CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Singing River Health System	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: September 30, 2006**
Provider	
vs.	
Novitas Solutions, Inc.	**Review of: PRRB Dec. No. 2016-D19 Dated: September 2, 2016**
Medicare Administrative Contractor	

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 Medicare Administrative Contractor (MAC) submitted comments, requesting reversal of the Board majority decision. The parties were notified of the Administrator's intention to review the Board majority decision. The CMS' Center for Medicare (CM) submitted comments, requesting reversal of the Board majority decision. Comments were also received from the Providers requesting that the Administrator affirm the Board majority 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 the MAC improperly excluded the inpatient days related to Uncompensated Care Pool (UCCP) services which CMS approved on March 24, 2006, under Hurricane Katrina Multi-State §1115 demonstration[1] from the Providers' disproportionate share Hospital (DSH) calculation. [2]

[1] In submitting its cost report, the Providers did not distinguish between days of care for the Medicaid expansion population and days of care for the uncompensated care days. There is no issue that properly documented days relating to the Medicaid expansion population are includable in the DSH calculation if otherwise eligible under the criteria. However, the Providers submitted all days as "Katrina Days" that had been approved and paid by the Mississippi Division of Medicaid under both provisions. *See* MAC's Exhibit 1-2. The MAC reviewed the submitted documentation and found that no documentation to support including days as related to the Medicaid expansion

The Board majority held that the MAC improperly excluded the Hurricane Katrina §1115 Waiver days from the calculation of the Providers' DSH percentage. The case was remanded to the MAC to allow for the inclusion of all inpatient days of care furnished under the waiver. In reaching this determination the Board majority stated that the DSH statute and post-2000 regulations required that all of the inpatient days provided under a §1115 waiver be included in the DSH calculation. The Board majority further noted that this determination was ratified with the passage of the Deficit Reduction Act (DRA) of 2005 when Congress amended the Federal DSH statute, 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 received benefits under a demonstration project approved under title Xl."

With respect to the UCCP days, the Board majority found no evidence to support the MAC's conclusion that the UCCP was not part of the §1115 waiver. The fact that under the waiver, hospitals were directed to file claims for both groups of waiver-eligible individuals without distinguishing between them, and the fact that the Federal government paid for all of the services received by evacuees and affected individuals under the waiver, without differentiating between the groups supported the Board majority concluded that, all individuals who received payment for inpatient services from the UCCP had to be regarded as Medicaid-eligible individuals because they were included in the Mississippi's §1115 waiver, and the Board majority found no distinction between the Mississippi Medicaid Expansion group and the UCCP group.

Two members of the Board dissented concluding that CMS' longstanding policy and case law applying CMS' interpretation dictates that Mississippi UCCP days not be included in the Medicaid fraction of the Medicare DSH adjustment calculation because patients associated with the UCCP are not "eligible for medical assistance" as required under 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). The dissenting Board members found that the UCCP days in question did not pertain to patients who "received benefits" under the Katrina Waiver but rather the UCCP days pertained to situations where the hospital itself was eligible (and applied) for payment from the UCCP based on the hospital's attestation that services furnished to an evacuee who was otherwise uncompensated because the individual who received those services had not paid or did not have insurance or was not otherwise eligible for Medicaid or any other coverage. The fact that hospitals had to establish that absent the UCCP payment, the services would become bad debit (i.e., uncollectible) confirms that the UCCP is quintessential bad debt reimbursement intended to directly benefit hospitals rather than patients. The dissenters also disagreed that the record supported the Board's conclusion that the State 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 and instead referred to documentation

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population and, therefore, determined that none of the Hurricane Katrina days could be included in the Medicaid fraction.

[2] *See* Providers' Supplemental Final Position Paper at 8. The Singing River Health System (SRHS) is owned by Jackson County, Mississippi. SRHS operates two hospitals: Singing River Hospital in Pascagoula and Ocean Springs. The two hospitals operate under one Medicare provider number. Singing River Hospital has 404 licensed hospital beds on its Pascagoula campus, while Ocean Springs Hospital currently maintains 136 licensed beds in Ocean Springs. SRHS also operates other facilities and provides other services in Jackson and Harrison Counties.

indicating the opposite Finally, the source for the funding of the UCCP was not the relevant Federal medical assistance percentage (Title XIX matching payments) as required under 42 CFR 412.106(b)(4(ii) but rather the source of the funding was under the DRA §6201(a)(1)(D). In contrast, Congress appropriated monies to pay the State's share of the FMAP on behalf of the State. The Dissenters also pointed out that the number of days at issue have been audited and contain no allowable §1115 days paid with matching Title XIX funds.

