CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of :	**Claim for :**
Banner Health System 2000 DSH Calculation Group **Provider** **vs.** **Blue Cross Blue Shield Association/ Noridian Administrative Services (f/k/a Blue Cross Blue Shield of Arizona** **Intermediary**	**Providers Cost Reimbursement Determination for Cost Reporting Period Ending: December 31, 2000** **Review of: PRRB Dec. No. 2009-D6 Dated: December 23, 2008**

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 Center for Medicare Management (CMM) requested review of the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were timely received from CMM requesting that the Administrator reverse the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Providers'[1] State-funded categories of assistance (hereinafter collectively referred to as the State-funded eligibility group)[2] qualify as Medicaid days for

[1] The Providers in this appeal are three short-term acute care hospitals: Good Samaritan Regional Medical Center, Desert Samaritan Medical Center, and Banner Mesa Medical Center. Stipulations, dated July 18, 2008, ¶ 1. During the period at issue, each of the Providers was operated by Banner Health System. Stipulations ¶ 2.

purposes of determining the Providers' Medicare disproportionate share hospital adjustments (DSH) for the fiscal year 2000.

The Board held that the Intermediary improperly excluded Arizona's State funded eligibility group patient days associated with the Arizona Health Care Cost Containment System (AHCCCS) program from the numerator of the Medicaid fraction of the Medicare DSH calculation. Relying on Portland Adventist Medical Center v. Thomas, 399 F.3d 1091 (9th Cir. 2005)(Portland), the Board held that all patients eligible for medical assistance under a State plan approved under Title XIX must be included in the DSH adjustment regardless as to how they became eligible. The Board held that this included patients who became eligible for Medicaid as a result of the §1115 waiver provisions. The Board also held 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 received direct Federal Financial Participation (FFP) for this low-income population.

The Board noted that Title XIX of the Act authorized the use of Federal funds to help States offset the costs of providing medical assistance to eligible low-income individuals. The Board also noted that, to receive these funds, a State must have a "State plan" approved by the Secretary (i.e., CMS) and administered according to the Medicaid requirements. However, the Secretary, may waive the Medicaid requirements through §1115 (demonstration project waiver) of the Act, to approve "experimental, pilot, or demonstration projects" that go beyond the Medicaid requirements in order to promote innovative approaches to meeting the health care needs of low-income individuals. The Board noted that the State of Arizona did not have a traditional Medicaid program. Instead, the State of Arizona operated its Medicaid program as a §1115 waiver project that was approved by the Secretary on July 13, 1982. Therefore, the Board concluded that the AHCCCS program was the "State plan" approved by the Secretary. This approval included all the AHCCCS programs and sub-programs, irrespective of how they were funded, because §1115 of the Act, requires that all costs of the demonstration project be regarded as expenditures under the State plan. The Board agreed with the Portland Court's conclusion.

The Board was also persuaded by two additional factors that supported the inclusion of the State-funded eligibility group days in the DSH calculation. First, despite the fact that AHCCCS did not receive direct Federal financial participation (FFP) for these beneficiaries,

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[2] See e.g. Providers' Final Position Paper at 14. The Provider's AHCCCS program, *inter alia*, covers the following three groups of individuals, which are at issue: Medically Indigent/Medically Needy (MI/MN); Eligible Low Income Children (ELIC); and Eligible Assistance to Children (EAC).

the Board noted that the State funded its capitation and DSH payments to providers with all of the funds it received from the Federal, State and local governments. The Board held that this indirect funding, or the lack of direct FFP, did not prohibit a population from being considered part of the "State plan approved under Title XIX." Secondly, the fact that AHCCCS could have included the State-funded eligibility group as optional groups under a traditional Medicaid State plan (even without a waiver), and received direct FFP, persuaded the Board that the State-funded eligibility group patient days should be included in the Providers' Medicare DSH calculation.

SUMMARY OF COMMENTS

CMM submitted comments requesting that the Administrator reverse the Board's decision. CMM disagreed with the Board's decision and argued that for the year at issue, the State-funded eligibility group patients were not eligible for medical assistance under a State plan approved under Title XIX, as required by the Medicare DSH statute.

