CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of: **HCA DSH-Colorado State Database Group Appeals** **Provider** **vs.** **Novitas Solutions, Inc.** **Medicare Administrative Contractor**	**Claim for:** **Fiscal Years Ending: 2004-2012** **Review of:** **PRRB Dec. No. 2016-D17** **Dated: September 12, 2016**

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 mandated in section 1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. §1395oo(f)). Comments were received from the Medicare Administrative Contractor (MAC) and the Centers for Medicare (CM), CMS, requesting that the Board's decision be reversed. The parties were notified of the Administrator's intention to review the Board's decision. The Providers commented, requesting that the Board's decision be affirmed. Accordingly, this case is now before the Administrator for final agency review.

Issue

The issue before the Board was whether patient days which the Providers have identified as "inactive"[1] in the Colorado State Medicaid program should be included in the Medicaid proxy that is used in the calculation of the Medicare payment for the disproportionate share hospitals (DSH).

[1] The status designation of "inactive" was a code indicating that an individual was located in the Medicaid eligibility system but not verified as eligible for Medicaid for the requested dates of service.

Board's Decision

The Board found that the MAC improperly excluded the "inactive unpaid patient days at issue from the Medicaid fraction of the Medicare DSH adjustment calculation for the fiscal years under appeal. Accordingly, the Board directed the MAC to include these days in the relevant Medicaid fraction for the Medicare DSH adjustment.

Summary of Comments

The MAC submitted comments requesting that the Board' decision be reversed. The MAC stated that the Board decision in essence found that the Providers were not required to meet the burden of proof to document the patient day claimed, where the Colorado Medicaid system for determining eligibility for the Colorado State Medicaid program data base (Colorado Benefits Management System or CBMS) was subject to various problems that made it challenging for the Provider to document Medicaid eligibility. The Board held that each day classified as ineligible must be included in Medicaid fraction, thereby absolving the Provider of its burden of proof. The Board's decision exceeds it authority and impermissibly shifts the burden of proof contrary to 42 CFR 412.106(b)(4)(iii).

The MAC explained that the Providers and the Board acknowledged that the "ineligible" classification by CMS meant that patient day was not counted in the Medicaid DSH fraction as the patient was not eligible for Medicaid inpatient hospital benefits on that specific day. Section 951 of the Medicare Prescription Drug, Improvement, Modernization Act of 2003 (MMA) requires CMS to arrange to furnish to IPPS hospitals "the data necessary for such hospitals to compute the number of patient days used in computing the [DSH} percentage under such section under such section for that hospital for the current cost reporting period." The Board improperly found that section 951 of MMA imposed a condition precedent on the Provider's burden of proof so that burden did not apply until CMS "complied "with section 951. The Board then improperly found that CMS through the Colorado State Medicaid program system data base (CBMS) failed that condition precedent (in failing to determine eligibility) so that the burden did not fall to the Provider. The Board found no evidence that CMS controlled the CBMS or could influence it or that the CBMS was the means of determining Medicaid eligibility (in fact finding the opposite by recognizing multiple Medicaid eligible individuals were determined and added to the Medicaid fraction. The MAC concluded the condition precedent the Board found was created by section 951 is not supported by the statute, case law, committee notes or the congressional record and that the Provider always bears the burden of proof challenging a MAC determination.

The Centers for Medicare (CM) submitted comments requesting that the Board decision be reversed. CM stated that the MAC properly excluded "inactive" unpaid Medicaid days from the Providers' DSH adjustment. CM stated that verification of the data required by the MMA is a separate and distinct issue from the duty to arrange to furnish the data and not required by the MMA. CMS has interpreted its obligation under the MMA for the Medicaid fraction as well as the SSI ratio to extend only to providing personally identified information (PII) that hospitals can then use to verify the records with the State. (70 Fed. Reg. 47278, 47438 (Aug. 12, 2005). The obligation does not extend to guaranteeing that states are able to verify all requests of the hospitals. This distinction is found in 42 CFR 412.106(b)(4(iii) which as noted by the Board separately requires that hospitals furnish data adequate to demonstrate Medicaid eligibility and distinctly to verify that data for eligibility with the State. The data CMS is required to provide under the MMA is the data required to specifically identify individual patients (name, birthdate, social security number, etc.) The Hospitals must then verify Medicaid eligibility with the State agency for an individual patient.

CM explained that the determination of the numerator of the Medicaid fraction is two steps: first the hospital gathers the necessary PII data to allow them to verify that a particular person was eligible for Medicaid on a particular day (and arrangement to furnish this PII data is required under MMA); second the hospital verifies eligibility using the {II data (attained in the first step) with the respective Medicaid agency. Verification of the data is the Provider's responsibility.

CM stated in this case, the Providers were in possession of the necessary PII data required under the MMA. The breakdown occurred and the harm suffered when the providers at least partially due to untimely requests were unable to verify Medicaid eligibility for the PII data required and supplied under the MMA and already in its possession, with the State. The MMA makes no mention of eligibility verification and thus any attempt on the part of the Board to conflate CMS duty to provide information with the Provider's independent duty to verify data with the state is incorrect. CM also stated that even if the MMA section 951 imposed an obligation for MCS to arrange to furnish the verification of data. CMS has obligated, Section 951 only requires that the Secretary arrange to furnish the data" which CMS has meet. The Medicaid program rules require the States to maintain auditable data that could be used in the Medicare DSH calculation and that the Secretary has "arranged" for the States to provide this data to the Provider. During this period Colorado's data systems had serious issues that materially affected its ability to provide accurate data to the providers but was not a failure of the Secretary. Federal laws govern a State's data system (42 CFR 433.112 and Part 11 of the State Medicaid Manual) and the state of Colorado was out of compliance with some of these laws. CMS has worked continuously with Colorado to correct these problems. Medicaid is a voluntary cooperative Federal State program and CMS has limited ability ensure Colorado's compliance with the relevant Federal requirements .CMS both provided funding for the data systems and went further to take

steps to attempt to ensure providers were able to verify eligibility for the individual patient. CMS cannot be faulted for Colorado's failure.

Even assuming that the Secretary had not complied with section 951, CM contended that the Board incorrectly concluded that the failure altered one of the fundamental principles of the Medicare system: providers have the burden to demonstrate their entitlement to payment from Medicare by proving auditable data and that Congress intended to displace this fundamental rule. Congress would have addressed the issue explicitly. Rather the purpose of section 951 seems to have been to ensure that CMS arranged to provide data to providers necessary to calculate the DSH payments, such as the SSI data needed for the Medicare/SSI ratio.

CM suggested that the Administrator remand the case to the Board to correct the error. While sympathetic to the Providers' situation, the MAC has allowed for the inclusion of the days in the Medicaid fraction where payment was actually demonstrated to have been made. But this does not mean that all of the patient days listed as "inactive" were days of patients eligible for Medicaid. Thus, it was clearly incorrect for the Board to order the inclusion of all the days. However, keeping in mind that Medicare payment cannot be made unless it is supported by auditable data, CM suggested the Providers and the MAC work to determine if some statistical extrapolation could satisfy this requirement if done with sufficient reliability.

