CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of: **QRS 1995, 1996, 1998-2007** **DSH/Pennsylvania General Assistance Day Group**	**Claim for Payment Determination for Cost Reporting Period(s) Ending:** **Various**
Provider **vs.**	
Blue Cross Blue Shield Association/ Novitas Solutions, Inc.	**Review of:** **PRRB Dec. No. 2013-D1** **Dated: November 20, 2012**
Intermediary	

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 Providers submitted comments, requesting that the Administrator review and reverse the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Providers, intermediary and the CMS' Center for Medicare (CM). 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 Pennsylvania Charity care Program (e.g., general assistance (GA))[1] days should be included in the numerator of the Medicaid proxy of the

[1] In its position paper the Providers stated that "The Providers in this Group Appeal provided inpatient care to individuals who are eligible for general assistance or otherwise qualify as charity care for the applicable periods." (Emphasis added.) Thus, the record is not clear that the days at issue solely involve patients that may

Medicare disproportionate share hospital (DSH) calculation pursuant to § 1886(d)(5)(F)(vi)(II) of the Social Security Act, as amended (Act).

The Board held that the Intermediary properly excluded Pennsylvania Charity Care Program days in the numerator of the Providers' Medicaid proxy. In reviewing the Medicaid DSH statute at § 1923 of the Act, the Board found that the statue mandated that a State Medicaid plan under Title XIX include a provision for a payment adjustment to hospitals which serve a disproportionate number of low income patients, i.e., a Medicaid DSH adjustment for hospitals that's independent of the Medicare DSH adjustment at issue in this case. The Board found that while the Medicaid DSH adjustment was eligible for Federal financial participation (FFP), the patient days at issue in this case are not directly eligible for FFP because they do not qualify as "traditional Medicaid" services described in § 1905(a) of the Act.

In addition, upon further review and analysis of the Medicaid DSH statute at § 1923 of the Act, the Board found that the term "medical assistance under a State plan approved under [Title] XIX" excluded days funded only by the state and charity care days even though those days may be counted for Medicaid DSH purposes. The Board reasoned that if Congress had intended the term "eligible for medical assistance under a State plan" (the only category of patients in the Medicaid utilization rate) to include the State funded hospital days and charity care days, the subsections adding those categories of days in the low income utilization rate would have been superfluous. Because the Pennsylvania Charity Care Program patient days were funded by "state and local governments" and included in the low income utilization rate, not the Medicaid inpatient utilization rate, the Board found that the Missouri Charity Care Program patient days did not fall within the Medicaid statute definition of "eligible for medical assistance under a State plan" at § 1923 of the Act.

Finally, the Board referenced *Adena Regional Medical Center v. Leavitt.*[2] The Court of Appeals for the D.C. Circuit held that the phrase "eligible for medical assistance under a State plan approved under title XIX" referred to patients who are eligible for Medicaid. The Court rejected the argument that the days of patients who were counted toward a Medicaid DSH payment must be counted toward the Medicaid fraction of the Medicare DSH calculation.

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[2] 527 F. 3d 176 (D.C. Cir. 2008).

SUMMARY OF COMMENTS

The Providers submitted comments, requesting that the Administrator review and reverse the Board's determination for the reasons set forth below.

The Providers' disagreed with the Board's determination that Pennsylvania Charity Care Program/General Assistance (GA) days were solely funded by the State and local governments. The Providers asserted that the Board determination was based on confusion between "cash benefits" and "medical benefits made available to GA recipients and also ignored the controlling State Plan". The Providers noted that "cash benefits" for GA populations were solely State funded, while inpatient benefits under Pennsylvania's GA program were "federalized under the State Plan, effective October 30, 1994. Moreover, Pennsylvania's State Plan provides the criteria for eligibility for the GA program and prescribes inpatient rates for GA patients which are identical to those payments made to hospitals for "traditional" Medicaid patients. The assumption that GA inpatient coverage is not provided for under the amendments to Pennsylvania State Plan approved by CMS is a clear factual error, which renders the Board decision unsustainable on a clear but narrow ground.

