INTRODUCTION AND BACKGROUND

Historically, the Medicare program has made disproportionate share hospital (“DSH”) payments as a percentage add-on to the standard payment amount per discharge under the prospective payment system for the operating costs of inpatient hospital services (“IPPS”). Social Security Act (“SSA”) § 1886(d)(5)(F); 42 C.F.R. § 412.106. A separate DSH adjustment also is provided for large urban hospitals under the prospective payment system for capital-related costs. See 42 C.F.R. § 412.320. This outline addresses the DSH payment under the IPPS for operating costs.

A new DSH payment method under IPPS became effective on October 1, 2013. The new DSH payment method blends the old payment method with a new payment for uncompensated care. The new payment is discussed in the first part of this outline. The original DSH payment method is discussed in the second part.

I. THE NEW DSH PAYMENT FOR UNCOMPENSATED CARE


The ACA changes to the DSH payment method grew out of a Medicare Payment Advisory Commission (“MedPAC”) report to Congress in 2007. See MedPAC, Report to Congress, Medicare Payment Policy (Mar. 2007). The MedPAC report found that about 75% of the traditional DSH payment was not “empirically justified” by higher costs per case. Id. at 77. The report observed that a portion of the DSH payment could be redistributed as a means of offsetting a portion of hospitals’ costs of uncompensated care. Id. at 87.
The new DSH payment method consists of two parts. See SSA §1886(r). The first part is equal to 25% of the traditional DSH payment “that would otherwise be made” under the original DSH payment method discussed below. See SSA §1886(r)(1). The second payment is for uncompensated care costs. On August 19, 2013, the Centers for Medicare and Medicaid Services (“CMS”) published a final rule implementing the new payment for Federal fiscal year 2014 and beyond. 78 Fed. Reg. 50496, 50613-647.

A. ADDITIONAL PAYMENT FOR UNCOMPENSATED CARE

The additional DSH payment for uncompensated care is the product of three factors. For Federal fiscal year 2014, the three factors are: (1) 75% of an estimate of the aggregate amount of DSH payments that would have been paid for Federal fiscal year 2014 under the traditional DSH payment method; (2) an adjustment to that estimate to account for the percentage change in the estimated percent of the population under age 65 who are uninsured in Federal fiscal year 2013 as compared with the estimated uninsured percentage in 2014, less a small statutory reduction factor of 0.1 percentage points; and (3) each eligible hospital’s estimated percentage of the total uncompensated care costs incurred by all hospitals that are expected to qualify for the new DSH payment.

The new DSH payment method applies with respect to all discharges on or after October 1, 2013. Under the final IPPS rule for 2014, there will be no delay in the effective date or transition period and no stop-loss or stop-gain caps on payments under the new system.

The new payment method applies to all general acute care hospitals that are paid under the IPPS and qualify for the traditional DSH for a fiscal year. The new DSH payment does not apply to IPPS-exempt hospitals, IPPS hospitals that not qualify for the traditional DSH payment for a fiscal year, critical access hospitals, sole community hospitals that are paid on the basis of their own hospital-specific payment rate per discharge, Maryland hospitals that are paid under a Medicare waiver, and hospitals participating in a Rural Community Hospital Demonstration.

CMS calculated the additional DSH payment amounts for uncompensated care at the time it adopted the final rule for 2014, and those amount are listed in a Supplemental Data File on the CMS website for each IPPS hospital that is expected to qualify for DSH in Federal fiscal year 2014 (based on prior-period data). The final rule provides that
those amounts will not change based on actual data for 2014 that was not available when the final rule was adopted. See 42 C.F.R. § 412.106(g)(1)(iv). The one thing that could change is whether a hospital is finally determined to be eligible to receive any payment at all for uncompensated care.

A hospital that was expected to qualify for the traditional DSH payment for 2014, when the final rule was adopted, will receive interim payments of the uncompensated care amount for each discharge in any portion of the cost reporting period occurring in Federal fiscal year 2014. The hospital would be required to return the DSH uncompensated care payments, at the time of final cost report settlement, if the hospital does not qualify for the traditional DSH payment for the cost reporting period.

Conversely, a hospital that was not expected to qualify for the traditional DSH payment for 2014, when the final rule was adopted, will not receive interim per discharge payments for uncompensated care. But, if the hospital ultimately does qualify for the traditional DSH payment for 2014, then the hospital will receive an additional DSH uncompensated payment at the time of final cost report settlement.

B. DATA USED TO CALCULATE EACH HOSPITAL’S SHARE

For 2014, CMS calculated each hospital’s percentage share of the total DSH uncompensated care payment based on the hospital’s number of Medicaid and low-income Medicare/SSI patient days from an earlier cost reporting period in 2011 or 2010. In the preamble to the final rule for 2014, CMS stated that the agency will consider using other data reported on cost report worksheet S-10 to calculate this factor for future years after 2014, once hospitals have more experience reporting all of the data elements on worksheet S-10.

The number of Medicaid and Medicare/SSI days used to calculate the distribution of the aggregate total uncompensated care payment is not adjusted to account for different wage costs in different geographic areas or for differences in case mix. In addition, the Medicaid and Medicare/SSI days included in the calculation for 2014 do not include patient days in IPPS-exempt units of hospital, but CMS indicated that it may consider a later change to the rule to include those days.
C. APPLICATION OF TRADITIONAL DSH PAYMENT CAPS

The traditional DSH payment (reduced to 25%) will be calculated and paid as always on an interim basis, per discharge, subject to final reconciliation at cost report settlement. The 12% DSH payment cap to that applies to some small urban and rural hospitals under the traditional DSH payment method will continue to apply to the reduced traditional DSH payment that will be made under the new rules. The traditional DSH payment that will be made to these hospitals under the new law cannot exceed a 3% payment add-on (12% \times 0.25). But, this cap does not apply to the additional DSH payment for uncompensated care costs. Thus, in some circumstances, the combined total DSH payment made to these hospitals under the new law could exceed 12% of the IPPS base payment rate per discharge.

D. LOGISTICS FOR NEW PAYMENT

Hospitals that are expected to qualify for the traditional DSH payment, as reflected in the DSH Supplemental Data file, will receive interim payments per discharge for the uncompensated care payment. The interim payment amounts per discharge are reflected in the DSH Supplemental Data file. Those per discharge amounts reflect the pre-determined payment amount for the whole of Federal fiscal year 2014, divided by the hospital’s expected number of discharges in that year, which CMS estimated using an average number of discharges by the hospital in a prior three-year period. The sum of those per-discharge payments will be reconciled, at final cost report settlement, with the pre-determined aggregate amount due for Federal fiscal year 2014. When the hospital cost reporting period overlaps two Federal fiscal years, the DSH uncompensated care payment will be reconciled with a pro-rata share of total amount reflected in the Supplemental Data File for the Federal fiscal year.

E. ADDITIONAL PAYMENT BY MEDICARE ADVANTAGE PLANS

The final rule for 2014 clarified a significant question regarding the DSH payment for uncompensated care costs by Medicare Advantage plans under Part C of the Medicare. In general, Medicare program requirements provide that the Medicare Advantage plans must pay a hospital what “original Medicare” would have paid, under parts A and B, when the hospital treats plan enrollees out-of-network. In addition, many plans pay in-network providers on the same basis under contractual arrangements with
the hospitals. In the final rule, CMS confirmed that Medicare Advantage plan payments to such hospitals must include the per-discharge payment amount for uncompensated care costs.

II. THE ORIGINAL DSH ADJUSTMENT METHOD

A. OVERVIEW

As noted above, the existing DSH payment methodology applies through September 30, 2013 and will determine one part of the DSH payment made to hospitals after that date. See SSA §§ 1886(d)(5)(F) and 1886(r).

Under the original DSH payment method, there are two alternative means for determining a hospital’s qualification for the DSH adjustment and the amount of the payment add-on for qualifying hospitals. The first, most common, method is based on a hospital’s “disproportionate patient percentage.” The second method, commonly referred to as the “Pickle” method, is based on a hospital’s percentage of revenues attributable to State and local funding (excluding Medicaid and Medicare revenues) for low-income patient care.