The Provider submitted comments requesting that the Board's decision be affirmed. The Provider stated that CMS incorrectly maintains that section 951 imposes no responsibility to assure that hospitals have access to state Medicaid eligibility data. But only requires that CMS furnish personally identifiable information. CMS also incorrectly argued that the Providers' burden of verifying Medicaid eligibility could not be shifted to CMS due to the agency's failure to meet its statutory duty to arrange to provide the hospitals the data needed to verify Medicaid eligibility with the State. The Board properly allowed the Hospitals other reasonable means of establishing an appropriate number of Medicaid patient days to be counted in the DSH payment calculus.

The Providers argued that section 951 of the MMA imposes a duty on CMS to ensure that Hospitals have access to data needed to verify Medicaid eligibility with the State. The "data necessary" language in the MMA indisputably included State verification of Medicaid eligibility, a requirement first imposed by CMS in HCFA Ruling 97-2 and codified in 42 CFR 412.106(b)(4)(iii). The regulatory scheme was in place when Congress enacted section 951 and directed the Secretary to arrange to furnish hospitals all the information necessary without exception to compute both the Medicaid and Medicare/SSI fraction. The latter fact undercuts CMS 2005 final rule that there is two-part process of furnishing necessary data verses ensuring state verification of Medicaid eligibility. The Providers contended that CMS clearly understood its obligation and it shown reports revealed that

CMS knew about the specific problems in Colorado as far back as 2004. CMS chose not to, for example, put in place regulatory State plan requirements,

The Providers argued that CMS is also incorrect to maintain that it has no statutory obligation but to furnish personal identifying information. CMS does not provide or arrange to furnish any of this information to hospitals for all of its patients. Neither CMS, nor any State, would have any of this information except as to some patients who are enrolled in Medicare or Medicaid and, thus, neither CMS, or a State, is in a position to provide a hospital with individual identifiers for all hospital inpatients as is necessary to confirm which of these patients are eligible for Medicaid. Instead, that Hospitals routinely collect this information from their patients, but the Hospitals cannot obtain State verification of Medicaid eligibility from the patients which is the information section 951 addresses.

The Providers also argued that precedent supports the Board's decision on the burden of proof. The Provider demonstrated that the state's records reflecting "inactive" status is inaccurate and unreliable. The Providers made all possible attempts to obtain correct verification from the State, the MAC and CMS. The Provider also provided other evidence that the inclusion of the "inactive patient days is a reasonable and conservative means of determining the hospitals' Medicaid fraction for the cost years at issue. This is like that shown in Bay State Medical Center vs Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008), where the hospital's inability to demonstrate more precisely the impact of CMS calculation was held not to be a permissible basis for CMS to deny relief where the "government was in possession of the records necessary to make a fuller demonstration. That principal should be applied here. CMS knows that at least some, if not all, of the days were eligible for Medicaid during the applicable dates of service. The Provider also referred to controlling D.C. circuit case law stating that the burden of proof shifts when the defendant has greater access to information. CMS must present countervailing evidence to disallow these patient days.

The Providers also claim that the result is also dictated by the Paper Work Reduction Act. CMS requirement for State eligibility verification is a new paperwork burden imposed upon Hospitals without the Office of Management and Budget (OMB) approval. Finally, the Administrator should not attempt to pass the responsibility to the agency's contractor as proposed by CM.

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 timely received 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.[2] 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.[3] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income or SSI. 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.[4]

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.[5] If the State plan is approved by CMS, under section 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.[6] However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive

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[2] Section 1901 of the Social Security Act
[3] Section 1902(a)(10) of the Act.
[4] Section 1902(a)(1)(C)(i) of the Act.
[5] *Id.* § 1902 *et seq.*, of the Act.
[6] *Id.*

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, section 1901 of the Social Security Act sets forth that appropriations under that title are "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services…."

Section 1902(a)(7)(A) of the Social Security Act provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with, inter alia, (A) the administration of the plan.[7] The regulation at 42 CFR 431.302 sets forth the "purposes directly related to State plan administration, which includes:

> (a) Establishing eligibility.
> (b) Determining the amount of medical assistance;
> (c) Providing services for beneficiaries; and
> (d) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan

Section 1903(a)(3) of the Act provides for FFP in State expenditures for the design development or installation of mechanized claims processing and information retrieval systems and others.[8] In addition, section 1903(r) of the Act imposes certain standards and conditions on mechanized claims processing and information retrieval systems (including eligibility determination system) in order for these systems to be eligible for Federal funding under section 1903(a) of the Act. The regulation provides for a mechanized claims processing and information retrieval system which includes a "system of systems"

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[7] This provision was implemented at 42 CFR 431.300, *et seq.* The regulation at 42 CFR 431.300(a) explains that section 1902(a)(7) of the Act requires that a State plan must provide safeguards that restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan. This subpart specifies State plan requirements, the types of information to be safeguarded, the conditions for release of safeguarded information, and restrictions on the distribution of other information. The regulation at 42 CFR 431.301 states that under the State plan requirements, a State plan must provide, under a State statute that imposes legal sanctions, safeguards meeting the requirements of this subpart that restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan.

[8] 42 CFR 433.110. The HHS regulations and CMS procedures for implementing these regulations are in 45 CFR part 75 and 45 CFR part 95, subpart F and part 11, State Medicaid manual

developed to support a Medicaid Management Information System (MMIS) and Eligibility and Enrollment (E&E) may be implemented as discrete independent interoperable elements. The MMIS is used to process claims for Medicaid payment from providers of medical care and services furnished to beneficiaries under the medical assistance program and to perform other functions necessary for economic and efficient operations, management and monitoring and administration of the Medicaid program.[9]

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[10] 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 payment reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[11] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[12] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[13] In addition from its inception, section 1815(a) of the Act has provided that:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it…. except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

Concerned with increasing costs, Congress also enacted Title VI of the Social Security Amendments of 1983.[14] This provision added section 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.[15]

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[9] 42 CFR 433.111(b)(2)(ii).
[10] Pub. L. No. 89-97.
[11] Section 1811-1821 of the Act.
[12] Section 1831-1848(j) of the Act.
[13] Under Medicare, Part A services are furnished by providers of services.
[14] Pub. Law No. 98-21.
[15] 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 reimbursed 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 (DRG) subject to certain payment adjustments.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, Congress directed the Secretary to provide a payment adjustment for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…."[16] referred to as the DSH adjustment. To be eligible for the DSH adjustment, an IPPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage. Section 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" or Medicare/SSI fraction, and the "Medicaid low-income proxy" or Medicaid fraction, 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 patients day 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 patients days for such period.

The first computation, the Medicare/SSI fraction is addressed at 42 CFR 412.106(b)(2). The second computation, referred to as the Medicaid fraction, is set forth at 42 CFR 412.106(b)(4) (2004) and provides that:

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[16] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). *See also* 51 Fed. Reg. 16,772, 16,773-16,776 (1986).

> Second computation. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
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> (i) 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
> (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.[17]

Relevant to this case, section 951 of the Medicare Prescription Drug, Improvement, Modernization Act of 2003 (MMA) (Pub. Law 108-173) set forth, effective December 8, 2003, the following provision:

> Furnishing Hospitals with Information to Compute DSH Formula.

