PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D22

PROVIDER–
Florida Section 1115 LIP Rehab DSH Waiver Days Groups

Provider Nos.: Appendix A

vs.

MEDICARE CONTRACTOR –
First Coast Service Options

DATE OF HEARING -
October 3 & 4, 2016

Cost Reporting Periods Ended -
Various

CASE NOS.: 14-0682G; 14-1124G

INDEX

ISSUE STATEMENT

Whether the Low-Income Pool Section 1115 waiver days should be included in the Medicaid fraction of the Low Income Patient ("LIP") calculations.[1]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly excluded the Low-Income Pool § 1115 Waiver days from the numerator of the Medicaid fraction when calculating the Providers' LIP payments.

INTRODUCTION

The cases under appeal consist of multiple Florida inpatient rehabilitation facilities (collectively referred to as "IRFs"" or "Providers").[2] These IRFs provided inpatient services to individuals who were uninsured or underinsured, and received payment under a Medicaid Section 1115 waiver program known as the Florida Low-Income Pool program. The Centers for Medicare & Medicaid Services ("CMS") approved the Florida waiver to allow federal Medicaid matching payments to cover some of the costs of services to these individuals. The Providers would like to include the Florida Low-Income Pool inpatient days when calculating the Medicare LIP payments on their cost reports. The Medicare Contractor, First Coast Service Options excluded these days when finalizing the LIP payments for these IRFs for fiscal years 2007 - 2011 and 2013.

The Providers timely appealed the exclusion of these days from the LIP calculations and satisfied all jurisdictional requirements for a hearing before the Board.[3] The Board held a live hearing on

---

[1] Hr'g Tr. Day 1, ("Tr. 1") at 6:4-11, Oct. 3, 2016.

[2] The Board held a consolidated hearing on the Florida Low-Income Pool issue that included group cases for acute care hospitals (Case Nos. 09-0580GC, 13-3376GC, 14-0871GC, 14-3832G, 15-0446G, and 15-3474G) and group cases for inpatient rehab facilities (Case Nos. 14-0682G and 14-1124G). Subsequently, the Board decided the inpatient rehab facilities low income patient ("IRF-LIP") issue and the acute care hospital DSH issue are distinct as it relates to jurisdiction. Therefore, the Board is issuing a separate decision for the acute care hospital group of cases and the IRF group of cases. *See* Appendix A for a list of IRFs in Case Nos. 14-0682G and 14-1124G. The Board closed IRF appeals in Case Nos. 14-2151G, 14-3340G, and 14-4057G in October 2016.

[3] The Board granted jurisdiction for the Providers' LIP adjustments in Case Nos. 14-0682G and 14-1124 because, similar to the decision in *Bethesda Hosp. Ass'n v. Bowen,* 485 U.S. 399 (1988), the providers self-disallowed the Section 1115 Low-Income Pool days at issue from their submitted cost reports. Further, in accordance with its decision in *Mercy Hosp. v. First Coast Serv. Options, Inc.* ("*Mercy*"), PRRB Dec. No. 2015-D-7, 2015 WL 10381780 (Apr. 3, 2015) *rev'd* 2015 WL 3760091 (CMS Administrator Review, Jun. 1, 2015), the Board finds for the years under appeal neither 42 U.S.C. § 1395ww(j)(8) (2007) nor 42 C.F.R. § 412.630 (2007) preclude Board review of the LIP adjustment as the Statute and regulations only preclude administrative or judicial review with regards to the establishment of the methodology to classify a patient unto the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payment for outliers and special payments, and the area wage index. As in *Mercy*, the Board finds the LIP adjustment is an adjustment to the Federal rate not specifically enumerated in the adjustments precluded from review. Further, as explained in *Mercy*, the Board finds the Providers in this case are not challenging "the establishment of" either the federal rates or "the establishment of" the LIP adjustment to those rates as the Providers are not challenging any part of the August 2001

October 3 and 4, 2016. Mark D. Polston, Esq., Ethan P. Davis, Esq., and Christopher Kenny of King & Spalding represented the Providers. Ed Lau, Esq., and Joe Bauers, Esq., of Federal Specialized Services represented the Medicare Contractor.

