CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Akin Gump 2006-2008 Florida Low Income Pool Waiver Days Groups	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: Various**
Provider	
vs.	
Medicare Administrative Contractors First Coast Service Options, Inc.	**Review of: PRRB Dec. No. 2018-D49 Dated: September 21, 2018**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. The CMS' Center for Medicare (CM) submitted comments, requesting review and modification of the Board's decision. The Provider also submitted comments requesting that the Administrator reverse the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether, a certain category of Medicaid waiver days should be included in the numerator of the Medicaid fraction used to calculate the Providers' disproportionate share hospital (DSH) payments. The specific days at issue are attributable to patients who received assistance under Florida's Low-Income Pool (LIP) Medicaid waiver.

The Board held that the Medicare Administrative Contractor (MAC) properly excluded patient days associated with Florida's LIP § 1115 waiver days from the numerator of the Medicaid fraction when calculating the Providers' DSH payment. In reaching this determination the Board concluded that the Secretary intended to limit the inclusion of patient days in the DSH calculation to individuals who become eligible under the terms of a

waiver program or who receive specific medical services provided under a waiver program. The Board concluded that there was no defined group of eligible Medicaid or § 1115 waiver individuals receiving benefits under the Florida's LIP program to determine whether the benefits from the program were similar to traditional Medicaid benefits.

SUMMARY OF COMMENTS

The CM submitted comments requesting that the Administrator review and affirm the Board's decision but on alternative grounds. CM agreed with the Board's determination but believes that the legal arguments supporting the Board's conclusion are not focused on the primary reason that the days should not be included. The Board's determination is based on there not being a defined group of patients receiving benefits under the program instead of whether Florida's LIP program provides inpatient hospital benefits to individuals.

CM contends that the days associated with Florida's LIP are charity care days and therefore, not "eligible for medical assistance" for purposes of inclusion in the numerator the Medicaid faction. CM insists that "patients must be eligible for medical assistance inpatient hospital benefits under an approved State Medicaid plan (or similar benefits, including inpatient hospital benefits, under a § 1115 demonstration project) in order for their hospital inpatient days to be counted as Medicaid days in the calculation of a hospital's DSH patient percentage."[1] In this case, CM argues that Florida's LIP does not meet this requirement because the Florida's LIP does not provide benefits to individual patients; it provides benefits to hospitals. The actual benefits received under Florida's LIP are direct payments and distributions to safety net providers to offset hospitals' uncompensated costs of providing health care to uninsured and underinsured populations. A payment to offset uncompensated costs is not an inpatient hospital benefit.

The Provider submitted comments requesting that the Administrator review and reverse the Board's decision. The Provider contends that the Board's decision and CMS' comment are both contrary to the terms and conditions of the waiver, which plainly specified that the LIP population was "made eligible" under the waiver. They are also incompatible with the plain language and prior statements of the intent of the DSH regulation, which imposes no requirement that a State must make individualized eligibility determinations or that an individual must be eligible to enroll in the LIP waiver program.

The Board's decision and CMS' comment ignore the plain language of the waiver's terms and conditions, which expressly include individuals covered under the LIP program as "Medicaid eligibility group or MEG, under the waiver. The purpose of the waiver is to permit the state to provider healthcare benefits to low-income individuals who are expressly defined by CMS as a Medicaid eligibility group in the waiver approval documents. More

[1] 68 Fed. Reg. 45346, 45420-21 (Aug. 1, 2003)(final rule).

specifically, the STC at page 25 expressly state that "[f]unds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. Inpatient hospital services are included in that statutory definition of medical assistance. Accordingly, the waiver provides coverage for medical costs – including inpatient hospital services – for a finite group of patients that are specifically defined as Medicaid eligibility group under the terms of the waiver.

The Board's rationale and CMS' argument find no support in the DSH regulation or in section 1115 of the Act. Neither the Board nor CMS dispute that the LIP payments at issue here were made for inpatient hospital services. Instead, they contend that the LIP waiver does not provide benefits for any particular individual. But neither the Board nor CMS argues that payment for individual's inpatient hospital care is not a benefit to him or her; rather, their only point is that the LIP waiver does not require individualized eligibility determination by the State and does not involve individual enrollment in the program. In essence, the Board and CMS would require that in order for the LIP waiver days to be included in the DSH calculation, the LIP population must be required to apply for coverage and become enrolled in a program, which presently the DSH regulations do not impose. To the contrary, the regulation itself only requires that the patient be "eligible for inpatient hospital services" under an approved waiver.

For these reason, the Provider request that the Board's decision be reversed and that the Administrator order that all of the Florida LIP waiver days at issue be included in the numerator of the Medicaid fraction.

