PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2016-D18

PROVIDER –
CCT&B 2005-2006 Hurricane Katrina
§ 1115 Waiver UCP Days Group

Provider Nos.: 25-0078; 25-0097

vs.

MEDICARE CONTRACTOR–
Novitas Solutions, Inc.

DATE OF HEARING –
November 13, 2014

Reporting Periods Ended –
2005-2006

CASE NO.: 10-1020G

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ISSUE

Whether the Medicare Contractor properly excluded the Hospitals' patient days attributable to Mississippi's § 1115 Waiver, from the calculation of the Hospitals' disproportionate share hospital ("DSH") percentage. [1]

DECISION

The Medicare Contractor improperly excluded the Hurricane Katrina § 1115 Waiver days from the calculation of the Hospitals' DSH percentage. The appeal is remanded to the Medicare Administrative Contractor to allow for the inclusion of all inpatient days of care furnished to individuals who were eligible for Medicaid under the § 1115 waiver.

INTRODUCTION

Forrest General Hospital and Southwest Mississippi Regional Medical Center (collectively the "Hospitals") provided services to individuals evacuated from other states and to Mississippi residents who were affected by Hurricane Katrina. The Centers of Medicare and Medicaid Services approved waivers under Section 1115 to allow federal Medicaid payment to cover the costs of these services. However, in calculating the DSH reimbursement for fiscal years 2005 and 2006, the Medicare Contractor excluded inpatient days under Mississippi's Hurricane Katrina § 1115 Waiver from the DSH calculation.[2] The Hospitals timely appealed and satisfied all jurisdictional requirements to challenge the exclusion of these days from the DSH calculation.

The Provider Reimbursement Review Board ("Board") held a live hearing on November 13, 2014. The Hospitals were represented by Thomas L. Kirkland, Esq. The Medicare Contractor, Novitas Solutions, Inc.[3], was represented by Brendan G. Stuhan, Esq. of the Blue Cross and Blue Shield Association.

STATEMENT OF THE FACTS

The Medicare program pays these Hospitals for inpatient services through Medicare's inpatient prospective payment system ("IPPS"). Under IPPS, Medicare pays hospitals predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4] One of these adjustments, the Medicare DSH adjustment, pays certain qualifying hospitals that treat a disproportionate share of low income patients. The Medicare DSH adjustment is calculated using two fractions known as the Medicare

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[1] Transcript, ("Tr.") at 6.
[2] For Forrest General Hospital, the cost reporting periods under appeal are FYEs 9/30/05 and 9/30/06. For Southwest Mississippi Regional Medical Center, the cost reporting period under appeal is FYE 9/30/06.
[3] TriSpan was the Medicare Administrative Contractor responsible for making the adjustments. CMS reassigned the administrative contract first to Pinnacle Business Solutions, Inc. and then to Novitas Solutions, Inc.
[4] 42 C.F.R. Part 412.

fraction and the Medicaid fraction.[5] A hospital's Medicaid fraction is calculated by using, as the numerator, the number of patient days of service to Medicaid-eligible patients (but not entitled to Medicare Part A), divided by the total number of patient days.[6] This case focuses on whether the numerator of the Medicaid fraction should include patient days for individuals who were eligible for benefits under the Mississippi § 1115 waiver.

Medicaid is a joint Federal and state program established in Title XIX of the Social Security Act (the "Act").[7] To participate in the Medicaid program and receive federal matching funds (commonly referred to as Federal Medicaid Assistance Percentage or "FMAP"[8]), a State must enter into an agreement ("State plan") with the Federal government describing the individuals covered, services provided, reimbursement methodologies for providers, and other administrative activities.

Federal law provides states flexibility in operating Medicaid programs through multiple waivers of federal requirements. To address the medical needs of its residents and demonstrate new approaches in providing health care that are likely to promote Medicaid program objectives, a State may choose to apply for, and include in its State plan, a demonstration program under Section 1115 of the Act.[9] The Secretary has delegated the administration of these demonstration projects to CMS which approves, and provides federal matching funds for, various waivers that expand both the populations who qualify for Medicaid and expand the health services available under a waiver. [10]

For purposes of the DSH computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.[11]

Mississippi's Section 1115 Waiver Program

On September 22, 2005, the Centers for Medicare and Medicaid Services ("CMS") approved the State of Mississippi's Section 1115 waiver to provide Medicaid and SCHIP[12] coverage for evacuees displaced from Louisiana, Mississippi, Alabama, and Florida, and those otherwise affected by Hurricane Katrina. The demonstration project extended and expedited Medicaid/SCHIP eligibility to individuals who were displaced to Mississippi as a result of the hurricane and met certain income eligibility standards. [13]

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[5] *See* 42 C.F.R. § 412.106.
[6] 42 C.F.R. § 412.106(b)(4).
[7] 42 U.S.C. § 1396; 42 C.F.R. § 430.0.
[8] Social Security Act, Title XIX, § 1905
[9] Social Security Act, Title XI, codified at 42 U.S.C. §1315.
[10] 42 U.S.C. § 1315(a)(2)(A).

[11] 42 C.F.R. § 412.106(b)(4).
[12] State Children's Health Insurance Program ("SCHIP"), Social Security Act, Title XXI.
[13] *See* Hospitals' Final Position Paper, Exhibit P-9 at 89-90.

The demonstration project also permitted Mississippi to "reimburse providers that incurred uncompensated care costs for medically necessary services and supplies for Katrina evacuees and affected individuals who did not have coverage under Medicare, Medicaid, SCHIP, private insurance, or under State-funded health insurance programs"[14] for a five-month period. CMS separately approved Mississippi's UCCP plan on March 24, 2006[15] and incorporated this program into Mississippi's 1115 waiver.[16]

Because of the unanticipated nature of the crisis, Mississippi's Medicaid program had no way to receive and process electronically claims under the §1115 waiver. Hospitals were directed to submit paper claims in "batches" of 50 claims, undifferentiated as to whether they were claims for Medicaid-eligible evacuees and affected individuals or claims under the UCCP pool.[17] The Hospitals in this case counted inpatient days for all individuals who received inpatient services (i.e. "Katrina days") under the waiver in the Medicaid fraction of the DSH calculation in their 2005 and 2006 cost reports.[18]

The Medicare Contractor excluded all Katrina days in the final settlement of these cost reports.[19] The Contractor first argued that the Secretary had discretion to determine the scope of the waiver and "whether individuals impacted by the waiver may be considered Medicaid eligible for purposes of the DSH calcualtion's (sic) Medicaid fraction[20] and the *Cookeville Reg'l Med Center v. Leavitt*[21]decision affirmed this discretion. The Medicare Contractor asserted that it had sought clarification from CMS in 2007 and 2009 and received confirmation that UCCP patient days could not be counted in the DSH calculation because payment for the UCCP was not paid from Title XIX funds. [22]