SUMMARY OF COMMENTS

The Provider submitted comments, requesting that the Administrator affirm the decision of the Board majority decision in this case.

The Provider agreed with the Board majority determination that the post-2000, CMS' Medicare DSH regulations and polices included patient days for individuals who were receiving benefits under an expansion waiver in the Medicaid DSH calculation because § 1115 individuals are to be regarded as Medicaid eligible individuals since they receive benefits under a demonstration project approved under Tittle XIX. As the Board majority noted, there is no distinction between the benefits provided to individuals who qualified for benefits under the waiver as Medicaid-eligible or under the UCCP. Therefore, the Board majority decision fully support the conclusion that the MAC improperly excluded the Hurricane Katrina § 1115 waiver days from the calculation of the Provider's DSH percentage.

The CM submitted comments requesting that the Administrator reverse the Board majority decision. The CM argued that the regulations do not permit including in the Medicaid fraction of the Medicare DSH payment adjustment, patient days during which a hospital provided uncompensated care to patients not eligible for "inpatient hospital services" under a Medicaid State plan or § 1115 demonstration project. In 2003, the Secretary clarified this policy of including § 1115 patient days in the Medicaid fraction "only to the extent that those individuals receive inpatient benefits under the § 1115 demonstration project."[3]

The CM noted that the Hurricane Katrina demonstration project had many elements. The Project included providing inpatient hospital benefits to certain populations displaced by Katrina and also compensation under the UCCP for the Katrina event. Reimbursement from the UCCP did not make any individual eligible for inpatient hospital benefits, nor did it directly pay for such services. Rather, the UCCP was a pool of money from which a hospital could request a share for the cost of providing health care to uninsured patients who did not pay the hospital for their treatment. Under the UCCP, it is the hospital that is eligible and applies for (i.e., claims) the Mississippi UCCP payment to reimburse the hospital on a claim-by-claim basis for certain services furnished to (non-Medicaid eligible) evacuees between August 24, 2005 and January 31, 2006. Mississippi Medicaid itself explained that the waiver days payments were not part of its Medicaid Title XIX program. The CM further noted that Mississippi UCCP payments were paid through pass-through, funds and accounted for outside of Mississippi's Medicaid program fund. Thus, because the Mississippi

[3] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003) (final rule).

UCCP waiver days do not meet the "title XIX matching payments" requirement under 42 C.F.R §412.106(b)(4)(ii), they cannot be included in the numerator of the DSH Medicaid fraction.

Finally, CM noted that 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 Mississippi UCCP days and have upheld CMS' policy of excluding charity days from the DSH calculation as an acceptable legal interpretation of 42 U.S.C. § 1399ww (d)(5)(F)(vi)(II).[4]

The MAC submitted comments requesting that the Administrator reverse the Board majority decision. The MAC agreed with the dissenting Board members determination that, the Mississippi UCCP days did not meet the Title XIX matching payments requirement under 42 C.F.R. 412.106(b)(4)(ii) because the source of funding for Mississippi's UCCP was funded by Congress solely through separate non-Medicaid-related funding under §§ 6201 (a)(1)(B) and 6201(a)(1)(D) of the DRA of 2005. In addition, the UCCP days at issue cannot be counted in the Medicare DSH calculation because the individual patients underlying the Mississippi UCCP are not a Medicaid expansion population and do not receive benefits under the waiver. Under the Mississippi UCCP, it's the Provider that receives the benefits.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Medicaid State Plan

Relevant to the issue involved in this case, two Federal programs, Medicaid and Medicare involve the provision of health care services to certain distinct patient populations. The Medicaid program is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children.[5] The program is jointly financed by the Federal and State governments and administered by the States according to Federal guidelines. Medicaid, under Title XIX of the Act, establishes two eligibility groups for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.[6] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) [42 USC 601 et seq.] and Supplemental Security

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[4] *See, Adena Reg'l Med. Ctr. v. Leavitt*, 527 F.3d 176 (D.C. Cir. 2008); *Univ. 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 4 (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 (D.D.C. 2010).