1. DISPROPORTIONATE PATIENT PERCENTAGE

In most cases, the DSH calculation is based on a hospital’s “disproportionate patient percentage.” SSA § 1886(d)(5)(F)(i)(I). The disproportionate patient percentage is the sum of two fractions. SSA § 1886(d)(5)(F)(vi). One fraction, referred to herein as the “Medicare Part A/SSI fraction” or “SSI fraction,” counts a hospital’s number of patient days for patients who were entitled to benefits under Medicare Part A and were entitled to federal supplementary security income (“SSI”) benefits and divides that number by the hospital’s total number of patient days for patients who were entitled to benefits under Medicare Part A. SSA §1886(d)(5)(F)(vi)(I) and 42 C.F.R. § 412.106(b)(2). The second fraction, referred to as the “Medicaid fraction,” counts a hospital’s number of patient days attributable to patients who were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the hospital’s total number of patient days for a cost reporting period. SSA § 1886(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b)(4). The calculation of these two fractions has been controversial from the beginning and is discussed in greater detail in the following sections of this outline.
2. "PICKLE DSH"

An alternative DSH methodology was established under the “Pickle Amendment” to section 1886(d)(5)(F)(i)(II) of the SSA. The Pickle method applies only to urban hospitals with at least 100 beds. The threshold for qualification under the Pickle Amendment is that at least 30% of a hospital’s net inpatient revenues must be attributable to State and local government subsidies (other than Medicaid/Medicare revenues) for indigent care. Only a handful of hospitals qualify for DSH under the Pickle method because CMS narrowly construes the statute to include Medicare and Medicaid revenues in the denominator and exclude those revenues from the numerator of the fraction used to determine a hospital’s qualification for the Pickle DSH payment. That construction has been upheld by two federal appellate courts. North Broward Hosp. Dist. v. Shalala, 172 F.3d 90 (D.C. Cir.), cert. denied, 528 U.S. 1022 (1999); University Med. Ctr. of S. Nev. v. Thompson, 380 F.3d 1197 (9th Cir. 2004).

B. DISPROPORTIONATE PATIENT PERCENTAGE

The disproportionate patient percentage determines both a hospital’s qualification for the DSH payment and the amount of the payment add-on for a qualifying hospital.

1. QUALIFICATION THRESHOLDS

For discharges on or after April 1, 2001, a hospital’s disproportionate patient percentage (the sum of the Medicaid and Medicare Part A/SSI fractions) must be at least 15% in order to qualify for a DSH payment. See 42 C.F.R. § 412.106(c)(1). For discharges prior to April 1, 2001, urban hospitals with less than 100 beds and most rural hospitals needed to have a higher disproportionate patient percentage to qualify for a DSH adjustment. See 42 C.F.R. § 412.106(c)(1).

2. DSH PAYMENT ADJUSTMENT

The disproportionate patient percentage also determines the amount of the DSH payment add-on. See 42 C.F.R. § 412.106(d). For example, for an urban hospital with at least 100 beds, the DSH adjustment increases in proportion to the difference between the hospital’s disproportionate patient percentage and the 15% qualification threshold. Id. For discharges on or after April 1, 2004, the DSH adjustment is capped at 12% for an urban hospital with less than 100 beds and for a rural hospital that has less than 500 beds and is not classified as a rural referral center or a sole community hospital. Id. There is
no cap on the DSH adjustment, for discharges on or after April 1, 2004, for an urban hospital with at least 100 beds, a rural hospital that has at least 500 beds, or a rural hospital classified either as a rural referral center, a sole community hospital, or both. *Id.*

3. **STRADDLE PERIODS**

In *Mountains Community Hospital v. BCBSA*, PRRB Dec. No. 2007-D59, *Medicare & Medicaid Guide (CCH)* ¶ 81,770 (Aug. 9, 2007), a majority of the Provider Reimbursement Review Board (“PRRB”) found that the fiscal intermediary should have calculated two disproportionate patient percentages for a hospital’s 2001 fiscal year: one for discharges before April 1, 2001 (when the threshold for qualification was a 40% disproportionate patient percentage) and another for the discharges occurring on or after April 1, 2001 (when the qualifying threshold was reduced to 15%). The Administrator reversed, concluding the statute and regulation require the calculation of a single disproportionate patient percentage for the year a whole, which would then be compared to the qualification thresholds applicable to discharges before and after April 1, 2001. *See CMS Adm’t Dec., Medicare & Medicaid Guide (CCH)* ¶ 81,793 (Oct. 2, 2007); *see also West Arizona Reg’l Med. Ctr. v. BCBSA*, PRRB Dec. No. 2006-D19, *Medicare & Medicaid Guide (CCH)* ¶ 81,505 (Mar. 3, 2006), rev’d CMS Adm’t Dec., *Medicare & Medicaid Guide (CCH)* ¶ 81,523 (Apr. 20, 2006) (finding same).

C. **MEDICARE PART A / SSI FRACTION**

1. **CALCULATED BY CMS FOR FEDERAL FISCAL YEARS**

CMS computes the Medicare Part A/SSI fraction for every hospital. *See 42 C.F.R. § 412.106(b)(2).* The SSI fraction is computed for each federal fiscal year (*i.e.*, the fiscal year ending on September 30th). *Id.* That ratio is applied to hospital cost reporting periods beginning in that federal fiscal year.

2. **RECALCULATION FOR COST REPORTING PERIODS**

The DSH regulation provides that a hospital may request to have the Medicare Part A/ SSI fraction recalculated for the hospital’s own cost reporting period. *42 C.F.R. § 412.106(b)(3).* The regulation provides that if a hospital elects this option, it must use the ratio computed for the cost reporting period. *See id.*

3. **CHALLENGES TO THE MEDICARE PART A/ SSI FRACTION**

In cases decided soon after *Baystate*, the CMS Administrator continued to maintain that the DSH regulation does not allow for recalculation of the SSI fractions to correct for errors. See *Beverly Hosp. v. BCBSA, PRRB 2008-D37, MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,112 (Sept. 23, 2008), rev’d, CMS Adm’r Dec., (Jan. 15, 2008); St. Mary’s Hosp. v. BCBSA, PRRB Dec. No. 2008-D7, MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,866 (Nov. 16, 2007), rev’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,879 (Jan. 15, 2008); St. Mary’s Mercy Med. Ctr. v. BCBSA, 2007-D63, MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,774 (Aug. 24, 2007), rev’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,853 (Oct. 22, 2007).

In 2010, however, CMS adopted a final rule amending the process used to calculate the Medicare Part A/SSI fractions for federal fiscal year 2011 and subsequent years. At the same time, CMS issued a Ruling addressing appeals of the calculation of the Medicare Part A/SSI fractions and two other issues for prior years. The 2010 rule and ruling are discussed below.
In *Auburn Regional Medical Center v. Sebelius*, 133 S.Ct. 817 (2013), a group of hospitals filed appeals with the PRRB in 2006 following the issuance of the Board’s decision in *Baystate*. The hospitals sought corrections to the SSI fractions for fiscal years back to 1986-1996. The appeals were filed decades after the expiration of the usual 180-day appeal period had expired for those years, but the hospitals contended that the 180-day appeal deadline should be “equitably tolled” because the PRRB decision in *Baystate* was the first indication of errors and omissions in CMS’s calculation of the SSI fraction, and these appeals were filed soon after PRRB issued its decision in that case. The Supreme Court ruled, in January 2013, that the 180-day appeal deadline is not “jurisdictional” in the sense that the 180-day period can never be extended for any reason. Nonetheless, the Court found that the presumption in favor of equitable tolling does not apply to the type internal administrative appeal deadline like the 180-day filing period for appeals to the PRRB. The Court further ruled that CMS’s regulation limiting late filings to those filed within three years of the date of the NPR for “good cause” is a permissible interpretation of the Medicare appeal statute.

In *Memorial Hospital at Gulfport v. Sebelius*, 2012 WL 6054763 (5th Cir. 2012), a group of hospitals sought to include days for patients who were dually eligible for Medicare Part A and Medicaid, but were not entitled to SSI benefits, in the numerator of the SSI fraction. The hospitals conceded that the statute, as written, does not include these patient days in the numerator of the SSI fraction but argued that the exclusion of these days is contrary to the intent of the statute. The Fifth Circuit affirmed the lower court’s decision that the hospitals failed to show that the exclusion of these days is contrary to congressional intent.

4. **FFY 2011 IPPS RULE AND RULING 1498-R**

In 2010, in response to the *Baystate* decision, CMS published a final rule establishing a new process for the calculation of the Medicare Part A/SSI fractions for federal fiscal year 2011 and later years. 75 Fed. Reg. 50042, 50275-86 (Aug. 16, 2010). The new process purports to adopt the corrections required by the *Baystate* decision. Among other things, under the new process, CMS will use beneficiaries’ own Social Security numbers in the data match process, and it will use a later match run date to pick
up a greater proportion of SSI entitlement determinations that are retroactively granted or restored for periods in the federal fiscal year.

In April 2010, CMS issued Ruling 1498-R. The Ruling addresses three issues for cost reporting periods beginning before FFY 2011, including the calculation of the Medicare Part A/SSI fraction. The Ruling provides that the new calculation process adopted in the final rule for FFY 2011, discussed above, will be applied to calculate the SSI fraction for a cost reporting period that has not yet been settled in a notice of program reimbursement and to recalculate a revised SSI fraction for a cost reporting period for which this issue has been challenged in a jurisdictionally proper pending appeal.