DISCUSSION

Since the implementation of the Prospective Payment System (PPS) in 1983, hospitals have been paid prospectively based on a formula that takes into account operating cost, primarily on a regional level, and utilizes diagnosis-related groups (DRGs) adjusted for regional differences. However, Congress has mandated a number of supplements to PPS that qualifying hospitals can receive. In 1986, Congress passed one such supplement providing for additional payments for hospitals that treat a "significantly disproportionate number of low income patients."[2] These payments are known as Disproportionate Share Hospital (DSH) payments or adjustments. The DSH adjustment available to hospitals is dependent on a hospital's disproportionate patient percentage (DPP). The DPP is determined by adding tow fractions, the Medicare and Medicaid fractions, as proxies for a hospital's low income patient population.[3]

[2] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[3] 42 U.S.C. § 1395ww(d)(5)(F)(vi).

Section 1115 Waivers

Section 1115 of the Act allows, the Secretary to waive, *inter alia*, selected provisions of §1902 of the Act for experimental, pilot, or demonstration projects (demonstrations). Federal Financial Participation (FFP) is provided for demonstration costs which would not otherwise be considered as expenditures under the Medicaid State plan, when the Secretary finds that the demonstrations are likely to assist in promoting the objectives of Medicaid. Section 1115(a) states in pertinent part that:

> In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title …. XIX, … in a State or States—
>
> (1) the Secretary may waive compliance with any of the requirements of section, … 1902, … to the extent and for the period he finds necessary to enable such State or States to carry out such project, and
>
> (2)(A) costs of such project which would not otherwise be included as expenditures under section, …1903, …shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, as may be appropriate, …

The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as: expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible; providing services not typically covered by Medicaid; using innovative service delivery systems that improve care, increase efficiency, and reduce costs. In general, § 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years. Demonstrations must be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver.[4]

States have used § 1115 demonstrations for different reasons. Some States have tested new approaches to providing coverage or improving the scope or quality of benefits in ways that would not otherwise be permitted under the statute. For example, some States have used § 1115 demonstrations to expand eligibility to individuals who would not otherwise qualify for benefits, or to establish innovative service delivery systems. Other demonstrations have constrained eligibility or benefits in ways not otherwise permitted by statute. For example, some demonstrations have provided for a more limited set of benefits than the statute

[4] See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html

requires for a specified population, implemented cost-sharing at levels that exceed statutory requirements, or included enrollment limits. Some demonstrations have involved financing approaches that are not contemplated in titles XIX of the Act. As such, demonstrations can have a significant and varied impact on beneficiaries, providers, States, Tribes and local governments. They can also influence policy making at the State, Tribal and Federal level, by introducing new approaches that can be a model for other States and lead to programmatic changes nationwide.[5]

CMS requires States to submit historical Medicaid expenditure data to support analysis needed to establish budget neutrality for all populations that will be affected by a proposed demonstration. In most cases, States must show on the basis of reasonable (with-and-without-waiver) cost projections that the proposed demonstration will not cost the Federal government more than the program could have cost in the demonstration's absence. Once the demonstration is operational, CMS requires States to report their actual expenditures, which are tracked and compared to the without-waiver estimates (which may be adjusted to account for caseload changes), to ensure that the demonstration remains budget neutral. Any Federal funding received by the State in excess of the without-waiver estimate must be returned to CMS.[6]

Inpatient Prospective Payment under Medicare

While Title XIX implemented medical assistance pursuant to a cooperative program with the States for certain low-income individuals, the Social Security Amendments of 1965[7] established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health,

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[5] "Medicaid Program; Review and Approval Process for Section 1115 Demonstrations", 75 Fed Reg. 56946 (September 17, 2010); "Medicaid Program; Review and Approval Process for Section 1115 Demonstrations; Application, Review, and Reporting Process for Waivers for State Innovation"; (Final Rules), 77 Fed Reg. 11677-11700 (February 27, 2012). Section 10201(i) of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148, enacted March 23, 2010) (the Affordable Care Act) also amended section 1115 of the Act by adding a new subsection (d) to require the Secretary to issue regulations within 180 days of enactment that would ensure the public has adequate opportunities to provide meaningful input into the development of State demonstration projects, as well as in the Federal review and approval of State demonstration applications and renewals.

[6] 77 Fed Reg. 11677-11700. *See also* "Insuring the Poor Through Section 1115 Medicaid Waivers." Coughlin, Lipman, Raja, *Health Affairs*, V 4, No. 1 (1995)(199-216). "The other Medicaid expansion authority is the section 1115 research and demonstration waiver. These waivers are designed to permit states to develop innovative solutions to a variety of health and welfare problems …The federal government may waive a number of standing Medicaid rules provided that the change is budget –neutral that is that the costs are no higher than would be expended in the absence of the waiver. ...[S]tates had requested authorization to expand coverage to the uninsured using existing Medicaid funds to pay for the expansion, all of these states propose to achieve savings by using manage care plans to serve current Medicaid recipient and to limit the cost of new enrollees. States often propose to use current disproportionate share hospital payments to expand coverage, rather than using these funds to make lump sum payment to hospitals. States often propose to use savings from reductions in other state programs in some cases state's propose new revenues. The end result is that in principle coverage for the uninsured is expanded at relatively small new government cost." CRS Report for Congress. "Medicaid and SCHIP Section 1115 Research and Demonstration Waivers," Evelyne Baumrskins (September 2008)("The programs also vary in the way they are financed. The two most prominent sources are 1) savings resulting from increased use of manage care by current and newly entitled enrollees and 2) Medicaid disproportionate share hospital funding diverted from …hospitals. States also rely on premium control from Medicaid and cuts in other state programs.)