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[17] Effective 10/1/2009, the regulation was amended to add paragraph (iv). Paragraph (iv) states that: "For cost reporting periods beginning on or after October 1, 2009, the hospital must report the days in the numerator of the fraction in the second computation in a cost reporting period based on the date of discharge, the date of admission, or the dates of service. If a hospital seeks to change its methodology for reporting days in the numerator of the fraction in the second computation, the hospital must notify CMS, through its fiscal intermediary or MAC, in writing at least 30 days before the beginning of the cost reporting period in which the change would apply. The written notification must specify the methodology the hospital will use, the cost reporting period to which the requested change would apply, and the current methodology being used. Such a change will be effective only on the first day of a cost reporting period. If a hospital changes its methodology for reporting such days, CMS or the fiscal intermediary or MAC may adjust the number of days reported for a cost reporting period if it determines that any of those days have been counted in a prior cost reporting period."

> Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act on the basis of such data.[18]

In implementing this provision of the law, the Secretary stated the following in the Federal Register publication of the "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates" (Aug. 12, 2005)[19]:

> In the FY 2006 IPPS proposed rule (69 FR 23434), we proposed to implement a mechanism for implementing section 951 of Pub. L. 108-173, which requires the Secretary to arrange to furnish the data necessary for hospitals to compute the number of patient days used in calculating the disproportionate patient percentages. The provision is not specific as to whether it applies to the patient day data used to determine the Medicare fraction or the Medicaid fraction. We interpret section 951 to require the Secretary to arrange to furnish to hospitals the data necessary to calculate both the Medicare and Medicaid fractions. With respect to both the Medicare and Medicaid fractions, we interpret section 951 to require CMS to arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records, in the case of the Medicare fraction, against the CMS' records, and in

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[18] See also 42 USC 1395ww notes: "Furnishing Hospitals With Information To Compute DSH Formula, Pub. L. 108-173, title IX, Sec. 951, Dec. 8, 2003, 117 Stat.2427, provided that: "Beginning not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act [part A of this subchapter] on the basis of such data."

[19] 70 Fed. Reg. 47278 (Aug. 12, 2005). See also 70 Fed. Reg. 23306 (May 4, 2005) ("Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates")

> the case of the Medicaid fraction, against the State Medicaid agency's records.[20]

In discussing the implementation with respect to the Medicaid fraction, the Secretary explained that the numerator of the Medicaid fraction includes hospital inpatient days that are furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A. Under the regulation at 42 CFR 412.106(b)(4)(iii), hospitals are responsible for proving Medicaid eligibility for each Medicaid patient day and verifying with the State that patients were eligible for Medicaid on the claimed days. The number of Medicaid, non-Medicare days is divided by the hospital's total number of inpatient days in the same period. Total inpatient days are reported on the Medicare cost report, a number that is also available in the hospital's own records. The Secretary stated that:

> Much of the data used to calculate the Medicaid fraction of the DSH patient percentage are available to hospitals from their own records or from the States. We recognize that Medicaid State plans are only permitted to use and disclose information concerning applicants and recipients for "purposes directly connected with the administration of the [State] plan" under section 1902(a)(7) of the Act. Regulations at 42 CFR 431.302 define these purposes to include establishing eligibility (§ 431.302(a)) and determining the amount of medical assistance (§ 431.302(b)). Thus, State plans are permitted under the currently applicable statutory and regulatory provisions governing the disclosure of individually identifiable data on Medicaid applicants and recipients to provide hospitals the data needed to meet their obligation under §412.106(b)(4)(iii) in the context of either an "eligibility inquiry" with the State plan or in order to assist the hospital, and thus the State plan, in determining the amount of medical assistance.
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> In the process of developing a plan for implementing section 951 with respect to the data necessary to calculate the Medicaid fraction, we asked our regional offices to report on the availability of this information to hospitals and on any problems that hospitals face in obtaining the information that they need. The information we received suggested that, in the vast majority of cases, there are established procedures for hospitals or their authorized representatives to obtain the information needed for hospitals to meet their obligation under §412.106(b)(4)(iii) and to calculate their Medicaid fraction. There is no uniform national method for hospitals to verify Medicaid eligibility for a specific patient on a specific day. For instance, some States, such as Arizona, have secure online systems that providers may use to check eligibility information. However, in most States, providers send a list of patients to the

[20] 70 Fed Reg. 47441.

State Medicaid office for verification. Other States, such as Hawaii, employ a third party private company to maintain the Medicaid database and run eligibility matches for providers. The information that providers submit to State plans (or third party contractors) differs among States as well. Most States require the patient's name, date of birth, gender, social security number, Medicaid identification, and admission and discharge dates. States or the third parties may respond with either "Yes/No" or with more detailed Medicaid enrollment and eligibility information such as whether or not the patient is a dual-eligible, whether the patient is enrolled in a fee-for-service or HMO plan, and under which State assistance category the individual qualified for Medicaid. [ ]

We note that we have been made aware of at least one instance in which a State is concerned about providing hospitals with the requisite eligibility data. We understand that the basis for the State's objections is section 1902(a)(7) of the Act. The State is concerned that section 1902(a)(7) of the Act prohibits the State from providing eligibility data for any purpose other than a purpose related to State plan administration. However, as described above, we believe that States are permitted to verify Medicaid eligibility for hospitals as a purpose directly related to State plan administration under § 431.302.

In addition, we believe it is reasonable to continue to place the burden of furnishing the data adequate to prove eligibility for each Medicaid patient day claimed for DSH percentage calculation purposes on hospitals because, since they have provided inpatient care to these patients for which they billed the relevant payers, including the State Medicaid plan, they will necessarily already be in possession of much of this information. We continue to believe hospitals are best situated to provide and verify Medicaid eligibility information. Although we believe the mechanisms are currently in place to enable hospitals to obtain the data necessary to calculate their Medicaid fraction of the DSH patient percentage, there is currently no mandatory requirement imposed upon State Medicaid agencies to verify eligibility for hospitals. At this point, we continue to believe there is no need to modify the Medicaid State plan regulations to require that State plans verify Medicaid eligibility for hospitals. However, should we find that States are not voluntarily providing or verifying Medicaid eligibility information for hospitals, we will consider amending the State plan regulations to add a requirement that State plans provide certain eligibility information to hospitals.[21]

[21] 70 Fed. Reg. 47441-47442.

The Secretary addressed the following comments with respect to the interface of the State plan requirements and Medicaid eligibility data:

> Comment: Several commenters encouraged CMS to amend the Medicaid State plan requirements to require States to furnish Medicare eligibility data to requesting hospitals. Several commenters believed that variability in how State Medicaid agencies collect and manage Medicaid data make the process to convert and match hospital records to State Medicaid records extremely time-consuming and complex. The commenter believed that requiring every State to report Medicaid eligibility data in the same manner would decrease hospitals' administrative work. Several other commenters suggested that CMS not make any change to the States' requirements at this time, but continue to consider this idea as an option for the future. Another commenter suggested that CMS amend the State plan requirements to include a requirement that the States must make Medicaid eligibility information available in a timely manner, such as 90 days after receipt of a hospital's request. This commenter believed that States should be prohibited from charging hospitals a fee for accessing the data. Several commenters suggested that CMS modify the Medicaid State plan requirements to require that any contract between the State Medicaid agency and an MCO specify that the MCO would be required to submit reliable utilization data to the State to verify managed care days/patients.

