CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of: **St. Luke 2001-2007 DSH Inclusion of Title XIX Eligible CIRP Group**	**Claim for Payment Determination for Cost Reporting Period(s) Ending:** **2001 - 2007**
Provider **vs.**	
Blue Cross Blue Shield Association/ CGS Administrators, LLC	**Review of:** **PRRB Dec. No. 2013-D36** **Dated: September 9, 2013**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The Providers submitted comments, requesting that the Administrator review and reverse the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from the Intermediary and further comments were received from the Providers. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether days associated with patients covered under the Kentucky Hospital Care Program (KHCP) should be included in the numerator of the Medicaid proxy of the Medicare disproportionate share hospital (DSH) calculation pursuant to § 1886(d)(5)(F)(vi)(II) of the Act, as amended.

The Board held that the Intermediary properly excluded Kentucky Hospital Care Program days, otherwise called "KHCP" days, from the numerator of the Providers' Medicaid proxy. The Board held that the KHCP beneficiaries are not

eligible for Medicaid and the services provided under the KHCP are not matched with Federal funds, except under the Medicaid DSH program. In reviewing the Medicaid DSH statute at §1923 of the Act, the Board found that the statute mandated that a State Medicaid plan under Title XIX include a provision for a payment adjustment to hospitals which serve a disproportionate number of low income patients, i.e., a Medicaid DSH adjustment for hospitals that's independent of the Medicare DSH adjustment at issue in this case. The Board found that, while the Medicaid DSH adjustment was eligible for Federal financial participation (FFP), the particular patient days counted for the Medicaid DSH adjustment are not directly eligible for FFP because they do not qualify as "traditional Medicaid" services described in §1905(a) of the Act.

The Board stated that the only issue was whether the KHCP, which is a State funded program, which is included in the Kentucky State plan solely for the purpose of calculating the Medicaid DSH, constitute "medical assistance under a State Plan approved under [T]itle XIX" for purposes of the Medicare DSH Adjustment specifically the Medicaid fraction component. The Board determined that, upon further review and analysis of the Medicaid DSH statute at §1923 of the Act, that the term "medical assistance under a State plan approved under [Title] XIX" excluded days funded only by the State and charity care days even though those days may be counted for Medicaid DSH purposes. The Board reasoned that, if Congress had intended the term "eligible for medical assistance under a State plan" (the only category of patients in the Medicaid utilization rate) to include the State funded hospital days and charity care days, the subsections adding those categories of days in the low income utilization rate would have been superfluous. Because the KHCP days were funded by "state and local governments" and included in the low income utilization rate, not the Medicaid inpatient utilization rate, the Board found that the KHCP patient days did not fall within the Medicaid statute definition of "eligible for medical assistance under a State plan" at §1923 of the Act.

Finally, the Board referenced *Adena Regional Medical Center v. Leavitt*.[1] The Court of Appeals for the D.C. Circuit held that the phrase "eligible for medical assistance under a State plan approved under title XIX" referred to patients who are eligible for Medicaid. The Court rejected the argument that the days of patients who were counted toward a Medicaid DSH payment must be counted toward the Medicaid fraction of the Medicare DSH calculation.

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[1] 527 F. 3d 176 (D.C. Cir. 2008).

SUMMARY OF COMMENTS

The Providers submitted comments, requesting that the Administrator review and reverse the Board's determination. The Providers disagreed with the Board's determination that the KHCP days are not to be included in the Medicaid Proxy Numerator of the Medicare DSH. The Providers claimed that the Board erroneously found that the KHCP is State/local government funded under the *Adena Regional Medical Center* decision. Further, the Secretary has allowed hospitals located in §1115 Waiver States to count low income days attributable to "non-Medicaid" eligible patients in the Medicaid proxy numerator; diametrically opposed to the interpretation and application of the same Medicare provision in this at issue in this case.