[7] Pub. Law No. 89-97.

and hospice care,[8] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[9] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[10] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[11] This provision added §1886(d) of the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[12]

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimburse their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based on diagnosis related groups or DRG subject to certain payment adjustments.

The Medicare DSH Adjustment

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to §1886(d)(5)(F)(i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…."[13] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[14] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, *alia inter*, its disproportionate patient percentage. Relevant to this case, with respect to the proxy method, §1886(d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" and the Medicaid low-income proxy", respectively, and are defined as follows:

> (I) the fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State

[8] Section 1811-1821 of the Act.
[9] Section 1831-1848(j) of the Act.
[10] Under Medicare, Part A services are furnished by providers of services.
[11] Pub. L. No. 98-21.
[12] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).
[13] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See also 51 Fed. Reg. 16772, 16773-16776 (1986).
[14] The Pickle method is set forth at section 1886(d)(F)(i)(II) of the Act.

> supplementation) under title XVI of this Act and the denominator of which is the number of such hospital's patients day for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this title.
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> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consists of patients who (for such days) were eligible for medical assistance under a State Plan approved under title XIX, but who were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital patient days for such period. (Emphasis added.)

CMS implemented the statutory provisions at 42 C.F.R. §412.106(2006). The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 C.F.R. §412.106(b)(2)(2006). Relevant to this case, the second computation, the "Medicaid-low income proxy", or "Clause II", is set forth at 42 C.F.R. §412.106(b)(4)(2006) and provides that:

> *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period…. (Emphasis added.)

Although not at issue in this case, CMS revised 42 C.F.R. 412.106(b)(4) to conform to HCFA Ruling 97-2, which was issued in light of Federal Circuit Court decisions disagreeing with CMS' interpretation of a certain portion of §1886(d)(5)(vi)(II) of the Act. In conjunction with this revision, CMS issued a Memorandum dated June 12, 1997, which explained the counting of patient days under the Medicaid fraction, stating that:

> [I]n calculating the number of Medicaid days, fiscal intermediaries should ask themselves, "Was this person a Medicaid (Title XIX beneficiary on that day of service?' If the answer is "yes," the day counts in the Medicare disproportionate share adjustment calculation. This does not mean that title XIX had to be responsible for payment for any particular services. It means that the person had to have been determined by a State agency to be eligible for Federally-funded medical assistance for any one of the services covered under the State Medicaid Title XIX plan (even if no Medicaid payment is made for inpatient hospital services or any other covered service)….

In order to clarify the definition of eligible Medicaid days and to communicate a hold harmless position for cost reporting periods beginning before January 1, 2000, for certain providers, CMS issued Program Memorandum (PM) A-99-62, dated December 1999. The

PM responded to problems that occurred as a result of hospitals and intermediaries relying on Medicaid State days data obtained from State Medicaid Agencies to compute the DSH payment that commingled the types of otherwise ineligible days listed with the Medicaid days.

In clarifying the type of days that were proper to include in the Medicaid proxy, the PM A-99-62 stated that the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. The PM explained that:

> 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). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits 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.

Consistent with this explanation of days to be included in the Medicare DSH calculation, the PM stated regarding the exclusion of days, that:

> Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program…. These beneficiaries, however, are not eligible for Medicaid under a State [P]lan approved under Title XIX, and therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical

> assistance beneficiaries, then it must contact the State for assistance in doing so.
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> In addition, if a given patient day affects the level of *Medicaid* DSH payments to the hospital, but the patient is not eligible for Medicaid under a State [P]lan approved under Title XIX on that day, the day is not included in the *Medicare* DSH calculation.
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> ****
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> Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. (Emphasis added.)

An attachment to the PM describes the type of day, description of the day and whether the day is a Title XIX day for purposes of the Medicare DSH calculation. In particular, the attachment describes "general assistance patient days" as "days for patients covered under a State–only (or county only) general assistance program (whether or not any payment is viable for health care services under the program). These patients are not Medicaid–eligible under the State plan." The general assistance patient day is not considered an "eligible Title XIX day." "Other State-only health program patient days" are described as "days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State program." Likewise, State-only health program days are not eligible Title XIX days. Finally, charity care patient days are described as "days for patients not eligible for Medicaid or any other third-party payer and claimed as uncompensated care by a hospital. These patients are not Medicaid eligible under the State plan." Charity care patient days are not eligible Title XIX days.[15]

In the August 1, 2000 Federal Register, the Secretary reasserted the policy regarding general assistance days, State-only health program days, and charity care days.

