CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Saint Mary's Hospital – Milwaukee **Provider** **vs.** **Blue Cross Blue Shield Association/ National Government Services, LLC-WI** **Intermediary**	**Providers Cost Reimbursement Determination for Cost Reporting Period Ending: June 30, 1999** **Review of:** **PRRB Dec. No. 2009-D27** **Dated: June 24, 2009**

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 parties were notified of the Administrator's intention to review the Board's decision. CMS' Center for Medicare Management (CMM) commented, requesting reversal of the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue is whether the Intermediary improperly calculated the Provider's Medicare DSH adjustment by excluding 365 Long Term Respiratory Unit (LTRU) patient days from the Medicaid proxy of the DSH calculation.

The Board noted that the underlying legal issue in this case is whether a patient eligible for Medicare Part A, but who exhausts his/her Medicare Part A benefits, is still "entitled" to Medicare benefits and days should be excluded from the Medicaid proxy. The Board explained that this issue is not new, and it has consistently applied the holdings of the Court in Jewish Hospital, Inc. v. Secretary of Health and

Human Services,[1] to its resolution. The Board based its decision on the Court's definition of "entitled" as follows: "To be entitled to some benefit means that one possesses the right or title to that benefit. Thus, the Medicare proxy fixes the calculation upon the absolute right to receive an independent and readily defined payment."[2] The Board considered the Court's definition consistent with the requirements of the statute and the plain language of the Act. Accordingly, the Board found that the exhausted days were not "entitled" to Medicare Part A benefit and, accordingly, the DSH Medicaid fraction should be revised to permit the Provider to include the 365 LTRU days.

COMMENTS

CMM commented, requesting that the Administrator reverse the Board's decision. CMM disagreed with the Board's ruling that the "exhausted days are not 'entitled' to Medicare Part A benefits." CMM contended that entitlement to Medicare Part A benefits precludes dual-eligible inpatient days from being included in the Medicaid proxy of the Medicare DSH calculation. For example, when a Medicare beneficiary exhausts his/her inpatient hospital benefits, those benefits will be renewed when the beneficiary has not been in a hospital or Skilled Nursing Facility (SNF) for 60 days. CMM noted that this fact supports the notion that it is the benefit period that may exhaust or expire, not the entitlement itself. Therefore, under CMS' interpretation of the statute and the regulations, the days at issue are not included in the numerator of the Medicaid fraction of the DSH calculation.

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.

The Social Security Amendments of 1965[3] 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,[4] and Part B, which is supplemental voluntary

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[1] Jewish Hospital, Inc. v. Secretary of Health and Human Services, (hereinafter Jewish Hospital), 19 F.3d 270, 275 (6th Cir. 1994).
[2] Id. at 275.
[3] Pub. Law No. 89-97.
[4] Section 1811-1821 of the Act.

insurance program for hospital outpatient services, physician services and other services not covered under Part A.[5] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[6] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[7] 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.[8]

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 one of almost 500 diagnosis related groups (DRG) subject to certain payment adjustments.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to Section 1886(d) (5) (F) (i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…."[9]

There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[10] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage or DPP. 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" or "Medicare fraction" and the Medicaid low-income proxy" or "Medicaid fraction", respectively, and are defined as follows:

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[5] Section 1831-1848(j) of the Act.
[6] Under Medicare, Part A services are furnished by providers of services.
[7] Pub. Law No. 98.21.
[8] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).
[9] 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).
[10] The Pickle method is set forth at section 1886(d) (F) (i) (II) of the Act.

> (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.)

The Secretary implemented the statutory provisions at 42 C.F.R. §412.106 (1999) and explained that the hospital's DPP is determined by adding the results of two computations and expressing that sum as a percentage.

The first computation, the "Medicare fraction" is set forth at 42 C.F.R. §412.106(b) (2) (1999). The regulation at 42 C.F.R. §412.106(b) provides that:

> (b) *Determination of a hospital's disproportionate patient percentage. (1) General rule*. A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
> (2) *First computation: Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS-
> (i) Determines the number of covered patient days that-
> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;
> (ii) Adds the results for the whole period: and
> (iii) Divides the number determined under paragraph (b) (2) (ii) of this section by the total number of patient days that-
> (3) *First computation: Cost reporting period.* If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written

> request including the hospital's name provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.
> (4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of 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…..

