CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the cases of:	**Claim for:**
Southwest Consulting UMass Memorial Health Care and Steward Health 2009 DSH CCHIP Section 1115 Waiver Day Groups Providers vs. Novitas Solutions, Inc. Medicare Administrative Contractor	Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: September 30, 2009 Review of: PRRB Dec. No. 2017-D4 Dated: January 27, 2017

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 majority decision. CMS' Center for Medicare (CM) and the Medicare Administrative Contractor (MAC) submitted comments, requesting reversal of the Board's decision. Comments were also received from the Providers requesting that the Administrator affirm 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 days attributable to patients who were eligible for, and received, assistance through the Massachusetts Commonwealth Care Health Insurance Program (CCHIP), under a CMS approved § 1115 waiver, should be included in the numerator of the Medicaid fraction for purposes of the Providers' Medicare Disproportionate Share Hospital (DSH) adjustment calculation.

The Board majority held that the MAC's exclusion of days from the DSH calculation was contrary to Federal statute and regulation. The Board stated that the DSH statute and post-2000 regulations require that all of the inpatient days provided under the CMS approved § 1115 waiver be included in the DSH calculation because § 1115 individuals are to be regarded as Medicaid eligible individuals as they receive benefits under a demonstration project approved under Title XI. As such, all individuals who received inpatient services

from the CCHIP must be regarded as Medicaid-eligible individuals because they were included in Massachusetts § 1115 waiver.

The Board majority found no meaningful distinction between a State providing traditional Medicaid benefits through a managed care plan enrollment and one providing a premium subsidy to CCHIP eligible individuals to purchase health care from the same managed care plan as provided to traditional Medicaid eligible individuals. The Board majority further indicated that the managed care plan provides inpatient hospital services as one of its plan benefits, and the Federal government reimburses the cost of the premium subsidy through Federal Financial Participation (FFP)[1] in the same manner as it does for the traditional Medicaid population.

Two members of the Board concurred with the Board majority's determination and concluded that CCHIP beneficiaries were a section 1115 expansion waiver population that had inpatient benefits as part of their benefits package; and days associated with CCHIP beneficiaries should be included in the Providers' Medicare DSH adjustment for the fiscal years at issue. In reaching this determination, the concurring Board members concluded that the payments of premiums qualified as "medical assistance" as that term is defined at 42 U.S.C. 1396e and 1396u2 of the statute. The concurring Board members also concluded that the medical assistance received by CCHIP beneficiaries included "inpatient benefits." Furthermore, the funding source for the CCHIP premiums received Federal matching dollars because the Safety Net Care Pool (SNCP) is funded, in part, by redirected state Medicaid DSH funds, which in turn are based on Federal Medical Assistance Percentage (FMAP). Therefore, because CCHIP beneficiaries received inpatient benefits as part of their benefit package under the §1115 waiver, the days associated with the CCHIP days should be included in the Providers' Medicare DSH adjustment calculation for the fiscal years at issue.

SUMMARY OF COMMENTS

The CM submitted comments requesting that the Administrator reverse the Board's findings and affirm that the MAC properly excluded patient days for patients who were eligible for CCHIP from the numerator of the Medicaid fraction of the DSH calculation.

The CM noted that the § 1115 demonstration project days can only be included in the numerator of the Medicaid fraction, for the purposes of calculating a hospital's DSH adjustment, if those patients receive inpatient benefits under the § 1115 demonstration project. In this case, patients eligible for CCHIP are not eligible for inpatient benefits; they are eligible for premium subsidies. The fact that the subsidized premium can be used to

[1] In this decision the term Federal Financial Participation (FFP) is used interchangeably with Federal Medical Assistance Percentage (FMAP) and are used to refer to the Federal matching share payment of the Title XIX Medicaid financing.

purchase inpatient benefits is irrelevant: the §1115 program at issue does not provide the benefits, it provides the subsidy and, therefore, days associated with these patients cannot legally be counted as Medicaid days in the calculation of a hospital's DSH patient percentage.

