PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2017-D4

PROVIDERS –
Southwest Consulting UMass Memorial Health Care and Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Groups

Provider Nos.: See APPENDIX A

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

HEARING DATE –
April 16, 2015

Cost Reporting Period Ended –
September 30, 2009

CASE NOs.: 14-1394GC; 14-1732GC

INDEX

ISSUE

Whether days attributable to patients who were eligible for, and received, assistance through the Massachusetts Commonwealth Care Health Insurance Program ("CCHIP"), a CMS-approved § 1115 waiver, should be included in the numerator of the Medicaid fraction for the Medicare Disproportionate Share Hospital ("DSH") adjustment calculation.[1]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board majority finds that the days in these appeals that were attributable to patients who were eligible for, and received, assistance through CCHIP, a CMS-approved § 1115 waiver demonstration program, should be included in the numerator of the Medicaid fraction of the Medicare DSH adjustment calculation. Accordingly, the Board majority remands these appeals to the Medicare Contractor to recalculate the Hospitals' Medicare DSH adjustment payment for FY 2009.

INTRODUCTION

Appendix A lists the twelve hospitals participating in these consolidated group appeals ("Hospitals" or "Providers"). Each of the Hospitals are located in Massachusetts and the cost reporting period at issue for of them is FY 2009. The Medicare contractor[2] assigned to each of the Hospitals is National Government Services, Inc. ("Medicare Contractor").

The Hospitals' DSH consultant, Southwest Consulting Associates, identified a number of patient days attributable to individuals receiving assistance through CCHIP for each of the Hospitals. The Medicare Contractor excluded those patient days from the numerator of the Medicaid fraction when calculating each of the Hospitals' Medicare DSH percentage for FY 2009 resulting in a lower Medicare DSH payment for FY 2009.

Each of the Hospitals timely appealed those adjustments and have met the jurisdictional requirements required for a hearing before the Board. The total reimbursement amount in dispute for these group appeals is over $6 million.

The Provider Reimbursement Review Board ("Board") held a live hearing on April 16, 2015. The Hospitals were represented by Christopher L. Keough, Esq. of Akin, Gump, Strauss, Hauer & Feld, LLP. The Medicare Contractor was represented by Brendan G. Stuhan, Esq. of the Blue Cross and Blue Shield Association.

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[1] *See* Transcript ("Tr.") at 6.

[2] The term "Medicare contractor" refers to both fiscal intermediaries and Medicare administrative contractors.

STATEMENT OF THE FACTS

A. BACKGROUND ON MEDICARE DSH ADJUSTMENT CALCULATIONS

The Medicare program pays the Hospitals for inpatient services through Medicare's inpatient prospective payment system ("IPPS"). Under IPPS, Medicare pays the Hospitals predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3] One of these adjustments, the Medicare DSH adjustment, provides additional payments to 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 fraction and the Medicaid fraction.[4] Each of the Hospital's Medicaid fraction is calculated by using as the numerator, the number of patient days of service for which patients were eligible for Medicaid (but not entitled to Medicare Part A), divided by the total number of patient days.[5] This case focuses on whether the numerator of the Medicaid fraction should include patient days for individuals who were eligible for CCHIP.

B. BACKGROUND ON MEDICAID STATE PLANS AND § 1115 WAIVERS

Medicaid is a joint Federal and state program established in Title XIX of the Social Security Act (the "Act").[6] To participate in the Medicaid program and receive federal matching funds (commonly referred to as federal financial participation or "FFP"), 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 law and demonstration programs. To address the medical needs of its residents, a State may choose to apply for, and include in its State plan, a demonstration program under § 1115 of the Act. Section 1115 allows CMS to waive various Federal Medicaid eligibility and benefits requirements and provide Federal matching funds for State expenditures.[7]

For purposes of the Medicare 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 § 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.[8]

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[3] 42 C.F.R. Part 412.
[4] *See* 42 C.F.R. § 412.106.
[5] 42 C.F.R. § 412.106(b)(4).
[6] 42 U.S.C. § 1396; 42 C.F.R. § 430.0.
[7] 42 U.S.C. § 1315(a)(2)(A).
[8] 42 C.F.R. **§** 412.106(b)(4).