The Providers furthered argued that the Board's reliance on *Adena* is misplaced. The Providers asserted that the Board's reliance on *Adena* is inconsistent with the Secretary's regulations at 42 C.F.R. §412.106(b)(4), amended January 2000. These regulations expressly permit hospitals located in section 1115 "waiver" states to count in the numerator of the non-Medicare fraction of the Medicare DSH calculation all inpatient days funded through §1115 demonstration projects, irrespective of whether they are attributable to individuals who qualified for, or who could qualify for, traditional "Medicaid benefits" as categorically or medically needy. Thus, by abandoning traditional Medicaid eligibility as a precondition to a patient day being included in the numerator of the so-called Medicaid DSH fraction, the Secretary can not rationally deny hospitals the right to count low-income patients who are not receiving services outside of §1115 demonstration projects on the basis that they do not qualify for traditional "Medicaid" benefits.

The Providers also argued that it is arbitrary and capricious to interpret and apply the exact same Medicare provision as requiring Medicaid eligibility in States in which medical assistance is delivered under a traditional State Plan, and where non-"Medicaid eligible" indigent patient are paid for through Medicaid DSH adjustments, while simultaneously disavowing that requirement for section 1115 waiver States. The Providers argued that there is no valid explanation given for permitting hospitals located in §1115 states - for example, in Delaware - to count non-Medicaid eligible patients whose care is funded under Title XIX - while denying equivalent treatment to hospitals in other states that are reimbursed for

treating substantially equivalent low-income non-Medicaid populations through DSH payments funded under Title XIX.

Finally, the Providers argued that the Secretary's regulatory treatment of Pennsylvania hospitals compared with peer hospitals located in §1115 waiver States violate the Providers' Equal Protection rights under the United States constitution. The Providers noted that the Secretary's stated purpose for relaxing the putative "Medicaid eligibility" requirement was to protect financially vulnerable hospitals that "partner with States" by treating large number of indigent patients covered exclusively at low rates paid through a medical assistance plan. However, by excusing traditional Medicaid only for hospitals in §1115 states, while invoking entirely semantic distinctions for denying the same protection to similarly situated Pennsylvania hospitals, directly "frustrates" that very purposed.

CMS' Center for Medicare (CM) submitted comments stating that the Board's conclusion was accurate and appropriate. Contrary to the Providers' arguments, CM asserted that CMS' policy has not, at any time, permitted State-only days to be included in the Medicare DSH calculation. CM disagreed with the Providers' argument that there was "no rational distinction" between Pennsylvania GA patients and patients who receive Medicaid under §1115 demonstrations in certain States. CM noted that §1115 days are used by patients whose care is considered to be an approved expenditure under Medicaid, whereas, State-only funded benefits like GA are not considered Medicaid expenditures. Moreover, the Providers themselves have acknowledged that Pennsylvania GA patients are not Medicaid beneficiaries. Finally, CM argued that Congress and the Courts have considered this issue and have upheld CMS' determination to exclude GA days from the numerator of the Medicaid fraction in 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 received timely are included in the record and have been considered.

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.[3] The program is jointly financed by the Federal and

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

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.[4] 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.[5]

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.[6] 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.[7] 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

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[4] Section 1902(a) (10) of the Act.
[5] Section 1902(a) (1) (C) (i) of the Act.
[6] Id. § 1902 et seq., of the Act.
[7] Id.

1902 sets forth the criteria for State plan approval.[8] 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),[9] which addresses a hospital's Medicaid inpatient utilization rate, or under paragraph (B),[10] which addresses

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[8] 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."

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

[10] Subsection (B) provides that for purposes of subsection (a)(1), a hospital which meets the requirements of subsection (d) is deemed to be a disproportionate share hospital if— "(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent." (3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—(A) the fraction

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

Section 1115 of the Social Security 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—

(expressed as a percentage)— (i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this title (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and (ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and (B) a fraction (expressed as a percentage)— (i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and (ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period. The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this title).