The Providers claimed the Board's conclusion is incorrect that the KHCP is funded by State and local government" as the Board's determination did not take into account Kentucky's Revised Statute (KRS) §205.640, which stated that "provider tax revenues and federal matching funds shall be used to fund the [Medicaid] disproportionate share program." The Providers also argued that the Board's own analysis supports the Providers' contention that the KHCP days are to be included in the Medicaid inpatient utilization rate (and thus includable in the Medicaid Proxy Numerator) because it represents patient days for patients "eligible for medical assistance under a State plan. The Providers noted that the Secretary of Health and Human Services (Secretary), in litigation filings, has acknowledged this point that "individuals for who the State receives federal matching funds are those eligible for medical assistance under a Title XIX State plan."[2] The Board also incorrectly relied upon the court rationale in *Adena* in justifying its conclusion that these days should not be included. In fact, the only payment Kentucky hospitals receive for these patients comes from the Title XIX program and, thus, the Board's decision is incorrect.

In addition, the Providers argued that "Pickle Method" further demonstrates disparate treatment of the days in this case. The Providers argued that the KHCP days should be included in the Medicaid Proxy Numerator, because the Pickle method excludes revenue from Title XIX services while, the Medicare Medicaid Proxy includes all medical assistance provided under Title XIX. In other words, the calculations each deal with the same population---if KHCP revenues are attributable to a State plan under Title XIX for exclusion under the Pickle method, then KHCP days must also be attributable to a State plan approved under Title XIX for (Medicare DSH) Medicaid Proxy purposes. The days and their corresponding

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[2] See Providers' Comments at 3 (dated Oct. 8, 2013).

revenues cannot change character from one statutory provision to the next within Title XVIII. The KHCP is not a State funded program and the Board's according reliance on *Adena* is incorrect.

Finally, the Providers' disagreed with the Board's reliance on *Adena* in concluding that KHCP should be excluded from the Medicaid proxy calculation because the KHCP patients are not eligible for "traditional Medicaid". Traditional Medicaid eligibility varies from State to State at the option of the state as approved by CMS in the respective State plans. A patient may not meet Kentucky's "traditional Medicaid" requirements yet meet such "traditional" eligibility in a number of other States. Kentucky chose to pay for this population through its KHCP fund as a de facto expansion of the population eligible for medical assistance under the Title XIX plan. The Providers' argued that the Board's reliance on "traditional Medicaid" eligibility as the criteria for excluding KHCP days is wholly arbitrary and lacks a rational basis.[3]

The Intermediary submitted comments requesting that the Administrator decline to review the Board's decision or, in the alternative, affirm the Board's decision. The Intermediary stated that the key issue with respect to KHCP days was whether the KHCP patients whom the Providers served were eligible for medical assistance under a State plan approved under Title XIX. The Intermediary noted that the Kentucky Revised Statutes §205.6405(5) stated that "[s]ervices provided to individuals who are eligible for medical assistance [i.e., Medicaid] or the Kentucky Children's health Insurance Program do not qualify for reimbursement under this section and KRS § 205.641." Therefore, patients who are eligible for medical

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[3] Finally, the Providers argued that the Secretary's refusal to include KHCP days in the Medicare DSH calculation, while permitting patient days associated with similarly situated patients in §1115 waiver States violate the Providers' right under Equal Protection Clause of the Fourteenth Amendment of the United States Constitution. The Providers noted that the Secretary's stated purpose for disclaiming the need for traditional Medicaid eligibility in non-Medicaid §1115 expansion populations were purportedly to conform to Congressional intent to protect those hospitals that were treating large volumes of low-income patients. However, excusing traditional Medicaid only for hospitals in §1115 States, while invoking entirely semantic distinctions for denying the same protection to similarly situated Providers in Kentucky and in other non-§1115 waiver States, is discriminatory and lacks a rational basis. The Providers raised this argument for the first time in its comments to the Administrator.

assistance are expressly excluded from the Kentucky Medicaid disproportionate share program.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Relevant to the issue involved in this case, two Federal programs, Medicaid and Medicare involve the provision of health care services to certain distinct patient populations. The Medicaid program is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children.[4] The program is jointly financed by the Federal and State governments and administered by the States according to Federal guidelines. Medicaid, under Title XIX of the Social Security Act, establishes two eligibility groups for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.[5] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) [42 USC 601 et seq.] and Supplemental Security Income or SSI [42 USC 1381, et seq.] Participating States may elect to provide for payments of medical services to those aged, blind, or disabled individuals known as "medically needy" whose incomes or resources, while exceeding the financial eligibility requirements for the categorically needy (such as an SSI recipient) are insufficient to pay for necessary medical care.[6]

In order to participate in the Medicaid program, a State must submit a plan for medical assistance to CMS for approval. The State plan must specify, inter alia, the categories of individuals who will receive medical assistance under the plan and the specific kinds of medical care and services that will be covered.[7] If the State plan is approved by CMS, under §1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as "medical assistance" under the State plan.