[5] Section 1901 of the Social Security Act (Pub. Law 89-97).

[6] Section 1902(a) (10) of the Act.

Income or SSI [42 USC 1381, et seq.] Participating States may elect to provide for payments of medical services to those aged blind or disabled individuals known as "medically needy" whose incomes or resources, while exceeding the financial eligibility requirements for the categorically needy (such as an SSI recipient) are insufficient to pay for necessary medical care.[7]

In order to participate in the Medicaid program, a State must submit a plan for medical assistance to CMS for approval. The State plan must specify, *inter alia*, the categories of individuals who will receive medical assistance under the plan and the specific kinds of medical care and services that will be covered.[8] If the State plan is approved by CMS, under §1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.

Within broad Federal rules, States enjoy a measure of flexibility to determine "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.[9] However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for "medical assistance" under the State plan.

In particular, §1901 of the Act sets forth that appropriations under that title are "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services…." Section 1902 sets forth the criteria for State plan approval.[10] As part of a State plan, § 1902(a) (13) (A) (iv) requires that a State plan provide for a public process for determination of payment under the plan for, *inter alia*, hospital services which in the case of hospitals, take into account (in a manner consistent with §1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs. Notably, §1905(a) states that for purposes of this title "the term 'medical assistance' means the payment of part or all of the costs" of the certain specified "care and medical services" and the identification of the individuals for whom such payment may be made.

Section 1923 of the Act implements the requirements that a State plan under Title XIX provides for an adjustment in payment for inpatient hospital services furnished by a disproportionate share hospital. A hospital may be deemed to be

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[7] Section 1902(a) (1) (C) (i) of the Act.

[8] *Id.* § 1902 et seq., of the Act.

[9] *Id.*

[10] 42 C.F.R. §200.203 defining a State plan as "a comprehensive written commitment by a Medicaid agency submitted under section 1902(a) of the Act to administer or supervise the administration of a Medicaid plan in accordance with Federal requirement."

a Medicaid disproportionate share hospital pursuant to §1923(b)(1)(A),[11] which addresses a hospital's Medicaid inpatient utilization rate, or under paragraph (B),[12] which addresses a hospital's low-income utilization rate or by other means and (e) which provides a special exception.[13] The low income criterion relies, *inter alia*, on the total amount of the hospital's charges for inpatient services which are attributable to charity care. Congress has revisited the Medicaid DSH provision several times since its establishment. In 1993, Congress enacted further limits on DSH payments pursuant to § 13621 of Pub Law 1003-66 that took into consideration costs incurred for furnishing hospital medical assistance under the state plan or have no health insurance (or other source of third part coverage for services provided during the year. (The Medicaid DSH payments may not exceed the hospital Medicaid shortfall; that is the amount by which the costs of treating Medicaid patient exceeds hospital Medicaid payments plus the cost of treating the uninsured.)

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[11] Section 1923(b) states that "Hospitals Deemed Disproportionate Share.— (1) For purposes of subsection (a)(1), a hospital which meets the requirements of subsection (d) is deemed to be a disproportionate share hospital if— (A) the hospital's Medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State" In addition, paragraph "(2) For purposes of paragraph (1)(A), the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere."

[12] Subsection (B) provides that for purposes of subsection (a)(1), a hospital which meets the requirements of subsection (d) is deemed to be a disproportionate share hospital if— "(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent." (3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—(A) the fraction (expressed as a percentage)— (i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this title (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and (ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and (B) a fraction (expressed as a percentage)— (i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and (ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period. The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this title).

[13] Paragraph (e) provides a "Special Rule."

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—
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> (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
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> (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.[14]

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 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

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

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.[15]

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.[16]

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[15] "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

[16] 77 Fed Reg. 11677-11700. *See also* "Insuring the Poor Through Section 1115 Medicaid Waivers." Coughlin, Lipman, Raja, *Health Affair*s, 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.)

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[17] established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[18] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[19] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[20] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[21] 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.[22]

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. . .."[23] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle

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

[18] Section 1811-1821 of the Act.

[19] Section 1831-1848(j) of the Act.

[20] Under Medicare, Part A services are furnished by providers of services.

[21] Pub. L. No. 98-21.

