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|  | Whether Medicare Part A eligible-but-unpaid days were properlytreated in the calculation of the Medicare DSH payment. |

**A. Facts**

The issue in this case is whether certain dual-eligible days, including exhausted benefit and Medicare secondary payor days, are properly included in the Medicare fraction used to calculate the Providers’ disproportionate share hospital (“DSH”) adjustment.

Hospitals are paid for services to Medicare patients through a prospective payment system (“PPS”). Under PPS, inpatient-operating costs are reimbursed based on a prospectively determined formula taking into account national and regional operating costs. The PPS legislation contains a number of provisions that adjust reimbursement based on hospital-specific factors. See 42 U.S.C. §1395ww(d)(5). This case involves one of the hospital-specific adjustments, the DSH adjustment. The DSH adjustment, effective in 1986, requires the Secretary to provide increased PPS reimbursement to hospitals that serve a “significantly disproportionate number of low-income patients.” 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the DSH adjustment, and the amount of the adjustment it receives, depends on the hospital's “disproportionate patient percentage.” See 42 U.S.C. § 1395ww(d)(5)(F)(v).

A hospital’s disproportionate patient percentage (“DPP”) is determined by adding the results of two computations and expressing the results as a percentage. As indicated in 42 U.S.C.

§ 1395ww(d)(5)(F)(vi) and 42 C.F.R. § 412.106, the two computations are the Medicare fraction (first computation) and the Medicaid fraction (second computation). The Medicare fraction is determined by dividing the number of days of care that are furnished to patients who were entitled to Medicare Part A (or Medicare Part C) benefits and who were “entitled to Supplemental Security Income (“SSI”) benefits” by the number of days of care that are furnished to patients who were entitled to Medicare Part A (or Medicare Part C). The Medicaid Fraction is determined by dividing the number of hospital patient days for patients who (for such days) were eligible for medical assistance under a State Plan approved under Title XIX for such period but not entitled to benefits under Medicare Part A by the total number of the hospital's patient days for such period. A provider whose DSH percentage meets certain thresholds receives an adjustment that results in increased PPS payment for inpatient hospital services. 42 U.S.C. § 1395ww(d)(5)(F)(ii).

This appeal concerns a dispute involving “dual eligible” days and whether or not these days are properly included in the published SSI percent. The term dual-eligible refers to patients who are eligible to receive benefits under both Medicare Part A and a state Medicaid program, generally the elderly poor. See *Allina Health System v. Sebelius*, F. Supp. 2d, CA No. 09-cv-1889, 2013 WL 5530609, \*1, \* 2 (D.D.C. Oct. 8, 2013) (citing *McCreary v. Offner*, 172 F.3d 76, 78 (D.C. Cir. 1999)). There are multiple types of dual eligible days including, for instance, days for individuals who are eligible for both Medicare and Medicaid, but who have exhausted their Medicare benefits for the days at issue (“dual eligible exhausted benefit days”), days for which a party other than Medicare –such as a state Medicaid program or an employer-sponsored health plan – has paid for patient services in full and for which Medicare makes no payment by statute (“dual eligible Medicare Secondary Payor days”) (see *Allina*, 2013 WL 5530609 at \*2; 42 U.S.C. § 1395y(b)(2)) and days furnished to Medicare patients who are also entitled to social security income (“SSI”) benefits (“SSI dual eligible days”).

There are no material facts in dispute. The parties agree that the MAC included inpatient

days where the patient was eligible for Medicaid and Medicare was the secondary payer (“dual eligible MSP days”) and where Medicare benefits were exhausted (“dual eligible exhausted days”) in the Medicare fraction of the DSH adjustment.

The Providers contend that Part A non-covered days must all be excluded from the Medicare Part A/SSI fraction and the Medicaid eligible portion of those days must be included in the numerator of the Medicaid fraction.