The MAC submitted comments requesting that the Administrator reverse the Board decision. The MAC maintained that CCHIP patients are not "eligible for medical assistance" as required under the Medicare DSH statute, and that CCHIP patients were not deemed "eligible for Medicaid" on a given day as specified at 42 C.F.R. § 412.106(b)(4)(i).

The MAC noted that a § 1115 waiver does not make CCHIP patients eligible for inpatient hospital services under MassHealth (Medicaid), but rather the waiver allows the expenditure of funds from the SNCP to provide premium assistance to CCHIP eligible individuals. Under MassHealth, Title XIX pays directly for inpatient services, while under the CCHIP, the SNCP funds pay for premiums, not for the inpatient services themselves. Moreover, it is not the CCHIP patient population that is eligible for Title XIX matching payments. Rather, it is the pool of funds used to provide premium assistance for the purchase of CCHIP that is matched by Title XIX funds. The regulation at 42 C.F.R. § 412.106(b)(4)(i) and (ii) only include days of care furnished to patients who were eligible for Medicaid services that were paid for with Title XIX funds, and not days of service furnished to any patient who bought insurance using a subsidy that was partially funded via Title XIX matching funds.

Finally, the MAC noted that there are only two situations when the days of care can be included in the Medicaid fraction under § 1115 waivers: (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. In this case, neither situation is implicated for the uninsured and non-Medicaid-eligible patients premiums paid for under the CCHIP. The CCHIP served a different purpose than the Waiver and did not purport to make uninsured, and non-Medicaid-eligible patients eligible for Medicaid services.

The Providers submitted comments, requesting that the Administrator affirm the decision of the Board. The Providers noted that the plain language of the DSH regulation, including the deeming provision, provides that a patient is deemed eligible for Medicaid whenever the patient is eligible for inpatient hospitals services under a waiver authorized under §1115(a)(2).

In this case, the record shows that CCHIP is covered by an approved §1115 waiver. Second, Massachusetts received Federal funding for expenditures to provide premium assistance to individuals eligible for assistance under the CCHIP. With respect to premium assistance, the Providers noted that premium assistance is defined in the Medicaid statute as an

acceptable form of medical assistance that qualifies for Federal financial participation under title XIX. Finally, all CCHIP patients received benefits covering inpatient hospital services through the same Medicaid managed care plans that otherwise provided the same core benefits to other Medicaid recipients in Massachusetts. Therefore, since CCHIP beneficiaries received inpatient benefits as part of their benefit package under the § 1115 waiver, the days associated with the CCHIP days should be included in the Providers' Medicare DSH adjustment calculation for the fiscal years at issue.

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.[2] 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.[3] 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 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.[4]

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.[5] 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

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[2] Section 1901 of the Social Security Act (Pub. Law 89-97).
[3] Section 1902(a) (10) of the Act.
[4] Section 1902(a) (1) (C) (i) of the Act.
[5] *Id*. § 1902 et seq., of the Act.

specified percentage (the Federal medical assistance percentage) of the amounts expended as "medical assistance" under the State plan and also based on, *inter alia*, expenditures under §1923 for purposes of the Medicaid DSH payment.

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.[6] 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.[7] 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 a Medicaid disproportionate share hospital pursuant to §1923(b)(1)(A),[8] which addresses a hospital's Medicaid inpatient utilization rate, or under

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[6] *Id.*

[7] 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."

[8] 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

paragraph (B), which addresses a hospital's low-income utilization rate or by other means and (e) which provides a special exception.

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, … 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, … 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,

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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."

which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver.[9]

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.

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[10] 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,[11] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[12] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[13] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[14] 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.[15]

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

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

[11] Section 1811-1821 of the Act.

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

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

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

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

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…."[16] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[17] 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.)

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[16] 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).

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

CMS implemented the statutory provisions at 42 C.F.R. §412.106(2009). The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 C.F.R. §412.106(b)(2)(2009). 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)(2009) 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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> 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.[18]

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

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[18] *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.")*

> 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.[19]

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.[20] 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.[21]

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 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.[22] 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.

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

> 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.[23]

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).

> 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.