[22] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

[23] 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).

method."[24] 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 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(2005). The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 C.F.R. §412.106(b)(2)(2005). 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)(2005) 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. 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.

[24] The Pickle method is set forth at section 1886(d)(F)(i)(II) of the 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.

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 <u>patient's</u> eligibility for Medicaid benefits as determined by the State, not the <u>hospital's</u> eligibility for some form of Medicaid payment. Second, the focus is on the patient's eligibility for <u>medical</u> 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 <u>medical assistance under an approved Title XIX State plan</u>, 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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> 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.[25]

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 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.[26]

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.[27] 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.[28]

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

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[25] *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.")*

[26] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

[27] 65 Fed. Reg. 3136 (Jan. 20, 2000).

[28] *Id.*

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 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.[29] 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 matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment.
>
> 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.
>
> 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.[30]

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).

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[29] *Id.*

[30] 65 Fed. Reg. 3136, 3136-3137.

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.

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

Comment: Several commenters were concerned with the inclusion in the January 20, 2000 interim final rule with comment period of expansion waiver days in the Medicaid portion of the Medicare DSH adjustment calculation. States without a Medicaid expansion waiver in place believed that States that did have a Medicaid expansion waiver in place received an unfair advantage. In addition, comments from Pennsylvania hospitals supported the continued inclusion of general assistance days in the Medicaid portion of the Medicare DSH adjustment calculation as well as expansion waiver days. Finally, some commenters urged HCFA to revise the Medicare DSH adjustment calculation to include charity care days.

Response: 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 States that have a section 1115 expansion waiver in place, these days are considered to be Title XIX days by Medicaid standards.

Some States operate under a section 1115 waiver without an expansion (for example, Arizona). The days that are utilized by patients under the section 1115 waiver are already part of the Medicaid portion of the Medicare DSH adjustment calculation because the section 1115 waiver includes patients who otherwise would have been eligible for Medicaid Title XIX.

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. Therefore, Pennsylvania, and other States that have erroneously included these days in the Medicare disproportionate share adjustment calculation in the past, will be precluded from including such days

> in the future. We would like to point out that these States were held harmless from adverse action in this matter for any cost reporting period beginning prior to December 31, 1999. We are in the process of preparing a Report to Congress on the Medicare DSH adjustment calculation which presents various options for calculating the adjustment.[31] (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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> If a hospital were to include the days attributable to patients receiving benefits under such a limited benefit, the hospital would be able to receive higher DSH payments, perhaps substantially, for patients who may otherwise be insured for inpatient care. For example, these limited demonstrations provide benefits that may be needed to supplement private insurance coverage for individuals who do not have incomes low enough to qualify for Medicaid under the State plan. We do not believe such patients should be counted in the DSH patient percentage as eligible for title XIX.
>
> 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

[31] "Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates", 65 FR 47054, 47086-87(August 1, 2000).

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.

The Deficit Reduction Act of 2005 (DRA)[32]

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:

[32] 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).

> (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."

In addition § 6201(e) of the DRA or 2005, provided funding for Hurricane Katrina demonstration projects and directed the Secretary to make different payments for health care services for each of four separate populations: (1) evacuees receiving health care under the project (§6201(a)(1)(A)(i)); (2) affected individual (people located in disaster relief counties) receiving health care under the project (§ 6201(a)(1)(C)); (3) evacuees who were uninsured and not Medicaid-eligible (§ 6201(a)(1)(B)); and (4) affected individuals who were uninsured and not Medicaid-eligible (§6201(a)1)(D)). The DRA allowed the Secretary to pay for the non-federal share of expenditures for Medicaid-eligible evacuees and affected individuals,[33] and allowed the Secretary to pay for the total uncompensated care costs for uninsured and non-Medicaid-eligible evacuees and affected individuals.[34]

As a result of this legislation, federal funds were, in effect, used to pay for both Medicaid-eligible and uninsured, non-Medicaid-eligible patients. But the DRA did not merely appropriate $2 billion and direct the Secretary to reimburse states for medical assistance provided under § 1115 Hurricane Katrina demonstration projects,' as it easily could have done. Rather, the DRA carefully distinguished and differentiated between the populations and the source from which the Federal funds paying for each population originated. The "non-Federal share" funds were paying for the share off costs that state Medicaid programs would otherwise have had to bear; costs that were eligible for federal matching funds under title XIX plans. Meanwhile, the costs of care for uninsured, non-Medicaid-eligible individuals and evacuees – costs that would ordinarily not have been covered by the state Medicaid programs and federal funds – was simply covered by Federal appropriated funds under the DRA not related to Title XIX funds.

