis because we believe this is the most efficient approach." 51 Fed. Reg. 31454 (Sept. 3, 1986))

> of it disproportionate share adjustment whether the result is higher or lower than the percentage computed based on the Federal fiscal year." (Emphasis added.) [71]

That is, a provider cannot request such a recalculation and chose the higher Medicare fraction. The regulatory language plainly does not incorporate any procedures for revising the Medicare fraction based upon later data. Rather, the regulation provides for a provider's Medicare fraction to be final, once calculated by CMS, except in the instance where a provider has requested the computation be based on its cost reporting period.

Finally, in response to the specific commenters, the Secretary had the opportunity to specifically address this issue in the final rule to the FFY 2006 final rates. [72]The Secretary specifically rejected the use of updated SSI eligibility information (which the commenter argued may include retroactive approvals etc.), for use by CMS to revise calculations of hospital DSH Medicare fractions. Consequently the Secretary clearly had a policy of calculating the SSI fraction based upon specific data, within certain timeframes, and not subject to later revision.

Moreover, the Administrator finds that this policy is consistent with IPPS. Notably, where the Secretary has allowed for corrections of data underlying inpatient prospective payments or IPPS, the Secretary has set forth specific procedures and timeframes for doing so consistent with the aims of IPPS (e.g., wage index). In contrast, no process was implemented in the regulations at 42 C.F.R. § 412.106 for the recalculation of the CMS Medicare fraction.
Likewise, the Secretary has determined that the refusal to recalculate underlying IPPS data is also rational and consistent with the aims of the inpatient PPS. Specifically, the regulation for determining eligibility for the rural referral center status required the use of a provider's published 1981 case mix index (CMI). The Secretary refused to recalculate a provider's 1981 CMI for purposes of determining its eligibility for rural referral center status under IPPS.[73] The court in *Board of*

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[71] 51 Fed Reg. 31459-60.

[72] 70 Fed. Reg. 47278, 47439-47440.

[73] In reference to a specific objection raised by a commenter regarding the CMI, the Secretary announced: "We do not believe that hospitals should be allowed to substitute other criteria for the one we published in the NPRM (notice of proposed rulemaking. We selected the 1981 case-mix index for this criterion because it represents the most current published data available at the time. The basic tenet of the prospective payment system is that the rates paid to hospitals are determined prospectively and are based on the best data available at the time. Thus, a hospital knows in advance what its payment amounts will be." See 49 Fed. Reg. 34728 34743-44 No commenters raised the issue of recalculating the SSI ratio in the

*Trustees of Knox County Hospital v.Shalala*, 135 F 2d 493 (7th Cir. 1998), specifically addressed the provider's challenge to the Secretary's use of a published 1981 case mix index (CMI). The provider argued that CMS ought to accept a recalculated CMI because its study conducted by a nationally recognized consulting firm, was based on 100 percent of the provider's 1981 Medicare discharges. In contrast, the Secretary's calculation was based in large part on the MEDPAR file, which included information concerning only 20 percent of the Provider's 1981 discharges. However, the Court accepted that the Secretary's policy serves the interests of accuracy, uniformity and administrative convenience and concluded that the Secretary's policy of relying solely on her own calculation of a provider's 1981 CMI was not arbitrary and capricious.

The Secretary, as a matter of policy, also declined to recalculate the outlier payments to account for the difference between the estimated and actual outlier payments. See e.g., 49 Fed. Reg. 234, 265-66. In response to commenters, the Secretary pointed out that this policy applied regardless of whether the aggregate outlier payments resulted in more or less than the statutory five- six percent of the total projected DRG prospective payment. Such a policy promoted finality, efficiency and certainty in the process. The court in *County of Los Angeles v. Shalala*, 192 F. 2d 1005 (1999), upheld this policy observing that: "while we have recognized that retroactive corrections may not ultimately undermine PPS, we have emphasized that that 'does not establish that a prospective–only policy is unreasonable.' *Methodist,* 38 F. 3d at 1232." *County of Los Angeles v. Shalala*, 192 F. 2d 1005, 1020 (1999).

Similarly, the Secretary's policy in this instance promotes administrative finality and certainty in the process. The Secretary's policy is neutral in that the SSI ratio remains the same regardless of whether a later recalculation would result in a higher or lower Medicare fraction. This neutrality ensures predictability in the process by preventing unexpected shifts in the payment rates based on later data. The agreement between the Provider and the Consultant acknowledges this possibility in providing for the Consultant to be liable for any decreases in the Provider's DSH payment as a result of litigation.[74]

In fact, the Administrator notes that a hospital that enters into a "data use agreement" (DUA) with CMS may request to receive a limited data set of the MedPAR data for its patients for a given cost year, and such data will indicate whether or not a patient was eligible for SSI. In this case, the Provider request its

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initial rule implementing the DSH SSI calculation and thus the issue was not explicitly addressed in the final rule.

[74] Intermediary Exhibit I-10, p. 11. See also *Baystate*, CMS, Administrator Dec. 2006 D-20, (CCH)¶81,506, (May 11, 2006), herein incorporated by reference.

DUA data for other cost years at issue (FY 2000-2002), however, the updated MedPAR data for those years reflected an SSI ratio that was lower than what CMS originally published.[75]. For those years, the Provider did not request that CMS revise the SSI ratio to reflect the updated ratio. Consistent with the stated policy, the Intermediary did not issue reopening notices and attempt to recover DSH payments for those years where the ratio was lower.

Thus, the Administrator finds that the regulation precludes the recalculation of the Medicare fraction based on updated or corrected data.[76]

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[75] See Provider's Exhibit 39 "Comparison of Routine Use Data to Published SSI Percentage"

[76] See also generally Administrator decision, *Baystate*, CMS Administrator Dec. 2006 D-20, (CCH)¶81,506, (May 11, 2006), herein incorporated by reference.

**<u>DECISION</u>**

<u>Issue No. 1</u>

The Administrator affirms the Board's decision on Issue No. 1.

<u>Issue No. 2</u>

The Administrator reverses the Board's decision on Issue No. 2.

<u>Issue No. 3</u>

The Administrator reverses the Board's decision on Issue No. 3.

<u>Issue No. 4</u>

The Administrator reverses the Board's decision on Issue No. 4.

**THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF THE HEALTH AND HUMAN SERVICES**

Date: **_11/21/08__** **_/s/___________________________**

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