The Ruling is controversial for two reasons. First, in addition to applying the new calculation process, the Ruling indicates that CMS would also add to the revised SSI fraction for cost reporting periods beginning before October 1, 2004, the patient days for patients who may have been eligible for Medicare Part A benefits but whose inpatient hospital care was not paid for under Part A due to exhaustion of Part A benefits, Medicare’s secondary payer status or other reasons. This would occur even if a hospital did not appeal any issue on those days and even if the hospital appealed to have those days excluded from the SSI fraction and included in the numerator of the Medicaid fraction to the extent that the patient was eligible for Medicaid. Second, the Ruling purported to require the PRRB to remand all pending appeals either on the SSI fraction or on the so called “non-covered” Medicare Part A days (for years before FFY 2004) for recalculation by the intermediary.

The remand provisions of the Ruling and the provisions purporting to require the addition of the so-called “non-covered” days to the SSI fraction have been challenged by hospitals in several group appeals. In Southwest Consulting Dual Eligible Days Groups, for example, the PRRB granted expedited judicial review of the remand provisions of the Ruling. PRRB Dec. No. 2010-D36 (June 14, 2010). The CMS Administrator reversed that decision and the case is now pending in federal district court.

5. PROVIDER ACCESS TO DATA

From 1986 to 2000, CMS maintained that the Privacy Act prohibited the agency from disclosing to providers the patient-specific SSI data used to compute the Medicare Part A/SSI fractions. In 1995, a federal district court ruled that disclosure of this data,
pursuant to an appropriate protective order, was required as a matter of due process. 


In August 2000, CMS published notice of a “routine use” under the Privacy Act, which permits disclosure of the patient-specific SSI data that CMS used to calculate a provider’s SSI ratio. *See* 65 Fed. Reg. 50,548, 50,549 (Aug. 18, 2000). To obtain the data under this provision, a hospital must have a pending appeal concerning the SSI ratio and must sign a Data Use Agreement with CMS. A form Data Use Agreement, a required “disclosure statement,” and accompanying instructions are posted on the CMS website. CMS charges $900-1200 for each fiscal year that ends before December 8, 2004.

Section 951 of the Medicare Prescription Drug, Improvement and Modernization Act (“MMA”) of 2003, Pub. L. No. 108-173 (2003) required HHS to arrange by December 8, 2004 to furnish hospitals with the data necessary to compute the number of patient days used in calculating the disproportionate patient percentage. Section 9651 apparently was intended to ensure hospitals’ access to the data needed to perform their own computation of the disproportionate patient percentage, including the SSI patient days in the numerator of the Medicare Part A/SSI fraction and the Medicare Part A entitlement data needed to verify both the denominator of the Medicare Part A/SSI fraction and the numerator of the Medicaid fraction.

On August 12, 2005, CMS published a final rule implementing Section 951 of the MMA. 70 Fed. Reg. at 47,438-44. Under the new rule, for cost reporting periods ending after December 8, 2004, CMS will furnish a hospital with the “routine use” data that CMS used to compute the hospital’s Medicare Part A/SSI fraction, regardless of whether the hospital has an appeal pending on the SSI issue, and without charge. The data will be furnished either for the federal fiscal year in which the hospital cost reporting period begins or for the months within the two federal fiscal years that encompass a hospital cost reporting period. After many years’ delay, during which CMS had a placed a moratorium on responding to requests for this data, the agency has just recently resumed producing the data in response to hospital requests.
D. ENTITLED TO BENEFITS UNDER MEDICARE PART A

As noted above, the Medicare Part A / SSI fraction is intended to include patient days for patients who were “entitled to benefits under part A” of the Medicare Act. The meaning of that phrase, “entitled to benefits under part A,” is in dispute. Currently, CMS construes this phrase, for purposes of the DSH payment calculation, to refer to an individual’s status as having qualified at some point for enrollment in Medicare Part A. Thus, under CMS’s current policy, this term includes patient days for Medicare beneficiaries who did not receive Medicare Part A benefits for their inpatient hospital care. This interpretation includes patients who elected to receive Medicare benefits through enrollment in a Medicare Advantage plan under Part C, patients who had exhausted Part A benefits for inpatient hospital services, and patients whose care was not paid for by Medicare Part A because Medicare was a secondary payer. The question whether these types of patients were “entitled to benefits under part A” also impacts the numerator of the Medicaid fraction, which includes days for patients who were eligible for Medicaid but not entitled to Medicare Part A.

1. PART C DAYS

The Medicare + Choice (“M+C”) program, now referred to as Medicare Advantage, was enacted in the Balanced Budget Act of 1997. In order to enroll in a M+C or Medicare Advantage plan, an individual must be entitled to benefits under Medicare Part A and enrolled in Medicare Part B. SSA § 1851(a)(3). Once enrolled, an individual is no longer entitled to have payment made on his or her behalf under Part A of the Medicare Act, but instead receives benefits through the M+C or Medicare Advantage plan “under this part,” which is Part C of the Act. SSA § 1851(a)(1)(B).

CMS Policies. In 2003, CMS “propos[ed] to clarify” that M+C days “should not be included in the Medicare [SSI] fraction” and that the Medicaid-eligible portion of these days may be counted in the numerator of the Medicaid fraction 68 Fed. Reg. at 27,208. The proposed rule was not acted upon in the final IPPS rule for the federal fiscal year beginning on October 1, 2003. 68 Fed. Reg. at 45,422.

In the final IPPS rule for the federal fiscal year beginning on October 1, 2004, CMS changed course and “adopt[ed] a policy” to include M+C days in the Medicare Part
A/SSI fraction, effective October 1, 2004, and to exclude the Medicaid-eligible portion of these days from the Medicaid fraction. 69 Fed. Reg. at 49,099.

Case Law Developments. The first federal court case to address the treatment of M+C days in the DSH adjustment calculation was Northeast Hospital Corp. v. Sebelius, 699 F. Supp. 2d 81 (D.D.C. 2010). The district court held that Medicare Part C beneficiaries were “not entitled to benefits under part A” and, therefore, M+C patient days could be included in the numerator of the Medicaid faction. See id. The court noted that the Medicare statute is clear on its face, finding that “[o]nce that individual enrolls in a M+C plan, however, he is no longer ‘entitle[d] to have payments made under, and subject to the limitations in, [Medicare] parts A and B.’” Id. at 93. Further, the court found that even if the statute had been ambiguous, the Secretary’s departure from the agency’s prior interpretation of the statute was arbitrary and capricious, making the exclusion of such days invalid. Id. at 95. On appeal, the D.C. Circuit affirmed for a different reason. Northeast Hosp. Corp. v. Sebelius, 657 F.3d 1, 13 (D.C. Cir. 2011). In applying the usual Chevron standard of review, the panel majority concluded that the pertinent statutory language is ambiguous; however, the panel unanimously ruled that the agency’s current interpretation cannot be applied retroactively periods before the 2004 change in policy. Id. The court concluded that the agency’s argument that the 2004 rulemaking did not adopt a policy change was “belied” by the record.

Allina Health Servs. v. Sebelius, 904 F. Supp.2d 75 (D.D.C. Nov. 15, 2012), the federal district court in DC declared invalid and vacated the 2004 rulemaking, and subsequent amendments to the DSH regulation, regarding the treatment of Part C days in the DSH calculation. The district court concluded that the agency did not properly follow the notice and comment rulemaking requirements prescribed by the Administrative Procedure Act and that the agency failed to provide a rational explanation for the 2004 change in policy. CMS appealed the district court’s decision to the D.C. Circuit.

2. PART A EXHAUSTED BENEFIT DAYS

The Medicare Part A benefit for inpatient hospital services covers a limited number of days of inpatient hospitals services for any given spell of illness. 42 U.S.C. § 1395d(a)(1); 42 C.F.R. § 409.61(a). An individual who has used all available days for a
spell of illness is said to have “exhausted” her entitlement to Medicare Part A benefits for that hospital stay. See, e.g., 55 Fed. Reg. 35,990, 35,996 (Sept. 4, 1990) (explaining the Department’s original view that an individual is no longer “entitled to benefits under part A,” for purposes of calculating a hospital payment adjustment under the Medicare Act, after she has “exhausted” her part A benefit for inpatient hospital services in a spell of illness).

When CMS implemented the DSH adjustment in 1986, the agency indicated that the Medicare Part A/SSI fraction would include only patient days paid by Medicare, consistent with CMS’ original policy to count only Medicaid paid days in the numerator of the Medicaid fraction. See, e.g., 51 Fed. Reg. 31,454, 31,460-61 (Sept. 3, 1986). The intent was to count patient days as reported on the Medicare cost report, id. at 31,460, and a patient day was never counted on the cost report as a “Medicare” day or a “Medicaid” day unless Medicare Part A or Medicaid, respectively, paid for that day.

This policy was consistent with CMS’ interpretation of the term “entitled” in other Medicare payment contexts. For example, in 1990, CMS published a statement in the Federal Register explaining that “[e]ntitlement to payment under part A ceases after the beneficiary has used 90 days in a benefit period and has either exhausted the lifetime reserve days or elected not to use available lifetime reserve days.” 55 Fed. Reg. at 35,996.