The MAC further maintained that federal regulation specifically limited patient days to "only those days for populations under the section 1115 waiver who were or could have been made eligible under a State plan."[23] The Contractor argues that individuals who received hospital services paid under the UCCP were "uninsured, non-Medicaid eligible patients" and who could not be made eligible for Medicaid services to be counted in the DSH fraction.[24] The UCCP served "a different purpose than the Waiver did, and did not

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[14] *Id.*, at 90.
[15] Provider's Exhibit P-21.
[16] *Id.* at 1.
[17] See: Provider's Post-Hearing Brief, Supplemental Exhibit P-23; Tr. at 75, 92-93.
[18] *See:* Provider's Final Position Paper at 11.
[19] See: Medicare Contractor's Final Position Paper, Exhibits I-2, I-3, I-4. There appeared to be some confusion at the hearing regarding whether the exclusion of Medicaid days from DSH was related solely to the UCCP days, or included all of the Katrina days related to the Medicaid-eligible evacuees as well. *See:* at Tr. 85:4-11 the MAC's counsel stated that only UCCP days were excluded; at Tr: 129-132, a Provider's witness testified that all waiver days were excluded. *See also*: Tr. 84, 91, 100, 127-128. The Hospitals' Post-Hearing Brief confirmed that all Waiver days were excluded. *See:* Providers' Post-Hearing Brief at 9, 17.
[20] Medicare Contractor's Final Position Paper, at 6.
[21] 531 F.3d 844, 846 (D.C. Cir. 2008)
[22] Medicare Contractor's Final Position Paper at 8.
[23] Medicare Administrative Contractor's Post Hearing Brief at 4.
[24] *Id.* at 11-12.

purport to make uninsured and non-Medicaid eligible patients eligible for Medicaid services."[25]

The Contractor next argued that hospitals could only count inpatient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver.[26] The Contractor argues that the Section 6201 of the Deficit Reduction Act authorizes the Secretary to pay the "non-Federal share of expenditures under title XIX of the Social Security Act" and there are, therefore, no matching payments from the State. Thus, the Contractor is justified in excluding all inpatient Katrina days because they do not meet the requirements of the DSH regulation at 42 C.F.R. §106(b)(4)(ii).

Finally, the Medicare Contractor explains that it is justified in excluding all of the Katrina days—Medicaid-eligible evacuees and UCCP days because the Hospitals submitted claims for these two groups together. Even if the Contractor should have allowed the Medicaid-eligible days, there was no way to distinguish them from the UCCP days.[27] The Medicare Contractor maintains that the Hospitals would have to provide additional documentation to include any Katrina days.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Medicaid Eligible Individuals

The Board majority finds that the Medicare Contractor's exclusion of Katrina days from the DSH calculation was contrary to 2005 federal statute and regulation. To put it simply, the law changed and the Medicare Contractor failed to follow new policy. Prior to January, 2000, the federal DSH regulation, 42 CFR § 412.106(b)(4), allowed only those individuals who qualified under a § 1115 waiver to be included in the DSH calculation *who were or could have been made eligible under a State Medicaid plan*.[28] CMS rewrote this regulation in an interim final rule published January 20, 2000 which explicitly states:

> Effective for discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act."

In a subsequent regulation published on August 1, 2000, CMS responded to concerns that hospitals in States without a Medicaid expansion waiver were disadvantaged because they could not count general assistance or charity care days in the DSH calculation.[29] CMS responded:

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[25] *Id.*
[26] *Id.*at 4.
[27] Tr. 158:3-12.
[28] (emphasis added)
[29] 65 FR 47054, 47087 (August 1, 2000)√

> While we initially determined that States under a Medicaid expansion waiver could not include those expansion waiver days as part of the Medicare DSH adjustment calculation, *we have since consulted extensively with Medicaid staff and have determined that section 1115 expansion waiver days are utilized by patients whose care is considered to be an approved expenditure under Title XIX*. While this does advantage some States that have a section 1115 expansion waiver in place, these days are considered to be Title XIX days by Medicaid standards.[30]

These regulations make clear that post-2000, CMS' Medicare DSH policy included patient days for individuals who were receiving benefits under an expansion waiver in the Medicaid DSH calculation.[31]

This decision was then "ratified" in the Deficit Reduction Act of 2005 when Congress amended the federal DSH statute, 42 USC § 1395ww(d)(5)(F)(vi), to allow inclusion of "patient days not so eligible[for medical assistance under a State plan approved under Title XIX] *but who are regarded as such because they receive benefits under a demonstration project approved under title XI*."[32]

In the same law that ratified CMS' regulation including Section 1115 days in the DSH calculation, Congress created "Multi-State Section 1115 Demonstration Project" to respond to the Hurricane Katrina crisis.[33] This waiver authorized federal payment to the States for medical assistance under Title XIX and XXI for "evacuees and affected individuals" using simplified eligibility guidelines and allowed a State to pay uncompensated care costs for evacuees and affected individuals who did not have other health coverage and for individuals who may be eligible for coverage under Title XIX or XXI but whose costs for medically necessary supplies and services exceeded those included in the State-approved Medicaid or SCHIP program.[34]

The Board majority finds that CMS approved the Mississippi Katrina waiver as required and that this waiver expanded eligibility for individuals who would not otherwise be eligible for Medicaid as well as for additional services, including payment for inpatient care from the uncompensated care pool.[35] Under the Katrina waiver, it appears that the

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[30] (emphasis added) *Id.* It is notable that CMS Medicare staff explicitly credits CMS' Medicaid staff in deciding that Section 1115-covered individuals, without qualification, were to be considered Medicaid-eligible individuals.

[31] CMS revisited this issue in the 2004 IPPS rule, which clarified that in order for patient days for individuals under a Section 1115 expansion waiver to be counted for DSH purposes, the waiver had to provide benefits that are "similar to those available to traditional Medicaid beneficiaries, including inpatient benefits" in contrast to "limited benefit" waivers. *See:* 68 FR 45,346, 45,420-21 (August 1, 2003). The parties did not argue that the Katrina waiver was a limited benefit waiver.

[32] Deficit Reduction Act, Section 5002(a), (b), P.L. 109-171, 120 Stat. 4, February 8, 2006. (emphasis added)

[33] Deficit Reduction Act of 2005, Section 6201(a)(1). *See:* Provider's Final Position Paper, Exhibit P-12.

[34] *Id.*

[35] *See:* Providers' Post-Hearing Brief, Exhibit P. Supp. Ex 23 at 37.

hospital filed claims for both groups of waiver-eligible individuals without distinguishing between them and that the federal government paid for all of the services received by evacuees and affected individuals under the waiver without differentiating between the groups.[36]

A plain reading of the DSH statute and post-2000 regulations requires that all of the inpatient days provided under this waiver likewise be included in the DSH calculation because Section 1115 individuals *are to be regarded as* [Medicaid eligible individuals] *such because they receive benefits under a demonstration project approved under title XI.* Individuals who received payment for hospital inpatient services from the UCCP must be regarded as Medicaid-eligible individuals because they were included in Mississippi's §1115 waiver.