CMM stated that AHCCCS operated Arizona's "Medicaid" program, Arizona's §1115 demonstration project, and several State-only plans that were not approved under the State Medicaid plan or under §1115 of the Social Security Act. CMM noted that the populations at issue were covered by State-only programs and were not covered by Arizona's State Medicaid plan or by Arizona's §1115 demonstration program (though some children received benefits through the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act). CMM stated that, on April 1, 2001, Arizona's §1115 demonstration program was modified to include the MI/MN, ELIC, and EAC populations. However, for the year at issue, from January 1, 2000 through December 31, 2000, the patients in the program were not covered under a §1115 waiver program.

CMM further stated that the Board's analysis was inconsistent with Section 1886(d)(5)(F)(vi)(II) of the Act which mandates that patient days that are included in the Medicaid fraction represent "patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX…" since the patients at issue were not eligible for Medicaid. CMM noted that the statute further states that the Secretary is to include days of patients eligible for medical assistance under a state plan approved under Title XIX and that the Secretary may, "to the extent and for the periods the Secretary determines appropriate, include patient days of patients not so eligible, but who are regarded as such because they receive benefits under a demonstration project approved under Title XI." CMM contended that the statute clearly makes a distinction between the

days of patients who are actually eligible under the State plan and the days of patients who are merely treated as such because they are eligible through a demonstration project like AHCCCS. However, CMM maintained that the populations at issue did not become eligible under §1115 until after the year that is at issue in this case and, therefore, whether the populations could have been included in the Medicaid fraction under a §1115 waiver authority is a moot point.

CMM also cited Adena Regional Medical Center v. Leavitt,[3] where the Court of Appeals for the District of Columbia held that the phrase "eligible for medical assistance under a State plan approved under Title XIX" in §1886(d)(5)(F)(vi) referred to patients eligible for "medical assistance" as it is defined in the Medicaid statute in §1905(a). Under the statute, patients receiving "medical assistance" under a State plan are those who are eligible for Medicaid and, since State-funded eligibility group populations are not by definition eligible for Medicaid, they cannot be said to be receiving "medical assistance under a State plan."

CMM also pointed out that the same facts have already been rejected by the United States District Court for the District of Arizona. In Phoenix Memorial Hospital , et al. v. Leavitt,[4] the court held that "for the time period relevant to this case," the State-only patients, "were not eligible for medical assistance under Arizona's Medicaid plan, even though they were eligible for medical assistance under AHCCCS." CMM noted that, in addressing the issue of whether the State-only patients at issue were "part of" a State Medicaid plan,[5] the Court found that, in approving "fourteen specific waivers that were granted so that Arizona could implement its demonstration project, [n]one of the waivers related to providing medical assistance to MN/MI patients."[6] CMM noted that the court found that the approval letter showed that the Secretary approved the waiver application and not the "AHCCCS" program. Moreover, the waiver application did not seek approval to include the State-only patient days in AHCCCS, or the Medicaid plan.

CMM stated that the Board based its decision, in large part, on its belief that the Intermediary's exclusion of State-funded eligibility group days from the DSH calculation was inconsistent with provisions of the §1886(d)(5)(F)(vi) and §1115 waiver. The Board agreed with the Ninth Circuit Court of Appeals ruling in Portland. However, CMM contended that, unlike the population at issue in Portland, to the extent that any of the State-funded eligibility group populations in this case received Federal funds, they did so

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[3] Adena Regional Medical Center v. Leavitt, 527 F.3d 176 (D.C. Cir. 2008).
[4] Phoenix Memorial Hospital , et al. v. Leavitt, No. 2:07-CV-1720 (D. Ariz. Jan. 13, 2009).
[5] Id. at 17.
[6] Id. at 20.

pursuant to Title XXI, not Title XIX. Further, there were no expenditures for these days under §1115(a)(2) for the period at issue, because the populations at issue were not eligible under a §1115 waiver. Therefore, CMM argued that Portland was irrelevant to this case.

CMM concluded that CMS policy did not, at any time, permit State-only days to be included in the DSH calculation, despite revising its policy so that expansion groups could be included in the DSH calculation as of January 20, 2000.[7] Given that the inpatient days associated with the State-funded eligibility group populations were part of the "State-only" programs and did not become a part of a §1115 waiver program until 2001, they do not meet the DSH statutory or regulatory requirements for inclusion in the Medicare DSH calculation. Therefore, CMM stated that the Intermediary correctly excluded the State-funded eligibility group inpatients days from the Medicare DSH calculation.

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 that were timely received are included in the record and have been considered.