Thus, the regulation at 42 CFR 412.106(b) stated, effective October 1, 2008, 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

[23] 65 Fed. Reg. 3136, 3136-3137.

> 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:
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> (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.
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> (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.
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> (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)[24]

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.
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> (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:
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> "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

[24] 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).

> because they receive benefits under a demonstration project approved under title XI.".
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> (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.
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> (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.*

FINDINGS:

In this case, the Providers argue that days of care provided to patients who were in the CCHIP should be included in the Providers' Medicare DSH adjustment calculation for the fiscal years at issue on grounds that CCHIP beneficiaries received inpatient benefits as part of their benefit package approved under a § 1115 waiver and that premium payments were matched with Federal financial participation (FFP).

The Massachusetts §1115 Waiver Amendment, submitted May 1, 2006, began as a means to address changes in the law affecting financing of the State Medicaid programs through Intergovernmental Transfers Funding and the prior waiver of the upper payment limit (UPL) for Medicaid managed care organizations (MMCO) for the State. In renewing the waiver, CMS required conformity with the Balanced Budget Act of 1997 managed care regulations which replaced the UPL with actuarially sound rates and the termination of all then-existing Intergovernmental Transfers (IGT) funding mechanism. As the "Section 1115 Waiver Amendment" submitted May 1, 2006 explains, the State addressed these issues, *inter alia*, by redirecting:

> Federal and State funds from providers of uncompensated care to individuals in an insurance based health care system. This allowed the state to preserve the $385 million in federal funds at risk because of the change in federal MCO reimbursement requirement…To limit federal financial exposure, CMS agreed to create a capped Safety Net Care Pool, included under the section 1115 waiver's total budget neutrality ceiling dedicated to reducing the number of uninsured state residents. Matchable expenditures under the Safety Net Care Pool are capped at $1.34 billion annually. This figure is derived from the SFY 2005 MCO supplemental payment amount (SFY 2005 $770 million) and the State's aggregate DSH limit ($574.5 Million FFY 2005) Working with CMS, the [State] has identified $385 million in existing state general fund health expenditures that are not otherwise matched with Federal Funds (i.e. costs not otherwise matchable or CNOM) to replace the disallowed IGTs."[25]

In its review, the Board majority found that the CCHIP days in the appeal related to individuals who were enrolled in the same managed care plans and received the same core health benefits as other Mass Health recipients, including inpatient services. The Board found no meaningful distinction between a State providing traditional Medicaid benefits though a managed care enrollment and providing a premium subsidy to CCHIP-eligible individuals to purchase health care from the same managed care plan as provided to traditional Medicaid-eligible individuals. The Board concluded that: "The managed care plan provides inpatient hospital service as one of its plan benefits and the federal government reimburses the costs of the premium subsidy through the FFP in the same manner as it does for the traditional Medicaid eligible individuals."

In its concurring opinion, two Board members concluded that the major elements in determining whether to count §1115 Waiver days are: Do the days pertain to "section 1115 expansion waiver population?; Does the §1115 expansion waiver population receive "medical assistance"?; Is the "medical assistance" paid using FMAP?; and Does the medical assistance included inpatient benefits? Finding these days pertain to a §1115 expansion waiver population, the concurring decision found that the payments of premiums qualifies as

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[25] Provider Exhibit P-5 at 3. The Attachment C "Safety Net care Pool Resources and Uses" includes the foregoing document labeled the "FY 2005-FY 2007 Sources and Uses" and shows various sources of funding and expenditures, including the Federal matching, Hospital assessments, insurance surcharges, state general funds and is available at: http://www.mass.gov/eohhs/docs/eohhs/cms-waiver-2006/cms-attachment-c-safety-net.pdf

See also Intermediary I-5 "Special Terms and Conditions" regarding the origination of the funds and capping of SNCP Funds at 8.

medical assistance "as confirmed by 42 USC 1396e and 1396u-2" (§1906[26] and §1932[27] of the Social Security Act.). In addition, the concurring members found that the funding of the payment was with Federal matching funds because the SNCP is funded in part by "redirected state Medicaid DSH funds which in turn are based on FMAP." Finally the two members found that the "medical assistance" included inpatient benefits.