The Board majority also finds no support for the Medicare Contractor's conclusion that the UCCP was not part of the § 1115 waiver. The March 24, 2006 letter from CMS clearly states that the UCCP was approved "under your Hurricane Katrina Multi-State section 1115 demonstration…" citing the Project Numbers of the previously-approved Medicaid and SCHIP waiver.[37] The CMS Special Terms and Conditions for the Mississippi Hurricane Katrina Relief demonstration program attached to the UCCP approval letter included special terms and conditions specific to the UCCP.[38] Finally, a Memorandum from the Executive Director of Mississippi Medicaid directs state Medicaid providers to file UCCP claims on the same UB-92 or CMS-1500 forms as used to file Medicaid claim and that they would receive payment on the "regular Medicaid remittance advice."[39] This evidence leads to a conclusion that the UCCP was part of the Katrina waiver and that Medicaid claims were filed and payment made in the same fashion as for UCCP patients as for the Medicaid-eligible patients covered by the waiver. The Board majority concludes that the Medicare Contractor improperly excluded, from the DSH calculation, all days included in the Katrina waiver.[40]

Matching Requirement

The Medicare Contractor next argues that the patient days for the uncompensated care population "were not paid for using Title XIX funds and were not eligible for Title XIX

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[36] The Board majority sees no distinction between the "benefits" provided to individuals who qualified for benefits under the waiver as Medicaid-eligible or under the UCCP. In either case, the hospitals filed claims for inpatient services to the Mississippi Medicaid program, received payment, and the Mississippi Medicaid program then received 100% reimbursement from the federal government.

[37] Exhibit P-21

[38] *Id.*, attached to the March 24, 2006 letter at 5 (or page 13 of complete exhibit).

[39] Provider's Post Hearing Brief, Exhibit P.Supp-22 at 24.

[40] This conclusion is supported by a recent Washington State federal court's analysis of various Section 1115 DSH cases: "The takeaway from the three decisions is that traditional Medicaid patients *and* 1115 populations are the *only* populations that are qualified for the calculation of DSH reimbursement purposes. *See*: *Verdant Health Commission v. Burwell*, 127 F. Supp. 3d 1116, 1123 (W.D.WA., 2015) discussing *Phoenix Mem'l Hosp. v. Sebelius*, 622 F.3d 1219 (9th Cir. 2010); *Adena Reg'l Med. Ctr v. Leavitt*, 527 F.3d 176 (D.C. Cir. 2008) and *Cooper Univ. Hosp. v. Sebelius*, 686 F. Supp. 2d 483 (D. N.J. 2009, aff'd. 636 F 3d 44 (3rd Cir. 2010). (emphasis added)

matching."[41] The Medicare Contractor provides no evidence of this assertion. In light of the actual facts of the Mississippi waiver, this argument is also disingenuous. The Medicare Contractor directs our attention to the language of DRA, Section 6201, which appropriated funds for the payment of the "non-federal share" of the costs of individuals described in subsections (a)(1)(A) and (C) while also paying 100% of the costs for the uncompensated care evacuees and affected individuals in subsections (a)(1)(B) and (D). The Medicare Contractor reasons that since there is no non-federal share, or "match" for the UCCP population, this population is not "eligible for Title XIX matching payments" and excluded from the DSH calculation.

The Contractor's rationale fails to account for the fact that *neither* the UCCP population *nor* the traditional Medicaid population encompassed by this waiver were eligible for Title XIX matching payments according to the more common cost sharing protocol, predicated upon non-emergent, non-disaster scenario circumstances, in which the state pays its portion from state funds. The facts of this case and the nature of the waiver are distinguishable from the traditional payment protocol insofar as they reflect the operational and financial challenges of expeditiously treating a predominantly displaced population suddenly created by an un-anticipated national disaster. Specifically, the DRA dictated that the federal government would pick up 100% of the costs for *both* the UCCP and the traditional Medicaid populations (i.e. the federal government's "normal" match under traditional Medicaid—in Mississippi's case—76% of the total costs, plus payment of the non-federal share, equals 100% for the Medicaid-eligible individuals under the waiver as well as 100% for the UCCP-covered individuals). The DRA made no distinction whatsoever between these populations. The Contractor's argument fails to convince the Board majority that there is a sound rationale for including the Medicaid-eligible part of the waiver population in DSH while excluding the UCCP population.

The Board majority finds support in its position in the Court's decision in *Cooper Hospital/University v. Burwell*. Here, the Court declared that the statute mandates that the demonstration project costs are " 'regarded as expenditures under the state [Medicaid] plan,' meaning that they are treated as reimbursable under Medicaid regardless of whether the underlying patients are Medicaid eligible."[42] There is simply no material distinction between these populations within the waiver, since the Hurricane Katrina waiver was approved by CMS, expenditures under the waiver must be regarded as reimbursable, and more to the point, "matchable" by Title XIX funds.

As a point of law that could be construed as tangentially related to this case, the Board majority sharply distinguishes between patient days "sanctioned" as part of an § 1115 waiver and those "state only" days, such as general assistance or charity care days, for which Medicare hospitals have long argued should be included in the Medicare DSH calculation. The Board believes that courts have correctly evaluated these days to be outside an §1115 waiver, not matchable by federal Title XIX funds and excluded from the

[41] Medicare Contractor's Post-Hearing Brief at 14.
[42] See: , __F. Supp.3d__, 2016 WL 1436646 (D.D.C. 2016)

Medicare DSH calculation.[43] These are not the facts presented in the current case. The Board majority believes that the UCCP days are included in the waiver, matchable by Title XIX funds just as the Medicaid-eligible waiver days. These days should be included in the Medicare DSH calculation.

Finally, the Board majority does not disagree that the Secretary has discretion in this matter as it, indeed, exercised such discretion when it changed the federal regulation in 2000. However, the Board majority rejects the Medicare Contractor's reliance on the D.C. Circuit Court's decision in *Cookeville Reg'l. Med. Ctr v. Leavitt*,[44] that CMS has the discretion to determine whether some or all of the § 1115 waiver days should be included for purposes of the DSH calculation. The *Cookeville* case discussed the Tennessee § 1115 waiver which was in place *prior* to the 2000 rule change and the Court concluded that it could not apply the *new* DSH regulation retroactively to a *pre-2000* cost report. The *Cookeville* decision clearly pertains to regulations that both pre – date and are substantially different from those that apply to the instant case; therefore *Cookeville* cannot and should not be regarded as a basis for deciding this case.

