PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D29

PROVIDER -
Arizona 96-99 DSH Group

Provider Nos. -
See attached list of Providers

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ Blue Cross and Blue Shield of Arizona (n/k/a Noridian Administrative Services)

DATE OF HEARING -
July 13, 2005

Cost Reporting Periods Ended -
Various

CASE NO.: 02-0361G

INDEX

ISSUE:

Whether Arizona state-funded days, such as Medically Needy/Medically Indigent (MN/MI), Eligible Low Income Children (ELIC), and/or Eligible Assistance Children (EAC) qualify as Medicaid days for purposes of determining the Provider's Medicare Disproportionate Share Hospital (DSH) adjustments for fiscal years 1994 through 2000.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due providers of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Disproportionate Share Hospital Adjustment Statutory And Regulatory Background:

Short-term hospitals are paid for services provided to Medicare patients under a Prospective Payment System (PPS). Under PPS, inpatient-operating costs are reimbursed based on a prospectively determined formula taking into account national and regional operating costs.

Section 1886(d)(5)(F)(i)(I) of the Social Security Act (SSA or the Act) specifies that the Secretary of the Department of Health and Human Services (Secretary) shall provide for an additional payment to hospitals that serve a significantly disproportionate number of low-income patients. The formula used to calculate a provider's DSH adjustment is the sum of two fractions, which are expressed as percentages. SSA §1886(d)(5)(F)(vi). The first fraction's numerator is the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income, excluding patients receiving

state supplementation only, and the denominator is the number of patient days for patients entitled to Medicare Part A. Id. The second fraction's numerator is the number of hospital patient days for patients who were eligible for medical assistance under a State plan approved under Title XIX for such period but not eligible for benefits under Medicare Part A, and the denominator is the total number of the hospital's patient days for such period. Id.; see also 42 C.F.R. §412.106(b)(4). The first fraction is frequently referred to as the Medicare Proxy and the second fraction, as the Medicaid Proxy. Providers whose DSH percentages meet certain thresholds receive an adjustment which results in increased PPS payments for inpatient hospital services. SSA §1886(d)(5)(F)(ii).

In the mid-1990's a controversy arose over HCFA's interpretation of the DSH formula as set forth under the Act. Pursuant to the Act, the Medicaid component of the DSH formula:

> 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 . . .

SSA §1886(d)(5)(F)(vi)(II) (emphasis added).

HCFA's regulation governing a provider's DSH percentage in effect at the time of the controversy referred to the "number of patient days furnished to patients *entitiled* to Medicaid." 42 C.F.R. §412.106(b)(4) (1993) (emphasis added). In applying the statute and the regulation, HCFA's interpretation substituted the concept of payment and coverage by Medicaid for each day of care, for the statutory standard of "eligibility" for Medicaid coverage thereby limiting the DSH adjustment to inpatient hospital days of service that were actually paid by a Medicaid state agency. However, in HCFA Ruling No. 97-2[1] (February 27, 1997), HCFA changed its prior policy of including in the DSH calculation only inpatient days of service which were actually *paid* by a Medicaid state agency in recognition of the holdings on this issue of the United States Courts of Appeals in the Fourth, Sixth, Eighth, and Ninth Circuits, all of which rejected HCFA's prior interpretation of including only patient days *paid* by Medicaid. Thus, in HCFA Ruling 97-2, HCFA conceded that it should include in the Medicaid fraction all days attributable to inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan, whether or not the hospital received payment for those inpatient hospital services.

The language in HCFA Ruling 97-2 and the implementing instructions regarding which individuals qualify as "eligible for medical assistance under a State plan approved under Title XIX" created a new controversy, in that it clarified HCFA's policy that days attributed to individuals eligible for general assistance and other state-only funded programs (collectively, "State-Only Program Days") should be excluded from the DSH calculation. Intermediaries in certain states historically had allowed providers to include

[1] See Provider Exhibit P-9.