The Secretary responded that:

> We are dedicated to working with the State Medicaid agencies to ensure that hospitals have access to data to verify Medicaid eligibility. While the commenters expressed concern that some hospitals find it burdensome to adapt the Medicaid eligibility data available from the States to their records, we do not believe these types of data processing concerns are significant enough to warrant changes to the State plan requirements. We are also aware that not all State agencies have the resources available to modify their systems in a standardized way. We note that the Center for Medicaid and State Operations in CMS has communicated CMS' expectation of compliance with hospitals' requests for Medicaid eligibility information to the State Medicaid agencies. If the State Medicaid agencies refuse to provide data to enable hospitals to calculate their DSH Medicaid fraction and meet their obligations under our regulations at §412.106(b)(4)(iii), we will consider amending the Medicaid State plan requirements to require the State agency to release the information to the requesting hospitals.
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> We also do not believe that we have the authority to require State Medicaid agencies to provide the Medicaid eligibility information free-of-charge.

> However, we do note that the State Medicaid Manual already requires that States not impose unreasonable fees on hospitals seeking eligibility information.

However, similar to this case, several commenters argued that Congress intended that CMS provide the Medicaid eligibility data to aid hospitals in calculating their own Medicare DSH patient percentage. The Secretary responded that:

> While we are aware that section 951 requires that CMS provide the data necessary for hospitals to calculate their Medicare DSH patient percentage, we stand by our belief that hospitals are in a better position to verify Medicaid eligibility with the State Medicaid agencies through their established mechanisms. Therefore, we believe hospitals have available to them the data necessary to calculate the Medicaid fraction for their Medicare DSH patient percentage. CMS will continue to work with State Medicaid agencies to ensure that Medicaid eligibility information is made available to hospitals.[22]

Similarly, one commenter suggested that the fiscal intermediaries or MACs, process hospital requests for Medicaid eligibility data and work with the State Medicaid agencies to obtain such data. Consistent with CMS prior response, the Secretary stated that:

> Under the regulations at § 412.106(b)(4)(iii), hospitals bear the burden of furnishing data adequate to provide eligibility for each Medicaid patient day claimed in the Medicare DSH calculation. This includes verifying with the State that a patient was eligible for Medicaid on each of the claimed days. As stated above, the information provided to CMS by the Regional Offices indicated that there are established procedures for hospitals or their authorized representatives to obtain the information needed for hospitals to meet their obligation under § 412.106(b)(4)(iii) and to calculate their Medicaid fraction. In light of this, we do not believe that fiscal intermediaries should be made responsible for verifying Medicaid eligibility with the State Medicaid agencies.[23]

The Secretary also addressed commenters concerns that some State Medicaid agencies were refusing to provide hospitals with Medicaid eligibility information. The Secretary stated that:

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[22] *Id.*

[23] 70 Fed. Reg. 47442-47443.

> We are not aware of any State Medicaid agency that is refusing to provide hospitals with current Medicaid eligibility information, and the commenters did not cite any such circumstances. However, we are aware that several State Medicaid agencies have previously expressed concern regarding hospital requests for historic Medicaid eligibility information. We note that section 2080.18 of the State Medicaid Manual limits the timeframe within which the State Medicaid agencies may provide eligibility information to requesting hospitals. Section 2018.18 clearly specifies that State Medicaid agencies may only provide eligibility information for dates within 12 months of the date of the request. Therefore, many States have expressed concern that responding to requests for eligibility data outside of that 12-month window would be in violation of CMS' policy. In light of past and pending appeals and litigation, we are working with the States to make sure historic information is available to requesting hospitals. The Center for Medicaid and State Operations released a memo to the CMS Regional Offices to be shared with the Medicaid State agencies. This memo, dated September 9, 2003, requested the full cooperation of the State Medicaid agencies in responding to hospital requests for historic Medicaid eligibility information. The States were specifically encouraged to retain Medicaid eligibility records in order to be able to comply with hospital requests for historic data, even if their normal record retention schedule would have allowed the destruction of such records. CMS' request to Medicaid State Agencies to provide hospitals with historical Medicaid eligibility data represents an exception to the general rule as stated in section 2080.18 of the State Medicaid Manual intended to assist hospitals to respond to the past and pending appeals and litigation.[24]

The Secretary also addressed the concerns of inaccurate or stale data:

> Comment: Several commenters stated that the data provided to hospitals from the Medicaid State agencies are often inaccurate. They noted that several fiscal intermediaries have refused to accept data from hospitals, which was obtained from the State Medicaid agencies.
>
> Response: The Medicaid State agencies maintain eligibility information on Medicaid recipients. To date, we have been made aware of accuracy problems insofar as the data requested are historic and the complete records may no longer be available. As previously noted, we have requested that the State Medicaid agencies comply with hospital requests for historic data and modify their record retention schedules appropriately. We suggest that hospitals experiencing problems with the quality of *current* Medicaid eligibility data

[24] 70 Fed. Reg. 47442-47443.

work with their fiscal intermediaries and State Medicaid agency to address the specific problems the hospital is encountering.

Finally, the Secretary addressed instructions to fiscal intermediaries indicating that hospitals may submit their own data to support the days included in the Medicaid fraction.

Response: While hospitals do bear the burden of verifying Medicaid eligibility for the patient days they submit to be included in calculation of their DSH Medicaid fraction, the State Medicaid agency must verify that, for those days, the particular patient was eligible for inpatient hospital benefits under an approved Medicaid State plan or section 1115 waiver program. If a hospital believes that the State Medicaid agency did not correctly determine the Medicaid eligibility of a patient on a specific day for which the hospital has additional and distinct evidence to indicate that the patient was in fact eligible for Medicaid on that day, the hospital may submit this information for review by the fiscal intermediary. The fiscal intermediary retains the right to determine whether the documentation is sufficient to warrant the inclusion of the days in the Medicaid fraction. While we currently have no plans to issue instructions to fiscal intermediaries on the verification of Medicaid eligibility, we will consider addressing this concern in future communication with fiscal intermediaries.

Comment: One commenter stated that certain Medicaid eligibility information must be made available to hospitals through the State Medicaid agencies. The commenter indicated that solely providing whether a patient is eligible for Medicaid is not sufficient to determine whether the hospital days associated with that patient should be included in the DSH Medicaid fraction calculation. Specifically, this commenter indicated that the State must also provide: the dates of eligibility for Medicaid or whether the patient was eligible for Medicaid during an inpatient stay, whether the recipient has met spend down requirements (if applicable), and the type of Medicaid benefits the recipient received. The commenter indicated that this information is critical in determining the days that should be included in the DSH Medicaid fraction calculation.

Response: We encourage hospitals to continue working with individual State Medicaid agencies to ensure that they have access to the information needed to determine Medicaid eligibility for purposes of the DSH Medicaid fraction. If hospitals are unable to obtain from the Medicaid State agencies data needed to calculate their DSH Medicaid fraction, we encourage them to notify their CMS Regional Office for assistance.

In this case, the Providers argued that section 951 of the MMA places upon CMS and its contractor an affirmative duty to provide the Medicaid eligibility status of the Providers' patients and, when the data is not forthcoming, the burden is shifted to CMS to rebut the Providers' claim for payment based upon the identified inactive days. In support of their claim, the Providers set forth the process and timeline by which they have arrived at a claim for "inactive" days to be included in the respective DSH calculations for the Providers in this group spanning fiscal years ending (FYEs) 2004 through 2006. The Providers relied on the record developed for the FYs 2004 through 2006, including testimony offered at the December 18, 2012 oral hearing to also support the claim for the FYs 2007 through 2012.[25] For the FYs 2004 through 2006, the Providers cited in excess of 30,000 "inactive days" for all providers and cost years. The total inactive days for the FYs 2007 through 2012 are set forth in the individual jurisdictional documents for those groups.