> General assistance days are days for patients covered under a State-only or county-only general assistance program, whether or not any payment is

[15] *See also*, Program Memorandum (PM) Transmittal A-01-13 which reasserted the policy regarding general assistance days, State-only health program days and charity care days. In addition, The PM, while restating certain longstanding interpretations in the background material, clarified certain other points for cost reporting periods beginning on or after January 1, 2000, with respect to a hold harmless policy. See Transmittal A-01-13; Change Request 1052 (January 25, 2001). The scope and basis for the hold harmless policy is set forth at length in the program memorandum. The Providers did not claim that the hold harmless policy was applicable to their cost reporting periods, prior to January 1, 2000. *See Cookville Regional Medical Center 531 F. 3d 844 (2008)(*"Before January 2000, the Secretary's policy was not to include expansion waiver patients in the Medicaid fraction. Dep't of Health & Human Servs., *Program Memorandum Intermediaries*, Trans. No. A-99-62 (Dec.1999). Despite this policy, some financial intermediaries included the expansion waiver population in the disproportionate share hospital adjustment. *Id.* The Secretary recognized this as a violation of the stated policy but did not attempt to recover the payments. *Id.")*

> available for health care services under the program. Charity care days are those days that are utilized by patients 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 under the State plan and are not considered Titled XIX beneficiaries.[16]

The Medicare DSH Adjustment/Section 1115 Wavier

Prior to 2000, the Secretary's policy was to include in the Medicare DSH calculation, only those days for populations under the Title XI § 1115 waiver who were or could have been made eligible under a State plan. The patient days of the "expanded" eligibility groups, however, were not to be included in the Medicare DSH calculation.[17] The policy of excluding § 1115 waiver expansion populations from the DSH calculation was revisited by CMS and, effective with discharges occurring on, or after, January 20, 2000, certain § 1115 waiver expansion days were to be included in the Medicare DSH calculation in accordance with the specific instructions as specified in more detail in the January 20, 2000 Federal Register.[18]

As the Secretary explained, some States provide medical assistance under a demonstration project (also referred to as a section 1115 waiver). In some § 1115 waivers, a given population that otherwise could have been made eligible for Medicaid under §§ 1902(r)(2) or 1931(b) in a State plan amendment is made eligible under the waiver. These populations are referred to as hypothetical eligibles, and are specific, finite populations identifiable in the budget neutrality agreements found in the Special Terms and Conditions (STC) for the demonstrations and the patient days utilized by that population are to be recognized for purposes of calculating the Medicare DSH adjustment. In addition, the § 1115 waiver may provide for medical assistance to expanded eligibility populations that could not otherwise be made eligible for Medicaid. At the time of the January 20, 2000 pronouncement, hospitals were to include in the Medicare DSH calculation only those days for populations under the § 1115 waiver who were or could have been made eligible under a State plan. Patient days of the expanded eligibility groups, however, were not to be included in the Medicare DSH calculation.[19] The Secretary stated that:

> In this interim final rule with comment period, we are revising the policy, effective with discharges occurring on or after January 20, 2000, to allow hospitals to include the patient days of all populations eligible for Title XIX

[16] 65 *Fed. Reg*. 47054 at 47087 (Aug. 1, 2000).
[17] 65 *Fed. Reg*. 3136 (Jan. 20, 2000).
[18] *Id.*
[19] *Id.*

> matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment.
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> One purpose of a section 1115 expansion waiver is to extend Title XIX matching payments to services furnished to populations that otherwise could not have been made eligible for Medicaid. The costs associated with these populations are matched based on section 1115 authority. In fact, section 1115(a)(2)(A) of the Act states that the "costs of such project which would not otherwise be included as expenditures under section * * * 1903 * * * shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures * * * approved under (Title XIX)." Thus, the statute allows for the expansion populations to be treated as Medicaid beneficiaries.
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> In addition, at the time that the Congress enacted the Medicare DSH adjustment, there were no approved section 1115 expansion waivers. Nonetheless, we believe allowing hospitals to include the section 1115 expanded waiver population in the Medicare DSH calculation is fully consistent with the Congressional goals of the Medicare DSH adjustment to recognize the higher costs to hospitals of treating low income individuals covered under Medicaid. Therefore, inpatient hospital days for these individuals eligible for Title XIX matching payments under a section 1115 waiver are to be included as Medicaid days for purposes of the Medicare DSH adjustment calculation.[20]

Relevant to this issue, the Secretary addressed concerns regarding the § 1115 waiver in the August 1, 2000 Federal Register stating that:

> Some States provide medical assistance (Medicaid) under a demonstration project (also referred to as a § 1115 waiver). Under policy in existence before the January 20, 2000 interim final rule, hospitals were to include in the Medicare DSH calculation only those days for populations under the section 1115 waiver who were or could have been made eligible under a State Medicaid plan. Patient days of the expanded eligibility groups, however, were not to be included in the Medicare DSH calculation.
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> In the January 20, 2000 interim final rule with comment period, we revised the policy, effective with discharges occurring on or after January 20, 2000, to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the

[20] 65 *Fed. Reg.* 3136, 3136-3137.