State-Only Program Days funded with state-only dollars in their DSH calculations even though Section 1886(d)(5)(F)(vi)(II) of the Act states that only days attributable to individuals "eligible for medical assistance *under a State plan approved under Title XIX*" are to be included in the DSH calculation. (emphasis added). Based on HCFA 97-2, several of the intermediaries that previously had allowed inclusion of State-Only Program Days in the DSH calculations began amending their policies on this issue and notifying their providers that the erroneously paid funds would be recouped.

Congressional leaders in Pennsylvania and New York intervened on behalf of their constituent hospitals, citing under financial harm if HCFA recouped DSH payments that had been made to providers that had State-only days included in their DSH adjustments. Following pleas for reconsideration of the proposed repayment, HCFA agreed to abandon its effort to recoup these funds. HCFA's decision was communicated in a letter dated October 15, 1999. The letter stated that HCFA would "quickly clarify [its] Medicare DSH policy both to [its] fiscal intermediaries and to hospitals." Id.

HCFA then issued its guidance to fiscal intermediaries, Program Memorandum A-99-62, on December 1, 1999 (the Program Memo)[2] addressing treatment of the State-Only Program Days on both a prospective and retrospective basis. For cost reporting periods beginning on or after January 1, 2000, HCFA declared that no State-Only Program Days would be counted as Medicaid days for purposes to the DSH calculation for any provider. It further clarified that "the term 'Medicaid days' refers to days on which a patient is eligible for medical assistance benefits under an approved Title XIX State plan." Program Memo at 2. Several examples of days that HCFA interpreted as not being "Medicaid days" were set out in an attachment.

For cost reporting periods beginning January 1, 2000, HCFA declared that hospitals could retain or receive DSH payments that included State-Only Program Days provided the hospitals met certain criteria. Hospitals were split into two groups. The first group included hospitals that had already received payments reflecting the inclusion of State-Only Days. For cost reporting periods beginning prior to January 1, 2000, HCFA directed intermediaries not to disallow the portion of Medicare DSH payments previously made to hospitals attributable to the inclusion of the State-Only Program Days. In addition, the Program Memo explained that for open cost reports, intermediaries were to allow only those State-Only Program Days if the hospital had *received* such payment in previous cost reporting periods settled before October 15, 1999.

The second group of hospitals focused on those that did *not* receive a Medicare DSH payment based on the inclusion of the State-Only Program Days but that had claimed the days in an appeal. For cost reports that were settled before October 15, 1999, if a hospital had never received any DSH payment based on the erroneous inclusion of State-Only Program Days and the hospital had not filed a jurisdictionally proper appeal with the Board on this issue prior to October 15, 1999, then intermediaries were not to pay the hospital DSH funds based on the inclusion of these types of days for any open cost reports for periods beginning prior to January 1, 2000. Moreover, intermediaries

[2] See Provider Exhibits P-10 and 11.

were instructed not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of State-Only Program Days in the Medicare DSH formula. However, if a hospital had filed a jurisdictionally proper appeal with the Board for any single fiscal year on this issue before October 15, 1999, the intermediary was to reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these State-Only Program Days in the DSH calculation.

BACKGROUND ON THE AHCCCS PROGRAM AND PROCEDURAL HISTORY OF THIS CASE**:**

Prior to 1982, the State of Arizona did not have a Medicaid program. In 1982, the State of Arizona proposed, and the Secretary of Health and Human Services approved, a plan to establish an experimental Medicaid program called Arizona Health Care Cost Containment System (AHCCCS). AHCCCS was approved under the provisions of §1115 of the Medicaid Act, 42 U.S.C. §1315,[3] which allow the Secretary to waive mandatory requirements of a traditional Medicaid program. Under 1115 waivers, a state may expand eligibility, change the scope of services provided, restrict a beneficiary's freedom of choice, limit providers that may participate in the program or modify methods of reimbursement.

