**i. Introduction to DSH**

In this appeal, the Providers argue that the MAC improperly excluded days attributable to patients who received assistance through the Massachusetts ConnectorCare program from the numerator of the Medicaid fraction of the disproportionate share hospital (“DSH”) calculation. The Providers contend that these days should be included in the Medicaid fraction as they relate to patients who were eligible for medical assistance under an approved and amended waiver authorized under section 1115(a)(2) of the Social Security Act.

Under the Inpatient Prospective Payment System (“IPPS”), special treatment is afforded those providers that service a disproportionate share of low-income patients. These providers are entitled to an additional payment determined in accordance with 42 C.F.R. § 412.106. The DSH adjustment is made up of two components – the Supplemental Security Income (“SSI”) fraction and the Medicaid fraction. The Medicaid fraction is the issue in dispute in this case. The Medicaid fraction is defined as follows:

The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital’s patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

1. For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

42 C.F.R. § 412.106(b)(4) **(Exhibit C-2)**

**ii. Medicare Administrative Contractor’s Overview Response**

The issue presented parallels a similar issue first decided by the Board in *Southwest Consulting UMass Memorial Health Care and Steward Health 2009 DSH CCHIP* [[1]](#footnote-1) *Section 1115 Waiver Day Groups v. National Government Services, Inc*. in PRRB Decision 2017-D4 (January 27, 2017). The Decision will be referred to as *UMass/Steward*. The Board decided in *UMass/Steward’s* favor that the CCHIP days in question should be counted in the numerator of the Medicaid fraction of the Medicare DSH payment calculation.

The Administrator reversed the Board’s Decision and the dispute proceeded into the Federal Courts. The D.C. District Court in *HealthAlliance Hospitals v. Azar,* 346 F. Supp. 3d (D.D.C. 2018) granted the Plaintiff’s motion for summary judgement and remanded the case back to DHHS/CMS.

The MAC is aware that a settlement was reached, and a payment was made on a discounted basis, however, the Settlement Agreement contained no admission of liability or default on the part of HHS. Given this fact, the underlying issue is not foreclosed from further argument. While the Settlement Agreement cannot be presented to the Board, the Appealing Groups can voice their disagreement with the MAC’s description and application of the prior proceedings. Much of the MAC’s arguments to follow come from the Administrator’s Decision in the previously cited reversal of Board Decision 2017-D4.

The difference between CCHIP and ConnectorCare is non-substantive as it relates to the dispute. As summarized by the Group at page seven of its Preliminary Position Paper, certain CCHIP participants became directly eligible for Massachusetts Medicaid because of the implementation of the Affordable Care Act (“ACA”). Those who didn’t, became eligible for financial support for being enrolled in health insurance plans under the newly designated ConnectorCare. The practical effect is that the number of disputed days dropped materially from coverage under the CCHIP program to ConnectorCare. The same disputed principles over which days count in the Medicaid fraction of the DSH formula remain. Those principles will be presented in the following sections of this Preliminary Position Paper.

**iii. The Massachusetts ConnectorCare Program**

MassHealth is the name of the health coverage programs administered by a state agency called the Executive Office of Health and Human Services Office of Medicaid. Like other Medicaid plans fulfilling Medicaid statutory mandates, MassHealth provides medical assistance to low income or disadvantaged individuals who, within income limits, are parents of children under 19, caretakers of young children, pregnant, chronically unemployed, disabled, or HIV positive, as well as programs created and funded entirely by Massachusetts with no federal assistance. **(Exhibit C-3 at pg. 2)** Generally, coverage includes inpatient hospital services.