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[4] Section 1901 of the Social Security Act (Pub. Law 89-97).
[5] Section 1902(a) (10) of the Act.
[6] Section 1902(a) (1) (C) (i) of the Act.
[7] Id. §1902 et seq., of the Act.

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.[8] However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for "medical assistance" under the State plan.

In particular, §1901 of the Social Security Act sets forth that appropriations under that title are "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services…." Section 1902 sets forth the criteria for State plan approval.[9] As part of a State plan, § 1902(a) (13) (A) (iv) requires that a State plan provide for a public process for determination of payment under the plan for, inter alia, hospital services which in the case of hospitals, take into account (in a manner consistent with §1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs. Notably, §1905(a) states that for purposes of this title "the term 'medical assistance' means the payment of part or all of the costs" of the certain specified "care and medical services" and list the specific identification of the individuals for whom such payment may be made.

Section 1923 of the Act implements the requirements that a State plan under Title XIX provides for an adjustment in payment for inpatient hospital services furnished by a disproportionate share hospital. A hospital may be deemed to be a Medicaid disproportionate share hospital pursuant to §1923(b)(1)(A),[10] which addresses a

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[8] Id.

[9] 42 C.F.R. §200.203 defining a State plan as "a comprehensive written commitment by a Medicaid agency submitted under section 1902(a) of the Act to administer or supervise the administration of a Medicaid plan in accordance with Federal requirement."

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

hospital's Medicaid inpatient utilization rate, or under paragraph (B),[11] which addresses a hospital's low-income utilization rate or by other means and (e) which provides a special exception.[12] The low income criterion relies, *inter alia*, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.[13]

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

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

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

[13] Congress has revisited the Medicaid DSH provision several times since its establishment. In 1993, Congress enacted further limits on DSH payments pursuant to section 13621 of Pub Law 103-66 that took into consideration costs incurred for furnishing hospital medical assistance under the State plan or have no health insurance (or other source of third part coverage for services provided during the year.(The Medicaid DSH payments may not exceed the hospital Medicaid shortfall;

While Title XIX implemented medical assistance pursuant to a cooperative program with the States for certain low-income individuals, the Social Security Amendments of 1965[14] established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[15] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[16] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[17] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[18] This provision added §1886(d) of the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[19]

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

Pursuant to §1886(d)(5)(F)(i) of the Act, concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…."[20] There are two methods to determine eligibility for a Medicare DSH adjustment: the

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that is the amount by which the costs of treating Medicaid patient exceeds hospital Medicaid payments plus the cost of treating the uninsured.)

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

[15] Section 1811-1821 of the Act.

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

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

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

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

[20] 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).

"proxy method" and the "Pickle method."[21] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, *alia inter*, its disproportionate patient percentage. Relevant to this case, with respect to the proxy method, §1886(d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" and the Medicaid low-income proxy", respectively, and are defined as follows:

> (I) the fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act and the denominator of which is the number of such hospital's patients day for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this title.
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> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consists of patients who (for such days) were eligible for medical assistance under a State Plan approved under title XIX, but who were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital patient days for such period. (Emphasis added.)

CMS implemented the statutory provisions at 42 C.F.R. §412.106.[22] The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 C.F.R. §412.106(b)(2). Relevant to this case, the second computation, the "Medicaid-low income proxy", or "Clause II", is set forth at 42 C.F.R. §412.106(b)(4)[23] and provides that:

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

[22] The cost years in this case are cost years ending 2001 through 2007.

