**A. Facts**

Pursuant to the audit adjustment numbers noted on the Schedule of Providers (Exhibit C-1), the MAC adjusted the Providers’ SSI Ratios, Medicaid Eligible Days, DSH payments, and protested amounts. For the Providers where the MAC adjusted to remove the protested amounts, the Providers had included the estimated reimbursement effect of the understated DSH payment due to the handling of Medicare/Medicaid dual eligible Part C days in their filed Protested Amounts on their cost reports. The MAC adjusted to remove these protested amounts in adjustments noted on the Schedule of Providers (Exhibit C-1).

The Providers’ appeal concerns the proper placement of days of care furnished to beneficiaries of Medicare + Choice plans (“M+C plans”) in the disproportionate share hospital ("DSH") formula, which is used to compute the additional amounts that are paid to hospitals that serve a disproportionate number of low-income patients.

The focus of the Providers paper is primarily on how Part C days are being handled in the Medicare (SSI) fraction. However, the MAC notes that the current case is intended to also address Part C days and the Medicaid fraction since the PRRB allowed the merging of case *21-0801GC AHMC Healthcare CY 2017 DSH Medicaid Fraction Medicare Managed Care Part C Days Group* into this group on 6/29/2021 (Exhibit C-13). The Providers’ Preliminary Position Paper (PPP) includes a slight reference to the Medicaid fraction in the Conclusion (PPP page 23):

The inclusion of Part C Days in the numerator and denominator of the Providers’ Medicare fractions in their DSH calculations is improper. The Providers request that the Board determine that Part C Days be excluded from the numerator and denominator of the Providers’ Medicare Fractions and included in their Medicaid Fractions instead.

Section 4001 of the Balanced Budget Act of 1997 (the "BBA") established the Medicare + Choice program by adding a new Part C to Title XVIII of the Act pursuant to Sections 1851 through 1859. As enacted by Section 4001 of the BBA, Section 1851 provides that in order to be eligible to enroll in an M+C plan, an individual must be entitled to benefits under Medicare Part A. Once an individual enrolls in an M+C plan, the individual receives payments under Medicare Part C rather than Medicare Part A. 42 U.S.C. § 1395w-21(a)(1)(B). The issue in this appeal concerns how days of care furnished to individuals who are enrolled in M+C plans ("M+C days") should be treated under the DSH formula.

The DSH formula is used to adjust the reimbursements for hospitals that serve a significantly disproportionate number of low-income patients. See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). A hospital’s adjustment is based on its disproportionate patient percentage (the "DPP"), which is statutorily-defined by the Medicare Act. See 42 U.S.C. § 1395ww(d)(5)(F)(v). The DPP is statutorily defined as the sum of two fractions, the "Medicare fraction" and the "Medicaid fraction."

The Medicare fraction is:

[T]he 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 [Medicare] and were entitled to supplementary security income [SSI] benefits…, and the denominator of which is the number of such hospital patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of [Medicare.]

42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).

The Medicaid fraction is:

[T]he fraction (expressed as a percentage), the numerator of which is 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 [Medicaid plan], but who were not entitled to benefits under part A of [Medicare], and the denominator of which is the total number of the hospital’s patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

The Providers seek to include M+C days in the Medicaid fraction of the DSH formula and exclude these days from the Medicare (SSI) fraction. Whether or not M+C days may be included in the Medicare fraction or the Medicaid fraction depends on whether patients enrolled in M+C plans were "entitled to benefits under Medicare Part A." This is because the Medicare fraction is determined based on patients who are "entitled to benefits under Medicare Part A." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The numerator of the Medicaid fraction includes patients who are eligible for Medicaid and may not include the days of patients who are "entitled to benefits under Medicare Part A." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

The Providers’ underlying assertion is that beneficiaries of M+C plans are no longer entitled to benefits under Medicare Part A, and that M+C days therefore should not be included in the Medicare fraction, and M+C days may therefore be included in the Medicaid fraction.

The Medicare Administrative Contractor ("MAC") contends that individuals who enroll in M+C plans remain entitled to benefits under Medicare Part A, and M+C days therefore may not be included in the Medicaid fraction of the DSH formula and must be included in the Medicare (SSI) fraction.