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

> (1) the Secretary may waive compliance with any of the requirements of section, … 1902, … to the extent and for the period he finds necessary to enable such State or States to carry out such project, and (2)(A) costs of such project which would not otherwise be included as expenditures under section, …1903, …shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, as may be appropriate, …

The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as: expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible; providing services not typically covered by Medicaid; using innovative service delivery systems that improve care, increase efficiency, and reduce costs. In general, §1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years. Demonstrations must be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver.[12]

States have used §1115 demonstrations for different reasons. Some States have tested new approaches to providing coverage or improving the scope or quality of benefits in ways that would not otherwise be permitted under the statute. For example, some States have used §1115 demonstrations to expand eligibility to individuals who would not otherwise qualify for benefits, or to establish innovative service delivery systems. Other demonstrations have constrained eligibility or benefits in ways not otherwise permitted by statute. For example, some demonstrations have provided for a more limited set of benefits than the statute requires for a specified population, implemented cost-sharing at levels that exceed statutory requirements, or included enrollment limits. Some demonstrations have involved financing approaches that are not contemplated in titles XIX of the Act. As such, demonstrations can have a significant and varied impact on beneficiaries, providers, States, Tribes and local governments. They can also influence policy making at the State, Tribal and Federal level, by introducing new approaches that can be a model for other States and lead to programmatic changes nationwide.[13]

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

[13] "Medicaid Program; Review and Approval Process for Section 1115 Demonstrations", 75 Fed Reg. 56946 (September 17, 2010); "Medicaid Program; Review and Approval Process for Section 1115 Demonstrations; Application,

CMS requires States to submit historical Medicaid expenditure data to support analysis needed to establish budget neutrality for all populations that will be affected by a proposed demonstration. In most cases, States must show on the basis of reasonable with-and-without-waiver cost projections that the proposed demonstration will not cost the Federal government more than the program could have cost in the demonstration's absence. Once the demonstration is operational, CMS requires States to report their actual expenditures, which are tracked and compared to the without-waiver estimates (which may be adjusted to account for caseload changes), to ensure that the demonstration remains budget neutral. Any Federal funding received by the State in excess of the without-waiver estimate must be returned to CMS.[14]

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

[14] 77 Fed Reg. 11677-11700. *See also* "Insuring the Poor Through Section 1115 Medicaid Waivers." Coughlin, Lipman, Raja, *Health Affairs*, V 4, No. 1 (1995)(199-216). "The other Medicaid expansion authority is the section 1115 research and demonstration waiver. These waivers are designed to permit states to develop innovative solutions to a variety of health and welfare problems …The federal government may waive a number of standing Medicaid rules provided that the change is budget –neutral that is that the costs are no higher than would be expended in the absence of the waiver. ...[S]tates had requested authorization to expand coverage to the uninsured using existing Medicaid funds to pay for the expansion, all of these states propose to achieve savings by using manage care plans to serve current Medicaid recipient and to limit the cost of new enrollees. States often propose to use current disproportionate share hospital payments to expand coverage, rather than using these funds to make lump sum payment to hospitals. States often propose to use savings from reductions in other state programs in some cases state's propose new revenues. The end result is that in principle coverage for the uninsured is expanded at relatively small new government cost." CRS Report for Congress. "Medicaid and SCHIP Section 1115 Research and Demonstration Waivers," Evelyne Baumrskins (September 2008)("The programs also vary in the way they are financed. The two most prominent sources are 1) savings resulting from increased use of manage care by current and newly entitled enrollees and 2) Medicaid disproportionate share

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[15] 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,[16] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[17] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[18] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[19] 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.[20]

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.

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…."[21] There are two methods to determine eligibility for a Medicare DSH

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hospital funding diverted from …hospitals. States also rely on premium control from Medicaid and cuts in other state programs.)

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

[16] Section 1811-1821 of the Act.

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

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

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

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

[21] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985

adjustment: the "proxy method" and the "Pickle method."[22] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, *alia inter*, its disproportionate patient percentage. Relevant to this case, with respect to the proxy method, §1886(d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" and the Medicaid low-income proxy", respectively, and are defined as follows:

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

CMS implemented the statutory provisions at 42 C.F.R. §412.106(2002). The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 C.F.R. §412.106(b)(2)(2002). 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)(2002) 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.)