> hospital's Medicare DSH adjustment. This policy was reflected in a revision to §412.106 of the regulations.

The Secretary also addressed the general assistance/charity car days generally, stating that:

> 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 patients 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 under the State plan and are not considered Title XIX beneficiaries.[21] (Emphasis added.)

In addition, the Secretary again spoke to the issue of §1115 days in the "Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates" 68 Fed. Reg. 27154 May 19, 2003) and final rule at 68 Fed. Reg. 45346 (August 1, 2003).

> [W]e have become aware that there are certain section 1115 demonstration projects that serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan. These section 1115 demonstration projects extend coverage only for specific services and do not include inpatient care in the hospital. Because of the limited nature of the coverage offered, the population involved may have a significantly higher income than traditional Medicaid beneficiaries.
>
> In allowing hospitals to include patient days related to section 1115 expansion waiver populations, our intention was to include patient days of section 1115 expansion waiver populations who receive benefits under the demonstration project that are similar to those available to traditional Medicaid beneficiaries, including inpatient benefits. Because of the differences between expansion populations in these limited benefit demonstrations and traditional Medicaid beneficiaries, we are proposing that the Medicare DSH calculation should exclude from treatment as Medicaid patient days those patient days attributable to limited benefit section 1115 expansion waiver populations (proposed § 412.106(b)(4)(i)).

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[21] "Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates", 5 FR 47054, 47086-87 (August 1, 2000).

> As we have noted previously, at the time the Congress enacted the Medicare DSH adjustment provision, there were no approved section 1115 demonstration projects involving expansion populations and the statute does not address the treatment of these days. 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.

Consequently, for the cost years involved the regulation at 42 CFR 412.106(b) stated in relevant part that:

> (4) Second computation. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day *only if the patient is eligible for inpatient hospital services* under an approved State Medicaid plan *or under a waiver authorized under section 1115(a)(2) of the Act on that day,* regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
> (ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, *hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.*
> (iii) The *hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day* claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

The Deficit Reduction Act of 2005 (DRA)[22]

The DRA of 2005 clarified the treatment by the Secretary of § 1115 waiver days, stating that:

> Section 5002. Clarification of Determination of Medicaid patient days for DSH computation.
> (a) In General.—Section 1886(d)(5)(F)(vi) of the Social Security Act is amended by adding after and below subclause (II) the following:
> "In determining under subclause (II) the number of the hospital's patient days for such period which consist 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.".
> (b) Ratification and prospective application of previous regulations.—
> (1) In General.—Subject to paragraph (2), regulations described in paragraph (3), insofar as such regulations provide for the treatment of individuals eligible for medical assistance under a demonstration project approved under title XI of the Social Security Act under section 1886(d)(5)(F)(vi) of such Act, are hereby ratified, effective as of the date of their respective promulgations.
> (2) No Application to closed cost reports.—Paragraph (1) shall not be applied in a manner that requires the reopening of any cost reports which are closed as of the date of the enactment of this Act.
> (3) Regulations Described.—For purposes of paragraph (1), the regulations described in this paragraph are as follows:
> (A) 2000 Regulation.—Regulations promulgated on January 20, 2000, at 65 Federal Register 3136 et seq., including the policy in such regulations regarding discharges occurring prior to January 20, 2000.
> (B) 2003 Regulation.—Regulations promulgated on August 1, 2003, at 68 Federal Register 45345 *et seq.*

Subsection (a) added language to § 1886(d)(5)(F)(vi) of the Act that was essentially identical to the language already in § 1115(a) that: "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 received benefits under a demonstration project approved under Title XI."

[22] Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, § 5002, 120 Stat. 4, 31 (February 8, 2006) (codified in part at 42 U.S.C. § 1395ww (d) (5) (F) (vi) (II).

The Florida Section 1115 Waiver

In this case, the Providers argue that the MAC erred in excluding Florida's LIP § 1115 waiver days from the final settlement of the cost reports because the plain text of the statute and regulations specify that the LIP is a Medicaid Reform eligibility groups (MEGs),under the waiver.[23] The Provider asserts that the LIP payment cannot be differentiated from the § 1115 waiver "expansion" group whose inpatient days do qualify for Medicare DSH calculations. The Administrator finds that under CMS regulations, days of care may be included in the Medicaid fraction in only two situations: (1) where the patient to whom the care is furnished is made eligible for inpatient hospital services by the waiver; or (2) where the patient to whom the care is furnished is in a population eligible for Title XIX matching payments under a waiver (expansion population). Neither situation is implicated here.