Relevant to the issue involved in this case are two Federal programs, Medicaid and Medicare, which covers 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, disabled, or members of families with dependent children.[8] 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 Social Security 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.[9] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income or SSI. 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.[10]

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[7] 65 Fed. Reg. 3136.

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

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

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

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.[11] If the State plan is approved by CMS, under §1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.

Within broad Federal rules, States enjoy a measure of flexibility to determine "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.[12] 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 Social Security 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.[13] 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 section 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 provide for an adjustment in payment for inpatient hospital services furnished by a disproportionate share hospital. A hospital maybe deemed to be a Medicaid disproportionate share hospital pursuant to §1923(b) (1) (A), which addresses a hospital's Medicaid inpatient utilization rate, or under

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[11] Id. §1902 et seq. of the Act.

[12] Id.

[13] 42 CFR 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."

paragraph (B), which addresses a hospital's low-income utilization rate. The latter criterion relies, inter alia, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.[14]

Congress recognized that the various conditions and requirements of Title XIX of the Act, under which a State may participate in the Medicaid program created certain obstacles to potentially innovative and productive State health-care initiatives. Consequently, Title XI of the Act was amended to allow States to pursue such innovative programs.[15] Under §1115 of subchapter XI of the Act, a State that wishes to conduct such an innovative program must submit an application to CMS for approval. CMS may approve the application, if, in their judgment, the demonstration project is likely to assist in promoting the objectives of certain programs established under the Act, including Medicaid.[16] To facilitate the operation of an approved demonstration projects, CMS may waive compliance with specified requirements of Title XIX, to the extent necessary, and for the period necessary, to enable the State to carry out the demonstration project.[17] In addition, CMS may direct that costs of the demonstration project that would not "otherwise" qualify as §1903 Medicaid expenditures, "be regarded as expenditures under the State plan approved under [Title XIX]."[18]

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[19] established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health,

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[14] Congress has revisited the Medicaid DSH provision several times since its establishment. In 1993, Congress enacted further limits on DSH payments pursuant to section 13621 of Pub. Law 103-66 that took into consideration costs incurred for furnishing hospital services by the hospital to individuals who are either eligible for Medicare assistance under the State plan or have no health insurance (or other source of third part coverage for services provide during the year). The Medicaid DSH payments may not exceed the hospital's Medicaid shortfall; that is; the amount by which the costs of treating Medicaid patients exceeds hospital Medicaid payments, plus the cost of treating the uninsured.

[15] Section 1115 of the Act.

[16] Id.

[17] Id.

[18] Id.

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

and hospice care,[20] and Part B, which is a supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[21] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[22] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[23] 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.[24]

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 reimbursed 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 pre-determined 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 (DRG) subject to certain payment adjustments.

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…."[25] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[26] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, inter alia, 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:

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[20] Section 1811-1821 of the Act.
[21] Section 1831-1848(j) of the Act.
[22] Under Medicare, Part A services are furnished by providers of services.
[23] Pub. Law No. 98.21.
[24] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).
[25] 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).
[26] The Pickle method is set forth at section 1886(d) (F) (i) (II) of the Act.

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

CMS implemented the statutory provisions at 42 C.F.R. § 412.106. The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 C.F.R. § 412.106(b)(2). 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) (2000) and provides that:

> *Second computation*. The fiscal intermediary determines, for the hospital's same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. (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. [27] The PM was in response 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).

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

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[27] The Providers did not raise the hold harmless provision as an alternative ground for supporting payment and, thus, the issue is not addressed in this decision.

> 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 plan 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 plan 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 document to substantiate the number of Medicaid days claimed. [28] (Emphasis added.)

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

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[28] 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.

> General assistance days are days for patients covered under a State-only or county-only general assistance program, whether or not any payment is available for health care services under the program. Charity care days are those days that are utilized by patients who cannot afford to pay and whose care is not covered or paid by any health insurance program. While we recognize that these days may be included in the calculation of a State's Medicaid DSH payments, these patients are not Medicaid eligible under the State plan and are not considered Titled XIX beneficiaries.[29]

In addition, for the relevant fiscal period in dispute, 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.[30] This policy did not affect the longstanding policy of not counting general assistance or State–only days in the Medicare DSH calculation. 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 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.[31]

In 2001, CMS issued a Program Memorandum (PM) Transmittal A-01-13[32] which again stated, regarding Medicaid DSH days, that:

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[29] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

[30] 65 Fed. Reg. 3136 (Jan. 20, 2000). ("In some section 1115 waivers, a given population that otherwise could have been made eligible for Medicaid under section 1902(r)(2) or 1931(b) in a State plan amendment was made eligible under the section 1115 waiver. This population was referred to as hypothetical eligible, and is a specific, finite population identifiable in the budget neutrality agreements found in the Special Terms and Conditions for the demonstrations. The patient days utilized by that population are to be recognized for purposes of calculating the Medicare DSH adjustment. In addition, the section 1115 waiver may provide for medical assistance to expanded eligibility populations that could not otherwise be made eligible for Medicaid. Under current policy, 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 expected eligibility groups however, were not to be included in the Medicare DSH calculation.")