The Commonwealth Care Health Insurance Program (“CCHIP”) was established by Chapter 58 of the 2006 Massachusetts Acts for the purpose of reducing uninsured in the Commonwealth. It was created in order to provide subsidies to assist eligible individuals in purchasing health insurance. Eligibility was determined in conjunction with and used the procedures of the office of Medicaid. **(Exhibit C-4 at pg. 39)** The Safety Net Care Pool (“SNCP”) was established effective July 1, 2005, as part of the MassHealth Medicaid Section 1115 Demonstration for the purpose of reducing the number of uninsured residents in the Commonwealth. SNCP funding could be used for Commonwealth Care to provide premium assistance for the purchase of private health insurance by individuals who were not otherwise eligible under the State plan or the demonstration. **(Exhibit C-5 at pg. 7)**

Commonwealth Care, which began October 1, 2006, was a subsidized insurance program for adults who had limited or no access to health insurance coverage and were not otherwise eligible for MassHealth. While funded under Title XIX, Commonwealth Care operated much differently than MassHealth programs. **(Exhibit C-3 at pg. 3)**

The September 2006 MassHealth Transmittal Letter ALL-142 from the Medicaid Director to all MassHealth participating providers stated that Commonwealth Care would provide subsidies towards the purchase of private health insurance to those residents not eligible for MassHealth benefits and that, while Commonwealth Care was not MassHealth, MassHealth would assist the Health Insurance Connecter Authority in processing eligibility for potential enrollees. **(Exhibit C-6 at pg. 1)**

Under the federal Affordable Care Act (“ACA”), starting in 2014, individuals meeting certain eligibility criteria with income not in excess of 400% of the federal poverty level (“FPL”) can qualify for federal *Premium Tax Credits* to lower the cost of private insurance. A Premium Tax Credit can only be used to lower the costs of private insurance meeting the criteria to be *Qualified Health Plans* (“QHPs”) that are purchased through a Marketplace. The ACA created a federal Marketplace but also allows states to use their own state-based Marketplaces instead. Massachusetts is one of just 12 states with a state-based Marketplace. The Commonwealth Health Insurance Connector Authority (the Health Connector) is the Massachusetts state-based Marketplace. Individuals can purchase QHPs through the Health Connector with or without help paying the costs. **(Exhibit C-7 at pg. 9)**

The ConnectorCare is a program of subsidized private health insurance plans for certain individuals with family income that does not exceed 300% of the federal poverty level (“FPL”) and who are not eligible for MassHealth (Medicaid), Medicare or other affordable health coverage. **(Exhibit C-7 at pg. 10)**  The ConnectorCare program is constructed based on Commonwealth Care. To maintain the same level of affordability as Commonwealth Care, Massachusetts amended its existing Medicaid Section 1115 Waiver to create ConnectorCare, ‘wrapping” federal subsidies with additional state subsidies to meet a state affordability schedule that exceeds the federal standard. **(Exhibit C-8 at pg. 4)**

For individuals with income not in excess of 300% FPL, Massachusetts has lowered the costs of a subset of QHPs by supplementing the federal Premium Tax Credits with added state-funded premium and cost-sharing subsidies in order to create ConnectorCare coverage and make it as affordable as the predecessor Massachusetts Commonwealth Care program.

To be eligible for ConnectorCare, individuals must –

1. Satisfy the federal eligibility criteria (45 C.F.R. § 155.305 (a)(1)-(3)**)** for purchasing a QHP through the Health Connector;

* Resident of Massachusetts,
* Not incarcerated at the time of enrollment, and
* U.S. citizens or non-citizens who are “lawfully present” in the U.S.

1. Satisfy the federal eligibility criteria to qualify for Premium Tax Credits (45 C.F.R. § 155.305 (f));

* Have expected annual Modified Adjusted Gross Income (“MAGI”) over 100% FPL but not over 400%,
* EXCEPTION: There is no minimum income for lawfully present non-citizens with income less than 100% FPL who are not eligible for MassHealth due to their immigration status.
* Not be eligible for or enrolled in “minimum essential coverage,”
* Not be eligible for or enrolled in employer-sponsored insurance that constitutes “minimum value” and is considered “affordable” as those terms are defined by the ACA, and
* File a federal tax return with required forms for each year in which the individual receives an Advance Premium Tax Credit and, if “married” at the end of the tax year, files as married filing jointly unless the reason for filing as married filing separately is abuse or abandonment by the other spouse.