**B. Argument**

**1. The Regulation Dictates that M+C Days May Only be Included in the Medicare Fraction for Fiscal Years Ending After 2004**

The Secretary addressed the issue of whether M+C days could be included in the Medicare fraction or the Medicaid fraction of the DSH formula via notice and comment rulemaking in 2003 and 2004. In 2003, the Secretary issued a Notice of Proposed Rulemaking (the “NPRM”) in which the Secretary proposed a policy relating to the placement of M+C days in the DSH formula. *See* 68 FR 27,208 (May 19, 2003) (Exhibit C-3). In pertinent Part, the NPRM stated:

We note that under § 422.50, an individual is eligible to elect an M+C plan if he or she is entitled to Medicare Part A and enrolled in Part B. However, once a beneficiary has elected to join an M+C plan, that beneficiary’s benefits are no longer administered under Part A.

Therefore, we are proposing to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction. 68 FR 27,208 (May 19, 2003)

In August 2003, CMS announced that it was still reviewing comments (68 FR 45,422) (see Exhibit C-4). In August of 2004, CMS announced in a final rule that M+C days would be included in the Medicare fraction of the DSH formula. *See* 69 FR 49,093 and 49,099 (August 11, 2004) (Exhibit C-5). The Secretary explained in the final rule that:

In regard to M+C days, we proposed that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. The patient days should be included in the count of total patient days in the denominator of the Medicaid fraction, and if the M+C beneficiary is also eligible for Medicaid, the patient's days would be included in the numerator of the Medicaid fraction as well. (69 FR 49,093)

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Under existing § 422.1, an M+C plan means “health benefits coverage offered under a policy or contract by an M+C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan.” Generally, each M+C plan must provide coverage of all services that are covered by Medicare Part A and Part B (or just Part B if the M+C plan enrollee is only entitled to Part B).

We have received questions whether the patient days associated with patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation. The question stems from whether M+C plan enrollees are entitled to benefits under Medicare Part A since M+C plans are administered through Medicare Part C.

We note that, under existing regulations at § 422.50, an individual is eligible to elect an M+C plan if he or she is entitled to Medicare Part A and enrolled in Part B. However, once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A. In the proposed rule of May 19, 2003 (68 FR 27208), we proposed that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary would not be included in the Medicare fraction of the DSH patient percentage. Under our proposal, these patient days would be included in the Medicaid fraction. The patient days of dual-eligible M+C beneficiaries (that is, those also eligible for Medicaid) would be included in the count of total patient days in both the numerator and denominator of the Medicaid fraction.

Comment: Several commenters indicated that they appreciated CMS's attention to this issue in the proposed rule. The commenters also indicated that there has been insufficient guidance on how to handle these days in the DSH calculation. However, several commenters disagreed with excluding these days from the Medicare fraction and pointed out that these patients are just as much Medicare beneficiaries as those beneficiaries in the traditional fee-for-service program.

Response: Although there are differences between the status of these beneficiaries and those in the traditional fee-for-service program, we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction. As noted previously, if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at §412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation. (69 FR 49,099)

(Exhibit C-5)

The final rule makes it apparent that at least as early as August 2004, when the final rule was issued, the Secretary interpreted the DSH statute to require that M+C days be included in the Medicare fraction and excluded from the Medicaid fraction. This appeal relates to M+C days during a fiscal year ending after the final rule was issued that announced the revision of 42 C.F.R. § 412.106(b)(2)(i) (Exhibit C-2).

**2. The Regulation Requiring M+C Days to be Included in the Medicare Fraction and Excluded from the Medicaid Fraction Constitutes a Reasonable Interpretation of the Statute**