(Pub. L. No. 99-272). See also 51 Fed. Reg. 16772, 16773-16776 (1986).

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

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 [P]lan 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 [S]tate [P]lan, 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

> [P]lan, 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:

> 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. 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.

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

> General assistance days are days for patients covered under a State-only or county-only general assistance program, whether or not any payment is available for health care services under the program. Charity care days are those days that are utilized by patients who cannot afford to pay and whose care is not covered or paid by any health insurance program. While we recognize that these days may be included in the calculation of a State's Medicaid DSH payments, these patients are not Medicaid eligible under the State plan and are not considered Titled XIX beneficiaries.[23]

CMS issued a Program Memorandum (PM) Transmittal A-01-13,[24] which again stated, regarding two specific types of Medicaid DSH days, that:

> *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. Sometimes 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

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[23] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

[24] 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.")*

> 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. (Emphasis added.)

In addition, prior to 2000, the Secretary's policy was to include in the Medicare DSH calculation, only those days for populations under the Title XI section 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.[25] 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 section 1115 waiver expansion populations from the DSH calculation was revisited by CMS and, effective with discharges occurring on, or after, January 20, 2000, certain section 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.[26]

As the Secretary explained, some States provide medical assistance under a demonstration project (also referred to as a section 1115 waiver). In some section 1115 waivers, a given population that otherwise could have been made eligible for Medicaid under sections 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 section 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 section 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.[27] The

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[25] 65 Fed. Reg. 3136 (Jan. 20, 2000).
[26] 65 Fed. Reg. 3136 (Jan. 20, 2000).
[27] 65 Fed. Reg. 3136 (Jan. 20, 2000).

Secretary stated that:

> In this interim final rule with comment period, we are revising the policy, effective with discharges occurring on or after January 20, 2000, to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment.
>
> One purpose of a section 1115 expansion waiver is to extend Title XIX matching payments to services furnished to populations that otherwise could not have been made eligible for Medicaid. The costs associated with these populations are matched based on section 1115 authority. In fact, section 1115(a)(2)(A) of the Act states that the "costs of such project which would not otherwise be included as expenditures under section * * * 1903 * * * shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures * * * approved under (Title XIX)." Thus, the statute allows for the expansion populations to be treated as Medicaid beneficiaries.
>
> In addition, at the time that the Congress enacted the Medicare DSH adjustment, there were no approved section 1115 expansion waivers. Nonetheless, we believe allowing hospitals to include the section 1115 expanded waiver population in the Medicare DSH calculation is fully consistent with the Congressional goals of the Medicare DSH adjustment to recognize the higher costs to hospitals of treating low income individuals covered under Medicaid. Therefore, inpatient hospital days for these individuals eligible for Title XIX matching payments under a section 1115 waiver are to be included as Medicaid days for purposes of the Medicare DSH adjustment calculation. [28]

Relevant to this issue, the Secretary addressed concerns including those hospitals located in States such as Pennsylvania regarding the section 1115 waiver in the August 1, 2000 Federal Register stating that:

> Some States provide medical assistance (Medicaid) under a demonstration project (also referred to as a section 1115 waiver).

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[28] 65 Fed. Reg. 3136, 3136-3137.

Under policy in existence before the January 20, 2000 interim final rule, hospitals were to include in the Medicare DSH calculation only those days for populations under the section 1115 waiver who were or could have been made eligible under a State Medicaid plan. Patient days of the expanded eligibility groups, however, were not to be included in the Medicare DSH calculation.

In the January 20, 2000 interim final rule with comment period, we revised the policy, effective with discharges occurring on or after January 20, 2000, to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment. This policy was reflected in a revision to §412.106 of the regulations.

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

Response: While we initially determined that States under a Medicaid expansion waiver could not include those expansion waiver days as part of the Medicare DSH adjustment calculation, we have since consulted extensively with Medicaid staff and have determined that section 1115 expansion waiver days are utilized by patients whose care is considered to be an approved expenditure under Title XIX. While this does advantage States that have a section 1115 expansion waiver in place, these days are considered to be Title XIX days by Medicaid standards.