[23] Effective October 1, 1995, the second computation, the Medicaid fraction, set forth at 42 C.F.R. §412.106(b)(4), provided that:

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

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

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

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

However, effective for discharges occurring on or after January 20, 2000 certain changes were made: "Second computation. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply: (i) A patient is deemed eligible for Medicaid on a given day if the patient is eligible for medical assistance under an approved State Medicaid plan on such day, regardless of whether particular items or services were covered or paid under the State plan. (ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act. (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." (2000) Sub-paragraph (i) was further clarified to state that: "(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver." (2003) (This language was effective for the 2003-2007 cost years.)

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

In order to clarify the definition of eligible Medicaid days and to communicate a hold harmless position for cost reporting periods beginning before January 1, 2000, for certain providers, CMS issued Program Memorandum (PM) A-99-62, dated December 1999. The PM responded to problems that occurred as a result of hospitals and intermediaries relying on Medicaid State days data obtained from State Medicaid Agencies to compute the DSH payment that commingled the types of otherwise ineligible days listed with the Medicaid days.

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

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

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

> Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program…. These beneficiaries, however, are not eligible for Medicaid under a State [P]lan approved under Title XIX, and therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so. In addition, if a given patient day affects the level of *Medicaid* DSH payments to the hospital, but the patient is not eligible for Medicaid under a State [P]lan approved under Title XIX on that day, the day is not included in the *Medicare* DSH calculation.
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> Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. (Emphasis added.)

An attachment to the PM describes the type of day, description of the day and whether the day is a Title XIX day for purposes of the Medicare DSH calculation. In particular, the attachment describes "general assistance patient days" as "days for patients covered under a State–only (or county only) general assistance program (whether or not any payment is viable for health care services under the program). These patients are not Medicaid–eligible under the State plan." The general assistance patient day is not considered an "eligible Title XIX day." "Other State-only health program patient days" are described as "days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State program." Likewise, State-only health program days are not eligible Title XIX days. Finally, charity care patient days are described as "days for patients not eligible for Medicaid or any other third-party payer and claimed as uncompensated care by a hospital. These patients are not Medicaid eligible under the State plan." Charity care patient days are not eligible Title XIX days.

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

> General assistance days are days for patients covered under a State-only or county-only general assistance program, whether or not any payment is available for health care services under the program. Charity care days are those days that are utilized by patients who cannot afford to pay and whose care is not covered or paid by any health insurance program. While we recognize that these days may be included in the calculation of a State's Medicaid DSH payments, these patients are not Medicaid eligible under the State plan and are not considered Titled XIX beneficiaries.[24]

CMS issued a Program Memorandum (PM) Transmittal A-01-13,[25] which again stated, regarding two specific types of Medicaid DSH days, that:

> *Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State.* These patients are not Medicaid eligible. Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care of general assistance days. This, however, is not "payment" for those days and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicaid formula.
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> *Days for patients covered under a State-only (or count-only) general assistance program (whether or not any payment is available for health care services under the program).* These patients are not Medicaid-eligible under the State plan. (Emphasis added.)

In addition, prior to 2000, the Secretary's policy was to include in the Medicare DSH calculation, only those days for populations under the Title XI section 1115 waiver who were or could have been made eligible under a State plan. The patient days of the "expanded" eligibility groups, however, were not to be included in the

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

[25] The PM, while restating certain longstanding interpretations in the background material, clarified certain other points for cost reporting periods beginning on or after January 1, 2000, with respect to a hold harmless policy. See Transmittal A-01-13; Change Request 1052 (January 25, 2001). The scope and basis for the hold harmless policy is set forth at length in the program memorandum. The Providers did not claim that the hold harmless policy was applicable to the facts under their appeals. See Provider's March 31, 2011 Position Paper, received April 1, 2011.