1. Individuals must have annual income at or under 300% FPL to qualify for the subset of QHPs that are ConnectorCare plans under state law.

(*See* **Exhibit C-7 at pp. 11-13**)

**B. Arguments**

This appeal raises the question of whether a patient is deemed “eligible for Medicaid” on a given day as defined at 42 C.F.R. § 412.106(b)(4)(i). **(Exhibit C-2 at pg. 2)** Were the days for specific patients receiving assistance from the Commonwealth of Massachusetts’ ConnectorCare program eligible for inpatient hospital services under a waiver authorized under section 1115(a)(2) of the Social Security Act, and also eligible for Title XIX matching payments?

The regulation at 42 C.F.R. § 412.106(b)(4)(i) and (ii) only include days of care for those patients eligible for Medicaid services that were paid for with Title XIX funds and not days of service for patients who bought insurance using a subsidy that was partially funded via Title XIX matching funds. Days of care can be included in the Medicaid fraction under section 1115 waivers if (1) the care is furnished to the patient made eligible for inpatient hospital services under the waiver; or (2) the patient receiving the care is in a population eligible for Title XIX matching payments under a waiver. Neither situation is implicated for the uninsured and non-Medicaid-eligible patients’ premium paid for under the ConnectorCare program. The ConnectorCare program serves a different purpose than the Waiver and does not claim to make uninsured, and non-Medicaid-eligible patients eligible for Medicaid services.

The Providers do not argue that the patients receiving assistance from ConnectorCare are eligible for traditional Medicaid or MassHealth. However, the Providers do argue that the MAC’s exclusion of days from the DSH calculation is contrary to Federal statute and regulation and that, ConnectorCare became covered under Massachusetts’ approved section 1115 waiver, and therefore, the waiver days should be included in the Medicaid fraction. ConnectorCare offers subsidized insurance coverage that pays for medically necessary services provided by acute care hospitals and community health centers to low income uninsured people. The 2006 health reform law in Massachusetts requires that all adults must obtain health insurance if it is affordable. The ConnectorCare program is constructed based on Commonwealth Care, Massachusetts’s pre-ACA subsidy program for eligible state residents with low to moderate incomes.

The Section 1115 waiver days can only be included in the numerator of the Medicaid fraction for calculating the hospital’s DSH adjustment if those patients receive inpatient benefits under the Section 1115 waiver program. In this case, patients that were eligible for the ConnectorCare program are not eligible for inpatient benefits but are eligible for premium subsidies. The fact that the subsidized premium can be used to purchase inpatient benefits is irrelevant. The ConnectorCare program does not provide the benefits but it does provide the subsidy and, therefore, days associated with these patients cannot be counted as Medicaid days in the calculation of a hospital’s DSH payment.

The Section 1115 Waiver does not make patients under the ConnectorCare program eligible for inpatient hospital services under MassHealth, but allows the expenditure of funds from the Safety Net Care Pool (“SNCP”) to provide premium assistance to individuals under the ConnectorCare program. Under MassHealth, Title XIX pays for inpatient services, while under the ConnectorCare program, the SNCP funds pay for premiums, not for the inpatient services. It is not the patient population under the ConnectorCare program that is eligible for Title XIX matching payments; rather, it is the pool of funds used to provide premium assistance for the purchase of the ConnectorCare program that is matched by Title XIX funds.

The Providers generally argue that all patients receiving the subsidized insurance through ConnectorCare are receiving services that are “like” Medicaid assistance. However, the relevant analysis requires a determination of patient eligibility for Medicaid or MassHealth by the state – not the hospital; and eligibility for medical assistance under the approved state plan - not eligibility for assistance under a state-only program like ConnectorCare.

PM A-99-62, reissued as PM A-01-13 **(Exhibit C-9 at pp. 1-2)** states:

**Included Days**

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service….The statutory formula for “Medicaid days” reflects several key concepts. First, the focus is on the patient’s eligibility for Medicaid benefits as determined by the State, not the hospital’s “eligibility” for some form of Medicaid payment. Second, the focus is on the patient’s eligibility for medical assistance under an approved Title XIX State plan, not the patient’s eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term “Medicaid days” refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term “Medicaid days” does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a “Medicaid day” simply by virtue of some other association with the Medicaid program.