[31] Id.

[32] 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,

> Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State. These patients are not Medicaid eligible. Sometime Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care of general assistance days. This, however, is not "payment" for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicaid formula.
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> Days for patients covered under a State-only (or count-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan.

Finally, in a recently enacted legislation, Congress clarified the meaning of the phrase "eligible for medical assistance under a State plan approved under title XIX" with respect to patients not Medicaid eligible, but who are regarded as such, because they receive benefits under a demonstration project approved under title XI. Congress added language to §1886(d) (5) (F) (vi) (II) of the Act which stating:

> In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.[33]

This amendment to §1886(d) (5) (F) (vi) of the Act specifically addressed the scope of the Secretary's authority to include (or exclude), in determining the numerator of the Medicaid fraction of the Medicare DSH calculation, patient days of patients not eligible for medical assistance under a State plan but who receive benefits under a demonstration project

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with respect to the hold harmless policy. See Transmittal A-01-13; Change Request 1052 (January 25, 2001).

[33] 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).

approved under Title XI of the Act. This enactment clearly distinguishes those patients eligible to receive benefits under Medicaid from those patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.

In sum, for the cost year at issue, the Secretary has consistently required the exclusion of days relating to general assistance or State-only days. The policy distinguishes those days as for individuals that receive medical assistance under a Title XIX State plan that are to be counted and "other" days that are not to be counted. Examples of some of these other days include days for individuals that are not in fact eligible for medical assistance but may receive State assistance; days that maybe a basis for Medicaid DSH payment under the State plan only; or days related to individuals that may receive benefits under a Title XI plan. These other days are not counted for purposes of the Medicare DSH payment.

This particular case centers on whether Arizona's State-funded eligibility group patient days at issue should be included in determining the Providers' Medicare DSH adjustments for the fiscal year in dispute. Prior to 1982, the State of Arizona did not have a Medicaid program under Title XIX.[34] In May of 1982, the State of Arizona submitted a §1115 demonstration project waiver proposal to CMS.[35] CMS approved the §1115 demonstration project waiver on July 13, 1982, and the §1115 demonstration project waiver was implemented on October 1, 1982.[36] The system under which Arizona operates is called the Arizona Health Care Cost Containment System (AHCCCS). The AHCCCS program is a Statewide managed care system which delivers acute care services based on a prepaid, capitated approach.[37] For the cost years at issue, under Arizona's §1115 demonstration project waiver, as approved by CMS, only the categorically needy receive direct Federal Financial Participation (FFP).[38] These patients are called the Mandatory Eligible under Title XIX (Categorically Needy). The State also decided to provide services to three other groups, for which no FFP was paid, each with different State eligibility requirements. The Providers' refers to the groups as:

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[34] See, e.g., Stipulation ¶ 4, Providers' Exhibit P-2.
[35] See, e.g., Providers' Exhibit P-3.
[36] See, e.g., Providers' Exhibit P-4.
[37] See, e.g., Providers' Exhibits P-1 and P-2.
[38] See, e.g., Providers' Position Paper at 15; Declaration of Branch McNeal ¶ 5, Providers' Exhibit 11. As noted above, once a State's Medicaid plan is approved, the State is entitled to reimbursement from the Federal government for a portion of its payments to providers which furnish services to Medicaid recipients, known as "Federal financial participation" or FFP.