Consistent with the original intent of the regulation, the earliest decisions agency decisions affirmed that dual-eligible days attributable to patients who had exhausted Medicare Part A benefits should be counted in the Medicaid fraction. See Presbyterian Med. Ctr. of Philadelphia v. Aetna Life Ins. Co., CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 45,032 (Nov. 29, 1996) (affirming the PRRB’s decision that days billed to, and paid by Medicaid, after patients had exhausted Medicare Part A benefits, may properly be included in the Medicaid fraction).

After the issuance of Ruling 97-2, in which the agency had to broaden its interpretation of the Medicaid fraction to include all Medicaid-eligible days, CMS soon thereafter began issuing rulings to the effect that all Medicare Part A patient days had to be excluded from the numerator of the Medicaid fraction, regardless of whether Medicare Part A benefits were paid for those days. The agency also stated that all of these days were counted in the Medicare Part A/SSI fraction (when they were not).
In 1998, the PRRB again held that dual eligible patient days should be included in the numerator of the Medicaid fraction after the patient has exhausted Medicare Part A benefits. See Jersey Shore Med. Ctr., PRRB Dec. No. 99-D4, Medicare & Medicaid Guide (CCH) ¶ 80,083 (Aug. 26, 1998). The Administrator vacated the Board’s decision and remanded the case for a different reason, without commenting on the Board’s decision regarding Part A exhausted days. Jersey Shore Med. Ctr., CMS Adm’r Dec., Medicare & Medicaid Guide (CCH) ¶ 80,153 (Jan. 4, 1999).

In 2000, the CMS Administrator ruled that dual eligible days cannot be counted in the numerator of the Medicaid fraction, even after a Medicare beneficiary has exhausted Part A benefits, noting (incorrectly) that these days allegedly were counted in the Medicare Part A/SSI fraction. Edgewater Med. Ctr. v. BCBSA, PRRB Dec. Nos. 2000-D44 and 2000-D45, Medicare & Medicaid Guide (CCH) ¶¶ 80,434 and ¶ 80,435 (Apr. 7, 2000), aff’d, CMS Adm’r Dec. Medicare & Medicaid Guide (CCH) ¶ 80,525 (June 19, 2000). Similarly, in 2003, the CMS Administrator again ruled that dual eligible days cannot be counted in the numerator of the Medicaid fraction, even after exhausting Part A benefits, stating that these patients “are counted in the Medicare [SSI] proxy.” Castle Med. Ctr., CMS Adm’r Dec., Medicare & Medicaid Guide (CCH) ¶ 81,085 (Sept. 12, 2003).

In 2003, CMS published a notice of proposed rulemaking to permit hospitals to count these days in the numerator of the Medicaid fraction. 68 Fed. Reg. at 27,207. In that notice, CMS stated that under current policy all dual eligible patient days “are counted” in the numerator in the Medicare Part A/SSI fraction even after a Medicare beneficiary exhausts Part A benefits. That statement was not true.

In 2004, CMS admitted that the agency had never before counted Part A exhausted days in the Medicare Part A/SSI fraction. 69 Fed. Reg. at 49,098. Nevertheless, in the 2004 final rule, CMS amended the DSH regulation to begin counting Part A exhausted days in the Medicare Part A/SSI fraction effective for discharges on or after October 1, 2004. Id. at 49,098-99. CMS’ rationale for this policy change was that even though a patient may have exhausted benefits for inpatient hospital services, he or she “may still be entitled to other Part A benefits.” Id.
After the 2004 rule change, the CMS Administrator issued a number of decisions ruling that Part A exhausted days should be excluded from both of the fractions used to compute the disproportionate patient percentage for earlier cost reporting periods before the 2004 amendment to the regulations. See, e.g., Alhambra Hosp. v. BCBSA, PRRB Dec. No. 2005-D47, MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,371 (Feb. 15, 2005), rev’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,441 (Oct. 6, 2005); Saint Mary’s Hosp. v. BCBSA, PRRB Dec. No. 2008-D7, MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,866 (Nov. 16, 2007), rev’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,879 (Jan. 15, 2008); Mercy Med. Ctr. v. Wisconsin Physician Serv., PRRB Dec. No. 2010-D7, MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,502 (Dec. 4, 2009), rev’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,511 (Jan. 14, 2010); Allina Health Sys. 1995-2003 DSH Dual Eligible Days Grp., PRRB Dec. No. 2009-D35, MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,402 (July 30, 2009), rev’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,426 (Sept. 21, 2009); Sharp Coronado Hosp. and Healthcare Ctr., PRRB Dec. No. 2009-D32, MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,336 (July 15, 2009), rev’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,423 (Sept. 9, 2009); Columbia Saint Mary’s Hosp. v. BCBSA, PRRB Dec. No. 2009-D27, MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,328 (June 24, 2009), rev’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,419 (Aug. 27, 2009); Nat’l DSH Dual Eligible Grp. App., PRRB Dec. No. 2009-D26, MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,327 (June 23, 2009), rev’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,418 (Aug. 24, 2009).

The first federal court to consider this issue was the United States District Court for the Western District of Michigan in Metropolitan Hospital, Inc. v. Department of Health & Human Services, 702 F. Supp. 2d 808 (W.D. Mich. 2010). The hospital in this case challenged the application of the new rule to its 2005 cost reporting period. The district court found the DSH statute to be “clear and unambiguous” and declared that the Secretary’s regulation, 42 C.F.R. § 412.106(b), invalid to the extent it (1) calls for the DSH Medicare Part A/SSI fraction to include days of care furnished to patients who are not entitled to Part A benefits, and (2) calls for the exclusion from the Medicaid fraction of days of care furnished to patients who are “eligible for” Medicaid but not “entitled to”
Medicare Part A benefits. *Id.* at 825. The Sixth Circuit reversed, concluding that the meaning of this phrase is ambiguous and CMS’ current interpretation is reasonable. *Metropolitan Hosp. v. United States Dept. of Health & Human Servs.*, 712 F.3d 248 (D.C. Cir. 2013).

In 2012, the U.S. District Court in D.C. addressed this same issue and ruled in favor of the hospital with respect to a 1997 cost reporting period, prior to the 2004 rulemaking. *Catholic Health Initiatives v. Sebelius*, 841 F.Supp.2d 270 (D.D.C 2012). In this case, the hospital challenged the exclusion of Medicaid-eligible patient days for patients who had exhausted Part A benefits. The district court found that the agency’s policies with respect to the DSH calculation had “flip-flopped” over the years on the question, *id.* at 278, and that the *Edgewater* decision (discussed above) and the 2004 rulemaking reflected a substantive change of policy and practice. *Id.* at 282. The court concluded that CMS’s current policy could not be retroactively applied to the hospital’s 1997 cost reporting period. *Id.* See also *Columbia Saint Mary’s Hosp. Milwaukee, Inc. v. Sebelius*, 2012 WL 4466491 (D.D.C. Sep. 28, 2012). On appeal, the D.C. Circuit reversed the district court’s decision in *Catholic Health Initiatives*, concluding that the meaning of “entitled to benefits under part A” is ambiguous, that CMS’ current interpretation to include Part A exhausted benefit days is reasonable, and the policy articulated in the *Edgewater* decision could be applied retroactively to earlier cost reporting periods of other hospitals that were not a party to the *Edgewater* case, regardless of whether that decision was “substantive sound.” *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 914).

3. **MEDICARE SECONDARY PAYER DAYS**

Section 1862(b)(2)(A) of the SSA provides that a Medicare beneficiary is not entitled to have Medicare payment made on his or her behalf when another third-party payor is responsible for the inpatient hospital care. CMS’ 2003 and 2004 rules (discussed above) did not expressly address the treatment of days attributable to dual-eligible patients when Medicare Part A benefits are not exhausted but Medicare does not make payment because Medicare is secondary to a group health insurer or other third-party payer. However, in the final IPPS rule for FY 2006, CMS stated that it “updated the regulations at § 412.106(b) to reflect the inclusion [in the Medicare Part A/SSI fraction]
of days for Medicare was not the primary payer.” 70 Fed. Reg. 47,278, 47,441 (Aug. 12, 2005). The preamble stated that this “policy change” applies to “FY 2005 and subsequent years.” Id.

A number of cases have addressed whether Medicare secondary payer days should be included in the Medicare Part A/SSI fraction or Medicaid fraction. The Board has uniformly ruled that they should be included in the Medicaid fraction, at least for periods prior to October 1, 2004, however, the Administrator has consistently reversed those decisions. See, e.g., Nat’l DSH Dual Eligible Grp. App., PRRB Dec. No. 2009-D26, MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,327 (June 23, 2009), rev’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,418 (Aug. 24, 2009); Allina Health Sys. 1995-2003 DSH Dual Eligible Days Grp., PRRB Dec. No. 2009-D35, MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,402 (July 30, 2009), rev’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,426 (Sept. 21, 2009). CMS Ruling 1498-R (see Section 3.4 above) would also apply to these days for cost reporting periods before October 1, 2004.