In October 2005, CMS approved the State of Florida's § 1115 waiver program for a period of 5-years, effective from July 1, 2006 through June 30, 2011.[24] One component of Florida's §1115 waiver program, the Low Income Pool (LIP), is a one billion dollar fund designed and intended to offset safety net providers' uncompensated costs of providing health care services to Medicaid and the uninsured and underinsured population.[25]

A review of Florida's § 1115 waiver program and the STC specifically at section 15 shows that the LIP program was put in place as part of Florida's transition from fee-for-service provider reimbursement to capped monthly payments to managed care providers. The LIP was to replace the State's Upper Payment Limit (UPL) funding mechanism for hospitals.[26] The Hospital Upper Payment Limit (UPL) program is a supplemental payment mechanism based upon Federal Medicaid regulations that allow States to make special Medicaid payments to compensate certain providers to make up the difference between Medicaid and Medicare payments for hospital services.[27] Federal law specifies that UPL calculations must only rely on services utilized by Medicaid beneficiaries that are paid on a fee-for-services basis.[28] Services provided to Medicaid beneficiaries in a managed care environment on a capitated basis cannot be counted for UPL payments. Thus, the structure of the UPL program prohibits hospitals from access to the UPL program payment for services provided to Medicaid patients enrolled in managed care plans, requiring a change in how the State of Florida distributed the supplemental UPL funds as it transitioned to a

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[23] *See* Provider's Comments, dated October 31, 2018 at pg. 2. *See also*, Special Terms and Conditions at 29 (stating that "Florida Medicaid Reform eligibility groups (MEGs), for reporting purposes, includes the LIP.

[24] *See* Provider's Exhibit P-4, Centers for Medicare and Medicaid Services, Florida Medicaid Reform Section 1115 Demonstration, Special Terms and Conditions (STC).

[25] *Id.* pg., 2.

[26] *See* MAC's Exhibit I-2, pg. 24 – 28; *See also*, https://www.gao.gov/new.items/d08614.pdf Medicaid CMS Needs More Information on the Billions of Dollars Spent of Supplemental Payments, May 2008.

[27] *See* 42 C.F.R. § 447.272 (2006). (42 CFR 447.272(b) states: "General rules. (1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter. (2) Except as provided for in paragraph (c) of this section, aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) of this section may not exceed the upperpayment limit described in paragraph (b)(1) of this section...")

[28] *See*, 42 C.F.R. § 438.60(2008).

Medicaid managed care environment. Because of this, in order to not financially disadvantage the Florida State Medicaid program providers, the subject Medicaid managed care waiver replaced the UPL program with a different supplemental program called the LIP which allowed payments that, *inter alia*, would allow Medicaid providers to not be disadvantaged by the transition to a Medicaid managed care setting of the services.[29]

As part of CMS' STC, paragraph 94 of § 15 states that:

> *Low Income Pool Permissible Expenditures*. Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS.

This STC provision states that funds from the LIP may be used for health care expenditures that would be "within the definition of medical assistance in Section 1905(a) of the Act" to cover for Medicaid shortfalls and uncompensated care. Such funds are not "medical assistance" for an individual eligible under the waiver but a definition of the type of uncompensated costs for which supplemental payments may be made to providers. The record and STC as reflected in Paragraph 15 shows that the LIP was a pool of State and Federal money which allowed the State of Florida to directly reimburse providers for the uncompensated cost of care that they provided to the uninsured, non-Medicaid-eligible patients.[30] The distribution of funds to the providers did not, however, make the individual

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[29] See Paragraphs 16, p. 26 of the Special Terms and Conditions, Medicaid Reform Section 1115 Demonstration, State of Florida Agency for Health Care Administration, Number: 11--W-00206/4 ("XVI. LOW INCOME POOL MILESTONES. 100..Pre-Implementation Milestones. The availability of funds for the LIP in the amount of $1 billion is contingent upon the following items prior to implementation: a. The State's submission and CMS approval of a Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP and entities eligible to receive reimbursement. b. Florida's submission and CMS approval of a State Plan Amendment (SPA) that will terminate the current inpatient supplemental payment limit (UPL) program effective July l, 2006, or such earlier date specific to the implementation of this demonstration. Nothing herein precludes the State from submitting a State Plan Amendment reinstituting· inpatient hospital supplemental payments upon termination of this demonstration. The State agrees not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration. c. The State shall submit a State Plan Amendment for CMS approval limiting the inpatient hospital payment for Medicaid eligibles to Medicaid cost as defined in the CMS 2552-96. d. The State shall submit for CMS approval of all sources of non-Federal share funding to be used to access the LIP. The sources of the non-Federal share must be compliant with all Federal statutes and regulations. e. The State's ability to access the restricted portion of funds at the time of implementation and for the duration of the demonstration shall be contingent upon the State's capacity to meet the following milestones outlined in this Section.")