Medicare DSH calculation.[26] This policy did not affect the longstanding policy of not counting general assistance or State–only days in the Medicare DSH calculation. The policy of excluding section 1115 waiver expansion populations from the DSH calculation was revisited by CMS and, effective with discharges occurring on, or after, January 20, 2000, certain section 1115 waiver expansion days were to be included in the Medicare DSH calculation in accordance with the specific instructions as specified in more detail in the January 20, 2000 Federal Register.[27]

In this case, the Providers argued that the Kentucky Hospital Care Program or KHCP days were included in the methodology for calculating the Medicaid DSH payments under the Kentucky State Plan approved under Title XIX. Consequently, the Providers argued that, KHCP patients are "eligible for medical assistance under a State plan approved under [Title] XIX" and must be counted in the Medicaid proxy numerator of the Medicare DSH adjustment. The Providers further argued that the days were not paid for with State-only funds as incorrectly found by the Board under the §1923 analysis of the "low income utilization" methodology. The Providers furthered argued that the "Pickle Method" of determining eligibility for the Medicare DSH payment supports their position that the KHCP days should be included in the Medicaid Proxy Numerator for the Medicare DSH. The Pickle method excludes revenues from Title XIX services, while the Medicaid Proxy at issue includes all medical assistance days (for which such revenues would be attributable) provided under Title XIX. The Medicaid DSH revenue cannot be excluded for purposes of the Pickle method and also have the days excluded from the numerator of the Medicaid proxy.[28]

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

[27] Id. Section 5002 of the Deficit Reduction Act of 2005 (DRA) (Pub. L. No. 109-171), also clarified the treatment by the Secretary of section 1115 days. As noted by the Court in *Cookville Regional Medical Center v Leavitt*, 531 F2d 844, 849 (D.C. Cir. 2008), with respect to section 1115 days, "'Congress ratified the Secretary's earlier policies, including the policy ... regarding discharges occurring prior to January 20, 2000,' to emphasize that the Secretary always had this discretionary authority."

[28] The Providers also argued in its comments to the Administrator, that the failure to include KHCP days in the Medicaid Proxy Numerator, and CMS' treatment of those days differently from the post-January 1, 2000, §1115 waiver days violated the Providers' rights under the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution. While the Providers argued that the *Portland* analysis equally applied to these days (Providers' Position Paper dated October 31, 2011, at 26-27), they did not challenge before the Board the notice and comment rulemaking to include §1115 days, nor raise an equal protection

The Administrator finds that §1886(d)(5)(F)(vi)(II) of the Act requires, for purposes of determining the Provider's "disproportionate patient percentage", that the Secretary count patient days attributable to patients who were eligible for medical assistance under a State plan approved under Title XIX of the Act, but who were not also entitled to Medicare Part A. The Administrator finds that the Secretary has interpreted the statutory phrase "patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX," to mean "eligible for Medicaid." Section 1905(a) of the Social Security Act defines "medical assistance" as payment of part or all of the costs of certain services and care for certain populations of individuals.

The Administrator finds that the days at issue are for patients who are not eligible for Medicaid, but rather they are attributable to patients whose data is used in the Kentucky Medicaid DSH calculation. The provision of the State plan submitted in the record shows the methodology for the Kentucky Medicaid DSH payments. The portion of the State plan provided does not show that these patients are eligible for the Federal Medicaid under §1905(a) of the Act.[29] The Attachment 4.19-A at p 7.5-7.6 explains regarding the Medicaid DSH methodology that:

> D. Disproportionate share hospital payments shall be fully prospective amounts determined in advance of the State fiscal year to which they apply and shall not be subject to settlement or revision based on changes in utilization during the year to which they apply. Payments prospectively determined for each state fiscal year shall be considered payment for that year, *and not for the year for which patient and cost data used in the calculation was taken.*
>
> E. The Department shall use patient and cost data from the most recently completed state fiscal year and DSH payments. DSH payments shall be made on an annual basis.

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argument. Regarding the argument timely raised, the days at issue are not the same type, nor statutorily authorized under the same provisions as *Portland*; the Providers are not located in the *Portland* jurisdiction (which even with respect to §1115 days was also issued prior to the DEFRA statutory clarification), and for those reasons, *inter alia*, the *Portland* rationale is not applicable here.

[29] See, Provider's Exhibit P-8 (showing portion of Kentucky State Plan that addresses Medicaid DSH payment eligibility and methodology for various types of health providers including acute care hospitals and does not demonstrate that the patient days are for patients eligible for Medicaid.)