The Providers contend that the “ConnectorCare patients” were eligible for medical assistance under the State plan. The Providers have developed their argument to arrive at the conclusion that patients receiving services under the ConnectorCare are eligible for Medicaid (Title XIX) matching payments through a section 1115 waiver. However, the description of the SNCP expenditures, i.e., the funding mechanism for ConnectorCare, does not mention eligibility of patients (because it does not make patients eligible) and clearly shows that it is funding for premium assistance to individuals receiving QHP coverage through the Marketplace. See excerpt from the CMS MassHealth Medicaid Section 1115 Demonstration Special Terms and Conditions (“STCs”) below:

Health Connector Subsidies. For dates of service January 1, 2014 through June 30, 2019, the Commonwealth may claim as allowable expenditures under the demonstration Health Connector subsidies as described below. The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide subsidies for individuals with incomes above 133 percent of the FPL through 300 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is above 133 percent of the FPL through 300 percent of the FPL. *Federal financial participation for the premium assistance portion* of Health Connector subsidies for citizens and eligible qualified non-citizens will be provided through the Designated State Health Programs authority under the SNCP pursuant to this STC. Allowable expenditures for Health Connector subsidies will not be subject to the DSHP cap and aggregate SNCP limit described in STC 51. (emphasis added)

*See* **Exhibit C-10 at pg. 52.**

The Providers argue that because federal funds match ConnectorCare payments, the patients receiving services paid through the ConnectorCare program must be eligible for Medicaid assistance. Even if the federal government matches ConnectorCare funding, it does not mean that the patient receiving ConnectorCare assistance is eligible for Medicaid or medical assistance within the meaning of Medicaid or even the approved state plan. The payment to the hospital as determined by the state is matched because it is a Medicaid DSH payment to supplement the payments the hospital receives for the medical assistance it has provided to patients who are eligible for Medicaid and did receive medical assistance. Indeed, some states predicate the receipt of Medicaid DSH payments to hospitals on the condition that they afford a certain amount of “free care” to needy patients. However, this condition does not make these patients eligible for Medicaid any more than the participation of patients in the Massachusetts ConnectorCare program makes them eligible for Medicaid.

To review the history of the heart of the dispute, in a 2017 hearing decision involving Commonwealth Care days, the Board found that the MAC’s exclusion of the days from the DSH calculation was contrary to Federal statute and regulation. See *Southwest Consulting UMass Memorial Health Care and Steward Health 2009 DSH CCHIP Section 1115 Waiver Day Groups v. National Government Services Inc.,* PRRB Dec. No. 2017-D4, (January 27, 2017)**.** The Board majority found no meaningful distinction between a State providing traditional Medicaid benefits through a managed care plan enrollment and one providing a premium subsidy to CCHIP eligible individuals to purchase health care from the same managed care plan as provided to traditional Medicaid eligible individuals. The Administrator reversed the Board’s decision. *See Southwest Consulting UMass Memorial Health Care and Steward Health 2009 DSH CCHIP Section 1115 Waiver Day Groups v. Novitas Solutions, Inc.[[2]](#footnote-2)*,Adm. Review of PRRB Dec. No. 2017-D4, (March 21, 2017) **(Exhibit C-11)**. The Administrator found that:

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

*See* **Exhibit C-11 at pg. 21.**

The Providers’ creative argument that somehow individuals who are ineligible for Medicaid are really eligible because of the presence of matching federal funds pursuant to the state plan fails. A patient is either determined to be eligible for Medicaid or the patient is not; there are no persons “assumed” to be eligible for Medicaid or any other program of federal financial assistance. The main issue is that SNCP is just a funding mechanism for hospitals; patients are not “eligible” for benefits under the SNCP in the way that an individual is eligible under either Medicaid or an 1115 waiver expansion.  Further, it is not thepatient benefits that areeligible for matching Title XIX payments**;** rather, it is the pool of funds used to provide premium assistance for the purchase of the ConnectorCare program that is matched by Title XIX funds. ConnectorCare subsidizes the cost of insurance of patients who are specifically determined to not be eligible for Medicaid or MassHealth. Temporary financial hardship does not make an individual eligible for Medicaid or MassHealth assistance.