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

> General assistance days are days for patients covered under a State-only or county-only general assistance program, whether or not any payment is available for health care services under the program. Charity care days are those days that are utilized by patients who cannot afford to pay and whose care is not covered or paid by any health insurance program. While we recognize that these days may be included in the calculation of a State's Medicaid DSH payments, these patients are not Medicaid-eligible under the State plan and are not considered Title XIX beneficiaries. Therefore, Pennsylvania, and other States that have erroneously included these days in the Medicare disproportionate share adjustment calculation in the past, will be precluded from including such days in the future. We would like to point out that these States were held harmless from adverse action in this matter for any cost reporting period beginning prior to December 31, 1999. We are in the process of preparing a Report to Congress on the Medicare DSH adjustment calculation which presents various options for calculating the adjustment.[29] (Emphasis added.)

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

> [W]e have become aware that there are certain section 1115 demonstration projects that serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan. These section 1115 demonstration projects extend coverage only for specific services and do not include inpatient care in the hospital. Because of the limited nature of the coverage offered, the population involved may have a significantly higher income than traditional Medicaid beneficiaries.
>
> In allowing hospitals to include patient days related to section 1115 expansion waiver populations, our intention was to include patient days of section 1115 expansion waiver populations who receive benefits under the demonstration project that are similar to those available to traditional Medicaid beneficiaries, including inpatient

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

> benefits. Because of the differences between expansion populations in these limited benefit demonstrations and traditional Medicaid beneficiaries, we are proposing that the Medicare DSH calculation should exclude from treatment as Medicaid patient days those patient days attributable to limited benefit section 1115 expansion waiver populations (proposed § 412.106(b)(4)(i)).
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> ***
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> If a hospital were to include the days attributable to patients receiving benefits under such a limited benefit, the hospital would be able to receive higher DSH payments, perhaps substantially, for patients who may otherwise be insured for inpatient care. For example, these limited demonstrations provide benefits that may be needed to supplement private insurance coverage for individuals who do not have incomes low enough to qualify for Medicaid under the State plan. We do not believe such patients should be counted in the DSH patient percentage as eligible for title XIX.
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> 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.

In addition, the Deficit Reduction Act of 2005 (DRA)[30] clarified the treatment by the Secretary of section 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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[30] 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).

> "In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.".
>
> (b) Ratification and prospective application of previous regulations.—
>
> (1) In General.—Subject to paragraph (2), regulations described in paragraph (3), insofar as such regulations provide for the treatment of individuals eligible for medical assistance under a demonstration project approved under title XI of the Social Security Act under section 1886(d)(5)(F)(vi) of such Act, are hereby ratified, effective as of the date of their respective promulgations.
>
> (2) No Application to closed cost reports.—Paragraph (1) shall not be applied in a manner that requires the reopening of any cost reports which are closed as of the date of the enactment of this Act.
>
> (3) Regulations Described.—For purposes of paragraph (1), the regulations described in this paragraph are as follows:
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> (A) 2000 Regulation.—Regulations promulgated on January 20, 2000, at 65 Federal Register 3136 et seq., including the policy in such regulations regarding discharges occurring prior to January 20, 2000.
>
> (B) 2003 Regulation.—Regulations promulgated on August 1, 2003, at 68 Federal Register 45345 *et seq.*

Subsection (a) added language to §1886(d)(5)(F)(vi) of the Social Security Act that was essentially identical to the language already in section 1115(a) that: "the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they received benefits under a demonstration project approved under Title XI."

The dispute in this case is over the meaning of the phrase "a patient eligible for medical assistance under a State plan approved under Title XIX". Several courts have analyzed the phrase "eligible for medical assistance under a State plan

approved under title XIX" both for State-only general assistance days and charity care days and have concluded that the phrase "eligible for medical assistance under a State plan approved under title XIX" means patients who are eligible for Medicaid under a Federal statute. This would not include general assistance State-only funded days. These cases include *Adena Regional Medical Center v. Leavitt*, 527 F.3d 176 (D.C. Cir. 2008)*; Cooper University Hosp. v. Sebelius*, 686 F.Supp.2d 483 (D.N.J. Sep 28, 2009); *aff'd.* 636 F.3d 44 (3rd Cir. Oct 12, 2010) *University of Washington Medical Center v. Sebelius*, 634 F.3d 1029 (9th Cir 2011).