**B. Arguments**

* 1. **“Entitled” vs. “Eligible” for Medicare Part A Benefits**

The issue raised by the Providers was specifically addressed by the Court of Appeals for the District of Columbia in *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 917 (D.C. Cir. 2013) (**Exhibit C-2**) and by the District Court of the District of Columbia in *Allina Health System v. Sebelius*, --- F. Supp. 2d ---, 2013 WL 5530609, \*1, \* 2 (D.D.C. Oct. 8, 2013) (**Exhibit C-3**). In *Catholic Health Initiatives*, the Provider contended that dual eligible exhausted days must be included in the Medicaid fraction of the DSH adjustment because the phrase “entitled to benefits under Part A of Medicare” meant the right to have payments made on the patient’s behalf – so for days where a patient had exhausted his right to payment, he was not “entitled to benefits,” and such days should be counted in the Medicaid fraction. *Id.*, 718 F.3d at 920. The Secretary contended, however, that the word “entitled” in the Medicare statute “is not in reference to the right of payment of a benefit, but rather the legal status of the individual as a Medicare beneficiary under the law.” *Id.*, at 919. Thus, entitlement to benefits under Part A is determined by 42 U.S.C. § 426(a), which states that “[e]very individual who…has attained age 65, and … is entitled to monthly [Social Security benefits]…shall be entitled to hospital insurance benefits under Part A of [Medicare].”

The Court held that the Secretary’s interpretation that entitlement to Medicare benefits was simply a matter of meeting the statutory criteria, not a matter of receiving payment, was reasonable and entitled to deference under *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-3 (1984). *Catholic Health Initiatives,* 718 F.3d at 920. In fact, the Court noted that this interpretation was actually a better interpretation than that advanced by the providers in that case and by the Providers here. *Id.* Therefore, both patients who have exhausted their Medicare Part A benefits, or for whom Medicare is the secondary payer were, nevertheless, entitled to benefits under Medicare Part A, having met the statutory criteria for eligibility. For this reason, days of care furnished to those patients must be included in the Medicare fraction.

The decision by the Court of Appeals in *Catholic Health Initiatives* was followed and endorsed by the District Court of the District of Columbia in *Allina Health System v. Sebelius*, --- F. Supp. 2d ---, 2013 WL 5530609, \*1, \* 2 (D.D.C. Oct. 8, 2013). In *Allina*, the fiscal intermediary excluded dual eligible MSP days and dual eligible exhausted days from the Medicaid fraction when it calculated the provider’s DSH adjustment. *Id.*, at \*3. The Board reversed that determination. *See* *Allina Health System 1995-2003 DSH Dual Eligible Day Group v. BCBSA/Noridian Admin. Serv’s*, PRRB Dec. No. 2009-D35 (July 30, 2009). The Administrator subsequently reversed the Board’s decision. *See Allina Health System 1995-2003 DSH Dual Eligible Day Group v. BCBSA/Noridian Admin. Serv’s*, Adm. Review of PRRB Dec. No. 2009-D35 (September 21, 2009). On appeal, the District Court granted the Secretary’s Motion for Summary Judgment, finding in favor of the Secretary.

The District Court first held that the Secretary’s interpretation of the statute did not violate the plain language of the Medicare statute, finding that the Court of Appeals’ decision in *Catholic*

*Health Initiatives* controlled the result. *Id.*, at \*4.

The Court also rejected *Allina’s* argument that dual eligible MSP days and dual eligible exhausted days had to be included somewhere in the DSH adjustment formula. The Court held that because *Allina* had never advanced an alternative claim that the Secretary wrongly construed the Medicare fraction of the DSH formula and should have counted the dual eligible days in the Medicare fraction even if these days were properly excluded from the Medicaid fraction, this theory could not be considered. *Id.*, at \*6.

The Court also rejected *Allina’s* contention that the terms “eligible” and “entitled” had different meanings in the DSH adjustment formula based on prior appellate court decisions. The Court found this argument “unpersuasive” because these cases had not dealt with the precise issue before the Court, and the Court of Appeals had declined to follow these cases in *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 398 U.S. App. D.C. 43 (D.C. Cir. 2011). *Id.*, at \*7. The Court also rejected *Allina’s* contention that the Secretary’s interpretation amounted to impermissible retroactive rulemaking, since the Court of Appeals in *Catholic Health Initiatives* had rejected this same contention. *Id.*

The Court thus disagreed that the interpretation pressed by *Allina* was compelled by the plain language of the Medicare statute, otherwise found that the Secretary’s interpretation was permissible and reasonable, and concluded that *Allina’s* attacks against the Secretary’s decision were without merit. *See* *Allina*, 2013 WL 5530609 at \*1. Since all of *Allina’s* arguments and claims have already been rejected by the District Court and the Court of Appeals for the District of Columbia, the Board should likewise reject these arguments and claims here.