In explaining the process by which these inactive days were identified for FYs 2004 through 2006, the Providers contended that, upon patients' admission, hospital staff members questioned patients or their representatives about any insurance coverage or other source of payment and that once a payment source such as commercial health insurance was identified, the admission and billing staff 's responsibility was satisfied and there was no inquiry into Medicaid eligibility (as Medicaid is the payer of last resort).[26] The Providers' witness testified that, when the patient was admitted the admissions and billings staff would not be attempting to get eligibility verified for those persons who might not get payment.[27] However, if no other source of payment was identified through the initial screening, then hospital staff would typically inquire about Medicaid eligibility. Where a patient disclosed that he or she had Medicaid or presented a Medicaid card with a Medicaid identification number, the Providers emphasized this alone would not be sufficient to establish Medicaid eligibility and that the Hospital would need to verify with the State that coverage was effective for the applicable period.[28] The Providers offered witness testimony that, during the cost reporting periods at issue, the verification process was extremely cumbersome and labor-intensive and "could not possibly be performed for each of the tens of thousands of patients admitted to each hospital in each year, the vast of majority of

[25] The Oral Hearing was held December 18, 2012 for the FYs 2004 through 2006. The Providers' respective appeals for HCA Group FY 2007 were filed from December 2009 through October 2012; for FY 2009 from October 2013 through February 2014; for FY 2010 from February 2014 through August 2015; for FY 2011 from September 2014 through February 2016; for FY 2012 for October 2014 through April 2016.

[26] Transcript of Oral Hearing (Tr.) 118-20, 245. Other payment sources might include health insurance provided through employment, coverage by an automobile liability policy, workers' compensation, or other third party liability.

[27] Tr. 124.

[28] Tr. 119-21.

whom are covered by other insurance and have no connection to Medicaid."[29] Consequently, manual verification was only conducted for certain patients.

The Providers acknowledged that the State had an online verification system that could be used to run eligibility queries, which it claimed could only be done one patient at a time. The Hospitals could also obtain eligibility verification using the following methods: by faxing patient information to the State and receive a fax back advising if the patient was eligible for Medicaid; or by phone to a Medicaid representative, or an automated phone system, that would advise whether the patient was eligible for Medicaid.[30] The Providers' witness claimed that each patient verification would require approximately five to seven minutes per patient inquiry.[31] When an individual had low-income and no other source of coverage, and was not already enrolled in Medicaid at the time of admission, hospital staff would assist patients to complete an application for Medicaid and obtain necessary documentation. The hospital staff would then monitor the application status through the State eligibility determination process as determinations of eligibility are typically made retroactive to cover the date of hospital services which could take several months. If the State ultimately confirmed the patient to be Medicaid eligible, the hospital billed and received a payment. Thus, the Providers stated that in Colorado, during the 2004 through 2006 cost reporting periods at issue, the process for obtaining verification of Medicaid eligibility, where there was no Medicaid payment for an inpatient hospital stay, was extremely difficult and labor-intensive and hampered by a 12 month rolling limit on the range of historic Medicaid eligibility data that could be searched. For these years, Colorado had no capacity to allow electronic matches of all the hospital patients in a single match process (a "batch" query) which could produce a Medicaid eligibility listing of all patient days in a fiscal year.[32]

In August 30, 2007, after the 2004 through 2006 cost years had been filed and the 2007 cost report was being prepared, the State issued a memorandum announcing that hospitals would be able to request batch processing, through a State-approved contractor, over a five-year historical search period.[33] The Providers also alleged it made eligibility inquiries

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[29] Tr. 124, 134, 176-77, 184-86. The Provider also submitted its written procedures for identifying Medicaid patients. In addition, the Provider submitted sample billing documentation, screen shots of the online verification system and of the fax verification method. Provider Exhibit 42.

[30] Tr. 122-24.

[31] Tr. 124-26.

[32] Tr. 135- 138.

[33] In 2005, the Providers witness stated that the State opened a temporary "window of opportunity" to run a "batch query" with what the Providers claimed was a longer search period. The opportunity to run the query was open from January 2005 through April 2006, but it only allowed a search for Medicaid eligibility for dates of service from July 2002 through April of 2004.

through third party vendors at .50 to .60 cent per inquiry. However, the latter batch data returned by the State while verifying additional eligible days, also revealed discrepancies, because days that had been paid by Medicaid were now showing "inactive." The Providers contended that the number of inactive days that had been previously paid indicated a potential problem with "historic eligibility data" in records that the Providers were matching against in 2007 and later, for fiscal periods from 2004 through 2006.[34] Investigation with State Medicaid employees showed that some historical data for patients showed inactive days, although the Providers had received payment for such days because the eligibility span had been deleted or overwritten for the years 2004 through 2006.

In summary, the Providers' witness contended that in preparing the cost reports for the 2004 through 2006 cost years, it would pare down the lists of patients for whom they would try to verify Medicaid eligibility for purposes of supporting the Medicare DSH payment; download all the patients from their own electronic system, review the list to separate those more likely to have Medicaid eligibility, (for example, those for whom the admissions staff had identified in the initial intake screening process as having potential secondary or tertiary coverage by Medicaid) ; and identify those patients who might have the greatest impact on the Medicaid patient day count, for example patients with long lengths of stay. Individuals remaining on the pared down list were then checked against the States' eligibility records by manual verification processes used by the admissions and billing staff, (phone, fax, online verification on a case by case basis). Because the search period was limited to a rolling 12-month period, the verification list was checked at least twice before filing the cost report to coincide with the cost report and its filing period. The first checks were done mid-year to prevent a complete loss of data at the first part of the cost report period due to the 12-month search limit. The second manual check was performed several months after the year end to capture at least some of the delayed eligibility determinations. Prior to 2007 (and the batching allowed) the only verification responses the Providers received from the State were "eligible" or "not eligible" from the narrow population that was manually checked. Prior to 2007, the Providers did not receive an active/inactive designation for 2004-2006.[35] Instead, patients who were manually checked for Medicaid eligibility within the 12- month period were either verified as eligible or ineligible for that stay for the period requested.

The "inactive" status code was not used until 2007, when the State first implemented the new process permitting hospitals in Colorado to verify Medicaid eligibility through electronic "batch" queries. The Hospitals had employed a consulting firm to run full patient listings 'batch" verifications for the years previously verified manually. Only then, when the verification was reconciled outside the 12-month period was the inactive status apparently used for the 2004 through 2006 fiscal years. The subsequent 2007 batching yielded some additional days, which seems likely based, inter alia, on the accounting of

[34] *See also* P-31, a partial description of problem and timeline.
[35] Tr. 211-212. ("That whole issue wasn't even part of, you know…. ")

delayed Medicaid application processing and the expanded list of patients not previously checked. It is the "yield "of this post-12-month batching process conducted in 2007 and forward which, as testified to, is at issue because the Providers claim the results of the 2007 onward batching proves the inaccuracy of the original manual verification process for those years, when it showed 'inactive" status for days for which Medicaid was properly paid.