1. Medically Needy/Medically Indigent (MN/MI);
2. Eligible Low Income Children (ELIC); and
3. Eligible Assistance to Children (EAC).[39]

For the fiscal period in dispute, the MN/MI, ELIC, and EAC eligibility categories (State-funded eligibility group) patient days were funded with State and county funds.[40] Accordingly, the Intermediary's Medicare DSH computation for the Providers only included those AHCCCS days in which the patient was eligible to receive Federal Title XIX funds (Mandatory Eligible under Title XIX-Categorically Needy) in determining the Medicaid days to be included in the Medicaid fraction. The Providers disputed the Intermediary's exclusion of the State-funded Eligibility group patient days. The Providers' acknowledged that the State received no FFP for individuals included in these three groups. [41] However the Providers' contended that all days covered under the AHCCCS program including the State-funded eligibility group days should be included in the DSH computation as patients for such days were eligible for medical assistance under an approved State plan.[42]

However, the Administrator finds that AHCCCS, as a whole, is not Arizona's Medicaid plan. Rather, the AHCCCS has two components, one of which is Arizona's §1115 waiver for which it received FFP, and one of which is the State's program for providing health care to low-income persons who are not eligible for Medicaid. Relevant to that finding, §1886(d)(5)(F)(vi)(II) of the Act requires for purposes of determining a Provider's "disproportionate patient percentage" that the Secretary count patient days attributable to patients who were eligible for medical assistance under a State plan approved under Title XIX of the Act, but who were not also entitled to Medicare Part A. The Administrator finds that, as reflected at 42 C.F.R. § 412.106, the Secretary has interpreted this statutory phrase "patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX," to mean "eligible for Medicaid."[43] The Administrator further

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[39] See, e.g., Id. These three groups, the State-funded eligibility group, are comprised of persons who do not qualify as categorically eligible for Medicaid. These categories are funded entirely with State and county funds.

[40] Id. See also, e.g., Stipulation ¶ 7.

[41] See, e.g., Providers' Position Paper at 15. Stipulation ¶ 7.

[42] Providers' Position Paper at 19.

[43] See e.g. Cabell Huntington Hosp. Inc., v. Shalala, 101 F.3d 984, 989 (4th Cir. 1996) ("It is apparent that 'eligible for medical assistance under a State plan' refers to patients who meet the income, resource, and status qualifications specified by a particular state's Medicaid plan.…"); Legacy Emanuel Hospital v. Secretary, 97 F.3d 1261, 1265 (9th Cir. 1996)("[T]he

finds that the term "Medicaid" refers to the joint State/Federal program of medical assistance authorized under title XIX of the Act. If a patient is not eligible for Medicaid, than the patient is not "eligible for medical assistance under a State plan approved under Title XIX."

The Administrator finds that the language set forth in §1886(d)(5)(F)(vi)(II) of the Act requires that the day be related to an individual eligible for "medical assistance under a State plan approved under Title XIX" also known as the Federal Medicaid Program. The use of the term "medical assistance" at §§1901 and 1905 of the Act and the use of the term "medical assistance" at §1886(d)(5)(F)(vi)(II) of the Act is reasonably concluded to have the same meaning. As noted by the courts, "the inter-relationship and close proximity of these provisions of the statute presents a classic case for the application of the normal rule of statutory construction that "identical words used in different parts of the same act are intended to have the same meaning."[44] Therefore, the Administrator finds the language at §1886(d) (5) (F) (vi) (II) of the Act requires that for a day to be counted, the individual must be eligible for "medical assistance" under Title XIX. That is, the individual must be eligible for the Federal government program also referred to as Medicaid.

In contrast, the days involved in this case are related to individuals that are not eligible for "medical assistance" as that term is used under Title XIX and, thus, are not properly included in the Medicaid patient percentage of Medicare DSH calculation under §1886(d)(5)(F)(vi)(II) of the Act. Rather, the days in question are associated with the general assistance days provided under the State only portion of the AHCCCS. Arizona's AHCCCS oversees: 1) the Medicaid mandatory eligibles under the § 1115 demonstration project waiver approved under Title XI (not under a State plan as defined under § 1902 of the Act and 42 C.F.R. § 400.203 under Title XIX) for which the State receives matching FFP; and 2) the general assistance eligibles under the State Program for which the State receives no matching FFP. These latter days are not related to patients eligible for Medicaid and, hence, cannot be counted in the numerator of the Medicare DSH fraction.

The Providers, as the proponent of the rule, have the burden of proving by a preponderance of evidence[45] that such days were for patients eligible for medical assistance under an approved State plan [Medicaid] in order to demonstrate that such days should be included in

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Medicaid proxy includes all patient days for which a person was eligible for Medicaid benefits whether or not Medicaid actually paid for those days of service.")