The Administrator finds that there is no equivalency for purposes of the Medicare DSH calculation under 42 CFR 412.106 between a State providing traditional Medicaid benefits though a managed care enrollment and a State providing, through a waiver, a premium subsidy to CCHIP-eligible individuals to purchase health care from the same managed care plan. The Board is incorrect to find that "the federal government reimburses the costs of the

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[26] Section 1906 [42 U.S.C. 1396e] (a) and (c) provide in part: "Each State plan— (1) may implement guidelines established by the Secretary, consistent with subsection (b), to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this title in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2)); (2) may require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this title and subject to subsection (b)(2), notwithstanding any other provision of this title, that the individual (or in the case of a child, the child's parent) apply for enrollment in the group health plan; and (3) in the case of such enrollment (except as provided in subsection (c)(1)(B)), shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this title (exceeding the amount otherwise permitted under section 1916), and shall treat coverage under the group health plan as a third party liability (under section 1902(a)(25)). ***
(c)(1)(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of section 1903(a), to be payments for medical assistance….."

[27] Section 1932. [42 U.S.C. 1396u–2] in part explains that: "(a) STATE OPTION TO USE MANAGED CARE.—(1) USE OF MEDICAID MANAGED CARE ORGANIZATIONS AND PRIMARY CARE CASE MANAGERS.— (A) IN GENERAL.—Subject to the succeeding provisions of this section, and notwithstanding paragraph (1), (10)(B), or (23)(A) of section 1902(a), a State— (i) may require an individual who is eligible for medical assistance under the State plan under this title to enroll with a managed care entity as a condition of receiving such assistance (and, with respect to assistance furnished by or under arrangements with such entity, to receive such assistance through the entity), if— (I) the entity and the contract with the State meet the applicable requirements of this section and section 1903(m)or section 1905(t), and (II) the requirements described in the succeeding paragraphs of this subsection are met; and (ii) may restrict the number of provider agreements with managed care entities under the State plan if such restriction does not substantially impair access to services.

premium subsidy through the FFP in the same manner as it does for the traditional Medicaid eligible individuals."

Congress separately authorized the payment of premiums for Medicaid eligible individuals pursuant to section 1906 of the Act as "medical assistance." Under a separate provision, Congress authorized the enrollment of traditional Medicaid individuals pursuant to § 1932 in managed care plans. The Federal government authorization of the Federal share of the § 1923 Medicaid DSH funds that the State has used for premiums subsidy under the waiver is not the same as the authorization of the Federal share for the traditional Medicaid eligible individuals under §§ 1906 and 1932 and those latter provision are not applicable in this case.

Further, the payment of the premiums under CCHIP is through a waiver which allows for the use of Medicaid DSH funds in this alternative way and does not change the premium subsidy that is financed through the DSH Medicaid funding into "medical assistance." In particular, §1905(a) states that: "The term "medical assistance" means payment of part or all of the cost of the following care and services or the care and services themselves, or both" for certain Medicaid eligible] individuals including for, relevant for Medicare DSH purposes, "inpatient hospital services (other than services in an institution for mental diseases)." In this instance, the payment is for premiums and not involve the payment of inpatient hospital services and related care. Thus, the Administrator finds that premiums paid under the waiver do not constitute "medical assistance" as that term is defined at §1905(a) of the Act and, thus, the days attributable to the individuals for whom premiums were paid under the §1115 waiver are not included in the numerator of the Medicaid fraction under 42 CFR 412.106

The Board concurring also opinion incorrectly relies on §1906(a) and § 1932 for support that the premiums in this case used to pay for managed care insurance is "medical assistance under Title XIX. They are significant statutory distinctions for the payment of premiums under the waiver and the payment for traditional Medicaid-eligible individuals under §§1906 and 1932 of the Act. The statute specifically provides that payment under §1932 of premiums is considered medical assistance for purposes of the Federal Medical Assistance Percentage under section 1903(a) for the Medicaid eligible individuals. In addition, §1906 specifically allows for the required use of managed care organizations for the Medicaid eligible individuals. Concluding that the premiums in this case meet the definition of medical assistance by looking to sections 1906 and 1932 is flawed. The definition of medical assistance set forth at §1905 does not include premiums, except as specifically authorized by Congress under §1932 to Medicaid eligible individuals as specified; a narrow statutorily limited definition that is not applicable in this case or under the waiver provision at issue.