The Providers' requests for hearings, also reflected the above facts with respect to the pre-2007 individual manual inquires verses the post-2007 batch requests. The Providers first filed a request for the HCA Group Appeal for FYE 2004 by letter addressed to Board Chairperson Suzanne Cochrane, dated January 12, 2007, which objecting to the 12-month rolling data base and requested batch inquiries by the State, stating that:

> HCA believes that Colorado's State data base may be substantially understating eligible Medicaid days. The State has a system in place to allow eligibility checks throughout the year. The system is based on a rolling 12 months. However, there is no system to allow a provider to check all patients at one time after the end of the fiscal year. Also this system is not conducive to capturing those patients who receive Medicaid benefits retroactively (or to lose them retroactively.)
>
> The Providers are requesting the state to allow a batch processing eligibility match after year-end. The Providers are willing for the State to make a decision. In the meantime, the current process does not allow the Providers to complete the DSH calculation timely or to provide complete and accurate information to the fiscal intermediary for proper report filing or settlement.[36]

Reflecting the results of the State's subsequent "batching" capabilities (at least for some years outside the 12 month rolling period) and the subsequent identification of "inactive" days, the Providers stated that in the HCA 2009 Colorado State Database Appeal, that:[37]

> HCA believes that Colorado's State data base may be substantially understating eligible Medicaid days. HCA believes the number of Medicaid eligible days to be included in the DSH payment calculation should include patient days for individuals who were found in the Medicaid program rolls but were identified through a match against the State's electronic eligibility records as having been "inactive" for dates of service rendered by the Providers. It is undisputed that this 'inactive' status is, in CMS's words

[36] *See also* Providers' Request for Hearing for FYE 2005 (February 22, 2008), and, Request for Hearing for FYE 2006 (November 16, 2007) to the Board Chairperson, similarly setting forth the issue.

[37] *See also* HCA FY 2009 Group Appeal, (Model B Form-Tab 2) (Amount in Controversy $4,877,798)

> 'unjustifiably uncertain' due to numerous, well-documented, entirely undisputed problems with the State's electronic eligibility records system including the deletion and overwriting of electronic records of historic eligibility spans.
>
> The issue arises from the State of Colorado's failure to maintain an electronic records system that is capable of producing an accurate and complete listing of all Medicaid-eligible patient days for the cost reporting periods at issue.[38]

Likewise, for the HCA 2012 DSH Colorado State Data base appeal, the Providers stated that:

> The issue arises from the Hospital's request to the State of Colorado to conduct a match of patients with the state's electronic Medicaid eligibility data base. The patient listings were returned with many patients identified as "inactive: …For the inactive patients no additional information is returned indicating that the individual is enrolled in Medicaid but was not identified as eligible for the specific dates of service requested…The issue concerns days that were returned by the State's electronic database as inactive for eligibility…. One of the widely acknowledged problems is the problem of vanishing Medicaid eligibility spans. This problem has arisen because individual's eligibility data has been retroactively deleted or overwritten in the State's electronic data base.[39]

While the 2004 through 2006 years were pending, by letters dated August 19, 2011, the Providers' legal counsel made a demand to CMS and the MAC that the Medicaid eligibility status of the Providers' patients should be provided for purposes of calculating the DSH payment for FYs 2004 through 2006. The Providers knew the information was not in CMS' custody or the contractor's custody; that the State, a separate government entity, had sole custody of any Medicaid eligibility data, that the data being requested was historical data not available through the State's electronic system because it had been over written or

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[38] *See also* HCA FY 2007 Group Appeal (Model B Form-Tab 2) (Amount in Controversy $4,313,800)
HCA FY 2008 Group Appeal (Model B Form-Tab 2) (Amount in Controversy $4,430,035)
HCA FY 2010 Group Appeal (Model B, Form –Tab 2) (Amount in Controversy $4,433,600)
HCA FY 2011 Group Appeal, (Model B Form-Tab 2,) (Amount in Controversy $4,216,658)

[39] HCA FY 2012 Group Appeal (Model B Form-Tab 2)(dated October 27, 2014) which also expanded other basis for the challenge in addition to the "vanishing eligibility span" based on a July 2011 report issued by CMS detailing the areas the State was out of compliance with Federal statutes and regulations. (Amount in Controversy $5,299,939).

deleted, and that the only source of the information was in the State's paper files. The State confirmed the paper files resided in the respective counties wherein the patients were located in the State.[40] As reflected in several reports, the Providers were also aware that CMS had been working with the State on compliance issues one of which involved the vanishing eligibility span for historical data. By letter dated October 11, 2011, the Providers submitted a request to the State for manual search of its records for FY 4004 through 2006, and also filed a subpoena with the Board, for the State as the sole custodian of the records they sought.

The State in objecting to the subpoena filed before the Board, stated that the electronic data does not exist for the years requested (2004-2005) and any alleged detriment to the Providers was the result of their own failure to timely request eligibility data. The State explained that the Colorado Benefits Management System or CBMS is the State's eligibility database. Eligibility verification was available electronically 24 hours per day, 7 days per week. CBMS is a dynamic (versus a static) database which allows a worker to determine and re-determine eligibility for time periods in the past. For example, the State explained that if information is received today that would adversely impact eligibility for a past time period, CBMS can re-evaluate eligibility for that past time period, which may result in ineligibility. When it results in ineligibility (for example, the client belatedly reports an increase in income), the medical span is deleted. The State explained that this is known as the "vanishing med span" referred to in the Providers' request. When the medical span is deleted, the MMIS shows a paid capitation or claim (static) and no eligibility span. According to the State's General Provider Information manual, providers are required to verify eligibility before rendering services. When eligibility is verified, providers are given a "guarantee number" that ensures payment from Colorado Medicaid. The State explained in its attachment that checking for eligibility before rendering services exempted those claims from eligibility edits for that date of service.

The State pointed out that the Colorado Department's provider web portal allowed providers to submit claims, perform claim status inquiries, check client eligibility verification, and allows for provider demographic updates. The Providers in this case had access to eligibility data through the Department's provider web portal. The Department's provider web portal allows eligibility to be verified up to one year from the date of service. After one year from the date of service, the Providers can obtain eligibility data from the State Department's fiscal agent, Affiliated Computer Services, Inc. ("ACS") where the data search is run through the MMIS system. However, any retroactive eligibility verification can be subject to the "vanishing med span" referred to in the Providers' request. Therefore, providers are required to verify eligibility before rendering services to guarantee payment (or in this instance for the Providers' purposes, eligibility). In Colorado, Medicaid applications are processed at the county level. Therefore, any paper records can only be

[40] By letter dated October 11, 2011, HCA submitted a request to the State for manual search of its records.

found in Colorado's sixty plus counties throughout the State. No paper records of eligibility existed at the State level. The State in objecting to the manual search required by the subpoena to produce the records, stated it would require a full time staff person an average of one day per requested client to locate the client's file, travel to the county, perform the necessary research, and then copy records to verify eligibility. Significant travel costs (transportation and lodging) would exist as not all county offices are easily accessible in one day.[41] Consequently, the State pointed out the difficulties in trying to retrieve historical data at this time.