[44] Sullivan v. Stroop, 496 U.S. 478, 484 (1990); Commissioner v. Lundy, 516 U.S. 235, 250 (1996).

[45] 5 U.S.C. 556(d); 42 C.F.R. §405.1871(a)(3); 73 Fed. Reg. 30190, 30227 (May 23, 2008).

calculating the Medicare DSH payment. However, the Providers generally presented secondary source documents (as opposed to, for example, the original waiver approval). For example, the Providers submitted, at P-1, the 2002 AHCCCS Overview, and at P-2, CMS' overview of the "Arizona Statewide Health Reform Demonstration." The Provider also included CMS' Health Insurance Flexibility and Accountability (HIFA) Initiative Fact Sheet for 2001, and AHCCCS Medicaid Waivers effective in 2002, at Exhibits P-3 and P-4, respectively. These documents do not discuss the State-funded eligibility groups at issue in this case as included as part of the waiver for the period at issue. In addition, the Providers' Exhibit P-10, dated November 12, 2001, with related correspondence, shows Amendment Transmittal 91-25, which amends Attachment 4.19A, to allow for payment of Medicaid DSH under the §1115 waiver. The Medicaid DSH payment criteria is based on the "medical assistance inpatient utilization rate" and "low-income inpatient utilization rate" and is not related to payment of FFP for an individual The Administrator finds that such documents do not demonstrate that the days were for patients eligible for medical assistance under a State plan, i.e., for Medicaid patients.

In addition, documents supplied by the parties support a finding that the days were not for Medicaid eligible patients. The "2001 AHCCS Overview: Chapter 1 Beginning and Future of AHCCS,"[46] states that:

> The [AHCCS] is Arizona's Medicaid Program and the State's health care program for persons who do not qualify for Medicaid. **** In 1982, Arizona sought approval from CMS to operate a Statewide managed care programs through 1115 waiver authority.… CMS approved Arizona's waiver request, initially granting the State authority to operate an acute care program for 3 to 5 year period. **** Simultaneously, AHCCCS was charged with the new responsibility of operating 100 percent State-funded program for indigent persons who did not qualify for Medicaid. The program called the medically needy/medically indigent (MN/MI) program.
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> ****
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> [I]n 2001, CMS approved AHCCS request to expand the eligibility to 100 percent of the [Federal poverty level]….[47]

[46] Intermediary's Position Paper, Exhibit I-5.

[47] Id. at 1-5.

Thus, the Administrator finds that not only does the record fail to demonstrate that the groups at issue were eligible for Medicaid, but rather supports a finding that these were specifically excluded from Medicaid. In addition, the Administrator herein takes notice and incorporates the factual findings of the Administrator decisions in Good Samaritan Regional Medical Center, PRRB Dec. No. 2007-D35 and Arizona 96-99 DSH Group, PRRB Dec. No. 2007-D29. The Administrator also takes notice and herein incorporates the district court's factual findings in Phoenix Memorial Hospital, supra, at 18-24.[48]

Notably, the original §1115 waiver approved by CMS for the State of Arizona, excluded the State program (AHCCCS) from 14 provisions of the Social Security Act, for services that are mandatory services normally covered under traditional Medicaid and allowed the State to offer a tailored package of benefits to a targeted population. The Secretary specifically set out the fourteen specific waivers that were granted so that Arizona could implement its demonstration project.[49] Significantly, none of the waivers related to providing medical assistance to the State-funded eligibility group are at issue in this case.[50] Thus, the approval indicated that the Secretary approved Arizona's waiver application; however, it did not indicate that he approved the entire AHCCCS. While the State's waiver application sought waivers for some of the statutory requirements for a State Medicaid plan in this case; it did not seek "approval" to include the State-funded eligibility groups in AHCCCS, or the State Medicaid plan for the cost year at issue.

In addition, during the relevant time periods, Arizona received direct FFP for patients only in the Mandatory Medicaid eligibility category. The funding source for the State-funded eligibility group was from the State and counties. If the State-funded eligibility group had been part of Arizona's approved Medicaid plan, then the State should have been receiving direct FFP from them. Instead, as the Providers acknowledge, they did not receive direct FFP for these individuals.[51]

The Board also found that, if the State had operated a traditional Medicaid program, the AHCCCS State-funded eligibility group days would be included in the traditional plan. The record does not show an analysis of the criteria for the State-funded eligibility group under the Medicaid optional eligibility criteria. Rather, the Providers' alleged that certain parts of the State-funded eligibility group would be eligible for Medicaid if they were to apply.[52]

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[48] See 42 C.F.R. §405.1875(e)(3)(ii).