Pursuant to its 1115 Waiver, AHCCCS is a state plan approved by the Secretary. The Secretary approved AHCCCS, and all of its programs and sub-programs, as part of Arizona's 1115 Waiver, irrespective of how the programs and sub-programs are funded.[4]

The AHCCCS program serves the following populations:

1. Mandatory Eligible under Title XIX (Categorically Needy): This group receives direct Federal Financial Participation (FFP);

2. Medically Indigent/Medically Needy (MI/MN). Eligibility for MI/MN assistance requires a person with an annual income less than 40% of the federal poverty level and ineligible for other AHCCCS eligibility categories.

3. Eligible Low Income Children (ELIC): Eligibility for ELIC requires a person to have an annual income below the federal poverty level and to be under 14 years of age.

4. Eligible Assistance Children (EAC): Eligibility for EAC assistance requires a person to have an annual income below the federal poverty level, to be eligible to receive food stamps, and to be under 14 years of age.

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[3] See Provider Exhibit P-15.

[4] See, Stipulated facts dated July 11, 2005; Stipulation No. 20.

The MI/MN, ELIC and EAC categories of assistance (collectively referred to as the MN/MI population) were approved under the AHCCCS waiver program, and were state-only categories of assistance even though the state could have included them as optional Medicaid eligibility categories receiving direct FFP.[5] The issue in this case is whether these Arizona State funded days, MI/MN, ELIC and EAC, qualify as "Medicaid days" for purposes of determining the Providers' Medicare DSH for fiscal years 1994 through 2000.

The Providers in this group are general acute care hospitals located in the State of Arizona. All of the providers participated in AHCCCS, and all were eligible to receive Medicare DSH adjustments during the fiscal years at issue. The Providers filed timely appeals with the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The approximate amount of Medicare reimbursement at issue is $27,404,000.

The Provider was represented by Roger N. Morris, Esquire, and Lisa E. Davis, Esquire, of Quarles & Brady Streich Lang, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Providers argue that the plain language of the DSH statute and regulations require the inclusion of the state-only days in the DSH calculation. The statute at 42 U.S.C. §1395ww(d)(5)(F)(vi) and the regulation at 42 C.F.R. §412.106(b) provide that "[h]ospital patient days for patients who are eligible for medical assistance under a State plan approved under title XIX" must be counted in the DSH adjustment. The Providers note that Arizona's AHCCCS program was approved as a Section 1115 Waiver by the Secretary and that all of its programs constitute its Medicaid State plan under the waiver statute. The Providers assert that the MN/MI populations were approved as part of its waiver program and, therefore, are eligible for and receive medical assistance under its State Medicaid plan, even though the State chose not to receive FFP for these patients. Since the MN/MI patients are eligible under its State plan, these days must be included in the Providers' DSH adjustment pursuant to the plain language of the DSH statute.

The Providers contend that the conclusion that the Section 1115 Waiver is part and parcel of the State plan is supported by three elements: (1) the regulatory definition of "State plan," (2) the statute governing payment for Section 1115 waivers, and (3) the 9th Circuit Court of Appeals' decision in Portland Adventist Medical Center v. Thomas, 399 F.3d 1091 (9th Cir. 2005)(Portland).[6]

First, CMS defines "State plan" to mean "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 program in accordance with Federal requirements." 42 C.F.R. §400.203. The Providers asserts that the State of Arizona submitted a comprehensive written commitment to administer the Medicaid program through

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[5] See Stipulations at 15 and 21.

[6] See, Providers' Notice of Supplemental Authority, July 5, 2005.

AHCCCS in its Application for Federal Assistance in 1982, and the Secretary approved the application. The Providers contend that the regulation does not limit the definition of "State plan" to the "check the box form" published by CMS.[7] Rather, the definition broadly encompasses a state's overall commitment to the provision of medical assistance in accordance with the Secretary's requirements. 42 C.F.R. §400.203. The Providers state that Arizona's overall commitment is to provide comprehensive medical assistance to low-income patients, and that this included the MN/MI population even though Arizona did not initially seek direct FFP for this group.