DECISION

The Medicare Contractor improperly excluded the Hurricane Katrina § 1115 Waiver days from the calculation of the Hospitals' DSH percentage. The appeal is remanded to the Medicare Administrative Contractor to allow for the inclusion of all inpatient days of care furnished under the waiver.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton Nix, Esq. (dissenting in part)
L. Sue Andersen, Esq.
Charlotte Benson, CPA (dissenting in part)
John Ahern, MBA

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

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[43] *supra*, note 43. It is well settled law that "state only" funded days such as general assistance days and charity days are excluded from the DSH calculation. These courts have found that CMS properly may exclude these days from the DSH calculation because these programs are not matched by federal Title XIX dollars as is required by federal regulation. This point is made most recently in *Cooper Hospital/University v. Burwell*, Med & Med. Guide (CCH) ¶305,600 (D.D.C., 2016), in which the Court stated: "the purpose of § 1115 was to *extend Medicaid matching payments* to services furnished to populations that otherwise could not have been made eligible for Medicaid."

[44] 531 F. 3d 844 (D.C. Cir. 2008)

DATE: September 19, 2016

Clayton Nix and Charlotte Benson, *dissenting in part*

The Mississippi § 1115 waiver related to Hurricane Katrina (the "MS Katrina Waiver") consists of two parts relevant to this appeal – the Medicaid expansion ("MS Medicaid Expansion") and the uncompensated care pool ("MS UCCP"). The Board majority finds that there is *not* a material distinction between the MS UCCP and the MS Medicaid Expansion and makes the following legal conclusions:

1. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b)(4) requires that MS UCCP days must be included in the Medicaid fraction of the Medicare DSH adjustment calculation; and

2. The individuals underlying MS UCCP days "were eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" pursuant to 42 C.F.R. § 412.106(b)(4)(ii).

We respectfully disagree. As explained below, based on our review of the law and regulations, the parties' contentions and the evidence submitted, we find that:

1. The patients underlying MS UCCP days were not in fact "eligible for medical assistance under a Title XIX state plan" (including the MS Katrina Waiver deemed to be part of such plan) per 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II); and

2. The MS UCCP was not funded according to the relevant federal medical assistance percentage ("FMAP") as required under 42 C.F.R. § 412.106(b)(4)(ii) but rather Congress funded it solely through separate non-Medicaid-related funding under §§ 6201(a)(1)(B) and 6201(a)(1)(D) of the Deficit Reduction Act of 2005 ("DRA").[1]

Accordingly, we respectfully conclude that CMS' longstanding policy interpreting 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), the case law applying that interpretation, and 42 C.F.R. § 412.106(b)(4) dictate that MS UCCP days cannot be included in the Medicaid fraction of the Medicare DSH adjustment calculations for the hospitals participating in this group appeal ("Hospitals") with respect to their fiscal years ("FYs") 2005 and 2006. Rather, only the days from the MS Medicaid Expansion may be included in the Medicaid fraction.

A. *CMS' longstanding policy interpretation of 42 U.S.C. § 1395ww(d)(5)(F)(iv)(II) and case law applying that interpretation confirm that uncompensated care pools generally are not included in the numerator of the Medicaid fraction of the DSH calculation.*

CMS longstanding policy interpreting 42 U.S.C. § 1395ww(d)(5)(F)(iv)(II) and case law applying that interpretation have firmly established that a hospital generally may not include days associated with an uncompensated care pool established under a State

[1] Deficit Reduction Act of 2005 ("DRA"), Pub. L. 109-171, § 6201, 120 Stat. 4, 132-34 (2006) (amending § 1886 of the Social Security Act, 42 U.S.C. § 1395ww(d)(5)(F)(vi)).

Medicaid plan in the numerator of the Medicaid fraction used to calculate Medicare DSH because the patients associated with those uncompensated care pool days are not "eligible for medical assistance" as required under 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). To illustrate that point, CMS Program Memorandum No. A-99-62 issued in December 1999 ("1999 Memorandum") provides the following guidance on what days may be included as allowable Medicaid days in the numerator of the Medicaid fraction of the Medicare DSH calculation:

> In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the ***patient's*** eligibility for Medicaid benefits as determined by the State, not the ***hospital's*** "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for *general* assistance under a State-only program. Third, the focus is on eligibility for *medical assistance under an approved Title XIX State plan*, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). . . . The term "Medicaid days" does *not* refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is *not* eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.[2]

Further, the 1999 Memorandum includes a non-exhaustive list of the types of days that are excluded from the numerator of the Medicaid fraction. The following are examples of the types of days that the 1999 Memorandum excludes:

1. "Charity Care Patient Days" which are "[d]ays for patients not eligible for Medicaid or any other third party payer, and claimed as *uncompensated* care by a hospital" because "[t]hese patients are not Medicaid-eligible under the State plan";[3] and

[2] (Emphasis in original.)
[3] (Emphasis added.)

2. "Medicaid DSH Days" which are "[d]ays for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State" because, even though "[s]ometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care or general assistance days," "[t]his . . . is not 'payment' for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicare formula."

As noted above, uncompensated care pools are a type charity care program that can be funded in part by federal Medicaid DSH dollars. Courts in multiple circuits have reviewed the application of CMS' policy to charity care programs under a State plan as well as other types of days similar to MS UCCP days and upheld CMS' policy as an acceptable legal interpretation of the Medicare DSH statutory provisions by finding that the patients underlying the subject days were not "eligible for medical assistance."[4]

At the time the 1999 Memorandum was issued, CMS had a Medicare DSH policy relating to § 1115 waiver programs that allowed in the numerator of the Medicaid fraction *only* those § 1115 days associated with patients who could have qualified for Medicaid through a traditional State Medicaid plan. As a result, at that time, CMS *excluded* from the numerator of the Medicaid fraction any days associated with patients who were covered under the State plan only by virtue of a § 1115 waiver.

In 2000, CMS altered this policy and expanded the types of § 1115 days included in the numerator of the Medicaid fraction. Specifically, in the Interim Final Rule issued on January 20, 2000 ("2000 Interim Final Rule"), CMS promulgated interim regulations at 42 C.F.R. § 412.106(b)(4)(ii) to specify that "hospitals may include [in the numerator of the Medicaid fraction] all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act."[5] Significantly, in the preamble to the 2000 Interim Final Rule, CMS reaffirmed its policy of excluding days from the Medicaid fraction those days associated with general assistance and charity care programs:

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

[4] *See Adena Reg'l Med. Ctr. v. Leavitt*, 527 F.3d 176 (D.C. Cir. 2008); *University of Wash. Med. Ctr. v. Sebelius*, 634 F.3d 1029 (9th Cir. 2011); *Cooper Univ. Hosp. v. Sebelius*, 636 F.3d 44 (3rd Cir. 2010); *Ashtabula Cnty. Med. Ctr. v. Sebelius*, 762 F. Supp. 2d 1 (D.D.C. 2011); *Covenant Health Sys. V. Sebelius*, 820 F. Supp. 2d 4 (D.D.C. 2011); *Northeast Hosp. Corp. v. Sebelius*, 699 F. Supp. 2d 81 (Mar. 29, 2010).
[5] 65 Fed. Reg. 3136, 3139 (Jan. 20, 2000).