C. MASSACHUSETTS' § 1115 WAIVER FOR ITS MEDICAID PROGRAM

Massachusetts Medicaid is commonly referred to as "MassHealth." In July 1998, CMS approved a § 1115 waiver for MassHealth that would run through 2002. Among other things, this waiver mandated enrollment in certain managed care programs for most Medicaid patients.[9]

In June 2004, Massachusetts submitted to CMS a waiver-extension request to continue the § 1115 waiver through 2008 and to establish a new fund known as the Safety Net Care Pool ("SNCP") designed to reduce the number of uninsured state residents.[10] CMS approved this amendment in January 2005.

In July 2006, CMS approved another amendment to the Massachusetts § 1115 waiver.[11] This amendment expanded Medicaid eligibility and created a new program called Commonwealth Care. This program allowed eligible individuals to enroll in a Medicaid managed care plan[12] and to receive a subsidy to pay plan premiums. Commonwealth Care was open to individuals who were otherwise not eligible for MassHealth.[13] Under the amendment, Massachusetts was authorized to claim Federal reimbursement for premium assistance paid by SNCP under the Commonwealth Care program[14] and these expenditures "shall, for the period of this Demonstration extension, be regarded as expenditures under the State's title XIX plan.[15]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

A. ARGUMENTS RELATED TO STATUTE AND REGULATIONS

The Medicare Contractor does not dispute that, beginning in October 1, 2006, Commonwealth Care became covered under Massachusetts' CMS-approved § 1115 waiver but argues that the program offers "subsidized insurance coverage" and that this coverage does not make a patient "eligible for Medicaid" as required by federal regulation.[16] Further, even if the federal government matches Commonwealth Care funding, "it does not mean that the patient receiving Commonwealth Care assistance is eligible for Medicaid or medical assistance…"[17] The Medicare Contractor contends that the days of care furnished to CCHIP patients do not fall into any of these categories.[18]

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[9] Providers' Post Hearing Brief at 7.
[10] Providers' Post Hearing Brief at 9.
[11] *See* Provider Exhibit P-5.
[12] *See* Medicare Contractor's Final Position Paper, Exhibit I-10 at 1 of 9.
[13] *See* Provider Exhibit P-9. The waiver was amended again in May 2007 for the period July 1, 2005 through June 30, 2008 and yet again in December 2008. *See also* Provider Exhibits P-16, P-17.
[14] *See* Provider Exhibit P-16 at 3.
[15] *Id.* at 1.
[16] Medicare Contractor's Final Position Paper at 5 and 7 of 12.
[17] *Id.* at 8 of 12.
[18] *See* Medicare Contractor's Post-Hearing Brief at 8.

The Medicare Contractor points out that it is undisputed that CCHIP patients are not eligible for Medicaid, as one of the statutory prerequisites for eligibility under the CCHIP is that "the individual is not eligible for any MassHealth program." The Medicare Contractor explains that this fact is evidenced in published guidance and was corroborated by the Hospitals' witnesses at the hearing.[19]

Finally, the Medicare Contractor contends the § 1115 waiver does not make CCHIP patients eligible for inpatient hospital services under MassHealth rather the waiver makes the expenditure of funds from the Safety Net Care Pool ("SNCP") to provide premium assistance to CCHIP- eligible individuals.[20] The Medicare Contractor points out that under MassHealth, Title XIX pays directly for inpatient services while under the Commonwealth Care, SNCP funds pay for premiums not for the inpatient services themselves."[21]

The Medicare Contractor argues that it is not the CCHIP patient *population* that is eligible for Title XIX matching payments. Rather, it is the *pool of funds used to provide premium assistance* for the purchase of Commonwealth Care Program insurance that is matched by Title XIX funds.[22] The Medicare Contractor asserts that 42 C.F.R. § 412.106(b)(4)(i) and (ii) included days of care furnished to patients who were eligible for Medicaid services that were paid for with Title XIX funds, not days of service furnished to any patient who bought insurance using a subsidy that was partially funded via Title XIX matching funds.[23]