The Administrator finds that CMS has reasonably interpreted section 951 as requiring the agency to provide necessary personal identification information based on CMS' determination that the Hospitals are in the best situation to provide and verify Medicaid eligibility information with the State. CMS observed that Hospitals will necessarily already be in possession of much of this information and that each State will have its own systems. Medicaid is a voluntary program which CMS oversees and in that role, CMS ensured there were no legal impediments for Hospitals to access this data under their State plan.

However, the Providers contended that there is no personal identifying information that a hospital would need from CMS, making CMS' interpretation irrelevant. First, regarding the SSI fraction, there is information that Hospitals would not have in their records. Further, regarding the Medicaid fraction, section 2080.18 of the State Medicaid Manual sets forth the information that maybe released to a provider. In addition, section 2080.18(C) provides limits on the information which will allow an entity to access that data, specifying:

> C. Accessing the Data. -- Providers may access the Medicaid eligibility information only by entering the recipient's Medicaid identification number or two or more of the following data elements:
> - o Recipient's full name, including middle initial;
> - o Recipient's date of birth;
> - o Recipient's social security number;
>
> AND by entering date(s) of service(s). If a span of service dates is entered, you determine the length of the span that is appropriate, not to exceed a maximum of 12 months prior to the query date. If a specific date of service is requested, the date cannot be more than 12 months prior to the query date.

[41] However, in lieu of the Manual search, the State worked with the Providers' consultant to provide access to alternative data (the "BHO project") in an attempt to identify additional days The Providers explained that this alternative data was not of significant benefit in that it identified only a limited number of additional days.

As multiple pieces of information may be needed to confirm Medicaid eligibility, it is conceivable that Hospitals may be missing all of the information needed to access State data bases to confirm eligibility for the dates of service, personal identification information that would be in possession of CMS for some patients. However, the fact that providers generally may be in a better position and have much of the information already needed to verify eligibility, only confirms CMS underlying rationale for deferring to providers the responsibility to obtain the Medicaid eligibility information from the State.

In addition, as CMS noted in its response to comments in the final rule, section 2080.18 of the State Medicaid Manual provides that: "Only eligibility information for dates within 12 months of the date of query may be furnished to providers." The record shows that in this case, a historical eligibility search, might show "inactive" because the data has been overwritten or deleted causing a vanishing eligibility span for noncurrent claims or the inactive day status maybe obscuring an ineligible status. The MAC, CM and the State have contended that an issue causing the "inactive day" status was one of the timeliness of the Providers' verification and that the verification manually checked timely and then searched again via the latter (with all patients) batch searches may have in fact yielded, together, a relatively accurate picture of eligibility.[42] However, in years where the Providers may not have made a timely complete manual or batch search, the possibility of deleted and not retrievable days would increase and conversely timely and frequent batch inquires reduced inactive day responses as the Providers' conceded at the hearing.[43]

Regarding the broader legal issue concerning the meaning and intent of section 951, the Administrator finds that, consistent with CMS' pronouncement and consideration of comments in the 2015 final IPPS rule as herein noted, section 951 did not create an affirmative obligation for CMS to provide the beneficiary eligibility data for Providers, but rather CMS correctly interpreted that provision so as to make sure there were no legal impediments to Hospitals' access to the State data and provide any PII that might assist in the data search. CMS interpretation is a reasonable interpretation of section 951, in light of the fact that Medicaid is a voluntary joint program and not a sole Federal program, that the data is in the States' respective custody, that there are 50 various State plans and data bases and that hospitals are in the best situation to access the data from the State. In addition, the plain language of the section 951 does not override the longstanding Medicare principle set forth in the statute and, more specifically in the DSH regulation, that providers must submit the necessary documentation required by the Secretary for payment to be made. Nothing in the language suggests that basic requirement has been subjugated by section 951. Further, even if such an operationally and legally impractical burden was placed on CMS, that

[42] The MAC at the hearing for example, reviewed a Provider that had filed an initial appeal form the original NPR and one from the revised NPR to look at the combined accuracy of the total number of days found eligible. Tr. 107-109.

[43] *See, e.g.*, n. 46.

burden has been met. [44] The record indicates that CMS efforts were made pursuant to the State plan requirements controlling Medicaid data systems. The record also shows that the Providers had access to the State data via several different means. To the extent that the State's data systems might have had issues, the record shows that CMS has worked with the State to bring it into compliance. However, the Medicaid program is separate and distinct from the Medicare program: the former a joint State and Federal financed program and the latter a Federal financed program. Thus, to use section 951 to shift the burden to CMS to provide the Medicaid eligibility data and require payment to the Providers where CMS cannot provide the State's eligibility data, is incorrect.

The record shows that the vanishing span and the reporting of "inactive days" maybe is r the result of ineligibility of overwrites/ deletions that occur in historical data. However, an "inactive day" status could also indicate a patient that was not eligible for Medicaid on the day of service. CMS emphasized the 12 month archival requirements of State programs and possible problems in accessing eligibility data beyond the 12-month historical data for hospitals. The State stressed the need for checking for eligibility prior to rendering service in order. The record confirms that the State offered a 24/7 on line verification system and fax system to verify Medicaid eligibility and that the "inactive" days was a product of full eligibility inquiries conducted in batches outside of the 12-month period for the 2004 through 2006 cost years.[45]

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[44] This conclusion that the section 951 does not intend to shift to CMS the responsibility to produce the Medicaid eligibility data is also reasonable in light of the fact that the Providers' interpretation would make the CMS Medicare program a data reservoir for the all Medicare and non-Medicare patients of all IPPS DSH Hospitals in order to ascertain whether they are Medicaid eligible. CMS specifically avoided such a similar role to expand its reservoir of data beyond the Medicare beneficiaries, with respect to the Marketplace risk adjustments by using EDGE servers controlled by the data-holding insurance companies that had CMS software that calculated the risk adjustment and relayed no patient specific data to CMS. In the instance of Medicaid data, the State's data systems and the Hospitals are the custodians of the individual specific patient data, not CMS.

[45] The Providers' counsel also suggested that by 2011, even as Medicaid eligible days increased, the consultant likely had been able to catch the days "while still active" causing a decrease in "inactive days" being reported. (Tr. 342) *See also* Tr, 323 (What's happening is we're capturing more active days with this quarterly matching. So we know the issue still exists in '10 and '11. We're just trying to capture the recipients when they're currently active to put them in the DSH calculation and get the Provider paid the current day. ….. We saw the DSH calculations that we are finishing for our providers were trending upward and stepped up in those later years, because we had additional days in there that in all likelihood had we waited until the end of the year to do our matching like we did in '04, '05, and 06 those numbers conceivably would have come back down, so they would have converted back to inactive potentially.")