Notably, the foregoing provisions under §§1906 and 1932 were not the basis for the waiver in this case, but rather involved the waiver for the provision at issue involved use of funds under §1923 of the Act. The use of FMAP discussed and relied upon by the Providers and the Board to justify inclusion of the days at issue is the Federal share of the payment for

§1923 funds authorized under the §1115 waiver. Notably, the following waiver was granted and enabled the State to implement the "approved Special Terms and Conditions" for the §1115 waiver.[28] The waiver list emphasized that all requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in the list "shall apply to the demonstration project…." for that period. The waiver which is applicable to the financing of the premiums involved in this case was specified at paragraph (5): "Disproportionate Share Hospital requirements: section 1902(a)(13)[[29]], insofar as it incorporates section 1923(c)(1)"[30]. The purpose of the waver is "to enable Massachusetts to not make DSH payments in accordance with the statutory requirement to hospitals after July 1, 2005." [31] The Funds referred in the waiver are still Medicaid DSH allotments, which along with funds for medical assistance, make up a State's total FMAP. The SNCP is itself made-up of a combination of a Federal Share, State share, hospital assessments and taxes, general state funds, etc.

The Medicaid DSH pool for which there is available matching Federal funds or FMAP, under §1923, is allowed to be used in this manner because of the §1115 waiver.[32] However, FMAP, under §1903 of the Act ("Payment to States") is made up of more than the funds expended for "medical assistance" and includes payments for DSH under §1923(f) of the Act.[33] The fact that FMAP is provided for the premiums at issue in this case does not make the associated expenditures the costs for "medical assistance. Thus, in this instance, the use of the Federal matching funds to finance the Safety Net Care Pool which is used to pay the premiums, does not demonstrate that the premiums by definition are considered "medical

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[28] Provider Exhibit P-10.

[29] Section 1902(a)(13) of the Act provides that: " (a) A State plan for medical assistance must— …. (13) provide—(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—… (iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs…."

[30] Section 1923(c) sets out the necessary Medicaid DSH payment adjustments under §1923 of the Act.

[31] Provider Exhibit P-10.

[32] Section 1905(b) of the Act ("Defintions") defines the term "Federal medical assistance percentage."

[33] Regarding payment to States, section 1903 of the Social Security Act provides that: "(a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966— (1) an amount *equal to the Federal medical assistance percentage (as defined in section 1905(b),* subject to subsections (g) and (j) of this section *and subsection 1923(f))* of the total amount expended during such quarter as medical assistance under the State plan;…."

assistance." Rather, the Federal funds are Medicaid DSH authorized under §1923 for which the methodology for payment under §1923(f) was waived as incorporated in § 1903(a)(13).[34]