Related to the issue in this case, several courts have analyzed the phrase "eligible for medical assistance under a State plan approved under Title XIX." Both for State-only general assistance days and charity care/uncompensated care days and have concluded that the phrase "eligible for medical assistance under a State plan approved under title XIX" means patients who are eligible for Medicaid under a Federal statute. 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

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[33] *See*, DRA §§ 6201(a)(1)(A)(i) and 6201(a)(1)(C)(i).

[34] *See*, DRA §§ 6201(a)(1)(B) and 6201(a)(1)(D).

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). The Administrator finds that these courts have upheld CMS' policy of excluding charity care or uncompensated care days from the DSH calculation as an acceptable legal interpretation of § 1886(d)(5)(F)(vi)(II), because the patients underlying the subject days were not "eligible for medical assistance" for purposes of inclusion in the numerator of the Medicaid fraction.

In *Cooper, supra*, the district court as adopted by the Court of Appeals for the Third Circuit, concluded that the phrase "eligible for medical assistance under a State plan approved under title XIX" referred to patients who are eligible for Medicaid. Therefore, the New Jersey Charity Care Program patient days could not be included in the numerator of the Provider's Medicaid proxy for purposes of determining the Provider's Medicare DSH adjustment. In *Phoenix Memorial Hospital v. Sebelius*, 622 F.3d 1219 (9th Cir. 2010), the Ninth Circuit found that since Arizona did not receive federal matching funds for its Medically Needy/Medically Indigent (MN/MI) patients, they were not part of Arizona's Medicaid plan. The Court upheld the lower court where a hospital was located in a State with a section 1115 waiver to cover its Medicaid eligible population and also had a State only part of its state health program.

In addition, the United States District Court for the District of Columbia has held that the numerator of the Medicaid fraction does not include "charity care" days. *See Northeast Hosp. Corp. v. Sebelius*, 699 F. Supp. 2d 82, 90 (D.D.C. 2010) (The court ruled that "medical assistance' is limited to patients who are eligible for Medicaid under the federal Medicaid statute .." and since Massachusetts uncompensated care pool patients "do not fall within one of the thirteen categories of individuals eligible for Medicaid, the Secretary properly excluded their patient days from the numerator of the Hospital's Medicaid fraction.

Finally, in the *University of Washington Medical Center v. Sebelius*, 634 F.3d 1029 (9th Cir 2011) the court recognized that: "Thus, the definition of "medical assistance" has four key elements: (1) federal funds; (2) to be spent in "payment of part or all of the cost"; (3) of certain services; (4) for or to "[p]atients meeting the statutory requirements for Medicaid". The court concluded that: "Because the Secretary has not granted Washington a waiver for its GAU and MI populations under section 1315, this provision does not operate to make these patients "eligible for medical assistance" under subchapter XIX of the Social Security Act. *See Phoenix Memorial Hospital*, 622 F.3d at 1226–27." In addition, the DRA provisions addressing the treatment of section 1115 waiver days, was addressed by the Court in *Cookville* for a pre-2000 cost year.[35]

As noted, relevant to this case, in response to Hurricane Katrina, CMS developed a new "demonstration initiative" to "ensure the continuity of health care services for victims of Hurricane Katrina." This demonstration project was announced via a September 16, 2005 memorandum pursuant to the DRA provisions.[36] Under this demonstration, evacuees who were displaced by Hurricane Katrina were provided the opportunity to enroll to receive services under

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[35] *See Cookeville Regional Medical Center v. Leavitt* 531 F.3d 844, 848-849, (D.C. 2008).

[36] *See* MAC's Exhibhit I-5 at 1.