STATEMENT OF THE FACTS

A. BACKGROUND ON THE MEDICARE LIP CALCULATIONS

The Medicare program began paying IRFs based on a perspective payment system ("IRF-PPS") beginning October 1, 2002[4]. The LIP adjustment[5] was created and implemented by the Secretary based on discretionary authority in 1398ww(j)(3)(A)(v) which empowers the Secretary to adjust the IFR-PPS payment rate "by other such factors as the secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities." The LIP adjustment uses the same DSH variable that is used by acute care hospitals with LIP being defined as (1+DSH) raised to the power of .4838.[6]

The DSH variable is calculated based on the sum of two fractions known as the Medicare fraction and the Medicaid fraction.[7] The Medicaid fraction is calculated by including in the numerator the number of inpatient days of service for Medicaid eligible patients who are not entitled to Medicare Part A, and dividing that number by the total number of hospital inpatient days.[8] The specific issue in this case is whether the numerator of the Providers' Medicaid fractions should include patient days for individuals whose inpatient services were partially paid under the Low-Income Pool portion of Florida's § 1115 waiver.

B. BACKGROUND ON MEDICAID STATE PLANS AND § 1115 WAIVERS

Medicaid is a joint Federal and state program established in Title XIX of the Social Security Act (the "Act").[9] To participate in the Medicaid program and receive federal matching funds (commonly referred to as Federal Medicaid Assistance Percentage or "FMAP")[10], a State must enter into an agreement ("State plan") with the Federal government describing the individuals covered, services provided, reimbursement methodologies for providers, and other administrative activities.

Final Rule (66 Fed. Reg. 41316, 41393 (Aug. 7, 2001)) in which the Secretary established the LIP adjustment. The Board recognizes the Administrator reversed the Board's decision in *Mercy* because 1395ww(j)(8) precludes review of the prospective payment rates under paragraph (3) as well as *all* adjustments articulated in subsequent paragraphs. The Board, however, remains unconvinced, and continues to disagree with the Administrator's overly broad interpretation. *See* Appendix A for a list of IRFs with jurisdictionally valid appeals.

[4] 42 U.S.C. § 1395ww(j)(1)(B).

[5] 42 C.F.R. § 412.624(e)(2) ("We adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services as determined by us.").

[6] 66 FR 41316, 41360 (Aug. 7, 2001).

[7] 66 FR at 41360 (showing the DSH formula).

[8] *Id.*

[9] 42 U.S.C. § 1396; *see also* 42 C.F.R. § 430.0.

[10] Social Security Act § 1905(b), 42 U.S.C. § 1396d(b).

Federal law provides flexibility in operating states' Medicaid programs through multiple waivers of federal requirements. To address the medical needs of its residents and demonstrate new approaches in providing health care that are likely to promote Medicaid program objectives, a State may choose to apply for, and include in its State plan, a demonstration program under Section 1115 of the Act.[11] The Secretary has delegated the administration of these demonstration projects to CMS which approves, and provides federal matching funds for, various waivers that expand both the populations who qualify for Medicaid and the health services available under a waiver.[12]

For purposes of the Medicaid fraction, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.[13] When determining the number of patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A (the numerator of the Medicaid fraction) the regulation allows hospitals to "include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act."[14]

C. FLORIDA'S § 1115 WAIVER FOR ITS MEDICAID PROGRAM

On June 30, 2006, CMS approved the State of Florida's Section 1115 waiver."[15] The waiver contains four program elements: (1) payment of risk-adjusted premiums for Medicaid enrollees in managed care plans; (2) enhanced benefit accounts to provide incentives to Medicaid enrollees for healthy behaviors; (3) an employer-sponsored insurance option to pay premiums for Medicaid-eligible individuals to purchase insurance through their employer; and (4) a Low-Income Pool designed "to provide direct payment and distributions to safety net providers in the state for the purpose of providing coverage to the uninsured through provider access systems ("PAS")."[16]

The fourth program element, the Low-Income Pool, is the portion of Florida's Section 1115 waiver at issue here. The primary objectives of the Florida Low-Income Pool were to:

(a) maintain the state's commitment to providing resources that assist safety-net hospitals in the achievement of their traditional commitment