In this case, the Provider argued that the Intermediary improperly excluded 365 LTRU patient days from the numerator of the Medicaid fraction of the Medicare DSH calculation. These were patient days for a Medicare beneficiary at the Provider who was both eligible for Medicaid and entitled to Medicare Part A benefits but had exhausted Medicare Part A benefits.[11] The Provider argued that, since the beneficiary had exhausted the Medicare Part A benefits, that the beneficiary was no longer "entitled" to Medicare. Therefore, the days should be included in the Medicaid proxy of the Medicare DSH calculation. The Board relying on the decision in Jewish Hospital[12] agreed.

The Administrator finds that the statutory phrase in the Medicaid proxy "but who were not entitled to benefits under Medicare Part A of this title" forecloses the inclusion of the days at issue in this case in the numerator of the Medicaid proxy. A review of the plain language of the statute reflects that the Medicare low-income proxy is intended to capture a distinct patient population. The Medicare low-income proxy, because it uses SSI as the income indicator, includes Medicare/Medicaid dual eligible patients. The Medicaid low-income proxy specifically excludes from its calculations patients entitled to Medicare Part A and limits its proxy to Medicaid-only eligible patients. The relevant language of the Medicaid proxy indicates that it is the status of the patients, as opposed to the payment for the day, which determines whether a patient day is included in the numerator of the Medicaid proxy.

The Social Security Act and the regulations at Title 42 of the Code of Federal Regulations recognizes the distinctive use of the term "eligible" in conjunction with Medicaid recipients and "entitled" in conjunction with Medicare beneficiaries. The distinctive use of these terms is consistent with the differences in the respective programs. As a general matter, Medicare is a social insurance program, in contrast

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[11] See, Stipulation of Facts, June 30, 1999, at ¶4 and ¶5.
[12] Supra, n. 1.

to Medicaid, which is a needs-based program. With respect to Medicare, certain populations are entitled (or have a legal right to) Medicare automatically[13] and others are "entitled" to Medicare once they have filed an application and are enrolled.[14] With respect to Medicaid, certain low-income individuals and families are "eligible" who fit into an "eligibility" group that is recognized by Federal and State law.[15] Because Medicaid is a needs-based program, the Medicaid program generally requires a determination of an individual's eligibility and also periodic re-determinations of "eligibility." Therefore the distinctive use of the term "entitled" in section 1886(d)(5)(F)(vi)(I) and (II) when referencing Medicare, as opposed to eligible, is not in reference to the right of payment of a benefit, but rather the legal status of the individual as a Medicare beneficiary under the law. As noted by CMM, even when a Medicare beneficiary exhaust his/her inpatient hospital benefits, these benefits will be renewed when the beneficiary has not been in a hospital or SNF for 60 days. Thus, while a Medicare beneficiary's benefit period may exhaust or expire, the entitlement for Medicare does not expire.

Accordingly, based on the plain language of the statute the Administrator finds that the statutory phrase in the Medicaid proxy "but who were not entitled to benefits under Medicare Part A of this title" forecloses the inclusion of the days at issue in this case in the numerator of the Medicaid proxy. Thus, the Intermediary properly excluded the Provider's 365 LTRU patient days from the Medicaid fraction of the Medicare DSH calculation.[16]

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[13] For example, under the Medicare statute, an individual who is at least 65 years of age is "entitled" to Medicare Part A benefits if he or she currently receives Social Security or Railroad Retirement Board Benefits. 42 U.S.C. §426(a). Such an individual is automatically entitled to Part A benefits and does not have to file an application for coverage. 42 C.F.R. §406.6(a).

[14] For example, an individual who is at least 65 years of age and who is eligible for, but does not currently receive, Social Security or Railroad Retirement Board benefits, is not entitled to Part A benefits *until* he or she files an application for Social Security or Railroad benefits. 42 U.S.C. §426(a) and 42 C.F.R. §406.6(c).

[15] See, e.g., Section 1905(a) and 42 C.F.R. §435.2 *et seq*.

[16] The Secretary addressed the policy of including dual-eligible patient days in the Medicare fraction at, inter alia, 68 Fed. Reg. 27207 (May 19, 2003) and 69 Fed. Reg. 48916, 49098 (Aug 11, 2004).

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: 8/24/09

/s/
Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services