E. THE MEDICAID FRACTION: “ELIGIBLE FOR MEDICAL ASSISTANCE”

1. IN THE BEGINNING

When the Secretary first implemented the DSH statute in 1986, the agency defined the numerator of the Medicaid fraction to include patient days for individuals who were “entitled to Medicaid but not to Medicare Part A.” See 42 C.F.R. § 412.106(a)(1)(ii) (1986). This rule conflated “eligible” (for medical assistance) with “entitled” (to benefits under Medicare Part A) and restricted the numerator of the Medicaid fraction to include only Medicaid-paid days; Medicaid-eligible but unpaid days were excluded. 51 Fed. Reg. 16,772, 16,777 (May 6, 1986); 51 Fed. Reg. 31,454, 31,460-61 (Sept. 3, 1986). This policy was litigated extensively in the courts, with four consecutive Circuits ultimately ruling that it violated the plain language and intent of the DSH statute. See Legacy Emanuel Hosp. & Health Ctr. v. Shalala, 97 F.3d 1261 (9th Cir. 1996); Deaconess Health Servs. Corp. v. Shalala, 83 F.3d 1041 (8th Cir. 1996) (per curiam); Jewish Hosp., Inc. v. Sec’y of Health & Human Servs., 19 F.3d 270 (6th Cir. 1994); Cabell Huntington Hosp., Inc. v. Shalala, 101 F.3d 984 (4th Cir. 1996).
2. **RULING 97-2**

In February 1997, CMS (then HCFA) issued Ruling 97-2, which changed CMS’ policy to conform to the decisions of the four circuit courts. Under the Ruling, the agency agreed to include Medicaid-eligible patient days in the numerator of the Medicaid fraction without regard to whether Medicaid paid for the day. The Ruling stated that the new policy would apply to all subsequent DSH determinations, including future determinations for prior cost reporting periods. However, the Ruling expressly prohibited fiscal intermediaries from reopening prior determinations on this issue. In 1998, CMS amended the DSH regulation (§ 412.106(b)(4)) to “conform the regulations to HCFA Ruling 97-2 (and hence to the four adverse [circuit] court decisions).” 63 Fed. Reg. 40,954, 40,985 (July 31, 1998).

3. **LITIGATION FOLLOWING RULING 97-2**

In 2001, the D.C. Circuit ruled that following the issuance of Ruling 97-2, CMS may be compelled to reopen DSH payment determinations that were issued prior to Ruling 97-2 and thus excluded eligible-but-unpaid Medicaid days from the numerator of the Medicaid fraction. Monmouth Med. Ctr. v. Thompson, 257 F.3d 807 (D.C. Cir. 2001). Because Ruling 97-2 reversed CMS’ existing regulation and because CMS issued the Ruling without invoking formal rulemaking under the Administrative Procedure Act, the D.C. Circuit found that the Ruling gave notice that CMS’ prior interpretation of the DSH statute was “inconsistent with law” and this notice triggered an automatic and mandatory duty under 42 C.F.R. § 405.1885(b) to reopen DSH determinations issued under CMS’ former interpretation.

Following the D.C. Circuit’s 2001 decision in Monmouth, hospitals brought hundreds of cases in federal district court in D.C. seeking similar relief. The D.C. district court ruled in favor of the hospitals in the lead case. In Re Medicare Reimbursement Litigation, 309 F. Supp. 2d 89 (D.D.C. 2004). The D.C. Circuit affirmed that decision and found that it was not necessary for a hospital to have requested discretionary reopening on this issue under 42 C.F.R. § 405.1885(a) because Ruling 97-2 expressly prohibited intermediaries from granting requests for reopening on this issue and because there was no avenue of relief available to the hospitals to secure their right to mandatory

4. PROGRAM MEMORANDUM NO. A-99-62

Although Ruling 97-2 confirmed that the numerator of the Medicaid fraction should not exclude eligible-but-unpaid Medicaid days, the Ruling did not fully address what counts as an “eligible” day in the Medicaid fraction. CMS issued further policy statements in that regard in Program Memorandum No. A-99-62 (Dec. 1999).

The 1999 Program Memorandum purported to clarify CMS’ policy as to the types of days that may be counted in the numerator of the Medicaid fraction. The Program Memorandum also enumerated several categories of days that should not be counted in the numerator of the Medicaid fraction: (i) days attributable to individuals who receive medical assistance as a beneficiary of a State or county-funded income support program that does not receive federal matching funds under Title XIX; (ii) “charity care” or other patient days that may be counted in the computation of a State’s Medicaid DSH payment to a hospital but are not attributable to an individual who is eligible for Medicaid under the State plan; and (iii) “ineligible waiver or demonstration population days.”

Program Memorandum A-99-62 also established a hold-harmless provision for cost reporting periods beginning before January 1, 2000. For these periods, a hospital could count an otherwise ineligible day if the hospital meets either one of two criteria: (1) the hospital had a “jurisdictionally proper appeal” on the treatment of the particular type of day in question as of October 15, 1999; or (2) the hospital included the type of day in question in the numerator of the Medicaid fraction and received a Medicare DSH payment based on that calculation prior to October 15, 1999.

CMS’ purported rationale for this hold-harmless policy, for periods beginning before 2000, is that some hospitals were confused by the prior lack of clarity in CMS policy and had a reasonable expectation that Medicare DSH payments should include these otherwise ineligible days. Under CMS’ interpretation of the hold-harmless policy, these hospitals would be allowed to receive and keep such payment, but other hospitals would not. This arguably unequal treatment of otherwise similarly-situated hospitals has been upheld by the courts. See, e.g., United Hosp. v. Thompson, 383 F.3d 728 (8th Cir. 2004).
In June 2010, the U.S. District Court in D.C. addressed the applicability of the hold-harmless policy. See Banner Health v. Sebelius, 715 F. Supp. 2d 142 (D.D.C. 2010). In Banner, the district court held that three hospitals were not entitled to relief under the hold-harmless policy because it was not the hospitals’ practice to include the disputed days in their DSH calculations and the hospitals never actually received DSH payments that included otherwise ineligible days. In contrast, for the fourth hospital in the case, since it was not clear what the practice was and that the hospital may have received the erroneous DSH payments, it remanded to the Secretary to resolve these issues and determine whether the hold-harmless policy could apply to this hospital. See id.; see also Phoenix Mem’l Hosp. v. Sebelius, 622 F.3d 1219 (9th Cir. 2010).

In February 2011, the U.S. District Court in D.C. addressed inclusion of Section 1115 expansion waiver days in the DSH payment calculation in connection with two Medicare cost reporting periods before a 2000 change in policy (discussed below). In Baptist Mem’l Hosp. v. Sebelius, 765 F. Supp. 2d 20, 21 (D.D.C. 2011), the hospital asserted that Program Memorandum A-99-62 set an improper retroactive deadline by requiring that hospitals appeal the exclusion of expansion waiver days prior to October 15, 1999. Id. at 27. The district court rejected this argument. Id. at 28. In addition, the district court found that the provider’s appeal made no mention on its face of expansion waiver days and that the appeal had no document trail demonstrating that the provider specifically raised the exclusion of expansion waiver days. Id. at 28-29. The court distinguished this case from Saint Joseph’s (discussed below), in which the attached adjustment number and workpapers specifically indicated that the disallowance was based on erroneous inclusion of non-Medicaid days. Because Baptist Memorial made no reference to the exclusion of expansion waiver days in the document trail or evidence in the record, the court determined that the provider was not entitled to hold harmless treatment under Program Memorandum A-99-62. Id. at 31. The D.C. Circuit affirmed this decision in an unpublished decision in 2012. See 2012 WL 1859132 (May 14, 2012).