[30] See Paragraphs 15 and 16, pp-24-26 of the Special Terms and Conditions, Medicaid Reform Section 1115 Demonstration, State of Florida Agency for Health Care Administration, Number: l1--W-00206/4
("XV. LOW INCOME POOL. 91. Low Income Pool Definition. A Low Income Pool (LIP) will be established to ensure continued government support for the provision of health care services to-Medicaid, underinsured and uninsured populations. The low-income pool consists of a capped annual allotment of $1 billion total computable for each year of the 5-year demonstration period. 92. Availability of Low Income Pool Funds. Funds in the LIP will become available upon implementation of Florida Medicaid Reform, which shall be no later than July I, 2006, provided the pre-implementation milestones are met as discussed below in Section XVI "Low Income Pool Milestones."93.Reimbursement and Funding Methodology Document. In order to define LIP permissible expenditures the State shall submit for CMS approval a Reimbursement and Funding

uninsured or underinsured patients eligible for inpatient services under Medicaid or through the section 1115 waiver.

For Medicare DSH payment purposes, CMS regulations provide that, for the purposes of inclusion in the numerator of Medicaid fraction, "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…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 authorized waiver." 42 C.F.R. § 412.106(b)(4)(i).[31] As noted above, the Secretary in 2003, clarified her policy on including § 1115 payments as days in the Medicaid fraction: she would include these § 1115 payments as DSH patient days "only to the extent that those *individuals* receive inpatient benefits under the section 1115 demonstration project."[32]

This is in contrast with the pool of funds used to benefit and pay safety net providers' to help cover the uncompensated costs of providing health care services to, inter alia, the uninsured and underinsured population, with funds that were partially funded via Federal matching funds. The LIP -Serves a different purpose and that is to provide funds, as determined solely by the Florida State legislature and not based on any specific patient or patient day.[33] The

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Methodology document for the LIP expenditures and LIP parameters defining State authorized expenditures from the LIP and entities eligible to document will need to be submitted as an amendment to the demonstration as defined in item six in Section ill, "General Program Requirements."94. Low Income Pool Permissible Expenditures. Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section l905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for_ the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed-upon by the State and CMS. 95 .. Low Income Pool Expenditures. Non.-Qualified Aliens. LIP funds cannot be used for costs associated with the provisions of health care to non-qualified aliens. 96. Low Income Pool Permissible Expenditures 10 percent Sub Cap. Up to 10 percent of the capped annual allotment of the LIP funds may be used for hospital expenditures other than payments to providers for the provision of health care services to an uninsured or underinsured individual. Payments from this sub-cap may be used for the improvement or continuation of specialty health care services that benefit the uninsured and underinsured, such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services, pediatric hospital services, teaching or specialty hospital services, or safety net providers. The reimbursement methodologies for these expenditures and the non-Federal share of funding for such expenditures will be defined in the Reimbursement and Funding Methodology Document as discussed in item 91 of this section and Section XVI, "Low Income Pool Milestones.") 97. Low Income Pool Permissible Hospital Expenditures-.Hospital cost expenditures from the LIP will be paid at cost and will be further defined in the Reimbursement and Funding Methodology Document utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs. The State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost t}lld this requirement is further clarified with the submission of a corresponding State Plan Amendment, as .outlined in the pre-implementation milestones in Section XVI, "Low Income Pool Milestones,." 98. Low Income Pool Permissible Non-Hospital Based Expenditures. To ensure services are paid at cost, CMS and the State will agree upon cost-reporting strategies and define them in the Reimbursement and Funding Methodology document for expenditures for non-hospital based services. 99. Permissible Sources of Funding Criteria. At least, 120 days prior to the demonstration implementation the State must submit for CMS approval the source of non-Federal share used to access the LIP, as-outlined in the pre-implementation milestones. The State shall not have access to these funds until the source of non-Federal share has been approved by CMS. CMS assures the State that it will review the sources of non-Federal share in a timely manner. Sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes) shall be impermissible.")

[31] *See* 42 C.F.R. § 412.106(b)(4)(i) as added by 68 Fed. Reg. 45346, 45420-21 (Aug. 1, 2003)(final rule).

[32] *See*, 68 Fed. Reg. 45346, 45420-21; 42 C.F.R. § 412.106(b)(4)(i).

[33] For a historical overview of the transition from the UPL funding mechanism to the LIP supplemental payment pool, *see* e.g., The Florida Senate Interim Report 2010-120 January 20 IO Committee on Health Regulation SUPPLEMENT AL MEDICAID PAYMENT http://archive.flsenate.gov/data/publications/20 l 0/Senate/reports/interim _reports/pdf/2010-120hr.pdf ("LIP/Medicaid Reform The LIP was established as part of the Medicaid managed care demonstration project. During the 2005 legislative session, CS/CS/SB 838 (enrolled) was passed authorizing the Agency to apply for a waiver to implement a Medicaid managed care pilot program. The waiver authority, codified in s. 409.91211, F.S., also included the creation of a LIP to replace the UPL funding mechanism for hospitals, provisions to preserve the state's ability to use IGTs, and provisions to protect the DSH program. Pursuant to the authority provided in CS/CS/SB 838 (enrolled) the Agency received

"Medicaid eligible group" or MEG as the "Low Income Pool" and not the uninsured/under insured individuals who may have incurred the uncompensated care costs.