In *Cooper, supra*, the district court as adopted by the Court of Appeals for the Third Circuit, concluded that the phrase "eligible for medical assistance under a State plan approved under title XIX" referred to patients who are eligible for Medicaid. Therefore, the New Jersey Charity Care Program patient days could not be included in the numerator of the Provider's Medicaid proxy for purposes of determining the Provider's Medicare DSH adjustment. In *Phoenix Memorial Hospital v. Sebelius*, 622 F.3d 1219 (9th Cir. 2010), the Court of Appeals for the Ninth Circuit affirmed a district court's judgment concluding that state-only funded health care program population were ineligible for inclusion in DHS adjustment calculation and hospitals were ineligible for hold harmless relief. Arizona operated two separate and distinct components, one of which was Arizona's section 1115 demonstration project and the other one was the state-funded health care program.

In the *University of Washington Medical Center v. Sebelius*, 634 F.3d 1029 (9th Cir 2011) the court recognized that: "Thus, the definition of "medical assistance" has four key elements: (1) federal funds; (2) to be spent in "payment of part or all of the cost"; (3) of certain services; (4) for or to "[p]atients meeting the statutory requirements for Medicaid". The court concluded that: "Because the Secretary has not granted Washington a waiver for its GAU and MI populations under section 1315, this provision does not operate to make these patients "eligible for medical assistance" under subchapter XIX of the Social Security Act. *See Phoenix Memorial Hospital*, 622 F.3d at 1226–27." In addition, the DRA provisions addressing the treatment of section 1115 waiver days, was addressed by the Court in *Cookville* for a pre-2000 cost year.[31] Consequently in finding that State only days were to be excluded from the numerator of the Medicaid fraction of the Medicare DSH calculation, courts have so ruled under facts similar to the one presented here and were aware of the Secretary's treatment of section 1115 waiver days in making such rulings.

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

In this case, the Providers argued that the GA program (and charity care) was included in the methodology for Medicaid DSH payments under the Pennsylvania State Plan approved under Title XIX and therefore the GA program qualified for Federal financial participation under the Medicaid DSH program. Consequently, GA patients are "eligible for medical assistance under a State plan approved under [Title] XIX" and must be counted in the Medicaid fraction of the Medicare DSH adjustment. The Providers also argued that the PM-99-62 resulted in unequal treatment of Providers through CMS' application of the hold harmless policy. Finally, the Providers also argued, for the first time in their comments to the Administrator, that the Secretary was arbitrary for including section 1115 inpatient days and not including the general assistance days as they are essentially equivalent. The Providers argued that the Secretary's discriminatory treatment of the hospitals located in non-section 1115 States, violates providers' rights under the Equal Protection Clause for cost years beginning on, or after, January 1, 2000.[32]

The Administrator finds that section 1886(d)(5)(F)(vi)(II) of the Act requires, for purposes of determining the Providers' "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 the Secretary has interpreted the statutory phrase "patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX," to mean "eligible for Medicaid."[33] Section 1905(a) of the Social Security Act defines "medical assistance" as payment of part or all of the costs of certain services and care for certain populations of individuals.

The Administrator finds that the days at issue are for patients who are not eligible for Medicaid but rather are only eligible for State-only general assistance or charity care. The Providers conceded this fact that the days at issue are for patients eligible for Pennsylvania's general assistance program or "otherwise qualify for charity

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[32] In general, a long held legal principle is that administrative agencies do not have the authority to address constitutional claims.