> F. Distributions to a Type I and Type II hospitals [[30]] shall be based upon each hospital's proportions of indigent costs determined as follows:
>
> Indigent Costs/Total Indigent costs x Available Funds = DSH Payment
>
> *Indigent costs* shall be the inpatient and outpatient costs of providing care to indigent patents. Indigent patients include patients without health insurance or other source of third party payment with incomes below 100 percent of the federal poverty level.[31]

Thus, the Medicaid DSH payment provided under the State plan is a prospective payment based on a formula that uses the prior period indigent patient and cost data. The Medicaid DSH payment is not considered "payment" for the year for which the data used in the calculation was taken and is not intended as even an indirect compensation for those patient days. The implementing State provision addressing the scope of the KHCP[32] also states at §205.640(5) of the Kentucky Revised Statute (KRS), that:

> Hospitals receiving reimbursement shall not bill patients for services submitted for reimbursement under this section and KRS 205.641. Services provided to <u>individuals who are eligible for medical assistance [Medicaid] or the Kentucky Children's Health Insurance Program do not qualify for reimbursement</u> under this section and KRS 205.641. Hospitals shall make a reasonable determination that an individual does not qualify for these programs and shall request the individual to apply, if appropriate, for medical assistance or Kentucky Children's Health Insurance on forms supplied by and in accordance with the procedures established by the Department for Medicaid Services, The Hospital shall document any refusal to apply and shall inform the patients that the refusal may result in the patient being billed for any serves performed. The hospital shall not be eligible for reimbursement if the patient was eligible for medical

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[30] Medicaid Type I hospitals are hospital with 100 beds or less; and Type II hospitals are hospitals with more than 100 beds that are not Type III hospitals (state university hospitals) or Type IV hospitals (state-owned mental hospitals).

[31] The Kentucky disproportionate share program is funded through provider tax revenues, State and Federal matching funds. §205.640(3) of the Kentucky Revised Statute.

[32] <u>See</u>, Intermediary's Exhibit I-8.

> assistance or Kentucky Children's Health Insurance and did not apply. (Emphasis added)

Further, a letter from the "Commissioner for the Cabinet for Health and Family Services for Medicaid Services to General Hospital and Mental Health"[33] states that:

> An individual is to be screened for Medicaid eligibility prior to making a determination of eligibility for DSH funding. If an individual meets the criteria to be referred for Medicaid, you may not submit their data for DSH funding. Only after an individual has applied and been denied Medicaid may you make a determination of eligibility for DSH funds. (Emphasis added.).

Consistent with the foregoing, the Kentucky "Medicaid Reimbursement Manual for Hospital Inpatient Services" Section II "Hospital Indigent Care Criteria" also requires that, with respect to indigent criteria, "the individual is not eligible for Medicaid."[34]

The Secretary has interpreted the term "eligible for medical assistance under a State Plan approved under Title XIX" means eligible for the Federal government program also referred to as Medicaid. In this case, the KHCP specifically excludes individuals who are qualified for Medicaid from the DHS computation. Section 1886(d)(5)(F)(vi) (II) of the Act requires that for a day to be counted, the individual must be eligible for "medical assistance" under Title XIX as interpreted and applied by the Secretary pursuant to her discretion. That is, the individual must be eligible for the Federal government program also referred to as Medicaid. Therefore, the Administrator finds that the individuals covered by the KHCP are not covered by "medical assistance" as described in Title XIX.

Regarding the expenditure of Federal financial participation, or FFP, for Medicaid DSH under the Medicaid program, generally, the issue of whether costs are regarded as expenditures under a State plan approved under Title XIX for purposes of calculating Federal matching payments to the State is different from the issue of whether patients are considered eligible for "medical assistance" under a State plan approved under Title XIX for purposes of calculating Medicare DSH payments to a hospital.[35] The statute clearly states that the patients' Title XIX eligibility for that

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[33] See, Intermediary's Exhibit I-9.
[34] Provider Exhibit P-2.