Medicaid or SCHP programs in whatever State they resided.[37] The demonstration population consisted of parents, pregnant women, and children under age 19, individuals with disabilities, low income Medicare recipients, and low income individuals in need of long-term care.[38] Under the terms of the demonstration initiative, CMS stated that States participating in the demonstration program would not be required to provide or demonstrate budget neutrality through "without waiver" and "with waiver" expenditure data. In addition, CMS agreed that individuals participating in the demonstration were presumed to be otherwise eligible for Medicaid in their respective Home State and costs to the Federal Government would have otherwise been incurred and allowable."[39] In the Memorandum, CMS only addressed these "Medicaid-eligible" evacuees, and not evacuees who were uninsured. On September 22, 2005, CMS approved the State of Mississippi's §1115 wavier.[40] The waiver provided the assistance describe in the Memorandum. In the Memorandum, CMS agreed that such individuals were "presumed to be otherwise eligible for Medicaid or SHIP in their respective home States.

In addition, the September 16, 2005 Memorandum, separate from the §1115 wavier, allowed the State of Mississippi to reimburse providers that incurred uncompensated care costs for medically necessary services and supplies for evacuees who did not have other coverage or relief options available, including title XIX and title XXI for a 5-month period, effective August 24, 2005 through January 31, 2006.[41] The Mississippi Division of Medicaid administered the Uncompensated Care Pool (UCCP). On March 24, 2006, CMS separately approved Mississippi's UCCP plan.[42] In the March 24th letter announcing that it had granted Mississippi the waiver, CMS thus dealt separately with the population of uninsured, non-Medicaid-eligible evacuees that CMS had not addressed in the Memorandum and that were not covered by inpatient services through the §1115 waiver.

In this case, the Providers claim that all patient days for individuals whose inpatient services were reimbursed under the Mississippi Hurricane Katrina §1115 demonstration waiver should be included in the Providers' Medicare DSH calculations. This includes both patients eligible for the expanded Medicaid eligibility as well as for individuals for which payment is made for inpatient services under the UCCP. The basis for the Providers' claim is the March 24, 2006 letter from CMS that states that the UCCP was approved under the Hurricane Katrina Multi-State §1115 demonstration. In addition, under the Katrina waiver, the Providers claim that hospitals were directed to file 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.

Under the plain language of the statute, the Administrator first finds that payment under the UCCP is not payment for an inpatient day attributable to a patient who was eligible for medical assistance under a State plan approved under

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[37] *Id.*
[38] *Id.* at 2.
[39] *Id.* at 2.
[40] *See*, Providers' Exhibit P-4.
[41] *Id.* at 2.
[42] *See*, Providers' Exhibit P-5.

Title XIX of the Act, but who were not also entitled to Medicare Part A. The Administrator finds that the Secretary has interpreted the statutory phrase "patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX," to mean "eligible for Medicaid."[43] Section 1905(a) of the Social Security Act defines "medical assistance" as payment of part or all of the costs of certain services and care for certain populations of individuals. For the cost year involved, the Secretary used her discretion (and as ratified by DRA and the amended §1886(d)(5)(F) of the Act) to include in her interpretation of the term eligible for medical assistance under an approved state plan under Title XIX, patients related to the Federally approved and authorized section 1115 waiver populations for whom expenditures for care is considered to be an approved expenditure under Title XIX. The language at §1886(d)(5)(F)(vi)(II) of the Act requires that for a day to be counted, the individual must be eligible for "medical assistance" under Title XIX as interpreted and applied by the Secretary pursuant to her discretion.[44] That is, the individual must be eligible for the Federal government program also referred to as Medicaid and for the cost year involved certain inpatients approved under a §1115 waiver to be treated as Medicaid expenditures.

Regarding the expenditure of Federal financial participation or FFP under a Medicaid DSH program, generally, the issue of whether costs are regarded as expenditures under a State plan approved under Title XIX for purposes of calculating Federal matching payments to the State is different from the issue of whether patients are considered eligible for medical assistance under a State plan approved under Title XIX for purposes of calculating Medicare DSH payments to a hospital. The statute clearly states that the patients' Title XIX eligibility for that day is a requirement. The individuals underlying the UCCP days did not "receive" any Medicaid benefits over a period of time of the waiver (e.g., 5 months) as demonstrated by the fact that they do not initiate or fill out an eligibility application and there is no income test or income eligibility requirement for UCCP claims. Rather, under the UCCP, it is the hospital that is eligible and applies for the UCCP payment to reimburse the hospital on a claim-by-claim basis.