The Providers initially emphasized the cumbersome effort needed to verify all patient's eligibility *concurrent* with the patients' admissions and or within the 12 month rolling window, which may have required five to seven minutes per patent with possible follow-up needed on newly applying Medicaid patients to explain the limited scope of the initial manual checks. Comparing the Providers' claims of the effort needed to verify eligibility to the economic benefit, shows that timely manual verification was economically viable. That is, while the effort to verify Medicaid eligibility concurrent with or prior to admission as the State instructed and/or within the 12-month period would indeed appear cumbersome, it is also economically viable and beneficial to do so. Even apart from the possibility of direct Medicaid payment, each additional day or patient verified eligible provides substantial benefits in the form of the DSH payment.[46]

The Provider also argued, and the Board accepted, certain proxy evidence in order to demonstrate that the Providers' eligible days had been undercounted and to justify the addition of these inactive days without Medicaid eligibility verification. The Providers argued that adding the inactive days for 2004 through 2006 would keep the Providers' Medicaid utilization rate consistent with the Providers' FY 2010-2011 rate which they maintained was the most accurate snapshot of the Providers utilization rate because of timely frequent quarterly batch matches possible for the FY 2010-2011. The Provider pointed out that its Exhibit 36 shows parity in Medicaid percentages for the Providers for 2004 through 2006 years when the inactive days are included compared to the 2010-2011 cost years. According to the Providers, to include the inactive days would increase these earlier years' Medicaid percentages to be consistent with the most accurate day counts reflected in 2010-2011. However, the Providers' analysis also overlooks changes in the law and economy and other factors that shows that Colorado Medicaid utilization rate /number of cases took a significant increase between 2006 and 2010 and most particularly in 2010.[47]

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[46] The Providers are claiming that the fiscal years 2004-2006 for all of the Providers exceeded $12 million in increase reimbursement for approximately 30,000 inactive days and 10,000 patients which if one assumes arguendo that the days were includable shows a day worth between $400-500 to a provider and a patient generally worth between $1200 to $1500 if Medicaid eligibility was confirmed. Individually, as an example, for. FY 2004, Swedish Medical Center: claimed $1,773,848 in controversy for 3969 inactive days relating to 1145 patients or an average of $449 per day and $1549 per patient if Medicaid eligibility was confirmed.

[47] Statistics show that between 2006 and the Providers' proposed 2010-11 "target" year the number of Medicaid cases significantly increased because of changes in law, economy, etc., and would not offer a similar landscape for comparison to justify the addition of inactive days in FYs 2004 through 2006 to show an equivalent utilization rate. For example, effective April 2010, the ACA gave states flexibility to expand Medicaid to adults to get an early start on the 2014 expansion. Since April 2010, Colorado expanded coverage to adults.http://www.coloradohealthinstitute.org/data-repository/category/health-coverage-and-the-uninsured/2004 See, e. g., "The Department of Health Care Policy and Financing,

The percentages without the inactive days overall would tend to mirror the Medicaid utilization increases over those years when compared to the 2010 target year and does not support including the inactive days.

Similarly, the Providers contended that adding the inactive days to their day count resulted in Medicaid utilization rates similar to the same periods nationally for hospitals' with over 100 beds. However, that is also flawed support as even a snapshot indicates that the Colorado Medicaid utilization rate has been significantly less than the national rate reflecting the differences of its State plan, economy and population from the national rate.[48] Further, the Providers use of the Health Care Cost Report Information System (HCRIS) data for other Colorado Hospitals' Medicaid utilization rate for the same years to support the increase of additional inactive days for the appealing Providers in order to create equivalence or parity with these other hospitals appears to undercut their challenge that accessing accurate data from the Colorado system for those years was impossible.[49]

Medicaid Caseload FY 2013-14 Budget Request February 15, 2013"; Figure 1- "Total Medicaid Caseload FY 200-01 to FY 2009-10" shows an increase of just below 100,000 cases between FY 2005-06 and FY 2009-2010) ("A graphical representation of aggregate Medicaid caseload history from FY 2002-03 is shown below. Medicaid in Colorado had double-digit growth rates in FY 2003-04 and FY 2004-05 of 10.78% and 10.48%, respectively. These high rates of growth ceased in FY 2005-06, and caseload declined by 0.95% in FY 2005-06 and by a further 2.48% in FY 2006-07. Monthly declines continued in the first half of FY 2007-08 but reversed in the second half, resulting in a nearly flat decline of 0.07% for the fiscal year. With the weak economy, caseload has continued to grow at double digit rates, with in annual growth of 11.44% in FY 2008-09, 14.19% in FY 2009-10, 12.41% in FY 2010-11, and 10.56% in FY 2011-12. Reasons for these recent growth rates will be discussed below.") https://www.colorado.gov/.../2012-3%20Medicaid%20Caseload%20Narrative.pdf

[48] As an example, the 2007 Medicaid enrollment as a percentage of population for Colorado was approximately 12 percent compared to 20 percent nationally. *See*, *e.g.*, "Medicare-Medicaid Enrollee State Profile- Colorado"; 2007 State Report published by Centers for Medicare & Medicaid Services; "Table 1. Medicare, Medicaid, and Medicare-Medicaid enrollment as a percent of population- Colorado compared to the United States 2007." This table uses "enrollment" as opposed to "cases" used in the prior referenced Medicaid cases statistics.
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html

[49] The Medicaid utilization rates source for other Colorado Hospitals' was the HealthCare Cost Report Information System (HCRIS) which contains the annual cost reports submitted by hospitals to Medicare under the same process and timelines the Hospitals in this appeal filed under and using the same Colorado data system which is under challenge in this appeal. The Providers seem to be proposing that the HCRIS data for these hospitals was more accurate than their own data, which challenges the assumption that accurate data was

Consequently, these proxy utilization rates do not support the Provider's contention that the Provider's Medicaid eligible days have been undercounted and, likewise, does not justify the inclusion of the "inactive days" as Medicaid eligible days. Finally, the Providers argued that denial of the requested claim is prohibited because of the Paperwork Reduction Act (PRA). However, among other things, the requirement that a Provider document its claim for payment falls within the PRA's exemptions for administrative actions and audits. *(See* 44 U.S.C. § 3518(c)(1)(B)(ii)).[50]

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not accessible from the Colorado systems. Either other hospitals were able to access accurate data, while the Providers did not (which would lend support to the CM and the Mac's contention that to some extent the factor of the timeliness of the Providers searches) or that the data is largely accurate for all hospitals, including the Providers (excluding the identified inactive days) in Colorado. However, regardless, these statistics do not support adding the days.

[50] *Alegent Health-Immanuel Medical Center v. Sebelius*t, 34 F.Supp.3d 160 (D.D.C. 2014) ("Plaintiff's argument that the PRA prevents the Secretary from requiring written affiliation agreements because she had not previously obtained approval from OMB fails for two reasons. First, the PRA does not create a private right of action and, even if it did, the requirement for a written affiliation agreement falls within the PRA's exemptions for administrative actions and audits. See 44 U.S.C. § 3518(c)(1)(B)(ii)….."(("Alegent is not attempting here to use the PRA as a shield against the penalty that the Secretary has imposed on it, but a sword to persuade the Court to find the Secretary in violation of the PRA. Unfortunately for the plaintiff, there is no basis in the statute or relevant case law for such a use—Alegent's PRA claim must therefore fail."); *MacKenzie Medical Supply, Inc. v. Leavitt,* 506 F.3d 341(4th Cir. 2007)("Secretary of Department of Health and Human Services (HHS) was not prevented, under Paperwork Reduction Act (PRA), from requiring documentation in addition to certificate of medical need (CMN) to substantiate durable medical equipment (DME) supplier's claims for Medicare reimbursement …since PRA specifically exempted agency investigations, and supplier was subject of audit by Secretary....")

Decision

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

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

Date: 11/14/2016

/s/
Patrick Conway, M.D., MSc
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services