---

[11] Social Security Act § 1115, 42 U.S.C. § 1315.
[12] 42 U.S.C. § 1315(a)(2)(A).
[13] 42 C.F.R. **§** 412.106(b)(4)(i).
[14] 42 C.F.R. **§** 412.106(b)(4)(ii).
[15] Provider's Final Position Paper, Provider Exhibits—Volume 1 ("Vol. 1"), Ex. P-2 at 1, Sep. 22, 2016; *see also* Vol. 1 Ex. P-4 (72 FR 29748, 29814 (May 29, 2007)). The Board notes that some Provider Exhibits contain more than one page number; however, the pages cited for the Provider Exhibits in this decision are the page numbers located in the lower right-hand corner of each page.
[16] Vol. 1 Ex. P-1, at 2.

to providing needed care to the Medicaid, underinsured and uninsured populations and

(b) extend the distribution of resources for that same purpose to a larger number of hospitals and to non-hospital providers of care.[17]

Although the Florida Low-Income Pool Reimbursement and Funding Methodology allows Low-Income Pool funds to pay medical care costs or premiums, Florida also chose to create a PAS to distribute Low-Income Pool payments directly to hospitals, clinics and other provider types.[18] Florida adopted a "basic distribution methodology" which paid hospitals, County Health Departments, Federally Qualified Health Clinics and other Safety Net providers on July 1st of each year. These distributions were based on a formula using a provider's costs, but not directly related to specific claims for the care of uninsured or underinsured individuals.[19] Hospital Low-Income Pool payments were totaled and compared to the total cost of providing medical services to the uninsured and Medicaid-eligible population, less reimbursement from Medicaid, or from other collection efforts. If the Florida Low-Income Pool payment exceeds the total costs, the provider must refund the overpayment amount.[20]

Providers are required to file a "[Low-Income Pool] Milestone Reporting Requirement document"[21] and perform a "Low-Income Pool Cost Limit calculation" in order to receive Florida Low-Income Pool distributions. The State must report back to CMS regarding the "impact the Low Income Pool had on the rate of uninsurance in Florida . . ."[22] "Individual patient accounts are not submitted to, or tracked by, the State or AHCA."[23] A portion of the Florida Low-Income Pool payments may be used for the improvement or continuation of specialty health care services such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services pediatric hospital services, teaching or safety net providers.[24]

D. PARTIES' CONTENTIONS

In the final settlement of cost reports for fiscal years 2007-2011 and 2013, the Medicare Contractor excluded all Florida Low-Income Pool days from the numerator of the Providers' LIP calculations, because it determined that Florida's Low-Income Pool payments should be characterized as charity care days or general assistance days which do not count for LIP purposes.[25] The Contractor relied on the Third Circuit's decision in *Nazareth Hospital v. Secretary of HHS*, 747 F.3d 172 (3d Cir. 2014), which differentiated Section 1115 waiver days

---

[17] Vol. 2 Ex. P-14 at 10.
[18] Vol. 1 Ex. P-5 at 4-5.
[19] Hospitals and other providers participating in PAS had to report the number of uninsured/underinsured individuals who received services, the number of days and types of hospital services provided. *See* Providers' Post-Hearing Brief at 17-18, Dec. 9, 2016; Vol. 2 Ex. P-14 at 54; Vol. 4 Ex. P-44, P-71.
[20] Vol. 2 Ex. P-15 at 5-11 (detailing the Recommended Reimbursement Methodology).
[21] Vol. 1 Ex. P-5 at 22.
[22] Medicare Contractor's Final Position Paper, Ex. I-2 at 7 ("Special Terms and Conditions"), Sep. 23, 2016.
[23] Vol. 1 Ex. P-6 at 1. AHCA is the Florida Agency for Healthcare Administration.
[24] Medicare Contractor's Final Position Paper, Ex. I-2 at 25.
[25] *See* Medicare Administrative Contractor's Final Position Paper at 3.

which should be counted for the DSH calculation, from charity care and general assistance days which should not be counted.[26] The Contractor also cites the Administrator's decision in *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Group vs. Novitas Solutions, Inc.* (Nov. 18, 2016) ("*Katrina*") which stated "Payments for the days involved in this case and in the charity care Medicaid DSH pool cases, are made to the hospitals and not as "medical assistance" for an individual."[27]