[33] 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 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.")

care" in its position paper.[34] With respect to the general assistance program patients, the Provider conceded that GA or general assistance involves "MA funded solely by State funds as authorized under Article IV of the [Pennsylvania] Welfare Code."[35] In addition, the provision of the State plan submitted in the record only shows the methodology for Medicaid DSH payments and not that these patients are eligible for the Federal Medicaid under section 1905(a) of the Act.[36]

The language at §1886(d)(5)(F)(vi)(II) of the Act requires that for a day to be counted, the individual must be eligible for "medical assistance" under Title XIX as interpreted and applied by the Secretary pursuant to her discretion.[37] That is, the

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[34] *See, e.g.* Providers' Position Paper ("The providers in this group appeal provided inpatient care to individuals who are eligible for general assistance or otherwise qualify as charity care for the applicable period. *Id*. at 6.")("Just because these patients do not qualify for the Categorically Needy or Medically Needy status, the Intermediary takes the position that they should not be included in the Medicare DSH formula. Id. at 15.)

[35] *See* Intermediary Exhibit I-1 at 10-11 (quoting Pennsylvania Public Welfare Code (62 P.S. §§ 403 and 443.1—443.4), part III entitled, "Medical Assistance Manual" §§ 1101.11 sets forth the "MA" regulations and policies. Section 1101.21 explains that the definition of General Assistance (GA) and that it is "MA" funded solely by the State." Pennsylvania appears to refer to the term "medical assistance" or MA in a broader context than just Medicaid and uses it to refer to the available Federal and State assistance programs. *See also* 55 Pa Code §1163.24 ("Scope of benefits for General Assistance recipients"…."General Assistance recipients, age 21 to 65, whose MA benefits are funded solely by State funds, are eligible for medically necessary basic health care benefits as defined in Chapter 1101.")

[36] Providers' Exhibit P-1 (showing portion of State Plan that addresses Medicaid DSH payment eligibility and methodology for various types of health providers including acute care hospitals.)

[37] For some of the cost years involved, the Secretary used her discretion (and as ratified by DRA and the amended section 1886(d)(5)(F) of the Act) to include in her interpretation of the term eligible for medical assistance under an approved state plan under Title XIX, patients related to the Federally approved and authorized section 1115 waiver populations for whom expenditures for care is considered to be an approved expenditure under Title XIX. The language at §1886(d)(5)(F)(vi)(II) of the Act states: "In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project

individual must be eligible for the Federal government program also referred to as Medicaid and for the cost year involved certain inpatients approved under a section 1115 waiver to be treated as Medicaid expenditures.

Regarding the expenditure of Federal financial participation or FFP for Medicaid DSH under the Medicaid program, generally, the issue of whether costs are regarded as expenditures under a State plan approved under Title XIX for purposes of calculating Federal matching payments to the State is different from the issue of whether patients are considered eligible for medical assistance under a State plan approved under Title XIX for purposes of calculating Medicare DSH payments to a hospital. The statute clearly states that the patients' Title XIX eligibility for that day is a requirement. Therefore, regardless of any possible indirect FFP through a Medicaid DSH payment, the days related to the State only GA program, operated and funded by the State of Pennsylvania (not Title XIX), or charity care days, are not counted as Medicaid days.

In addition, the Providers argued that there was no "equality between providers" in CMS' application of the PM-A-99-62 "hold harmless" provisions and the October 15, 1999 deadline. However, the Administrator notes that these arguments have been addressed in several court holdings. *See e.g. United Hospital v Thompson*, N. Civ.02-3479 (DWF/SRN)(June9, 2003) 2003 WL 21356086 (D.Minn.) which have found reasonable the Secretary's hold harmless policy and its application in PM-A-99-62. As explained by the court in *United Hospital:*

> [T]he agency intended to hold harmless hospitals that had reasonably relied upon a false belief that they were entitled to compensation for general assistance days….. A hospital that did not file an appeal on this issue [of GA days] prior to October 15, 1999 - the date on which CMS announced the resolution to the confusion over inclusion of general assistance days-did not manifest belief independent of the Program Memo--that it was entitled to such payment and presumably

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

> would not have made budget decisions based on a belief in such entitlements. United seeks to characterize the Program memo as a change or reversal of CMS's policy of which hospitals should have been given notice. Yet the Program Memo is on its face a clarification of existing policy. The record indicates that CMS's policy has consistently been that general assistance days are not relevant to the Medicaid fraction, and the program memo simply reiterates that position. The fact that hospitals other than United misunderstood the policy and acted in reliance upon that misunderstanding and the fact CMS decided to provide those hospitals with relief from their own mistake did not lead to the conclusion that CMS had some obligation to extend additional benefits to other hospitals." *Id.* at 5.