Several other cases have addressed the application of A-99-62’s hold-harmless provisions. In Saint Joseph’s Hospital v. BCBSA, PRRB Dec. No. 2004-D32, MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,183 (Aug. 12, 2004), the PRRB held that a hospital was entitled to protection under Program Memorandum A-99-62 with respect to a
disallowance of general assistance days because the hospital had appealed, before October 15, 1999, from an audit adjustment that had disallowed such days. The Administrator reversed the Board on the ground that the hospital had not identified these days with sufficient precision in the appeal documents that had been filed with the Board before October 15, 1999. *Saint Joseph’s Hosp. v. BCBSA*, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,265 (Oct. 13, 2004). The district court reversed the Secretary’s decision as arbitrary and capricious. The court found that the Board’s own instructions only required a short statement of the issue on appeal and that it was clear that the exclusion of general assistance days provided at least one reason for the appeal of the DSH determination. *Saint Joseph’s Hosp. v. Leavitt*, 425 F. Supp. 2d 94 (D.D.C. 2006); *see also Saint Joseph’s Hosp. v. BCBA*, PRRB Dec. No. 2007-D68, MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,779 (Sept. 14, 2007), aff’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,857 (Nov. 13, 2007) (where for FYs 1996-2000, the Provider was entitled to claim GA days based on the Court’s finding that the Provider had a valid appeal in FY 1995); *Rush Univ. Med. Ctr. v. Leavitt*, No. 06C 1500, 2007 U.S. Dist LEXIS 66244 (N.D. Ill. Sept. 4, 2007), aff’d, 535 F.3d 735 (7th Cir. 2008) (where the circuit court held that the provider had not properly appealed the exclusion of general assistance days from its DSH calculations and therefore was not entitled to hold-harmless protection); *LAC 98 DSH/Non-Federal Low-Income Days Grp. v. BCBSA*, PRRB Dec. No. 2008-D2, MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,861 (Oct. 11, 2007) (where the providers argued that they were entitled to include General Relief days in their FY 1998 DSH calculations based on the hold-harmless provisions of the Program Memorandum, but the Board found that the providers were not able to support their claims for such days prior to October 15, 1999); *Hosp. Dr. Pedro J. Zamora v. Cooperativo de Seguros de Vida de Puerto Rico*, PRRB Dec. No. 2003-D59, MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,045 (Sept. 24, 2003) (holding that a hospital was not entitled to hold-harmless protection for fiscal year 1997 because it had not appealed a disallowance of the same type of days for fiscal year 1996).

5. CHARITY CARE/MEDICAID DSH DAYS

Although there was a long line of PRRB decisions ruling that the numerator of the Medicaid fraction may include “charity care” days for which the State made payment

The federal courts have upheld CMS’ policy. The first federal court decision on the inclusion of Medicaid DSH days in the Medicaid fraction was issued in 2007. See Adena Reg'l Med. Ctr. v. Leavitt, 524 F. Supp. 2d. 1 (D.D.C. 2007), rev’d, 527 F.3d 176 (D.C. Cir. 2008). The Adena case involved Ohio’s Hospital Care Assurance Program (“HCAP”). The district court ruled that the Secretary’s determination to exclude HCAP days from the numerator of the Medicaid fraction violated the plain meaning of the Medicare Act. The Court of Appeals for the D.C. Circuit reversed the district court and held that HCAP is not part of Ohio’s State Plan and that HCAP patients are not “eligible for medical assistance” within the meaning of that term under the Medicaid Act because HCAP did not entail payment. Adena Reg’l Med. Ctr., 527 F.3d at 178. The court held that “medical assistance . . . has the same meaning in the Medicare DSH provision . . . as
it has in the federal Medicaid statute,” *i.e.*, “payment of part or all of the cost” of medical services. *Id.* at 179-80. Thus, since Ohio regulations specifically exclude Medicaid-eligible individuals from HCAP, the days of care attributable to HCAP patients are properly excluded from the Medicaid fraction.

In *Phoenix Memorial Hospital v. Sebelius*, the Ninth Circuit found that since Arizona did not receive federal matching funds for its Medically Needy/Medically Indigent (“MN/MI”) patients, they were not part of Arizona’s Medicaid plan. 622 F.3d 1219, 1226 (9th Cir. 2010). The Ninth Circuit ruled that Secretary’s decision that Arizona MN/MI patient days “were properly excluded from the Medicaid Low Income Proxy was not contrary to law, arbitrary or capricious, or unsupported by substantial evidence.” *Id.* at 1227.

In *University of Washington Medical Center v. Sebelius*, the Ninth Circuit ruled that the phrase “‘eligible for Medical assistance under a State plan approved under subchapter XIX’ is unambiguously limited to those eligible for traditional Medicaid.” 2011 U.S. App. LEXIS 2799, *12* (9th Cir. Feb. 11, 2011). The court concluded that “[e]ven though federal Medicaid money indirectly subsidized the medical treatment received by Washington’s General Assistance Unemployable and Medically Indigent populations, their care still does not meet this definition of ‘medical assistance’ [under the Medicaid statute].” *Id.* at *15.

In a short two-paragraph decision, the Third Circuit affirmed the district court’s decision in *Cooper University Hospital v. Sebelius* that although the Medicare DSH statute is ambiguous, the Secretary’s determination to exclude New Jersey Charity Care Program days from the numerator of the Medicaid fraction was a permissible interpretation of the statute. 686 F. Supp. 2d 483 (D.N.J. 2009), *aff’d* 2010 U.S. App. LEXIS 21206 (3d Cir. Oct. 12, 2010).

reached the same conclusion in *Waterbury Hosp. Ctr. v. Sebelius*, 2012 WL 4512506 (D. Conn. Sept. 29, 2012), with respect to Connecticut State Administered General Assistance days that were counted in the calculation of Medicaid DSH payments.

6. **SECTION 1115 WAIVER DAYS**

Section 1115 of the SSA authorizes HHS to waive certain requirements of Title XIX (the Medicaid statute) in connection with experimental or demonstration projects designed to study innovative programs that may assist in promoting the objectives of the Medicaid program. Section 1115(a)(1) authorizes the Secretary to waive Title XIX eligibility requirements, among other things. Section 1115(a)(2) of the Act provides that “the costs of such project[s] . . . shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan.”

In some cases, States have adopted waiver programs that do not expand upon the population of individuals who are eligible for assistance under the State but waive certain requirements of the statute (e.g., free choice of provider requirements) to accomplish some other goal (e.g., mandatory enrollment in a Medicaid managed care plan). There is no question that these types of waiver days may be counted in the Medicaid fraction. In other cases, however, states have adopted programs, with CMS’ approval, that waive certain eligibility standards in the Medicaid statute in order to provide medical assistance to an expanded population of individuals who might not otherwise qualify for Medicaid. The treatment of these so-called “expansion waiver” days is the subject of dispute between providers and CMS.

**CMS Rules.** Until 2000, the DSH regulation did not address the treatment of expansion waiver days in the DSH calculation. On January 20, 2000, CMS published an interim final rule providing that expansion waiver days could be counted in the numerator of the Medicaid fraction, effective for discharges on or after January 20, 2000. 65 Fed. Reg. 3136 (Jan. 20, 2000). This provision is now codified at 42 C.F.R. § 412.106(b)(4)(ii), which states that a hospital may count “all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115.” The 2000 interim final rule stated that expansion waiver days could not be counted in the Medicaid fraction for periods prior to January 20, 2000. 65 Fed. Reg. at 3136.
In a 2003 rulemaking, CMS amended the DSH regulation again to provide that expansion waiver days can only be counted in the Medicaid fraction if the expansion population receives inpatient benefits “that are similar to those available to traditional Medicaid beneficiaries.” 68 Fed. Reg. at 45,420-21. See also 42 C.F.R. § 412.106(b)(4)(i). This would exclude inpatient days attributable to patients who otherwise would not be eligible for Medicaid and who only receive limited benefits (e.g., outpatient family planning services) under a section 1115 expansion waiver.

**Case Law Developments.** In March 2005, the Ninth Circuit ruled that the Medicaid fraction must include expansion waiver days for periods prior to 2000. *Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091 (9th Cir. 2005). The court held that expansion populations under a section 1115 waiver must be included in the numerator of the Medicaid fraction because these individuals receive medical assistance under a State plan. In this regard, the court noted that section 1115 provides that the costs of such programs “shall” be considered “expenditures under the State plan.” In addition, the court concluded that its construction of the statute is consistent with Congress’ overarching intent to provide additional payment for hospitals that serve a large share of low-income patients.


**Deficit Reduction Act of 2005.** Section 5002(a) of the Deficit Reduction Act (“DRA”) of 2005, Pub. L. No. 109-171, 120 Stat. 4, amended the DSH statute with respect to 1115 expansion waiver days. The new provision states that in determining the number of Medicaid days in the numerator of the Medicaid fraction, “the Secretary may, to the extent and for the period the Secretary deems appropriate, include patient days of patients not so eligible [for medical assistance under a State plan] but who are regarded as such because they receive benefits under a demonstration project approved under title
XI.” This section purports to “ratif[y]” the Secretary’s regulations promulgated on January 20, 2000 (65 Fed. Reg. 3,136) and August 1, 2003 (68 Fed. Reg. 45,345), which provided that section 1115 days should be included in the Medicare DSH calculation for discharges on or after January 20, 2000. Despite its earlier ruling in favor of the hospitals, the district court in *Cookeville* concluded that it was bound by the DRA and issued a new decision excluding such days from the Medicaid fraction. The D.C. Circuit affirmed the decision, holding that “the extent of the Secretary’s discretion to exclude the expansion waiver population from the [DSH] adjustment” was unclear prior to the DRA, but that the DRA “clarified” this ambiguity by ratifying the Secretary’s policies regarding treatment of 1115 days prior to and after January 20, 2000. *Cookeville Reg’l Med. Ctr.*, 531 F.3d at 848.