Finally, although the Providers rely on the D.C. District Court’s decision which held that Commonwealth Care days must be included in the numerator of the Medicaid fraction, *HealthAlliance Hospitals v. Azar*,346 F. Supp. 3d (D.D.C. 2018), the MAC disagrees. It asserts that the Administrator’s rationale in *UMass/Steward.*for determining that these days do not qualify as allowable Medicaid days for inclusion in the numerator of the Medicaid fraction of the DSH payment calculation pursuant to 42 C.F.R § 412.106(b)(4)(i)is proper.

**C. Conclusion**

The days covered by the Massachusetts ConnectorCare program, if they can be identified, do not qualify as the type of day to be included in the Medicaid fraction of the DSH calculation. The MAC respectfully requests that the Board affirm the MAC’s exclusion of the ConnectorCare section 1115 waiver days from the numerator of the Medicaid fraction of the Medicare DSH adjustment calculation.

IV. CITATION OF PROGRAM LAW, REGULATIONS, INSTRUCTIONS, CASE LAW AND OTHER SOURCES

Law:

SSA § 1115(a)(2) Demonstration Projects

Regulations:

42 C.F.R. § 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients;45 C.F.R. § 155.305 Exchange functions in the individual market: Eligibility standards

Case Law:

*Southwest Consulting UMass Memorial Health Care and Steward Health 2009 DSH CCHIP Section 1115 Waiver Day Groups v. National Government Services, Inc.,* PRRB Dec. No. 2017-D4, (January 27, 2017);*Southwest Consulting UMass Memorial Health Care and Steward Health 2009 DSH CCHIP Section 1115 Waiver Day Groups v. Novitas Solutions, Inc.,* Adm. Review of PRRB Dec. No. 2017-D4, (March 21, 2017);*HealthAlliance Hospitals v. Azar,* 346 F. Supp. 3d (D.D.C. 2018)

Other Sources:

MassHealth Advocacy Guide 2012;MassHealth Medicaid Section 1115 Demonstration – CMS Special Terms and Conditions (July 2005, October 2014);ConnectorCare Advocacy Guide;HCFA Program Memorandum Intermediaries – Transmittal No. A-99-62 dated December 1999 (reissued as PM A-01-13 dated January 2001)

V. EXHIBITS

C-1 Schedule of Providers

C-2 42 C.F.R. § 412.106

C-3 MassHealth Advocacy Guide 2012 - Parts 1 & 2

C-4 2006 Mass. Acts, Ch. 58

C-5 MassHealth Medicaid Section 1115 Demonstration – CMS Special Terms and Conditions (July 2005)

C-6 MassHealth Transmittal Letter ALL-142 (September 2006)

C-7 ConnectorCare Advocacy Guide

C-8 Massachusetts Cost-Sharing Subsidies in ConnectorCare

C-9 HCFA PM A-01-13

C-10 MassHealth Medicaid Section 1115 Demonstration – CMS Special Terms and Conditions (October 2014)

C-11 *Southwest Consulting UMass Memorial Health Care and Steward Health 2009 DSH CCHIP Section 1115 Waiver Day Groups v. Novitas Solutions, Inc.*, Adm. Review of PRRB Dec. No. 2017-D4 (March 21, 2017)

1. CCHIP stands for “Commonwealth Care Health Insurance Program.” [↑](#footnote-ref-1)
2. The MAC associated with PRRB Dec. No. 2017-D4 is National Government Services, Inc., however, the Adm. Dec. at **Exhibit C-11** incorrectly references Novitas Solutions. [↑](#footnote-ref-2)