Second, the statute governing the granting of and payment for Section 1115 waivers directly binds the waiver to the "check the box form" completed as part of the Medicaid participation process. Section 1115 of the Act authorizes the Secretary to "waive compliance" with standard Medicaid requirements when it believes that a demonstration project will promote the objectives of Title XIX. 42 U.S.C. §1315(a)(1). If the Secretary exercises his authority and grants a waiver, then the "costs of such project which would not otherwise be included as expenditures under [Title XIX] . . . shall . . . be regarded as expenditures under the State plan, ..." 42 U.S.C. §1315(a)(2)(A).

Third, the 9th Circuit Court of Appeals interpreted the cost provision of Section 1115 of the Social Security Act and held that the statute ties or binds approved waivers to state Medicaid plans. Portland at 1096. The Court further decided that "expansion populations eligible under §1115 receive medical assistance 'under a state plan.'" Id. Therefore, any population that is part of the approved State plan must be considered in the DSH adjustment. To reach its decision, the Court focused on the policy underlying Medicaid as a social program. It reiterated that income status is the core element supporting DSH payments. The court stated that "Congress intended the Medicare and Medicaid fractions to serve as a proxy for *all* low-income patients." Id. citing Legacy Emanuel Hospital and Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996) (Legacy Emanuel). Relying on this principle, the Court pointed out that "patients receiving medical assistance do not cease to be low income by reason of being in the expansion population." Id. at 1097.

The Providers indicate that their position that FFP is not a prerequisite to the inclusion of MN/MI populations in the DSH calculation is also supported by the Board's decision in Castle Medical Center v. Blue Cross Blue Shield Association/United Government Services, LLC, PRRB Dec. No. 2003-D36 July 16, 2003, (Castle), aff'd in part and rev. in part, CMS Administrator Decision, September 12, 2003, and the 9th Circuit decision in Portland.

The Providers also note that the Section 1115 Waiver enabling statute does not deem "federal costs" alone to be expenditures under a state plan; in fact, the statute in no way limits which costs are deemed expenditures under a State plan. 42 U.S.C. §1315(a)(2)(A). Rather, the statute encompasses all costs required to implement and finance the 1115 Waiver in its entirety.

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[7] See Provider Exhibit P-23.

The Providers also assert that they are entitled to relief under the Program Memo for two reasons. First, the Intermediary had a practice of including MN/MI patient days in the DSH adjustment for each of the Providers in this appeal from 1982 through 2000. Therefore, for open cost reports, the Providers should continue to receive payments for MN/MI patient days. Second, and contrary to the Intermediary's assertion, the Providers did perfect jurisdictionally proper appeals before October 15, 1999.

The Providers point out that the Program Memo established the general rule that if the Intermediary had previously included MN/MI days in the DSH adjustment, it must continue to include them. It specifically states: "You are not to disallow . . . the portion of Medicare DSH adjustment payments previously made to hospitals attributable to the erroneous inclusion of general assistance or other State-only health program . . . or ineligible waiver or demonstration population days in the Medicaid days factor used in the Medicare DSH formula."[8] It further clarifies that "For cost reporting periods beginning before January 1, 2000, [the Intermediary must] continue to allow these types of [general assistance] days in the Medicare DSH calculation for all open cost reports in accordance with the practice followed for the hospital at issue before October 15, 1999. Id. The Providers note that this appeal only applies for cost reporting periods beginning before January 1, 2000. Therefore, since it was the Intermediary's practice to include MN/MI days in the Providers' DSH adjustment before October 15, 1999, then it must continue to do so.