The Providers argue that the Medicare Contractor erred in excluding Florida Low-Income Pool days from the final settlement of the cost reports because the plain text of the statute and regulations make clear that any inpatient day under a Section 1115 waiver project must be included in the Medicaid fraction.[28] They maintain that Florida Low-Income Pool patient days should be counted in the Medicaid fraction because the patients served by the Low-Income Pool are undeniably "eligible for inpatient hospital services."[29] They argue that there is no difference between inpatient services which are paid for directly through a "pool fund" from individuals whose services are paid for on a fee-for-service basis.[30]

The Providers further argue that CMS, in approving Florida's waiver project, intended to benefit a specifically identifiable population of uninsured and underinsured beneficiaries[31] as defined by the Special Terms and Conditions of the waiver and the Reimbursement and Funding Methodology.[32] Under the terms of the waiver this population cannot be equated with a hospital's charity care program or Medicaid assistance to general assistance beneficiaries. The language of the DSH regulation allows hospitals to include all days *attributable to populations eligible for Title XIX matching payments* in its DSH calculation.[33] According to the Providers it is clear under the waiver's Special Terms and Conditions, that Florida will receive federal matching funds for Low-Income Pool payments made to providers for medical services provided to the Florida Low-Income Pool population,[34] and the days associated with these patients should be counted in the LIP calculation.

The Providers also claim that the Florida Low-Income Pool program meets the terms of the regulation as it allows the inclusion of "all days attributable to *populations* eligible for Title XIX…", that is, counting of individuals in the aggregate.[35] They assert that under the terms of the regulation, it is sufficient that the hospitals know and can identify services provided directly to the Low-Income Pool eligibility group,[36] and that the Low-Income Pool payments are used for

---

[26] *Id.* at 5.
[27] Medicare Contractor's Post-Hearing Brief at 14, Dec. 9, 2016 (citing the Administrator's decision in CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Group v. Novitas Solutions, Inc., PRRB Dec. No. 2016-D18, 2016 WL 6299482 (Sep. 16, 2016) *rev'd* 2016 WL 7744987 (CMS Administrator Review, Nov. 18, 2016)).
[28] Providers' Final Position Paper at 13-16.
[29] *Id.* at 16-20.
[30] Tr. 1 at 12:15-13:12.
[31] Providers' Final Reply Paper at 4-7, Sep. 22, 2016.
[32] *Id.*
[33] Providers' Supplement to Post-Hearing Brief at 2-3, Jan. 4, 2017.
[34] *Id.* at 8.
[35] Providers' Final Position Paper at 20-21.
[36] *Id.* at 21.

health care expenditures (medical costs or premiums) that would be within the definition of medical assistance in the Medicaid Act.[37] The Providers further assert the Florida Low-Income Pool program clearly provides medical assistance payments for services provided to *individuals*, not providers.

The Providers also argue that the fact that the federal matching funds are computed in the aggregate rather than with respect to each individual Low-Income Pool patient is of "no consequence",[38] as this is no different than a State seeking matching funds for medical assistance to traditional Medicaid eligibility groups on an aggregate basis. The fact that CMS approved a § 1115 waiver project, specifically created a Medicaid eligibility group defined as uninsured and underinsured individuals, and funded their medical assistance through Low-Income Pool payments to the Providers, should be sufficient to allow the inclusion of these patient days in the Medicaid fraction.

The Providers distinguish the Administrator's *Katrina* decision from the facts in the current case, asserting that the Mississippi uncompensated care pool in *Katrina* was paid through funds appropriated under the Deficit Reduction Act of 2005 and was *not related to Title XIX* as Mississippi accounted for the funds outside its Medicaid program. The Providers argue that the source of federal funds matters because the Secretary's policy is clear that "hospitals may include all days attributable to population's *eligible for Title XIX matching payments* through a waiver approved under Section 1115 of the Social Security Act."[39]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The purpose of the Florida Section 1115 waiver for the Low-Income Pool population was to maintain the state's commitment to providing resources to assist safety-net hospitals to provide needed care to the Medicaid, underinsured, and uninsured populations; and to extend financial resources to additional hospitals and non-hospital providers of care."[40] The Low-Income Pool program provided one billion dollars in direct payment and distributions to safety-net providers to offset uncompensated costs of providing health care to uninsured and underinsured populations.[41]