In decisions issued after *Cookeville*, providers have so far been unsuccessful in arguing that Section 1115 waiver days should be considered Medicaid “eligible” days and included in the Medicaid fraction for periods prior to FY 2000. *See, e.g.*, *Saint Thomas Hosp. v. Sebelius*, 705 F. Supp. 2d 905 (D. Tenn. 2010); *Adventist DSH Waiver Days Grp. v. BCBSA*, PRRB Dec. No. 2010-D40, MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,667 (July 2, 2010).

In the most recent court case, *Adventist Health System v. Sebelius*, 795 F. Supp. 2d 704, 708 (D. Tenn. 2011), the plaintiff hospitals argued that the Secretary should have included expansion waiver days in the DSH calculation for fiscal years 1995 to 2000. The hospitals argued that when the Secretary approved the expansion waiver, she determined that the population would be regarded as eligible for medical assistance under the State Plan. *Id.* at 711. The court concluded, however, that the Secretary had a policy in place during the fiscal years at issue of not including expansion waiver populations in the numerator of the Medicaid fraction. *Id.* at 713. The Sixth Circuit upheld the district court’s decision on appeal. *Adventist Health System / Sunbelt, Inc. v. Sebelius*, 715 F.3d 157 (6th Cir. 2013). The Sixth Circuit concluded that the DSH statute, in effect before 2000, did not require the Secretary to count waiver days as Medicaid patient days in the DSH payment calculation and the Secretary’s decision to exclude those days was a permissible interpretation of the statute.
F. WHAT IS A PATIENT DAY FOR DSH PURPOSES?

The definition of inpatient days, for DSH purposes, is addressed in 42 C.F.R. § 412.106(a)(1)(ii). In general, the regulation provides that days in IPPS areas of a hospital should be counted. This provision was substantially amended in 2003, 2004 and 2009. As amended, the regulation now expressly excludes days in IPPS-exempt units, days in which inpatient beds are used for outpatient observation services, days in which swing-beds are used for skilled nursing services, and days in a unit or ward that does not generally provide an acute care hospital level of care.

1. METHOD FOR COUNTING DAYS

The DSH regulation indicates that a patient stay is counted in the Medicare Part A/SSI fraction for the year in which the patient is discharged. 42 C.F.R. § 412.106(b)(2). Prior to a 2009 amendment, the DSH regulation was silent as to the method that hospitals were required or permitted to use to aggregate days (e.g., by admission or discharge date) in the Medicaid fraction. See id. § 412.106(b)(4) (2008). Other guidance indicated, however, that Medicaid patient days should be included in the numerator of the Medicaid fraction for the year in which the patient is discharged. See, e.g., Castle Med. Ctr, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,085 (Sept. 12, 2003) (stating that Medicaid patient days “are to be calculated using discharges, not admissions”); OIG Report, Review of Medicare Disproportionate Share Hospital Payments for Methodist Hospital – Memphis for Fiscal Year 1999, Report A-04-03-02023 (Nov. 3, 2003) (finding that a hospital was overpaid for DSH because it counted some Medicaid-eligible days based on census instead of the date of discharge). In 2009, CMS amended the DSH regulation to permit hospitals to aggregate Medicaid patient days in the numerator of the Medicaid fraction in any one of three ways: by date of discharge, by date of admission, or by dates of service. 74 Fed. Reg. 43754, 43902-04 (Aug. 27, 2009). A hospital must notify the Medicare contractor in writing at least 30 days prior to the start of its cost reporting period if it wishes to change the method it uses to aggregate Medicaid days in the numerator of the Medicaid fraction for that cost reporting period. Id. at 43904. This change was made effective for cost reporting periods beginning on or after October 1, 2009. Id.
2. **LABOR/DELIVERY DAYS**

CMS generally has defined an “inpatient” as a patient admitted with an expectation of an overnight stay. In 2003, however, CMS amended the DSH regulation to “clarify” that a patient day should not be counted for a patient who is in an ancillary labor/delivery room at the census taking hour unless the patient had previously occupied a routine bed since admission. See 42 C.F.R. § 412.106(a)(1)(ii)(B); 68 Fed. Reg. at 45,419-20. The 2003 rule also stated that days in a labor delivery recovery and post-partum room must be allocated between labor and delivery time and recovery time. *Id.*


In 2009, CMS amended the DSH regulation to include all labor and delivery days for patients admitted as inpatients in the patient days used to calculate the DSH payment. *See 74 Fed. Reg. 43757, 43899-901 (Aug. 27, 2009).* That rule was made effective only prospectively for cost reporting periods beginning on or after October 1, 2009. *Id.*

Subsequently, CMS conceded in federal court that labor and delivery days are inpatient days payable under the prospective payment system, and, as such, these days should be counted in both fractions used to calculate the DSH payment even for periods before October 1, 2009. *See Northeast Hosp. Corp. v. Sebelius*, 699 F. Supp. 2d 81, 95-96 (D.D.C. 2010). Accordingly, the district court vacated CMS’ contrary decision in that case.

Shortly after the district court decision in *Northeast*, CMS issued Ruling 1498-R. The Ruling requires CMS to count all labor and delivery room days for admitted patients as patient days in the DSH calculation for cost reporting periods beginning before October 1, 2009 that are either not yet settled in a notice of program reimbursement or have a jurisdictionally proper appeal pending on this issue.
3. **OUTPATIENT OBSERVATION DAYS**

In some cases, a hospital may use an inpatient bed for observation of an individual who has not been admitted. In 2003, CMS also amended the DSH regulation to “clarify” that such outpatient observation services are not counted as an inpatient day or an available bed day for DSH purposes. See 42 C.F.R. § 412.106(a)(1)(ii)(B) (2003); 68 Fed. Reg. at 45,418-19. As later amended, effective for cost reporting periods beginning on or after October 1, 2004, the regulation provided that outpatient observation services could be counted if the patient is later admitted for acute inpatient care. 42 C.F.R. § 412.106(a)(1)(ii)(B) (2004). In 2009, CMS again amended the DSH regulation to provide that outpatient observation days cannot be counted as patient days in the DSH calculation even if the patient is later admitted as an inpatient. See 74 Fed. Reg. 43899, 43905-08 (Aug. 27, 2009). This change was made effective for cost reporting periods beginning on or after October 1, 2009. Id.

4. **SWING-BED DAYS**

“Swing-bed” hospitals are permitted to use hospital beds as needed for the provision of services that are paid as skilled nursing facility services. 42 C.F.R. §§ 482.66, 485.645. CMS’ 2003 amendments to the DSH regulation also “clarified” that the days in which swing-beds are used to provide skilled nursing services are not counted as inpatient days or available bed days for DSH purposes. See 42 C.F.R. § 412.106(a)(1)(ii)(B); 68 Fed. Reg. at 45,418-19. In *District Memorial Hospital of Southwestern North Carolina, Inc. v. Thompson*, 261 F. Supp. 2d 378 (W.D.N.C. 2003), a federal district court reversed CMS’ determination that swing-bed skilled nursing days should be excluded from the Medicaid fraction for periods prior to FY 2003. However, this decision was reversed by the Fourth Circuit holding that the Secretary’s interpretation was at least a reasonable construction of the regulatory language and it more closely fit the policy considerations underlying the regulation than the hospital’s interpretation. *District Mem’l Hosp. of Sw. North Carolina, Inc. v. Thompson*, 364 F.3d 513 (4th Cir. 2004).

*Sixth Circuit Exception.* In a case concerning a period prior to the 2003 amendment to the DSH regulation, the Sixth Circuit held that outpatient observation bed days and swing-bed days must be counted in a hospital’s bed count for DSH purposes.
Clark Reg’l Med. Ctr. v. United States Dep’t of Health & Human Servs., 314 F.3d 241 (6th Cir. 2002). The Clark Regional case addressed the bed count for DSH purposes and did not address whether these days should be counted as inpatient hospital days in the Medicaid fraction for purposes of the DSH calculation. In 2004, however, CMS issued a memorandum notifying fiscal intermediaries that CMS was acquiescing in the Sixth Circuit decision. The 2004 memorandum directed the fiscal intermediaries to count these days as inpatient days in the Medicaid fraction in all future cost report settlements for periods prior to October 1, 2003, for hospitals located in the Sixth Circuit. See Memorandum Dated August 25, 2004, From Director, Hospital and Ambulatory Policy Group and Acting Director, Medicare Contractor Management Group. In St. Vincent Mercy Medical Center v. BCBSA, the Board agreed with an Ohio hospital’s contention that observation days should not be included in the Medicaid fraction because the Clark Regional decision was limited to the issue of the number of available patient beds. PRRB Dec. No. 2008-D35, MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,110 (Sept. 15, 2008). The Administrator reversed finding that the intermediary properly included observation days in the DSH calculation based on the August 2004 CMS memorandum and stating that for hospitals in the Sixth Circuit it is “appropriate to treat patient days for DSH purposes in the same manner as the beds in which they occur.” St. Vincent’s Mercy Med. Ctr., CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,211 (Nov. 17, 2008).