The Providers note that the Intermediary included MN/MI days in the Providers' Medicare DSH adjustment from 1982 until 1990.[9] Thereafter, the Intermediary continued to include MN/MI days in the Providers' Medicare DSH adjustment from 1994 through 2000.[10] The Provider indicates that the Intermediary used the AHCCCS Report to calculate each Provider's Medicare DSH,[11] and that the "highest Rate Code" of "3010" used by the Intermediary included the MN/MI populations.[12] Since the Intermediary has historically included MN/MI days in the Medicare DSH adjustment for each of the Providers in this appeal, all MN/MI days should continue to be counted in the DSH adjustment.

The Providers contend that they all filed perfected jurisdictionally proper appeals. At least three of the Providers filed jurisdictionally proper appeals on the exclusion/understatement of MN/MI days prior to October 15, 1999. To the extent that the appeals of the other hospitals were filed after October 15, 1999, they contend that they should nevertheless benefit from the inclusion of MN/MI patient days in their DSH adjustments because they could not have known what days were being excluded from their cost reports. They further contend that to the extent that they may not have specifically appealed the exclusion/understatement of MN/MI days in the DSH

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8 See, Provider's Hearing Exhibit P-22.
9 See, Stipulations 30.
10 Tr. at 177, line 6; 178, line 13; 187, line 6; and 198, line 3-12.
11 Tr. at 181, line 20 – 182, line 13.
12 See Providers' Post Hearing Brief at 19, notes 12 and 13.

adjustment, federal regulations enable hospitals to add issues to existing appeals at any time prior to hearing. 42 C.F.R. §405.1841(a).

The Providers also note the Board's decision in St. Joseph's Hospital v. Blue Cross Blue Shield Association, PRRB Dec. No. 2004-D32, August 12, 2004, which held that inclusion of general assistance days in the cost report, in and of itself, was sufficient to preserve a jurisdictionally proper appeal under the Program Memo. All of the Providers in this appeal included MN/MI days in their cost reports prior to October 15, 1999.[13] Likewise, in Castle, the Board found that claiming "title XIX" days alone was enough to validate the appeal. The Providers claim that they did not distinguish between AHCCCS patients or eligibility categories. They considered all AHCCCS patients to be Medicaid patients and eligible for inclusion in the DSH adjustment. Thus, the Providers included all Medicaid days, derived from their census data, on their as-filed cost reports from 1994 through 2000. Accordingly, when the Providers submitted their calculations of Title XIX patient days on their cost reports, they did not have any information upon which to distinguish between or exclude MN/MI populations from mandatory Medicaid populations. Moreover, the Providers expected that all of the filed days, including MN/MI days, would be included in the DSH adjustment. The Intermediary used the Abridged AHCCCS Report supplied by the audit manager to make its adjustments, but this information was not provided to the Providers. Thus, upon audit, the Providers had no basis upon which to distinguish between the categories of days adjusted in the DSH calculation, so they could only appeal the difference between the audited amount and the amount submitted on their cost reports.

Finally, the Providers argue that the Program Memo is arbitrary and results in inequitable treatment for hospitals that complied with CMS policy regarding State-funded eligibility group days.

The Intermediary contends that days related to programs not funded by Title XIX cannot be counted. It cites 42 U.S.C. §1395ww(d)(5)(F)(vi) which states that the numerator of the Medicaid proxy is "the number of the hospital's patient days . . . which consists of patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX, . . ." Therefore, the Intermediary argues that Medicaid covered days include only those days for which benefits are payable under Title XIX.

The Intermediary argues that its position is also supported by Medicare's Hospital Audit and Audit Quality Review Program, which states that days associated with "general medical assistance programs operated and funded exclusively by the State (but not Title XIX) are not counted as Medicaid days." Also, 61 Federal Register at 46207 (August 30, 1996) states that "[i]f a State chooses to adopt some sort of a waiver program and elects to cover people who would not have otherwise been eligible for care, those persons will not be included as Medicaid days in the current formula, . . ."