According to the Medicare Contractor, the additional days of care furnished to the CCHIP population distorts the DSH calculation in general, and the Medicaid fraction in particular, as a proxy for the share of low income patients served by particular hospitals and asserts that Congress never anticipated the inclusion of these groups in the DSH calculation.[24] The Medicare Contractor concludes since CCHIP patients are not eligible for Medicaid, are not made eligible for inpatient hospital services under the waiver, and are not an expanded eligibility population that receives Title XIX matching payments, the Contractor properly excluded the days of care from the numerator of the Medicaid fraction.[25]

The Hospitals in these appeals believe the CCHIP days should be included in the numerator of the Medicaid fraction when calculating the Medicare DSH payment. They point to the waiver approval documents that define expenditures to provide premium assistance under the SNCP as one of several Medicaid Eligibility Groups covered under the waiver.[26] The Hospitals also point out that each patient day at issue in these appeals

[19] *See* Medicare Contractor Exhibit I-7 at 2; Tr. at 103:5-18.
[20] Medicare Contractor's Post Hearing Brief at 7.
[21] *Id.*
[22] *Id.* at 10.
[23] *Id.* at 10 -11.
[24] *Id.* at 11.
[25] *See* Medicare Contractor's Post-Hearing Brief at 12.
[26] Providers' Post Hearing Brief at 10-11.

was verified by the Medicaid office as being covered by Commonwealth Care under the Section 1115 waiver that received federal matching funds.[27]

B. BOARD MAJORITY'S ANALYSIS AND FINDINGS

The § 1115 waiver's expenditure authority undeniably allowed Massachusetts to claim Federal reimbursement under SNCP for the CCHIP premium assistance.[28] As noted above, the CMS Expenditure Authority clearly states that the § 1115 demonstration program expenditures, including Commonwealth Care premium assistance, is regarded as expenditures *under the State's Title XIX plan*.[29] Testimony at the hearing made clear that all of the days in this appeal are for CCHIP patients federally funded under the waiver.[30] The record also shows that the CCHIP days in this appeal relate to individuals who were enrolled in the same managed care plans and received the same core health benefits as other MassHealth recipients, including inpatient hospital services.[31] The Board majority is not persuaded by the Contractor's argument that the terms of 42 C.F.R. § 412.106(b)(4)(i) and (ii) were designed to include days of care furnished to patients who were eligible for Medicaid services that were paid for with Title XIX funds, not days of service furnished to CCHIP patients that received insurance subsidies that was partially funded via Title XIX matching funds.[32]

The Board majority finds no meaningful distinction between a State providing traditional Medicaid benefits through a managed care plan enrollment and providing a premium subsidy to CCHIP-eligible individuals to purchase health care from the same managed care plan as provided to traditional Medicaid-eligible individuals. The managed care plan provides inpatient hospital services as one of its plan benefits, and the federal government reimburses the cost of the premium subsidy through FFP in the same manner as it does for the traditional Medicaid population.

The Board majority is not persuaded by the Medicare Contractor's argument that the inclusion of CCHIP patient days in the Medicare DSH calculation distorts or would otherwise defeat the use of the Medicare DSH calculation as a proxy of the number of low income individuals served by Massachusetts hospitals. In this regard, the Board majority notes that CMS itself acknowledged that SNCP funds were to be used to provide premium assistance to "low income individuals"[33] which appears to be fully consistent with the Medicare DSH calculation as a low income proxy.