Uncompensated care pools, such as the LIP, are a type of charity care program that can be funded in part by Federal Title XIX matching funds. Courts in multiple circuits have reviewed the application of CMS' policy to charity care programs, that is, supplemental payments used to pay uncompensated/charity care, under a State plan as well as other types of days similar to Florida's LIP days and have upheld CMS' policy of excluding charity days from the DSH calculation as an acceptable interpretation of section 1886(d)(5)(F)(vi)(II) of the Social Security Act and a proper application of its regulation. The individual patients underlying the subject days were not "eligible for medical assistance" under either title XIX or a waiver for purposes of inclusion in the numerator of the Medicaid fraction.[34] That the uncompensated care/charity care pool is implemented pursuant to the· waiver of the UPL supplemental payment program does not transform the former UPL program into a program for an expanded population. The Low Income Pool, as its name indicates, does not make individuals eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act, but rather, provides a pool of funds for the benefit of Hospitals who may share in its distribution for uncompensated care through a waiver approved under section 1115 of the Social Security Act.

CMS has repeatedly explained that uncompensated care/charity care pools do not meet that standard whether provided under an approved State plan (e.g., Medicaid DSH supplemental payment) or as a supplemental payment pursuant to a waiver. Case law has previously upheld that supplemental (uncompensated care) payments (such as for Medicaid DSH pool) are not "medical assistance" as that term is used in the statute for the Medicare DSH calculation nor "inpatient hospital services under an approved State Medicaid plan or...authorized under section 1115(a)(2) of the Act on that day." Similar to the cases involving Medicaid DSH pools, there is not a waiver patient population that is eligible for

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approval of the waiver application on October 19, 2005. The federally-approved waiver are accompanied by Special Terms and Conditions (numbered 11- W-00206/4) which, combined, constitute the guiding agreement between the state and the federal government on the implementation of the Medicaid reform proposal. Florida's Medicaid Reform Waiver is a 5-year demonstration, which began July l, 2006 and runs through June 30, 2011. The Centers for Medicare and Medicaid Services (CMS) Special Terms and Conditions (STC) document describes the details of the Medicaid Reform 1115 demonstration waiver. Section 15 of the STC describes the creation of the LIP. The LIP: Replaces the hospital upper payment limit (UPL) program; Was established to ensure continued government support for the provision of health care services to Medicaid, underinsured, and uninsured populations; and Is a capped annual allotment of$ l billion total computable for each year of the 5-year Medicaid demonstration period. [] According to the STC, funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Social Security Act. These health care expenditures may be incurred by the state, by hospitals, clinics, or by other provider types f6r uncompensated medical care costs of medical services for the uninsured and Medicaid shortfalls (after all other Title XIX payments are made). The LIP can also be used for payments for provider access systems and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the state and the federal CMS. The STC require the state to submit a yearly Reimbursement and Funding Methodology document for LIP expenditures that includes: LIP parameters, state-authorized expenditures from the LIP and entities eligible to receive reimbursement, for CMS approval. In order for Florida to access the total annual $l billion annual allocation of LIP funds, the STC outlines milestones that must be met by the state for each year of the Medicaid demonstration.")

[34] These cases include *Adena Regional Medical Center v. Leavitt,* 527 F.3d 176 (D.C. Cir. 2008); *Cooper University Hosp. v. Sebelius,* 686 F.Supp.2d 483 (D.N.J. Sep 28, 2009); *aff'd* 636. F.3d 44 (3rd Cir. Oct 12, 2010) *University of Washington Medical Center v. Sebelius,* 634 F.3d 1029 (9th Cir 2011); *Covenant Health Sys. v. Sebelius,* 820 F. Supp. 2d 4 (D.D.C. 2001); *Northeast Hosp. Corp. v. Sebelius,* 699 f. Supp. 2d 81 (D.D.C. 2010).

Title XIX matching payments. It is the pool of funds used to fund the LIP that is matched by Federal Title XIX funds. The LIP was designed to reimburse providers for uncompensated care under a prescribed formula. Reimbursement to the provider did not make the individuals, for whom the provider received the LIP supplemental distributions, an individual eligible for (section 1905) "medical assistance" for inpatient services. Thus, because the Florida's LIP days at issue here do not meet the requirement under 42 C.F.R. §412.106(b)(4)(i) and (ii), they cannot be counted in the numerator of the DSH Medicaid fraction.

Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the MAC properly excluded the LIP § 1115 waiver days from the numerator of the Medicaid fraction when calculating the Providers' DSH payment. The applicable law and regulation requires an individual be eligible for inpatient services benefits under the waiver, in order for the patient day to be counted in the numerator of the Medicare DSH payment, the Administrator affirms the Board's decision, for the foregoing reasons.

DECISION

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

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

Date: Nov. 26, 2018

/s/
Demetrios L. Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services