The Intermediary also disagrees with the Providers' reliance on the hold harmless provision of the Program Memo that directs intermediaries to allow, for open cost

[13] Tr. at 208, lines 10-16.

reports, "only those types of otherwise ineligible days that the hospital received payment for in previous cost reporting periods settled before October 15, 1999." The Intermediary indicates for cost reporting periods ending prior to 12/31/1990, the state had been commingling days not eligible for Title XIX in state reports, but that since 1990, general assistance days have been correctly excluded from the Medicare DSH adjustment. The Intermediary asserts that the Providers had no expectation of being paid for state-only days, as they did not include them in their cost reports nor did they include the issue as a protested item. In support of its assertion, the Intermediary submitted a comparison of the Medicare DSH adjustment reported on the as-filed cost reports with the finalized Medicare DSH adjustment.[14] Since, in most instances, the finalized Medicare DSH adjustment was higher than the amount that the Providers submitted on the as-filed cost report, this clearly shows that the Providers did not include state-only days on their as-filed cost reports. The Intermediary notes that the Questions and Answer pertaining to the Program Memo issued by CMS addressed this issue as follows:

> [i]f the hospital abandoned its expectation of receiving payment in those open cost reports . . . and did not even include this issue in the "protested amounts" line, the intermediary should not continue paying the Medicare DSH adjustment reflecting the inclusion of these types of days for those years.

Exhibit I-3 at Q-16.

In response to the Providers' argument that the Program Memo is arbitrary and results in inequitable treatment for hospitals that complied with CMS policy regarding State-funded eligibility group days, the Intermediary cites United Hospital v. Thompson, No. 02-3479, 2003 U.S. Dist. LEXIS 9942 (D. Minn. 2003), aff'd, 383 F.3d 728 (8th Cir. 2004), in which the court held that Program Memorandum A-99-66 does not violate the equal protection of hospitals.

The Intermediary does not agree with the Providers that the decision in Castle is relevant to this case. The Intermediary points out that even though both Arizona and Hawaii had 1115 waiver programs, the Hawaii program specifically allowed for the expansion of Medicaid coverage to general assistance and State Health Insurance Patients, whereas the AHCCCS program had no such expansion waiver and specifically chose to keep its MN/MI population in their state-only program. As such, the MN/MI population days are not a Medicaid eligible group and should not be included in the DSH calculation.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and guidelines, the parties' contentions, and evidence presented, finds and concludes as follows:

This case turns on the interpretation of two statutes: 42 U.S.C. §1395ww(d)(5)(F)(vi) which establishes the DSH adjustment and 42 U.S.C. §1315 which authorizes the

[14] See, Intermediary Exhibit I-7.

Secretary to approve "experimental, pilot, or demonstration projects" to promote innovative approaches to meeting the health care needs of low-income individuals. The Board notes that in a similar case, the 9th Circuit Court of Appeals addressed the interpretation of these two statutes. In Portland, supra, the court found that the plain language of the DSH and 1115 waiver statutes led it to conclude that DSH must include all patients eligible for medical assistance under Title XIX without regard to how they became eligible. Id. This includes patients who became eligible for Medicaid as a result of the §1115 waiver provisions. Id. The Board agrees with the reasoning in Portland and, applying similar reasoning, finds for the Providers in this case. The Board also finds that all patients eligible for medical assistance under a state plan approved under Title XIX must be included in the DSH adjustment without regard to whether the state receives direct FFP for this low-income population.

Title XIX of the Act (Medicaid) authorizes the use of federal funds to help states offset the costs of providing medical assistance to eligible low-income individuals. See 42 U.S.C. §1396 et seq. To receive these funds, a state must submit a "state plan" for approval by the Secretary, and it must administer the plan according to Medicaid requirements. 42 U.S.C. §1396d(a). These requirements regulate the manner in which the plan is implemented as well as which individuals may be covered. See 42 U.S.C. §1396(d)(a). Only expenditures made under an approved Medicaid state plan become eligible for federal matching payments. 42 U.S.C. §1396d (a)-(b).