Based on the above, the Board majority concludes that all the days in this consolidated group appeal meet the criteria of 42 C.F.R. § 412.106(b)(4) as they are attributable to

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[27] *Id.* at 18.
[28] *See* Provider Exhibit P-16 at 3; Provider Exhibit P-9 at 8, 22-23.
[29] Provider Exhibit P-16 at 1-3.
[30] Tr. at 81 -83.
[31] *See* Providers' Consolidated Response Brief at 4; Provider Exhibit P-6 at 2-4; Provider Exhibit P- 27. *See also* Provider's Post-Hearing Brief at 12; Tr. at 24, 52.
[32] Medicare Contractor's Post Hearing Brief at 10-11.
[33] Provider Exhibit P-7 at 2.

populations eligible for Title XIX matching payments through a CMS-approved § 1115 waiver.

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board majority finds that the days in these appeals that were attributable to patients who were eligible for, and received, assistance through CCHIP, a CMS-approved § 1115 waiver, should be included in the numerator of the Medicaid fraction of the Medicare DSH calculation. Accordingly, the Board majority remands these appeals to the Medicare Contractor to recalculate the Hospitals' Medicare DSH adjustment payment for FY 2009.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq. (concurring)
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA (concurring)
Jack Ahern, M.B.A.

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: January 27, 2017

Clayton J. Nix and Charlotte F. Benson, *concurring*

This case appeal turns on the Secretary's exercise of discretion in 42 C.F.R. § 412.106(b)(4) to "include patient days of patients not . . . eligible [for Medicaid] but who *are regarded as such because they receive benefits* under a demonstration project approved under title XI."[34] As explained more fully below, we concur with the majority and find that: (1) CCHIP beneficiaries were a "section 1115 expansion waiver population"[35] that had inpatient benefits as part of their benefits package; and (2) days associated with CCHIP beneficiaries should be included in the Providers' Medicare DSH adjustment calculation for the fiscal years at issue.

The major elements in determining whether to count § 1115 waiver days are:

1. Do the days at issue pertain to "section 1115 expansion waiver population"?
2. Does the "section 1115 expansion waiver population" receive "medical assistance" as defined in Title XIX of the Social Security Act?
3. Is the "medical assistance" paid using FMAP?
4. Does the "medical assistance" include "inpatient benefits"?

We agree with the Providers that the § 1115 waiver days meet the first three elements. First, it is clear that the CCHIP beneficiaries are Medicaid "expansion populations." Case in point is the table at the end of Section IV of the Special Terms and Conditions lists CCHIP as pertaining to certain "populations made eligible through the demonstration (additional populations)."[36]

Second, the payment of premiums qualifies as "medical assistance" as confirmed by 42 U.S.C. 1396e and 1396u-2.[37] Third, it is clear the funding for the payment of the CCHIP premiums is with federal matching dollars (more specifically FMAP) because the SNCP is funded, in part, by redirected state Medicaid DSH funds which in turn are based on FMAP.[38]

The key then is whether the "medical assistance" includes "inpatient benefits." The Special Terms and Conditions includes a table listing the benefits for the various expansion programs under the § 1115 waiver.[39] However, CCHIP is not included in this table. Further, it does not appear that the Special Terms and Conditions contain any

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[34] 42 USC § 1395ww(d)(5)(F)(vi) (emphasis added) (as amended by the Deficit Reduction Act § 5002).
[35] In the preamble to the final rules published on August 1, 2003, CMS uses the term "section 1115 expansion waiver populations." 68 Fed. Reg. 45346. 45420 (Aug. 1, 2003).
[36] Provider Exhibit P-18 at 18; Provider Exhibit P-19 at 13.
[37] *See also* Provider Exhibit P-17 at 7 (confirming that premium assistance under SNCP was not subject to the "single state agency" requirement).
[38] *See* Provider Exhibit P-19 at 2; State Medicaid Letter (discussion at Question 9 confirms that state Medicaid DSH allotments are funded through FMAP and that, when a state uses a § 1115 waiver to re-purpose Medicaid DSH allotments to provide health care coverage, CMS does not consider them to be "DSH expenditures").
[39] Provider Exhibit P-18 at 30-32.