[35] Not only as a matter of law is the Medicaid DSH payment not a payment for an eligible patient under §1905(a) of the Act, but this is also evident as the indigent

day is a requirement. Therefore, regardless of any possible indirect FFP through a Medicaid DSH payment (regardless under which provision of §1923 that the Medicaid DSH payment is made[36]), the days related to the Medicaid DSH program are not counted as Medicaid days. States are required to provide a Medicaid DSH provision under their State plan. The fact that Title XIX FFP funds are used to pay Medicaid DSH does not make the indigent patient whose data is used in that methodology eligible for Medicaid. By definition under the Kentucky Hospital Care Program, if the patient is Medicaid eligible, the patient cannot be considered "indigent" and the data cannot be used in the Medicaid DSH formula.

Finally, the Providers argued that Pickle Method supports their position that the KHCP days should be included in the Medicaid Proxy Numerator because the Pickle formula requires the exclusion of revenues from Title XIX services while, the Medicaid Proxy includes all medical assistance provided under Title XIX. That is, the Medicaid DSH revenue (the formula of which is based in part on the KHCP patients) cannot be included in the Pickle formula and, therefore, those related days should be included in the Numerator Medicaid proxy. The Administrator finds that there are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[37] However, only the proxy method is relevant to this group appeal. The Pickle method is solely used to determine whether a hospital in an urban area with 100 or more beds can demonstrate that more than 30

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costs related to the patient days at issue were used as part of a methodology to determine the Medicaid DSH payment prospectively for a subsequent period (see e.g. Providers' Exhibit P-3 at 7.6), which may in turn have been subject to reduction on a pro rata basis as the pool was inadequate.

[36] The Providers state that the Medicaid DSH payment formula under which it receives its Kentucky Medicaid DSH payments are not based upon its receipt of State and local government payments as found by the Board. As noted, §1923 of the Act provides two methods for defining the hospital's "low-income utilization" percentage rate 1) based on the amount of the subsidies for patient services received directly from State and local governments and 2) based on hospital's charges for inpatient hospital services which are attributable to charity care in a period. In addition a State plan may meet the statutory requirements by devising a Medicaid formula under §1923(e) of the Act for payment under, *inter alia*, a pooling methodology. The supplied State plan does not identify the statutory provision of §1923 of the Act under which the Kentucky Medicaid DSH payments are made; however, as noted above, the section under which the Medicaid DSH payments is authorized is not dispositive of whether the KHCP days can be included in the calculation of the Medicare DSH numerator of the Medicaid proxy in this case.

[37] The Pickle method is set forth at §1886(d)(5)(F)(i)(II) of the Act.

percent of its net inpatient care revenue is derived from State and local government payments for care furnished to indigent patients. When Congress specifically excluded Medicaid revenue, it did so knowing that the Medicaid DSH payment provision included a "low income" utilization methodology, which had a charity/indigent care component. The purpose of the Pickle method is to allow an urban hospital that services a large indigent patient population, whose services are paid by government funding, to qualify for Medicare disproportionate share payment. The Pickle method was named after its sponsor former Representative J.J. Pickle. It was created "[b]ecause of the concern that this proxy measure of low-income status might substantially understate the presence of low-income patients in some hospitals, most particularly public hospitals in states where the Medicaid eligibility standards are stringent."[38] (Emphasis added.) Contrary to the Providers' suggestions, the Pickle provision, in excluding Medicaid revenues (which would include Medicaid DSH payments as qualifying revenue) is not inconsistent with the proxy method, under §1886 of the Act, but is a separate means of qualifying as a Medicare DSH hospital.

In sum, the Administrator finds that the individuals qualified under the KHCP are not eligible for "medical assistance" pursuant to §1905(a) of the Act.[39] Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly did not include these days in the numerator of the Medicaid fraction.

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[38] H.R. REP. No. 99–241(I)(1985), reprinted in 1986 U.S.C.C.A.N. 579, 1985 WL 25954 *41

[39] 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)…. Patients receiving "medical assistance" as, it is defined in §1905(a) …., under a State plan are those who are eligible for Medicaid."

DECISION

The decision of the Board is affirmed in accordance with the foregoing opinion.

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

Date: 11/11/13

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