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[43] *See e.g. Cabell Huntington Hosp. Inc., v. Shalala*, 101 F.3d 984, 989 (4 th Cir. 1996) ("It is apparent that 'eligible for medical assistance under a State plan' refers to patients who meet the income, resource, and status qualifications specified by a particular state's Medicaid plan. . . ."); Legacy Emanuel Hospital v. Secretary, 97 F.3d 1261, 1265 (9 th Cir. 1996)("[T]he Medicaid proxy includes all patient days for which a person was eligible for Medicaid benefits whether or not Medicaid actually paid for those days of service.")

[44] The language at §1886(d)(5)(F)(vi)(II) of the Act states: "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." Deficit Reduction Act of 2005 (DRA), supra. As noted, this amendment to §1886(d)(5)(F)(vi) of the Act specifically addressed the scope of the Secretary's authority to include (or exclude), in determining the numerator of the Medicaid fraction of the Medicare DSH calculation, patient days of patients not eligible for medical assistance under a State plan but who receive benefits under a demonstration project approved under Title XI of the Act This enactment distinguishes those patients eligible to receive benefits under Medicaid from those patients who are regarded as such because they receive benefits under a demonstration project approved under title XI. This amendment left untouched CMS longstanding policy on general assistance days.

Mississippi Medicaid itself explained that the waiver day payment were not part of its Medicaid Title XIX program. Thus, the days were not attributable to patients eligible for inpatient hospital benefits under an approved State plan.

To that extent, the cases supporting the exclusion of "charity care days" paid under uncompensated care pools created under the Medicaid DSH statute under state plans are instructive. Payments for the days involved in this case and in the charity care Medicaid DSH pool cases, are made to the hospitals and not as "medical assistance" for an individual. However, they are also different in certain respect, though both uncompensated care days, as the UCCP days are not paid by Title XIX funding. In this case, the State set out that hospitals were specifically instructed that the uncompensated care paid through the UCCP cannot be included as uncompensated care in the Medicaid hospitals-specific DSH limit under §1923(g)(1)(A) of the Act. Instead the Providers argue that they should be included as they were provided under an approved §1115 waiver.

The Administrator finds hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under §1115 of the Social Security Act. In this case, the days were not "attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" as specified at 42 CFR 412.106(b)(4)(ii). The Mississippi UCCP payments were paid through funds appropriated under DRA, and Mississippi accounted for them outside its Medicaid program funds and not as Title XIX matching funds. These funds were distinguished from funds appropriate under DRA. Those funds were labeled as payment of the State's Title XIX Medicaid share of the matching funds for the expanded Medicaid population that were recognized under the waiver. Thus, because the UCCP days at issue here also do not meet the "Title XIX matching payments" requirement under 42 C.F.R §412.106(b)(4)(ii), they cannot be counted in the numerator of the DSH Medicaid fraction.[45]

Finally, the Providers argued that some of the Katrina days excluded by the MAC included days for the §1115 waiver Medicaid expansion population and therefore should be included in the Medicaid fraction of the Medicare DSH adjustment calculation. A review of the record however, shows no documentation to demonstrate that any of the 1681 days at issue were not uncompensated care days.[46] The Administrator finds that the Providers has the burden of proof to substantiate its claim[47] and the record shows that the Providers have not submitted any documentation to

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[45] As noted, in contrast, the DRA provided for Federal payment of 100 percent of the FFP (or the State's share of the Title XIX matching funds) for the Medicaid expansion patients covered under the waiver.

[46] See, MAC's Exhibit 1-2 at 5, 14-21. In addition, as noted in the dissenters' opinion, n. 18, there is no evidence in the record to support the Providers' contention that the State made no distinction between claims involving individuals who had coverage under the Medicaid Expansion and the Hospitals' claims for uncompensated care under the MS UCCP. Documentation in the record indicates the opposite.

[47] Section 1815(a) of the Act has provided that "The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it. . .. except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid if any prior period" In addition, specific to the DSH payment, 42 CFR §412.106(b)(4)(iii) state that: "The

refute the MAC's determination that all of the 1681 days were UCCP days. Accordingly, the Administrator finds that the MAC properly excluded 1681 days at issue from the Medicaid fraction of the Providers' Medicare DSH adjustment calculation for the fiscal year 2006.

DECISION

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

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

Date: 11/18/2016

/s/
Patrick H. Conway, M.D., MSc
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services

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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"