> *under the State plan and are not considered Title XIX beneficiaries*.[6]

CMS further reaffirmed its exclusion policy by reissuing the 1999 Memorandum as CMS Program Memorandum No. A-01-13 on January 25, 2001 ("2001 Memorandum").

On August 1, 2003, CMS issued a final rule ("2003 Final Rule") adopting that regulation as final without any revisions.[7] In the preamble to the 2003 Final Rule, CMS confirmed that the term "populations" as used in the regulations refers to "expansion populations" and clarified the extent to which the regulation applies to "expansion populations." In the preamble to the 2003 Final Rule, CMS explains that "expansion populations" encompass situations when a State "*extend[s] medical benefits* to a given population that could not have been made eligible for Medicaid under a State plan amendment under section 1902(r)(2) or section 1931(b) of the Act under a section 1115(a)(2) demonstration project . . . ."[8] CMS further clarified in the preamble that § 412.106(b)(4)(ii) only applies to "expansion populations" that "receive inpatient benefits." Specifically, CMS stated the following:

> Although we did not initially include patient days for *individuals who **receive** extended benefits* only under a section 1115 demonstration project, we nevertheless expanded our policy in the January 20, 2000 revision to these rules to include such patient days. We now believe that this reading is warranted only to the extent that those *individuals **receive** inpatient **benefits*** under the section 1115 demonstration project.[9]

Accordingly, CMS amended § 412.106(b)(4)(i) to replace the words "eligible for *medical assistance* under an approved State Medicaid plan" with the words "eligible for *inpatient hospital services* under an approved State Medicaid plan *or under a waiver authorized under section 1115(a)(2)* of the Act."[10] The above preamble language suggests that Medicare DSH statutory language "eligible for medical assistance" only applies if such "medical assistance" includes inpatient "benefits" regardless of whether it is under the traditional State plan *or* a § 1115 waiver.

In 2005, as part of the DRA, Congress considered the impact that § 1115 waiver days had on the Medicare DSH adjustment calculation and amended 42 USC § 1395ww(d)(5)(F)(vi) to confirm that the Secretary has the discretion to determine the extent to which expansion waiver populations are included in the Medicaid fraction. Specifically, DRA § 5002(a) amended § 1395ww(d)(5)(F)(vi) so that it reads:

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[6] (Emphasis added.)
[7] 68 Fed Reg. 45346, 45420-45421 (Aug. 1, 2003).
[8] *Id.* at 45420 (emphasis added).
[9] *Id.* at 45420-45421 (emphasis added).
[10] (Emphasis added.)

> In determining under subclause (II) 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, the Secretary may, *to the extent and for the period the Secretary determines appropriate*, include patient days of patients not so eligible but who *are regarded as such because they* ***receive benefits*** under a demonstration project approved under title XI.[11]

To this end, multiple courts have upheld and applied as relevant both CMS' pre-2000 policy and CMS' post-2000 policy for § 1115 days as delineated in 42 C.F.R. § 412.106(b)(4)(i)-(ii).[12]

B. *MS UCCP days cannot be counted in the Medicaid fraction because the MS UCCP does not furnish "medical assistance" as that term is used under 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and the patients underlying MS UCCP payments are not "eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) of the Act" as that phrase is used in 42 C.F.R. § 412.106(b)(4)(i).*

DRA § 5002(a) clearly confirms that the Secretary has the discretion *to determine the extent and time period* that patients who are eligible for a State plan by virtue of a § 1115 waiver may be regarded as "eligible for medical assistance under a State plan approved under Title XIX" for purposes of the Medicare DSH calculation. Significantly, Congress specified that this discretion is limited to patients who "*receive benefits* under a demonstration project approved under title XI."[13] This is a subtle but important distinction.

As explained below, we find that MS UCCP days do not pertain to patients who "receive benefits" under the MS Katrina Waiver. Rather, the MS UCCP days pertain to situations where the *hospital* itself is eligible (and apply) for payment from the MS UCCP based on the hospital's attestation that services furnished to an evacuee is otherwise uncompensated because the individual who received those services has not paid and does *not* have insurance, and is *not* otherwise eligible for Medicaid or any other coverage.

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[11] Deficit Reduction Act of 2005 ("DRA"), Pub. L. 109-171, § 5002(a), 120 Stat. 4, 31 (2006) (emphasis added) (amending § 1886 of the Social Security Act, 42 U.S.C. § 1395ww(d)(5)(F)(vi)).

[12] *See, e.g.*, *Cookeville Reg'l Med. Ctr. v. Leavitt*, 531 F.3d 844 (D.C. Cir. 2008), *cert. denied*, 555 U.S. 1212 (2009); *Rogue Valley Med. Ctr. v. Sebelius*, 410 Fed. Appx. 344 (D.C. Cir. 2010); *Phoenix Mem'l Hosp. v. Sebelius*, 622 F.3d 1219 (9th Cir. 2010); *Adventist Health Sys. v. Sebelius*, 715 F. 3d (6th Cir. 2013); *Banner Health v. Sebelius*, 715 F. Supp. 2d 142 (D.D.C. 2010); *Verdant Health Comm'n v. Burwell*, 127 F. Supp. 3d 1116 (2015) ("*Verdant*"). We recognize that the Ninth Circuit in *Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091 (9th Cir. 2005) ("*Portland*") appears to adopt a more expansive reading of the DSH statutory provisions as it pertains to § 1115 waiver days than CMS' interpretation as delineated at § 412.106(b)(4)(ii). However, we note that DRA § 5002(a) and subsequent decisions have curtailed the *Portland* holding. *See Verdant*, 127 F. Supp. 3d at 1121-1122.

[13] (Emphasis added.)

In making this determination, it is important to compare and contrast the MS Medicaid Expansion with the MS UCCP. The MS Medicaid Expansion provided Medicaid *coverage for displaced evacuees* on a temporary basis *for up to 5 months* if they met certain income eligibility requirements. The evacuees could apply for Medicaid using an expedited Medicaid eligibility application process and were required to complete a self-declaration of income.[14] We are convinced that the MS Medicaid Expansion population meets CMS' criteria for inclusion in Medicaid fraction of Medicare DSH adjustment calculation because the MS Katrina Waiver clearly extends Medicaid benefits (including but not limited to inpatient hospital benefits) to this population on a temporary basis for up to 5 months of coverage.[15] Therefore, we conclude that any days related to these individuals should be counted in the Medicare DSH adjustment calculation as they meet the criteria of 42 CFR § 412.106(b)(4)(i)-(ii).