Payment of these funds under Florida's Section 1115 waiver, however, is not dependent on a determination of Medicaid eligibility of particular individuals. Instead, the state provides funds under the waiver based on each provider's costs of providing indeterminate services to an indeterminate population, simply those who are "uninsured and underinsured." For a provider to receive a distribution from the fund, they are required to "submit documentation of their permissible expenditures which will be used to calculate a Low Income Pool Cost Limit."[42]

---

[37] *Id.* at 10.
[38] *Id.* at 21.
[39] Providers' Supplement to Post-Hearing Brief at 2 (citing 42 C.F.R. § 412.106(b)(4)(ii) (emphasis added)).
[40] Vol. 2 Ex. P-14 at 10.
[41] *Id.*
[42] Vol. 1, Ex. P-5 at 3.

The Board finds that the Medicare Contractor's exclusion of Florida Low-Income Pool days from the LIP calculation complies with the 2005 federal statute and regulation. Prior to January, 2000, the federal DSH regulation, 42 CFR § 412.106(b)(4), limited the inclusion of patient days for individuals who qualified under a § 1115 waiver *who were or could have been made eligible under a State Medicaid plan*.[43] CMS expanded this definition in an interim final rule published January 20, 2000 to include "*all days attributable to populations eligible for Title XIX matching payments"* through a waiver approved under section 1115 of the Social Security Act.

Under both versions of the regulation, it is clear that the Secretary intended to limit the inclusion of patient days in the DSH calculation to *individuals* who become eligible under the terms of the waiver, or who receive specific medical services provided under the waiver. It is not intended to include payments made to a hospital to compensate it for services provided to an unspecified population whose patient days will, then, be included in the Medicaid fraction.

The Board's determination on this issue is consistent with CMS' response to hospitals in States without a Medicaid expansion waiver, on concerns they were disadvantaged because they could not count general assistance or charity care days in the DSH calculation.[44] In the preamble of the August 1, 2000 regulation, CMS stated:

> 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 some States that have a section 1115 expansion waiver in place, these days are considered to be Title XIX days by Medicaid standards.[45]

These regulatory changes appear to make certain important clarifications. After August 2000, CMS' Medicare DSH policy focused on *patient days for individuals* who were receiving benefits under an expansion waiver. The regulation focuses on patients, not an amorphous population as the Providers argue. Florida's Low-Income Pool provides a gross payment to hospitals—a "distribution," to reimburse them for services provided to uninsured and underinsured individuals as an undifferentiated group, not identified or qualified individually for waiver services.[46] The Board finds that this is an important distinction and the Medicare Contractor properly excluded these patient days from the LIP calculation.

Second, federal DSH regulation specifies that the services provided to these patients must be "*considered to be an approved expenditure under Title XIX."* The waiver describes payment for

---

[43] 42 C.F.R. § 412.106(b)(4) (emphasis added).
[44] 65 FR 47054, 47087 (Aug. 1, 2000).
[45] 65 FR at 47087 (emphasis added).
[46] The Board recognizes hospitals are required to identify particular patients for whom services were provided under the terms of the Low-Income Pool. However, identification of eligible individuals under the terms of the waiver is not the focus of waiver requirements; it is the determination of the amount of the Florida Low-Income Pool distribution based on the costs of providing services to uninsured and underinsured individuals to the hospitals.

care to the "Medicaid, underinsured, and uninsured populations." The waiver does not adequately describe the exact nature of what is being paid for and whether it would be an "approved expenditure under Title XIX." This was highlighted in a letter from CMS to Mr. Carlton Snipes, Deputy Director of the Florida Medicaid program on August 25, 2009 criticizing the State for failing to provide sufficient guidance on the "allowable uninsured charges incurred by the providers", including charity care, bad debts and uncollected deductibles and co-insurance for commercial insurance.[47]

In two decisions, the Board has found that patient days from a Section 1115 waiver program qualify for inclusion in the DSH calculation. In a Massachusetts Section 1115 waiver which provided premiums subsidies for individuals whose income exceeds traditional Medicaid eligibility standards, the Board reasoned that the premium subsidy was provided to a discrete number of eligible individuals to purchase health care from the same managed care plan that provided health care to traditional Medicaid-eligible individuals. [48] Here, the Massachusetts program established eligibility criteria for applicants and provided a clearly established benefit—premium subsidy to enroll in a managed care plan which provided the same benefits as provided to traditional Medicaid-eligible individuals.