[49] See, e.g., Phoenix at 20; Intermediary's Positions Paper, Exhibit I-6.

[50] Id.

[51] Stipulations at ¶7.

[52] Providers' Position Paper at 19-20.

First, the only hypothetical Medicaid eligible that are counted are those for which FFP is paid under a waiver. Hence, alleging that a group is hypothetically Medicaid eligible but not under any approved or waiver does not meet the criteria of §1886(d)(5(F) of the Act. Second, even assuming, *arguendo*, such an analysis could support inclusion of the days, the Administrator finds that there is no demonstration in the record that the criteria for these general assistance populations are identical to the Medicaid optional eligibility criteria. Therefore, the Board's finding that the State-funded eligibility group at issue would have been included under the Medicaid optional category of patients in a traditional State plan is not supported by the record, nor relevant to the criteria of whether these days should be counted.

Further, regarding the expenditure of FFP under a Medicaid DSH program under section 1927 of the Act, generally, the issue of whether costs are regarded as expenditures under a State plan approved under Title XIX for purposes of calculating Federal matching payments to the State is different from the issue of whether patients are considered eligible for medical assistance under a State plan approved under Title XIX for purposes of calculating Medicare DSH payments to a hospital. The statute clearly states that the patients' Title XIX eligibility for that day is a requirement. Therefore, regardless of any possible Medicaid DSH payment and indirect FFP provided under Title XI, the general assistance population days operated and funded by the State of Arizona (not Title XIX) are not counted as Medicaid days.

The Board also found that its decision is supported by the Ninth Circuit's decision in Portland. The Administrator finds that the general assistance days at issue in this case are distinguished for several reasons from the days at issue in Portland. [53] Among other things, no direct FFP was expended for individuals in this case under §1115(a) (2) (or Title XIX) and, similarly, the State-funded eligibility group at issue is not referenced as an expanded eligibility group under the waiver. Thus, to the extent that any of the State-funded eligibility group populations in the instant case received indirect Federal funds, they did so pursuant to Title XXI, not Title XIX, therefore distinguishing the population at issue with the one in Portland. While Arizona may have operated under a §1115 waiver, these general assistance days were not approved by the Secretary and included for payment under the waiver.[54]

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[53] Further, even if one were to assume, *arguendo,* that these days were like the Portland days, the Administrator finds that Congress has intervened since Portland was issued. Section 5002 of Deficit Reduction Act (DRA)[53] ratified CMS' policy of not counting patient days of the expanded eligibility groups in the Medicare DSH calculation. Hence, the court's analysis of the statute under Portland has been since revisited by Congress

[54] Despite the fact that no direct FFP was paid for these individual, the Board has agreed with the providers' argument that, under a Portland analysis, the §1115 waiver enabling

Based on the record, the Administrator finds that the AHCCCS program has two separate and distinct components; the Arizona's §1115 demonstration project, and the State funded health care program for indigent which included the State-funding eligibility group. The State-funded eligibility group, for the year at issue, was not eligible for medical assistance under Arizona's Medicaid plan, nor were they eligible under §1115 waiver authority under AHCCCS. Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly did not count Arizona's State-funded eligibility group days at issue in this case in the numerator of the Medicaid fraction of the Medicare DSH calculation.

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statute does not deem "Federal costs" alone to be expenditures under a State plan. The Board has agreed that the statute in no way limits which "costs" are deemed expenditures under a State plan. Thus, the Board found that expenditures under the §1115 waiver (whether Federal, State or county) are equivalent to and deemed to be costs expended under the Title XIX. However, the Administrator finds that §1115(a)(2) states that "the costs of such projects *which would not otherwise be included as expenditures under section….1903* … shall to the extent and for the period prescribed by the Secretary be regarded as expenditures under the state plan approved under such title." This phrase specifically refers to section 1903 (FFP) expenditures, not State or local government expenditures as the Board and Providers contend. Therefore, even under a Portland analysis, the fact that a State with a §1115 waiver, has decided to expend State funds for general assistance population, is not a basis for including the related days of such a population in the numerator of the Medicaid fraction of the Medicare DSH calculation.

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: **2/24/09** **/s/**

Tim Hill
Acting Deputy Administrator
Centers for Medicare & Medicaid Services