However, we are not convinced that MS UCCP days (the second category), should be counted as Medicaid-eligible for the purpose of the Medicare DSH adjustment calculation. The MS Katrina Waiver specifies that the uncompensated care paid through the MS UCCP concerns care furnished to evacuees who have not paid for that care and are "without private insurance, Medicaid, or SCHIP in any state, Medicare, health care vouchers from any State, Federal or charity organization, or any other method of health care coverage at the time [care] was rendered."[16] To this end, the plain language of the waiver allows Mississippi to "reimburse *providers* that incur uncompensated care costs."[17] Thus, unlike the MS Medicaid Expansion population, individuals underlying the MS UCCP days at issue did not "receive" any Medicaid benefits over a period of time (*e.g.*, 5 months) as demonstrated by the fact that they do not initiate the MS UCCP process (*i.e.*, fill out an application) and there is no income test or income eligibility requirements for MS UCCP claims. Rather, under the MS UCCP, it is the hospital that is eligible and applies for (*i.e.*, claims) the MS UCCP payment to reimburse the hospital *on a claim-by claim basis*[18] for certain services[19] furnished to evacuees between August 24, 2005 and

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[14] *See* Provider Exhibit P-9 at 89-90 (CMS letter dated Sept. 22, 2005); DRA § 6201 (a)(1)(D).
[15] *See* Provider Exhibit P-9 at 94.
[16] Provider Exhibit P-21 at 3 (defining the population covered by the MS UCCP).
[17] Provider Exhibit P-9 at 90 (emphasis added).
[18] We note that the record is also devoid of any provider instructions from the Mississippi Department of Medicaid ("MS DOM") on the claims submission process for the MS Katrina Waiver and the sole MS DOM document in the record that addresses the processing of Katrina-related claims *only* relates to MS UCCP claims and does not mention claims relating to the expansion population. *See* Provider Exhibit P-22. We further note that the MS UCCP plan approved by CMS which states that MS UCCP claims "may be batched for submission to the Division of Medicaid" and "[e]ach batch of claims *must include as a cover* a completed Mississippi Division of Medicaid *Uncompensated Care* Reimbursement *Form* (see attached)." Provider Exhibit P-21 at 5 (emphasis added). To this end, an email from MS DOM to the Hospitals confirms that MS DOM accounted for the MS UCCP claims separately because "[w]e received a separate grant for the Katrina UCC[P] claims." Provider Exhibit P-19. Accordingly, unlike the Board majority, we reject, to the extent it is relevant, the Hospitals' assertion through testimony that Mississippi made no distinction between claims involving individuals who had coverage under the MS Medicaid Expansion and the Hospitals' claims for uncompensated care under the MS UCCP.
[19] The MS UCCP does not appear to reimburse for any and all uncompensated care that would otherwise be covered under the Mississippi Medicaid program. For example, the MS UCCP could "only reimburse for

January 31, 2006. However, the hospital is only eligible for payment from the MS UCCP if it establishes that, absent the MS UCCP payment, the services would become bad debt (*i.e.*, uncollectible).[20] The hospitals establish this fact by attesting to the following *for each MS UCCP claim*:

- The recipient had no other health care coverage available on the date of service;
- The provider received no reimbursement from any other source for this claim and/or expects to receive no reimbursement from any other source;
- The recipient is a Katrina evacuee or affected individual . . .; and
- The services and/or supplies were medically necessary and within the scope of the hurricane relief effort.[21]

The required attestation confirms that the MS UCCP is quintessential bad debt reimbursement and that the MS UCCP payment is intended to directly benefit hospitals rather than patients. Accordingly, we find that MS UCCP days cannot be counted in the Medicare DSH adjustment calculation because the individuals underlying MS UCCP are not a Medicaid expansion population and do not ***receive*** *benefits* under the waiver similar to the Medicaid program.[22]

Our inclusion in the Medicaid fraction of only those MS Katrina Waver days for patients who *receive benefits* (*i.e.*, the MS Medicaid Expansion days) is consistent with:

1. CMS policy delineated in the 1999 and 2001 Memoranda which distinguishes between an individual's eligibility for benefits and a hospital's eligibility for benefits;[23]

2. 42 C.F.R. § 412.106(b)(4)(i) which limits days to those for individuals eligible for medical assistance that includes inpatient benefits either under a traditional State plan or a § 1115 waiver;[24]

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emergency items and services with respect to dental care, eye care, and durable medical equipment." Provider Exhibit P-21 at 4.

[20] *See* Provider Exhibit P-21. The Medicare program defines the term "bad debts" as "amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services." Provider Reimbursement Manual, CMS Pub. 15-1, § 302.1 (definition of "bad debts").

[21] Provider Exhibit P-21 at 2.

[22] 42 C.F.R. § 412.106(b)(4); 68 Fed. Reg. 45420 - 45421.

[23] The fact that this policy was issued both before and after the 2000 regulatory change affecting § 1115 days confirms that CMS intended this policy to apply to § 1115 waiver days.

[24] There is indication the Secretary did not consider the MS UCCP to be part of the MS Katrina Waiver itself. In September 2005, shortly following Hurricane Katrina but before the DRA, CMS developed a model waiver application form that only included federal payment for a simplified eligibility determination process for out-of-state evacuees and in-state affected individuals who met the Medicaid eligibility requirements: children to age 19, parents, aged and disabled individuals, pregnant women whose income and resources met certain eligibility levels. *See* CMS State Medicaid Directors Letter, SHO Letter #05-001 (Sept. 16, 2005) (available at: http://downloads.cms.gov/cmsgov/archived-

3. DRA §§ 5002(a), (b)(1) which: (a) limit the Secretary's discretionary authority to patients who "*receive benefits* under a demonstration project approved under title XIX," and (b) ratify 42 C.F.R. § 412.106(b)(4) but only "insofar as [it] provide[s] for the treatment of individuals *eligible for medical assistance* under a demonstration project";[25] and

4. Case law such as the D.C. Circuit's 2008 decision in *Cookeville Reg'l Med. Ctr. v. Leavitt* in which the D.C. Circuit makes clear that the Secretary has the discretion to specifically limit the scope of reimbursement for a particular § 1115 waiver population.[26]

Finally, we respectfully disagree with the Board majority's position that the facts of this case are somehow unique and would not apply generally to any State-only program (*e.g.*, general assistance programs) included in a state Medicaid plan. We note that the Board majority decision's necessarily has the effect of broadening the phrase "eligible for inpatient benefits" as used in 42 C.F.R. § 412.106(b)(4)(i). Specifically, the Board majority's decision necessarily means that the phrase "eligible for inpatient benefits" has to be interpreted to encompass the MS UCCP plan as well as any other uncompensated care plan (regardless of whether it is under an approved State plan or a § 1115 waiver) because that phrase is followed by the phrase "*under an approved* State Medicaid *plan* ***or*** *under a waiver* authorized under section 1115(a)(2) of the Act."[27] We do not agree with

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downloads/SMDL/downloads/SHO091605.pdf). Assistance to hospitals to provide uncompensated care was not included in this template.

[25] (Emphasis added).

[26] 531 F.3d 844, 846 (D.C. Cir. 2008), *cert denied*, 555 U.S. 1212 (2009). *See also supra* notes 4, 11, 12. We note that there is no evidence in the record to confirm that CMS intended to appropriate any FMAP funds for the MS UCCP when CMS initially approved the MS Katrina Waiver. *See* Provider Exhibit P-9 at 101. Rather, all we have are the Congressional appropriation instructions in DRA § 6201 along with the guidance given in the conference report accompanying the DRA. *See* H.R. Conf. Rep. No. 109-362, at 357 (2005).