information on what benefits are included in the benefit package for the insurance purchased through CCHIP.[40] Notwithstanding, the record includes Massachusetts statutory provisions governing SNCP that were passed prior to the submission and approval of the § 1115 waiver.[41] These statutory provisions include the mandate that the CCHIP premium assistance program for individuals at or below 100 percent of the federal poverty level include procurement of "health insurance plans that include . . . inpatient services."[42] As acknowledged by the Providers', "there is no explicit statutory or regulatory requirement that Commonwealth Care [*i.e.*, CCHIP] plans provide coverage for inpatient hospital services to individuals with income *greater than* 100 percent of the Federal poverty level."[43] Notwithstanding, the record does contain information that confirms that all CCHIP beneficiaries (both those above and below 100 percent of FPL) did in fact receive inpatient benefits.[44] Based on the above information, the record suggests that:

1. CMS did not review or approve of a *specific* benefit package for CCHIP beneficiaries but rather allowed the state to later define that benefit package (and apparently could do so without any prior CMS approval);
2. Qualifying individuals below 100 percent of FPL had a right under state law to inpatient benefits and did in fact receive such benefits during the fiscal years at issue; and
3. Qualifying individuals above 100 percent of FPL did not have a right under state law or regulation to have inpatient benefits included in their benefits package but did in fact receive inpatient benefits during the fiscal years at issue.

Significantly, neither 42 C.F.R. § 412.106(b)(4) nor the discussion in the preamble to the 2003 Final Rule state that inpatient benefits must be delineated in the § 1115 waiver documents approved by CMS and/or that such benefits must be guaranteed under the § 1115 waiver. Rather, the preamble discussion only states in generic terms that inpatient benefits must be "received" under the § 1115 waiver.[45] This is a much lower bar and the evidence demonstrates that the days at issue meet this hurdle.

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[40] The Special Terms and Conditions describe CCHIP as "a commercial insurance-based premium assistance program" and stating that "[p]remium assistance is offered for purchase of health benefits from an MCO either licensed under MCL c. 175 by the Massachusetts Division of Insurance or substantially compliant with licensure requirements." Provider Exhibit P-18 at 30. However, it does not specify what "health benefits" such MCOs would be providing.

[41] *See* Provider Exhibit P-1 at 41 (session laws of 2006); Mass. Gen. Laws ch. 118H, § 6 (2013) (included at Provider Exhibit P-2 at 8).

[42] Mass. Gen. Laws ch. 118H, § 6 (2013).

[43] Providers' Post-Hearing Brief at 12 n.39 (emphasis added).

[44] *See, e.g.,* Provider Exhibit P-6 (contains information from CCHIP's website on the types of plans offered for all CCHIP beneficiaries (including those above 100 percent of FPL) and inpatient benefits is specifically listed).

[45] *See* 68 Fed. Reg. at 45420-45421.

Based on the above, we conclude that there is sufficient evidence to find that CCHIP beneficiaries received inpatient benefits as part of their benefit package under the § 1115 waiver and that the Medicare Contractor should include the CCHIP days at issue in the Providers' Medicare DSH adjustment calculation for the fiscal years at issue.

/s/
Clayton J. Nix, Esq.

/s/
Charlotte F. Benson, CPA

DATE: January 27, 2017

APPENDIX A

CASE NO. 14-1394GC

	Provider No.	Provider Name	FYE
1	22-0001	HealthAlliance Hospital, Inc.	9/30/2009
2	22-0049	Marlborough Hospital	9/30/2009
3	22-0058	UMMHC – Clinton Hospital	9/30/2009
4	22-0163	UMass Memorial Medical Center	9/30/2009

CASE NO. 14-1732GC

	Provider No.	Provider Name	FYE
1	22-0017	Steward Carney Hospital	9/30/2009
2	22-0020	St. Anne's Hospital	9/30/2009
3	22-0036	St. Elizabeth's Medical Center	9/30/2009
4	22-0067	Quincy Medical Center	9/30/2009
5	22-0073	Morton Hospital and Medical Center	9/30/2009
6	22-0080	Holy Family Hospital	9/30/2009
7	22-0111	Good Samaritan Hospital	9/30/2009
8	22-0174	Merrimack Valley Hospital	9/30/2009