Similarly in its decision in *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Group*[49], the Board majority found that inpatient days paid for under Mississippi's Section 1115 waiver which provided inpatient care to individuals who were uninsured as a result of job loss or other displacement due to Hurricane Katrina should be counted in the DSH calculation. In its decision, the Board majority noted two important facts--that the State of Louisiana made expedited determinations of eligibility for specific individuals and that hospitals made claims specific to these individuals--were significant in its decision to include these patient days in the DSH calculation.

By contrast the facts in this case do not reach that level as the Florida Low-Income Pool pays funds to hospitals for an indeterminate group of patients: an "uninsured" patient with no insurance or no source of third party coverage or an "underinsured" patient, whose insurance or third party coverage does not pay all of the costs of inpatient care.[50] The Board notes that while the waiver's Special Terms and Conditions specify that some parts of the waiver program expand Medicaid eligibility to additional individuals and allow additional individuals to enroll in Medicaid managed care programs,[51] the Low-Income Pool section of the waiver is silent on the eligibility or enrollment of specific individuals for participation in hospital reimbursement for their care.[52]

---

[47] Vol. 1 Ex. P-10 at 1, 8.
[48] Southwest Consulting UMass Memorial Health Care and Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Groups v. National Government Services, Inc., PRRB Dec. No. 2017-D4, 2017 WL 909303, at *6 (Jan. 27, 2017) *rev'd* 2017 WL 2403398 (CMS Administrator Review, March 21, 2017).
[49] CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Group v. Novitas Solutions, Inc., PRRB Dec. No. 2016-D18, 2016 WL 6299482 (Sep. 16, 2016) *rev'd* 2016 WL 7744987 (CMS Administrator Review, Nov. 18, 2016).
[50] Vol. 1 Ex. P-5 at 6; Vol. 2 Ex. P-15 at 14 (describing the definitions of "uninsured" and "underinsured").
[51] Medicare Contractor's Final Position Paper, Ex. I-2 at 8-13.
[52] *Id*. at 24-27.

Instead the Florida Low-Income Pool calculates additional payment to the hospital, this payment is not commensurate with the actual cost of care provided to eligible individuals. Under Florida's Low-Income Pool, individuals are not "eligible to enroll"—they simply receive medical care from one of the safety net hospitals and the hospital is fully or partially reimbursed for their care. The individual did not enroll and may not even know that the waiver even paid/reimbursed the hospital for the care that was provided. Rather the payment was a "distribution" of a pool of funds based not on individuals' claims but on a formula for the distribution of funds between hospitals and other health care facilities.

The Board finds that the lack of a defined group of eligible Medicaid or Section 1115 waiver individuals differentiates this waiver from either the Massachusetts UCCP pool eligible individuals or the Hurricane Katrina waiver-eligible individuals. This difference is significant because according to the federal DSH regulation *for the purpose of computing the Medicaid fraction*, a *patient* must be "deemed eligible for Medicaid on a given day only if the *patient is eligible* for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day . . . ."[53]

Under the Florida waiver program, patients who receive services from Low-Income Pool facilities are not required to apply for the hospital's charity care program, do not apply for or receive a Medicaid card, a certificate of coverage, have a right of reconsideration on appeal and do not receive a bill or notification when a claim is paid. [54] The hospital may seek to recover from the patient based on his/her ability to pay.[55] Patients included on the Milestone report are not based upon an established eligibility criterion but are based upon each providers' charity and bad debt policies, which will vary among providers.[56] These facts clearly indicate that it is not the individual patients whose eligibility is established and benefits paid on their behalf. Thus, the Board cannot find that this meets the terms of the DSH regulation.