[27] (Emphasis added.) To illustrate this point, we use the facts of *University of Wash. Med. Ctr.v. Sebelius*, 634 F.3d 1029 (9th Cir. 2011) ("UWMC") to demonstrate that a different legal outcome would have occurred in that case if 42 C.F.R. § 412.106(b)(4) (2005) had been in effect and was applied using the Board majority's position that the phrase "eligible for inpatient benefits" as used in 42 C.F.R. § 412.106(b)(4)(i) (2005) encompasses uncompensated care days under the MS UCCP plan. *UWMC* involved a *CMS-authorized* State Medicaid plan that included a general assistance ("GA") program which was partially funded using federal Medicaid DSH dollars (as opposed to funding through FMAP) and which covered inpatient hospital services. *Id.* at 1032. *See also Washington State Medicare DSH Group II v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2007-D05 (Nov. 22, 2006), *rev'd*, CMS Adm'r Dec. (Jan. 19, 2007); *Washington Gen. Assistance Days Group v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2013-D38 (Sept. 2013), *aff'd*, CMS Adm'r Dec. (Nov. 27, 2013). The Ninth Circuit ruled that the GA days at issue in *UWMC* could not be included in the Medicare DSH calculation because the GA populations "were not eligible for medical assistance under Washington's Medicaid plan." 634 Fed.3d at 1036. Under the Board majority's decision, a different outcome would have occurred because the phrase "eligible for inpatient benefits" in 42 C.F.R. § 412.106(b)(4)(i) would encompass a program such as the Washington's GA program. Specifically, a hospital inpatient covered by the GA program would necessarily be "eligible for inpatient hospital services under an approved State Medicaid plan . . . on that day." This conclusion is supported by the fact that § 412.106 (b)(4) contains no explicit requirement applicable to *Medicaid state plans* that the patients receiving inpatient services *under a Medicaid state plan* be "eligible for Title XIX matching payments." Such a requirement only applies to § 1115 waivers per § 412.106(b)(4)(ii).

such a result. It is contrary to the Agency's well established position (as born out in case law previously discussed) that charity care days under an approved State plan are not counted in the Medicaid fraction of the Medicare DSH calculation because they are not "eligible for medical assistance" as used in the Medicare DSH statutory provisions.[28] In this regard, we note that, if CMS intended its replacement in the 2003 Final Rule of the words "eligible for medical assistance" with "eligible for inpatient services" in 42 C.F.R. § 412.106(b)(4)(i) to have such a sweeping change in policy, one would expect that CMS would have given notice to the public and discussed this change and its impact on both State Medicaid plans and § 1115 waivers in the preamble to the 2003 Final Rule. Instead, the preamble to the 2003 Final Rule only discusses § 1115 waivers.

C. *MS UCCP days cannot be counted in the Medicaid fraction because the MS UCCP was not funded according to the relevant federal medical assistance percentage ("FMAP") as required under 42 C.F.R. § 412.106(b)(4)(ii).*

The source and manner of funding is relevant in this case because the Federal regulation at 42 C.F.R. § 412.106(b)(4)(ii) allows hospitals to include in Medicare DSH, patient days "attributable to *populations eligible for* ***Title XIX matching payments*** through a waiver approved under section 1115 of the Social Security Act."[29] As explained below, we find that MS UCCP days have no "Title XIX matching payments" because the source of funding for the MS UCCP cannot be considered FMAP under 42 U.S.C. § 1396b. Accordingly, we conclude that MS UCCP days cannot be included in the Medicare DSH adjustment calculation pursuant to 42 C.F.R. § 412.106(b)(4)(ii).

While the MS UCCP is funded 100 percent under DRA § 6201(a)(1)(D), the MS UCCP is not funded through "Title XIX *matching* payments" as required by 42 C.F.R. § 412.106(b)(4)(ii). The federal government makes matching Medicaid payments based on the federal medical assistance percentage ("FMAP") for the care of the categorically or medically needy.[30] As part of the conference report accompanying the DRA, Congress explained how FMAP works relative to a § 1115 waiver program:

> The . . . FMAP . . . is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to state with lower per capita income relative to the national average (and vice versa); *it is a statutory* minimum of 50 percent and ***maximum*** *of 83 percent*. . . .
>
> For purposes of FMAP reimbursement, *Section 1115 waivers are deemed to be part of a state's* ***Medicaid or SCHIP state plan*** (i.e., its "regular" Medicaid or SCHIP program).[31]

[28] *See supra* note 12.
[29] (Emphasis added.)
[30] *See* 42 U.S.C. § 1396b; *UWMC*, 634 F.3d at 1035.
[31] H.R. Conf. Rep. No. 109-362, at 357 (2005) (emphasis added).

Thus, it is clear that the Medicaid statute specifies that federal matching payments for a § 1115 waiver deemed to be part of a state's Medicaid plan must be between 50 and 83 percent.

Congress goes on to describe the § 1115 waiver programs related to Hurricane Katrina (including but not limited to the waiver approved for Mississippi) as follows:

> All of the waivers granted thus far under the Hurricane Katrina multi-state Section 1115 waiver demonstration *create a temporary eligibility period*, not to exceed five months, during which certain Hurricane Katrina evacuees will be *granted access to Medicaid and SCHIP services* in the host state (i.e., the state has been granted a Section 1115 waiver) based on simplified eligibility criteria. *In addition to creating temporary* ***Medicaid or SCHIP eligibility*** *for evacuees*, waivers for some states also create an uncompensated care pool that may be used through January 31, 2006, to augment Medicaid and SCHIP services for evacuees and to reimburse providers that incur uncompensated care costs for uninsured evacuees who do not qualify for Medicaid or SCHIP.[32]

The above discussion confirms that Congress did not view uncompensated care pools such as the MS UCCP as being part of the Medicaid state plan, or more specifically the Medicaid expansion populations related to Hurricane Katrina. This is borne out in how Congress provided *additional* or supplemental funding in the DRA for the Katrina Medicaid expansion populations (*i.e*., not 100 percent) in contrast with the separate but complete (*i.e.*, 100 percent) funding in the DRA for the Katrina uncompensated care pools such as the MS UCCP.

For the Medicaid expansion population of the waivers related to Hurricane Katrina, Congress appropriated monies to cover the state's share of FMAP which (as noted above) must by statute be equal to or greater than 13 percent but no greater than 50 percent. Significantly, Congress described this appropriation as the "[t]he non-Federal share" and specified that it "shall not be regarded as Federal funds for purposes of Medicaid matching requirements, the effect of which is to provide fiscal relief to the State in which the Medicaid eligible individual originally resided."[33] Accordingly, contrary to the Board majority's assertion, federal matching payments per the relevant FMAP percentages were in fact made for the Katrina-related Medicaid expansion populations. Through the DRA provisions, Congress makes clear that it merely appropriated monies to pay the state's share of the FMAP on behalf of the state.