5. SUBACUTE UNITS OR WARDS

Rule Prior to October 1, 2003. For periods prior to October 1, 2003, the DSH regulation provided that a hospital’s number of patient days includes days “attributable to areas of the hospital that are subject to the prospective payment system and excludes all others.” See 42 C.F.R. § 412.106(a)(1)(ii) (2002). Based on this provision, the Ninth Circuit ruled that the Medicaid fraction should include patient days in a unit of a hospital that was included in a hospital’s Medicare bed count but was licensed by the State as a subacute unit. Alhambra Hosp. v. Thompson, 259 F.3d 1071 (9th Cir. 2001). The Ninth Circuit concluded that the plain language of the regulation required CMS to count patient days in all geographic areas of a hospital that are subject to IPPS. In Sharp Coronado Hospital & HealthCare Center v. BCBSA, the PRRB, referencing Alhambra, held that the DSH regulation was plain on its face and required the inclusion of the subacute patient
days in the DSH calculation. See PRRB Dec. No. 2009-D32, Medicare & Medicaid Guide (CCH) ¶ 82,336 (July 15, 2009). However, the Administrator, also citing Alhambra, overturned the Board, finding first that because the subacute units were on a floor that was surrounded by nonpatient care units they did not meet the requirement for an area that was generally used to provide inpatient care services. Moreover, the Administrator found that the subacute units provided a level of care that was less than that provided by inpatient acute care units and, therefore, the days are not includable as inpatient days. See CMS Adm’r Dec., Medicare & Medicaid Guide (CCH) ¶82,423 (Sept. 9, 2009).

Rule After October 1, 2003. In 2003, CMS amended the DSH regulation to provide that a hospital’s number of patient days for DSH purposes includes days in units or wards of the hospital providing acute care services generally payable under the prospective payment system. 42 C.F.R. § 412.106(a)(1)(ii); 68 Fed. Reg. at 45,416-18. In the preamble to the 2003 rule, CMS stated that the new rule was intended to focus on the level of care that is generally furnished in an area or unit of a hospital. Regardless of whether a unit or ward is separately certified, inpatient days are not counted in the DSH regulation if the level of care furnished in a unit or ward generally is not consistent with the acute level of care that is paid under the IPPS. 68 Fed. Reg. at 45,417-18. The rule is not intended to focus on the level of care furnished to a particular patient. Id.

G. COUNTING OF IPPS INPATIENT BEDS FOR DSH PURPOSES

1. CMS REGULATIONS

A hospital’s bed count for DSH purposes is determined in accordance with the bed count rules for the indirect medical education adjustment (“IME”) under 42 C.F.R. § 412.105(b). See 42 C.F.R. § 412.106(a)(1)(i).

Prior to amendments adopted in 2003, the bed count for IME and DSH purposes took into account all available bed days, excluding “beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units.” 42 C.F.R. §§ 412.105(b), 412.106(a)(1)(i) (2002). Further guidance governing the IME bed count, which also applied for DSH purposes, is set forth in section 2405.3.G of the PRM. The Manual stated that beds in the following areas are excluded:
hospital-based skilled nursing facilities or in any inpatient area(s) of the facility not certified as an acute care hospital, labor rooms, PPS excluded units . . . , postanesthesia or post-operative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses’ and other staff residences, and other areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging.

PRM § 2405.3.G.

In August 2003, CMS amended the regulation governing the bed count for IME and DSH purposes. 68 Fed. Reg. at 45,415-16; see also 42 C.F.R. §§ 412.105(b) and 412.106(a)(1)(i) (2003). The amended regulation now provides that the bed count considers available bed days other than bed days attributable to the following: subacute units or wards; excluded distinct part hospital units; outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services; beds or bassinets in the healthy newborn nursery; and custodial care beds.

2. OUTPATIENT OBSERVATION AND SWING-BED DAYS

Even prior to the 2003 amendments to the regulations, CMS had asserted in some later cases that a hospital’s bed count should not include bed days attributable to the use of an inpatient bed for outpatient observation services or the use of a swing-bed for skilled nursing services that are not paid under the IPPS. Courts rejected this position as inconsistent with the plain meaning of the DSH and IME regulations and the guidelines in section 2405.3.G of the PRM. Decisions addressing the count of outpatient observation days and swing-bed skilled nursing days in the bed count for DSH include the following: Clinton Mem’l Hosp. v. BCBSA, PRRB Dec. No. 2010-D32, MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,660 (May 26, 2010), aff’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 82,654 (July 26, 2010) (holding that outpatient observation bed days are included in the bed count used to determine DSH eligibility); Clark Reg’l Med. Ctr. v. U.S. Dep’t of Health & Human Servs., 314 F.3d 241 (6th Cir. 2002) (holding that a hospital’s bed count for DSH purposes must include outpatient observation and swing-bed skilled nursing days); Edinburg Hosp. v. BCBSA, PRRB Dec. No. 2003-D23, MEDICARE & MEDICAID GUIDE (CCH) ¶ 80,981 (Apr. 29, 2003), aff’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,054 (July 3, 2003) (concluding that outpatient observation bed days are not included in the bed count for DSH purposes, but allowing a
hospital to round up its bed count from 99.91 to 100); *BBL 94-98 Observation Bed Days*


¶ 80,799 (Mar. 19, 2002), aff’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH)

¶ 80,864 (May 21, 2002) (noting that outpatient observation bed days should not be included in the bed count for DSH purposes, but following the Ninth Circuit’s decision in *Alhambra* because this group appeal is subject to judicial review in that circuit); *Cent. Texas Med. Ctr. v. BCBSA*, PRRB Dec. No. 2003-D2, MEDICARE & MEDICAID GUIDE (CCH) ¶ 80,911 (Oct. 16, 2002), aff’d, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 80,962 (Dec. 19, 2002) (ruling that the bed count for DSH purposes includes all bed days attributable to beds that are permanently available and maintained for lodging inpatients and includes days when an inpatient bed is used for outpatient observation or swing-bed services); *Presbyterian Hosp. of Greenville v. BCBSA*, PRRB Dec. No. 2002-D1, MEDICARE & MEDICAID GUIDE (CCH) ¶ 80,788 (Nov. 21, 2001), modified, CMS Adm’r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 80,852 (Jan. 25, 2002) (ruling that the bed count for DSH purposes includes all bed days attributable to beds that are permanently available and maintained for lodging inpatients and includes days when an inpatient bed is used for outpatient observation services).

*In North Okaloosa Medical Center v. BCBSA*, PRRB Dec. No. 2006-D54, MEDICARE & MEDICAID GUIDE (CCH) ¶ 81,611 (Sept. 26, 2006), the Board found that observation bed days should be included in the available bed count and used to determine the DSH reimbursement eligibility. The Board stated that 42 C.F.R. § 405.105(b) requires all beds to be included in the calculation of bed size unless specifically excluded under the regulation. Id. Additionally, this construction was supported by PRM § 2405.3.G. Id. The Board’s decision also relied on the Sixth Circuit decision in *Clark Regional Medical Center* to support a construction of the regulations and manuals that would include the Provider’s observation beds. Id. However, this decision was reversed by the Administrator who disagreed with the Board’s interpretation of the PRM section. “Specifically, . . . the PRM explains that: ‘a bed must be permanently maintained for lodging inpatients’ to be considered an available bed. . . . The beds used for other than inpatient lodging, are not counted. Therefore, if a bed is being utilized for another purpose, i.e., lodging a skilled nursing patient or for patient observation, it is not
available for inpatient lodging.” *North Okaloosa Med. Ctr. v. BCBSA*, CMS Adm’r Dec., *Medicare & Medicaid Guide (CCH)* ¶ 81,627 (Nov. 20, 2006). According to the Administrator, CMS has consistently excluded from the bed day count those bed days that are not paid as part of the inpatient operating cost of the hospital, that is, days not recognized as an inpatient operating cost under IPPS and as such, and as such the intermediary properly excluded these days. *Id.*

The United States District Court for the Northern District of Florida disagreed in the most recent court decision to address the observation bed issue. *North Okaloosa Med. Ctr. v. Leavitt*, 2008 U.S. Dist LEXIS 2296 (N.D. Fla. Jan. 11, 2008). The court relied on the regulations, the PRM, and congressional intent to find that the count of “available beds” does not exclude beds occasionally used for observation. *Id.* Following the reasoning in *Clark Regional Medical Center*, the court held that the Secretary’s decision to disallow beds that were concededly staffed and available for acute care inpatient use could not be reconciled with the clear language of the regulations and the PRM’s interpretative rules. *Id.*

3. **SIXTH CIRCUIT EXCEPTION**

CMS issued a memorandum in August 2004 notifying fiscal intermediaries that CMS is acquiescing in the Sixth Circuit decision in *Clark Regional* with respect to discharges prior to October 1, 2003 for hospitals located in Michigan, Ohio, Kentucky and Tennessee.

4. **LABOR / DELIVERY DAYS**