Finally, the most recent amendment to the DSH regulation in 2003 clarified that in order for Section 1115 patients days to be included in the DSH calculation, these days must be for "*populations who receive benefits under the demonstration project that are similar to those available to traditional Medicaid beneficiaries"*[57] and could not include individuals who received limited benefits, specifically citing family planning services.[58] The Board concludes

---

[53] 42 C.F.R. § 412.106(b)(4)(i) (emphasis added). While this regulation refers to the DSH adjustment, the LIP adjustment uses the same measure. *See* 66 FR 41360 (Aug. 7, 2001).
[54] Tr. 1 at 122:2-17, 256:11-20; Hr'g Tr. 2, ("Tr. 2") at 110:5-111:23, Oct. 4, 2016.
[55] Vol. 2 Ex. P-15 at 7. References to Primary Care Disproportionate Share and Rural Disproportionate Share programs on pages 6 and 8 are Medicaid Disproportionate Share programs in Florida and unrelated to the Medicare DSH program at issue in this case.
[56] Tr. 1 at 147:1-18,174:9-25, 214:14-22; Tr. 2 at 78:3-80:9.
[57] 68 FR 27154, 27207 (May 19, 2003) (emphasis added).
[58] *Id.* ("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.")

that, in the present case, it cannot determine whether the benefit to the patient was *similar to those available to traditional Medicaid beneficiaries*, limited or otherwise. The patient benefits under the Florida waiver cannot be ascertained with any certainty, and cannot, therefore, be counted in the Medicaid fraction.

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds that the Medicare Contractor properly excluded Florida's Low-Income Pool § 1115 Waiver days from the numerator of the Medicaid fraction when calculating the Providers' LIP payments.

BOARD MEMBERS PARTICIPATING

L. Sue Andersen, Esq.
Charlotte Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: February 8, 2018

APPENDIX A
SCHEDULE OF PROVIDERS

Schedule of Providers in Group

Group Name: K&S 2008 Low Income Pool Sec. 1115 Rehab DSH Waiver Days

Representative King & Spalding

Date Prepared 2/27/2015

Case No: 14-0682G

Issue: Whether days attributable to rehab patients who received assistance under Florida Low-Income Pool Sec. 1115 waiver be included in the DSH calculation

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	10-0018	Naples Community Hospital (Naples, Collier, FL)	First Coast Service Options - FL	9/30/2008	5/28/2013	11/21/2013	177	30, 47, 50	$57645	Direct Add	11/21/2013
2	10-0022	Jackson Memorial Hospital (Miami, Miami-Dade, FL)	First Coast Service Options - FL	9/30/2008	5/15/2013	11/12/2013	181	52	$178150	Direct Add	11/12/2013
3	10-0087	Sarasota Memorial Hospital (Sarasota, Sarasota, FL)	First Coast Service Options - FL	9/30/2008	5/28/2013	11/12/2013	168	10, 34, 52	$60682	Direct Add	11/12/2013

Total Amount of Reimbursement: $296477

Schedule of Providers in Group

Group Name: King & Spalding 2007 Low Income Pool Sec. 1115 Rehab DSH Waiver Days

Representative King & Spalding

Date Prepared 2/25/2015

Case No: 14-1124G

Issue: Whether days attributable to rehab patients who received assistance under Florida Low-Income Pool Sec. 1115 waiver be included in the DSH calculation

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	10-0018	Naples Community Hospital (Naples, Collier, FL)	First Coast Service Options - FL	9/30/2007	2/25/2013	8/26/2013	182	35, 40, 42	$59097	13-2168	11/28/2013
2	10-0022	Jackson Memorial Hospital (Miami, Miami-Dade, FL)	First Coast Service Options - FL	9/30/2007	2/28/2013	8/27/2013	180	54, 56	$238697	13-3144	11/28/2013
3	10-0087	Sarasota Memorial Hospital (Sarasota, Sarasota, FL)	First Coast Service Options - FL	9/30/2007	2/25/2013	8/22/2013	178	52, 58, 59, 60	$58000	13-2964	11/28/2013

Total Amount of Reimbursement: $355794