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[34] While not controlling, further illustration of the nature of the source of the funds, under discussion, is reflected in the State letter dated July 12, 2013, submitted in response to a CMS Medicaid DSH allotment proposed rule. (Provider Exhibit P-21.) The rule was promulgated because of changes in the law regarding the State Medicaid DSH allotment that excluded the amount of the DSH allotment reduction for certain DSH determinative factors such as the High Volume for Medicaid Inpatients Factor (HMF) and High Level of Uncompensated Care Factor (HUP). Under the proposed rule, the amount of the State's DSH allotment used for "non-coverage expansion purposes" would be subject to reduction. The Providers submitted the letter in support of its position that the days should be included. The State in its letter maintained that the §1115 DSH allotment used in the §1115 waiver for insurance premiums should be considered as used for "coverage expansion purposes." In response, CMS concluded that: "Amounts of DSH allotment included in budget neutrality calculations for non-coverage expansion purposes under approved demonstrations would still be subject to reduction. Uncompensated care pools and safety net care pools are considered non-coverage expansion purposes. *See* "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions", 78 Fed. Reg. 57293, 57308-57309 (Sept. 18, 2013). ("The statute requires that we take into account the extent to which a state's DSH allotment was included *in the budget neutrality calculation for a coverage expansion that was approved under section 1115 as of July 31, 2009. Prior to the implementation of this proposed rule, these states possess full annual DSH allotments as calculated under section 1923(f) of the Act.* Under an approved section 1115 demonstration, however, the states may have limited authority to make DSH payments under section 1923 of the Act because all or a portion of their DSH allotment was included in the budget neutrality calculation *for a coverage expansion under an approved section 1115 demonstration or to fund uncompensated care pools and/or safety net care pools.* For applicable states, DSH payments under section 1923 of the Act are limited to the DSH allotment calculated under section 1923(f) of the Act less the allotment amount included in the budget neutrality calculation. If a state's entire DSH allotment is included in the budget neutrality calculation, it would have no available DSH funds with which to make DSH payments under section 1923 of the Act for the period of the demonstration….Consistent with the statute, for states that include their DSH allotment in budget neutrality calculations for coverage expansion under an approved section 1115 demonstration as of July 31, 2009, we proposed to exclude from DSH allotment reduction, for the HMF and the HUF factors, the amount of DSH allotment that each state currently continues to divert specifically for coverage expansion in the budget neutrality calculation. *Amounts of DSH allotment included in budget neutrality calculations for non-coverage expansion purposes under approved demonstrations would still be subject to reduction. Uncompensated care pools and safety net care pools are considered non-coverage expansion purposes.… Comment*: One commenter recommended that CMS modify the BNF to include safety net care pool and uncompensated

Thus, regardless of the waiver, the Federal funds used to finance the safety net pool and in particular, the CCHIP insurance premium subsidy provision, are still considered Medicaid DSH funds and not Federal matching funds for "medical assistance."

In sum, the Administrator finds that, a §1115 demonstration project for which patients are eligible must include inpatient hospital benefits in order for the hospital inpatient days to be counted as Medicaid days in the calculation of a hospital's DSH patient percentage. The record shows that patients only become eligible for inpatient services under the CCHIP if they buy the insurance offered thereunder. The fact that the subsidized premiums can be used to purchase inpatient benefits is irrelevant. As such, the Administrator finds and concludes that CCHIP patients are not eligible for Medicaid or made eligible for inpatient services under the §1115 waiver, and so the days of care furnished to these patients cannot be included in the Medicaid fraction pursuant to 42 C.F.R. § 412.106(b)(4)(i).

Because of the source of the funding from Medicaid DSH under §1923 and the lack of Title XIX "medical assistance" underlying the days at issue, this case is related to the problems raised in cases involving uncompensated and charity care days. Similarly, regarding the expenditure of Federal financial participation or FFP under a Medicaid DSH program, generally, the issue of whether <u>costs</u> 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 <u>patients</u> 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. In this case, the record clearly shows that Title XIX matching funds are in fact §1923 Medicaid DSH funds used to assist CCHIP patients to pay for insurance that provides inpatient services to them if they need those services. It is not the individuals who receive premium subsides under CCHIP that are eligible for Title XIX matching payments. It is the pool of funds (i.e. Medicaid DSH funds) used to provide the premium assistance for the purchase of CCHIP premium subsidies that is matched by title XIX funds under §1923 of the Act.

Accordingly, the Administrator finds that the MAC properly excluded patient days for patients who were eligible for the CCHIP from the numerator of the Medicaid fraction of the DSH calculation for the fiscal periods at issue in this case.

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care pool amounts to be treated the same as coverage expansion initiatives. ….*Response*: The proposed and final DHRM takes into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation approved under section 1115 of the Act as of July 31, 2009, by excluding from the HMF and HUF amounts diverted specifically for a coverage expansion. *Uncompensated care pools and safety net care pools do not result in coverage expansion, so they are excluded from consideration as coverage expansion for purposes of this factor*. Accordingly, we finalized this provision of the rule as proposed.")

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: 3/21/17

/s/
Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services