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[32] *Id.* (emphasis added).
[33] DRA §§ 6201(a)(1)(A), 6201(a)(1)(C), 6201(c).

In contrast, the record confirms that the federal funding for the Hurricane Katrina-related uncompensated care pools such as the MS UCCP is entirely different from the federal funding of Medicaid state plans and Medicaid expansion populations. When Mississippi applied for the MS Katrina Waiver, the MS UCCP appeared to be a state-only program consistent with the Medicare program's general treatment of similar programs (*i.e.*, there was *no* matching federal contribution for the pool consistent with FMAP rates).[34] In this regard, it is not uncommon for a CMS-authorized State plan or § 1115 waiver to include certain state-only programs (*e.g.*, a general assistance or charity/uncompensated care program partially funded through federal Medicaid DSH dollars) even though such program is not treated as part of that state's Medicaid program for purposes of "medical assistance" under Title XIX and, thereby, not eligible for FMAP.[35]

Subsequent to the approval of Mississippi's waiver, Congress appropriated funding in DRA § 6201 to pay *all* (*i.e.*, 100 percent) of the expenses of the uncompensated care pools rather than splitting payment/funding responsibilities between the state and federal government consistent with the statutorily-prescribed FMAP rates. The DRA's unqualified 100 percent funding of the uncompensated care pools suggests that there was no FMAP otherwise designated for the uncompensated care pools when CMS originally approved the Mississippi's waiver in September 2010. Otherwise, it stands to reason that Congress would have handled it the same way that it provided additional funding for the Hurricane Katrina-related expansion populations where a "non-Federal" share was designated for FMAP purposes.[36] This conclusion is supported by Mississippi's treatment of the funding. When the Hospitals asked with the Mississippi Department of Medicaid ("MS DOM") whether FMAP funded the MS UCCP, MS DOM responded:

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[34] *See supra* notes 31, 32 and accompanying text; H.R. Conf. Rep. No. 109-362, at 357 (2005) (the DRA conference report). Significantly, in DRA § 6201(e), Congress noted that its funding in DRA was "in addition to any funds made available for the National Disaster Medical System . . . for health care costs related to Hurricane Katrina, including under a section 1115 project." *See also* Provider Exhibit P-21 at 2 (CMS informing Mississippi that "in a separate communication, we will inform you of the funding available for . . . [MS] UCCP expenditures, as authorized by section 6201" of the DRA). This suggests that funding of the MS Katrina Waiver may have been through the National Disaster Medical System. *See also* CMS report, "Summary of Federal Payments Available for Providing Health Care Services to Hurricane Evacuees and Rebuilding Health Care Infrastructure as of October 28, 2005" at 2 (Oct. 28, 2005) (describing the uncompensated care pools as relating to National Disaster Medical System or NDMS and that "[t]he uncompensated care pool excludes any supplemental payments and is without regard to the State's DSH allotment") (*available at*: https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/KatrinaFinancingFed102805.pdf).

[35] For example, the following cases involve a CMS-approved § 1115 waivers for Arizona that included a State-only program include: *Phoenix Mem'l Hosp. v. Sebelius*, 622 F.3d 1219 (2010); *Arizona 96-99 DSH Group v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2007-D29 (May 4, 2007), *rev'd*, CMS Adm'r Dec. (Jul. 6, 2007); *Good Samaritan Reg'l Med. Ctr. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2007-D35 (May 17, 2007), *rev'd*, CMS Adm'r Dec. (Jul. 13, 2007); *Banner Health Sys. 2000 DSH Calculation Grp. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2009-D06 (Dec. 23, 2008), *rev'd*, CMS Adm'r Dec. (Feb. 24, 2009). Similarly, *supra* note 27 provides an examples of cases involving a CMS-approved state plan. *See also Nazareth Hosp., et. al. v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No. 2010-D22 (Mar. 23, 2010); *Cooper Hosp. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2014-D11 (June 18, 2014).

[36] In appropriating monies for the uncompensated care pools at DRA §§ 6201(a)(1)(B) and 6201(a)(1)(D), Congress did not describe any portion of that payment as "non-Federal" (as defined at DRA § 6201(c)) unlike the monies appropriated for the Medicaid expansion populations at DRA §§ 6201(a)(1)(A) and 6201(a)(1)(C).

> We received a separate grant for Katrina UCC[P] claims. So the [MS UCCP] payments were technically not part of our Medicaid Title XIX program. We considered them pass through funds and accounted for them outside our program and MMIS system. We did reduce our uncompensated care cost calculations for our FY-08 and FY-09 Medicaid DSH payments based on the Katrina UCC[P] payments made in FY-06 and FY-07.[37]

Accordingly, we find that MS UCCP days do not meet the "Title XIX matching payments" requirement under 42 C.F.R. § 412.106(b)(4)(ii) because the source of funding for MS UCCP cannot be considered FMAP under 42 U.S.C. § 1396b.

D. *The record warrants remand of the days at issue to the Medicare Contractor for audit*.

As previously discussed, any days for the MS Medicaid Expansion population should be included in the Medicaid fraction of the Medicare DSH adjustment calculation. As a result, we reviewed the record to determine whether the days at issue included any MS Medicaid Expansion days. The record suggests that many (if not all) of the days at issue are associated with MS UCCP claims.[38] Notwithstanding, the record also suggests that the days at issue may include MS Medicaid Expansion days.[39] However, the record only includes a small portion of the remittance advices associated with the days at issue and it does not include any of the relevant documentation underlying these claims[40] or the Medicare Contractor's audit work papers addressing the MS Katrina Waiver days at issue.[41] Accordingly, if we were the majority, we would remand this case to the Medicare Contractor to: (1) audit the days at issue to determine which of these days are MS Medicaid Expansion days versus MS UCCP days; and (2) include in the numerator of the relevant Medicaid fraction for FYs 2005 and 2006 only those days which are adequately documented as MS Medicaid Expansion days.

/s/	/s/
Clayton J. Nix, Esq.	Charlotte F. Benson, C.P.A.

[37] Provider Exhibit P-19 at 1. The MS DOM response also confirms that MS DOM operated an uncompensated care pool during FYs 2008 and 2009.
[38] *See* Tr. at 95-100, 102-103, 110-112, 114-119, 181-189, 243-47.
[39] *See id.*
[40] For each claim associated with MS UCCP days, the Hospitals had to complete an attestation confirming, among other things, that the individual to whom the uncompensated care was furnished was not Medicaid eligible. *See* Provider Exhibit P-21. In contrast, each claim associated with MS Medicaid Expansion days involves an individual whose Medicaid eligibility could be "established by self-attestation of displacement, income, and immigration status" through an expedited application process. Provider Exhibit P-9 at 94.
[41] *See supra* note 18.