* 1. **The Secretary Did Not Violate the Administrative Procedures Act**

Pursuant to the version of 42 C.F.R. § 412.106(b)(2)(i) (2003) in place before the 2005 Final Rule was promulgated, CMS included only “covered” patient days in the Medicare fraction of a hospitals DSH adjustment. This had the effect of excluding dual eligible exhausted coverage patient days from the numerator and denominator of the Medicare fraction. In addition, CMS also excluded the days from the Medicaid fraction. As a result, the days were not counted at all when calculating a hospitals DSH adjustment.

However, on May 19, 2003, the Department of Health and Human Services (HHS) issued a Notice of Proposed Rulemaking (NPRM), wherein it stated that the current Medicare policy was to include dual eligible exhausted coverage patient days in the Medicare fraction of the DSH adjustment. 68 Fed. Reg. 27207-27208 at **Exhibit C-4**. Several commenters responded to the proposed ruling and pointed out the misstatement. On August 1, 2003, HHS issued the FY 2004 Final Rule stating that it was “still reviewing the large number of comments received on the proposed provision relating to dual-eligible patient days in the May 19, 2003” proposed rule. 68 Fed. Reg. 45421. As a result, it did not finalize any change in policy. On May 18, 2004, HHS issued the FY 2005 NPRM and stated that it would address comments from the FY 2003 NPRM in the FY 2005 Final Rule. 69 Fed. Reg. 28286. A few days before the end of the FY 2005 comment period, HHS posted a webpage notice acknowledging the 2003 NPRM’s misstatement of the then-applicable rule. It stated, “[o]ur policy has been that only covered patient days are included in the Medicare fraction.” A few commenters acknowledged HHS’s correction, while others voiced support for the erroneously stated status quo. In the FY 2005 Final Rule dated August 11, 2004, HHS noted:

Comment: We received numerous comments that commenters were disturbed and confused by our recent Web site posting regarding our policy on dual-eligible patient days. The commenters believed that this posting was a modification or change in our current policy to include patient days of dual-eligible Medicare beneficiaries whose Medicare Part A coverage has expired in the Medicaid fraction of the DSH calculation. In addition, the commenters believed that the information in this notice appeared with no formal notification by CMS and without the opportunity for providers to comment.

69 Fed. Reg. 49098 at **Exhibit C-5**. In response, HHS explained that the webpage posting “was not a change in our current policy,” but a “correction of an inadvertent misstatement” made in the FY 2003 NPRM. *Id*. The FY 2005 Final Rule finalized a policy of including dual eligible exhausted coverage patient days in the Medicare fraction of the DSH adjustment. 69 Fed. Reg. 49099.

Providers have argued that HHS did not follow the proper notice-and-comment procedures in implementing the FY 2005 Final Rule. Specifically, Providers contended that the Secretary misstated the then-existing policy in 2003 when he stated the policy included all dual-eligible days in the Medicare fraction and excluded them from the Medicaid fraction, even when the patient’s Medicare Part A benefits were exhausted. Therefore, HHS did not adequately give commenters an opportunity to respond before issuing the FY 2005 Final Rule, which violated the Administrative Procedure Act (APA).

On May 5, 2020, the U.S. Court of Appeals for the Ninth Circuit ruled in *Empire Health Foundation v. Azar*, 958 F.3d 873 that “HHS undoubtedly misstated the then-applicable rule in the 2003 Notice. Nevertheless, the 2003 Notice did describe the content of the 2005 Rule, even if it incorrectly characterized it as the then-applicable rule.” It ruled that the rulemaking process was certainly not perfect, but the FY 2005 Final Rule was a logical outgrowth of the proposed rule change, as commenters could reasonably foresee that after consideration of the proposed rule, HHS might choose to adopt the proposal or to withdraw it. “Commenters on the 2005 Rule were similarly apprised of a binary choice – under the new rule, dual eligible exhausted coverage patient days would be included in either the Medicare or the Medicaid fraction. In the end, they were included in the Medicare fraction.” Reference **Exhibit C-6**. The Court went on to affirm the district court’s summary judgment in favor of *Empire* and order vacating the 2005 Final Rule because it held that the 2005 Rule was substantively invalid, based on its previous binding decision in *Legacy Emanuel*. The MAC notes that the Ninth Circuit does not encompass the states where the disputed Providers are located, and this decision is therefore, not legally binding on them. However, this same issue was addressed by the U.S. District Court for the District of Columbia in *Stringfellow Memorial Hospital v. Azar*, 317 F.Supp.3d 168 (2018), which does govern the Providers in dispute. Reference **Exhibit C-7**. In *Stringfellow*, the Court agreed that the 2004 and 2005 Proposed Rules included “sloppy and confusing misstatements”, but that the FY 2005 Final Rule was a “logical outgrowth” of the 2004 Proposed Rule and was therefore, not a violation of the APA. It further ruled that the FY 2005 Final Rule is procedurally sound and the product of reasoned decision-making.