Ordinarily, state plans must meet the requirements of the Medicaid statute to receive funding. However, Congress has authorized the Secretary, through Section 1115 of subchapter XI of the Act, to approve "experimental, pilot, or demonstration projects" that go beyond these requirements in order to promote innovative approaches to meeting the health care needs of low-income individuals. 42 U.S.C. §1315. These projects must, in the judgment of the Secretary, be "likely to assist in promoting the objectives of . . . [Title] XIX." 42 U.S.C. §1315a. The Secretary may waive the Medicaid requirements set forth in 42 U.S.C. §1396a for these demonstration projects, and the costs of such projects "shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under [Title XIX]." 42 U.S.C. §1315a(1) - (2) (emphasis added).

The State of Arizona does not have a traditional Medicaid program. Instead, it operates its entire Medicaid program as a Section 1115 waiver project. The State of Arizona submitted its waiver proposal in May 1982, and the Secretary approved the waiver on July 13, 1982. The Board finds that under the Section 1115 waiver, AHCCCS is the "state plan" approved by the Secretary. The approval includes all the AHCCCS programs and sub-programs, irrespective of how the programs and sub-programs were funded,[15] because the waiver statute requires that all costs of the demonstration project be regarded as expenditures under the State plan.

The Board agrees with the Portland Court's conclusion that:

[15] These facts have been specifically acknowledged and stipulated to by the parties. See Stipulations 20 and 21.

> [t]he plain language of the statute requires us to conclude that §1115 does not confer on the Secretary discretion to characterize expenditures as Title XIX (Medicaid) expenditures for some purposes and not for others. On the contrary, while the provision gives the Secretary discretion in *approving* projects, the provision *requires* the Secretary to regard expenditures under §1115 projects designed to assist low income patients as Title XIX expenditures for the duration of such projects, and therefore to regard §1115 expansion populations as receiving medical assistance under a state plan approved under Title XIX.

Id. at 1099 (emphasis in original).

The Board is also persuaded by two additional factors that support the inclusion of the MN/MI population in the DSH calculation. First, even though AHCCCS does not receive direct FFP for its MN/MI population, it funds its capitation and DSH payments to providers with all of the funds it receives from the federal, state and local governments. Without this indirect funding, AHCCCS would not be able to finance and maintain coverage for all of the low-income populations eligible under its State plan. These facts are similar to those in Castle, in which the Board found that "capitated Medicaid payments to Medicaid 'HMOs' for all Quest covered beneficiaries, including [General Assistance] GA . . ." resulted in a de facto sharing of the costs of the program as a whole between Federal, State, and local governments. As in Castle, the Board finds that the lack of direct FFP does not prohibit a population from being considered part of the "State plan approved under Title XIX." 42 U.S.C. §1395ww(d)(5)(F)(vi); 42 C.F.R. §412.106(b)(4).

Second, AHCCCS could have included the MN/MI populations as optional groups under a traditional Medicaid state plan (even without a waiver), and could have received direct FFP. See Stipulations 15 and 16.[16] Instead, Arizona chose to include this low-income MN/MI population in its State plan but, for its own reasons, chose not to accept FFP funding for them. The Board observes that in Legacy Emmanuel low-income populations do not stop being low-income merely because the state did not pay for their services, and in a similar vein, concludes that AHCCCS' MN/MI population did not stop being low-income merely because the state chose to bear the entire cost.

The Board's finding for the Providers based upon the plain language of the 1115 waiver and DSH statutes, obviates the need to address the Providers' arguments that they are also entitled to include state-only days under the provisions of the Program Memo or that the Program Memo results in inequitable treatment of providers.

[16] The Board notes that in 2002, AHCCCS changed its State plan to include the MN/MI population as an optional group and has received direct FFP since that time.

DECISION AND ORDER:

The Board finds that the Intermediary's removal of patient days associated with AHCCCS' MN/MI population from the Providers' DSH calculations was improper. The Intermediary's adjustments are reversed.

Board Members Participating:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: May 4, 2007

Suzanne Cochran, Esquire
Chairman