The Providers also argued for the first time in its comments, *inter alia*, that these days are equivalent to section 1115 days section and therefore the failure to treat general assistance days in the same manner as section 1115 days for purposes of the DSH payment is, *inter alia*, arbitrary and capricious for cost years beginning on or after January 1, 2000.[38] The Providers did not preserve or develop this argument below. However, without conceding the fact that the Providers did not preserve or develop this argument below, the Administrator finds that the section 1115 waiver patient population is different from, and not equivalent to, the State-only general assistance patient population. As incorporated by reference and more fully set forth in N*azareth*,[39] on remand, there are a number of differences between section 1115 wavier inpatients and GA inpatients in Pennsylvania.[40] Section 1115 patients are part of an expanded population whose care is considered an approved Federal expenditure under Medicaid. That is, the costs associated with these populations are matched based on section 1115 authority. Notably, 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

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[38] The Provider also submitted additional documents for the first time in its comments not presented or briefed below and not generally in the public domain.

[39] *See, Nazareth Hospital and St. Agnes Medical Center*, PRRB Dec. No 2010-D22,

[40] *Id.* A general comparison of other waivers to the Pennsylvania General Assistance categorically and medically needy program allows for no presumption that they are basically the same plans and hence patient population. The category of patients, the services covered, the means of financing to maintain budget neutrality, the delivery system, and impact on other parts of the state plan reflects that these plan are separate and distinct from each other and not interchangeable, as in "but for the lack of a waiver approval" similarity.

(Title XIX)." In contrast, State-only inpatients are just that-patients receiving support for health care services under a State-only approved and funded program. As a general population, general assistance days as State-only programs may offer no, or varying, levels of payment for health care services (or medical insurance benefits), which can vary even from county to county or municipal jurisdiction within a state.

The eligibility criteria for the individual State section 1115 populations are federally approved and set forth in the terms and conditions of the section 1115 waiver project. Unlike the State general assistance program, the section 1115 waiver has been reviewed and approved by the Federal government as likely to assist in promoting the objectives of Medicaid. No such Federal determination has been made with respect to a State-only program. In addition, the expenditures under the section 1115 waiver must be budget neutral. The Medicaid expenditures under the waiver cannot exceed the expenditures that would have otherwise been spent under the Medicaid state plan. The State only funded program has no such restrictions.[41]

In this case, the days at issue involve Pennsylvania's GA patients and also charity care patients. The Administrator finds that the individuals covered by the Pennsylvania's GA program (and the "otherwise eligible for charity care" patients) are not eligible for "medical assistance" as described in Title XIX which requires entitlement for payment of part or all of a service under an approved State plan.[42] Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly did not include these days in the numerator of the Medicaid fraction. The applicable statutes require an individual be eligible for Medicaid, in order for the patient day to be counted in the numerator of the Medicare DSH payment. Section 1115 waiver patients have reasonable and rationally been determined to meet such statutory criteria (as explained above) by

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[41] Again without conceding the untimely raising of the section 1115 issue and related documents, the Administrator incorporates by reference the Administrator's decision, on remand, in *Nazareth Hospital and St. Agnes Medical Center*, PRRB Dec. No 2010-D22, including the discussion at n. 38 and pp 25-40 therein in response to the exhibits included as Providers' Exhibit C and D and similarly included in *Nazareth*.

[42] *See also, Adena*, 527 F.3d at 180, which 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) (42 U.S.C. § 1396d(a)). Patients receiving "medical assistance" as, it is defined in § 1905(a) (42 U.S.C. § 1396d(a)), under a State plan are those who are eligible for Medicaid.

the Secretary and State-only general assistance days have similarly been reasonably and rationally determined by the Secretary to not meet such statutory criteria for inclusion in the Medicaid fraction.

DECISION

The decision of the Board is affirmed with respect to the respective group appeals in accordance with the foregoing opinion.

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

Date: 1/15/13 /s/

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services