Finally, on June 24, 2022, the Supreme Court ruled in *Becerra v. Empire Health Foundation*, 597 U.S. \_\_\_\_ (2022), that in “calculating the Medicare fraction, individuals “entitled to [Medicare Part A] benefits” are all those qualifying for the program, regardless of whether they receive Medicare payments for part or all of a hospital stay.” Reference **Exhibit C-8**. The Court ruled that throughout the Medicare statute, “entitled to benefits” is essentially a term of art meaning “qualifying for benefits”, i.e., being over 65 or disabled and that if “entitled to benefits” instead bore *Empire’s* meaning, Medicare beneficiaries would lose important rights and protections, such as the ability to enroll in other Medicare programs. It ruled that the Department of Health and Human Services (HHS) regulation correctly construes the statutory language at issue and that Congress could not have intended to write a statute whose safeguards would apply or not apply, or fluctuate constantly, based on the happenstance of whether Medicare paid for hospital care on a given day. The Court reversed the judgment of the Court of Appeals and remanded the case for further proceedings consistent with its opinion.

**C. Conclusion**

In view of the foregoing factors, the Board should affirm the MAC’s inclusion of dual eligible MSP days and dual eligible exhausted days in the Medicare fraction of the Providers’ DSH adjustment and excluding these days from the Medicaid fraction.

IV LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

**United States Statutes:**

42 U.S.C. § 426(a);42 U.S.C. § 1395ww(d)(5);42 U.S.C. § 1395ww(d)(5)(F);42 U.S.C. § 1395y(b)(2)

**Regulations:**

68 Fed. Reg. 27207 - 27208 (May 19, 2003);68 Fed. Reg. 45421 (August 1, 2003);69 Fed. Reg. 28286 (May 18, 2004);69 Fed. Reg. 49098 - 49099 (August 11, 2004);42 C.F.R. § 412.106

**Law:**

*Allina Health System 1995-2003 DSH Dual Eligible Day Group v. BCBSA/Noridian Admin. Serv’s*, PRRB Dec. No. 2009-D35 (July 30, 2009);*Allina Health System 1995-2003 DSH Dual Eligible Day Group v. BCBSA/Noridian Admin. Serv’s*, Adm. Review of PRRB Dec. No. 2009-D35 (September 21, 2009);*Allina Health System v. Sebelius*, --- F. Supp. 2d ---, CA No. 09-cv-1889, 2013 WL 5530609, \*1 (D.D.C. Oct. 8, 2013);*Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013);*Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 398, U.S. App. D.C. 43 (2011);*Empire Health Foundation v. Azar*, 958 F.3d 873 (2020);*Becerra v. Empire Health Foundation*, 597 U.S. \_\_\_\_\_ (2022);*Stringfellow Memorial Hospital v. Azar*, 317 F. Supp.3d 168 (2018)

V. EXHIBITS

C-1: Final Schedule of Providers

C-2: *Catholic Health Initiatives Iowa Corp. v. Sebelius* (D.C. Cir. 2013)

C-3: *Allina Health System v. Sebelius* (D.D.C. Oct. 8, 2013)

C-4: 68 FR 27207-27208

C-5: 69 FR 49098-49099

C-6: 9th Circuit Ct of Appeals Decision in *Empire*

C-7: *Stringfellow v. Azar* Decision

C-8: *Becerra v. Empire Health* Supreme Court Decision