The Providers’ underlying assertion is that individuals enrolled in M+C plans are no longer entitled to benefits under Part A because they are no longer entitled to have payments made under Part A once they enroll in M+C plans. The fact that enrollment in an M+C plan changes entitlement to Medicare Part A payments, however, does not speak to an individual’s entitlement to benefits under Part A. Rather, 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].” In order to enroll in an M+C plan, a beneficiary must be entitled to benefits under Medicare Part A. Title 42 U.S.C. § 1395w-21(a)(3)(A) explains that “[i]n this title [42 U.S.C. §§ 1395 et seq.], . . . the term ‘Medicare + Choice eligible individual’ means an individual who is entitled to benefits under Part A and enrolled under Part B.” Every individual who is enrolled in an M+C plan is entitled to benefits under Part A at the time the individual enrolls in the M+C plan. These individuals continue to be age 65 and over and entitled to monthly Social Security benefits after they enroll in M+C plans and, therefore, remain “entitled to” Medicare Part A benefits under the statute. Indeed, a beneficiary is still “entitled to” Medicare Part A even if Medicare does not pay for the day at all.

While enrollment in an M+C plan results in payments being made under Part C instead of Parts A and B, this fact does not establish that an individual who is enrolled in an M+C plan is no longer entitled to Part A benefits. These individuals are still entitled to have payments made on their behalf from the Medicare Part A trust fund based on the actuarial value of Medicare Part A services provided to the M+C plan enrollees. 42 U.S.C. § 1395w-23(f). There is nothing in the Medicare statute that indicates that a beneficiary is not entitled to benefits under Medicare Part A merely because the payment from the Medicare Part A trust fund is made to the M+C plan instead of directly to a provider.

While the Providers may dispute that the DSH statute unambiguously states that individuals enrolled in M+C plans remain entitled to benefits under Part A, the Providers cannot be heard to complain that the Secretary’s interpretation of the DSH statute and related regulation are unreasonable. The Court of Appeals for the District of Columbia addressed this precise issue in *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. June 11, 2013) (Exhibit C-6). In *Catholic Health Initiatives*, 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 Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. June 11, 2013) at \*\*10-11. 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.*, at \*10. The MAC contends that the DSH statute unambiguously excludes M+C days from the Medicaid fraction. To the extent there is any ambiguity in the DSH statute, however, the Secretary clarified this ambiguity in the August 2004 final rule and resulting regulation, the reasonableness of which was confirmed by the Court in *Catholic Health Initiatives.*

**3. The “Allina” Proceedings**

The precise issue in this appeal was before the Court of Appeals for the District of Columbia in 2014 (s*ee* *Allina Health Services v. Sebelius,* 746 F.3d 1102) (Exhibit C-7). The history of those proceedings can be found in the ensuing Administrator’s Decision dated December 1, 2015 at pages 2 and 3 (Exhibit C-8).

The Providers appealed to the Provider Reimbursement Review Board (Board). In PRRB Decision No. 2010-D38 and the other related cases, the Board respectively granted expedited judicial review (EJR) regarding the "2004 rule.” The United States District Court for the District of Columbia granted a motion for summary judgment in favor of the Providers concluding that the Rule was not a "logical outgrowth" of the proposed rule and that it lacked a reasoned explanation. The Court vacated those portions of the 2004 Rule that applied to the DSH percentage calculation and remanded the case to the Secretary. The Secretary appealed the decision to the Court of Appeals for the District of Columbia. On appeal, the Secretary argued that the Rule was procedurally valid and that, even if the court were to determine that it was not valid, the Providers were not entitled to any specific relief as to the manner of the calculation of their FY 2007 payments, because the Secretary could reach the same interpretation of the statute on remand, even in the absence of the Rule.

The Court of Appeals for the District of Columbia, in *Allina Health Services v. Sebelius*, 746 F.3d. 1102 (D.C. Cir. 2014), held that the Secretary did not provide adequate notice and opportunity to comment before promulgating the FFY 2005 IPPS rule, and so affirmed the portion of the district court's opinion vacating the rule. The Court of Appeals ruled that the District Court improperly ordered the Secretary to recalculate DSH payments to include the Part C days in the numerator of the Medicaid fraction, holding that the agency was free to decide "how to resolve the problem." Accordingly, the case was remanded to the Secretary to determine whether patient days for Part C patients should be counted in the Medicare fraction of the Disproportionate Patient Percentage for the hospitals at issue in FY 2007 or the numerator of the Medicaid fraction.

In the Remand Decision, the Administrator presented a detailed analysis of why the issue presented in this Appeal should be decided against the Provider Group. On page 46 of the Decision, the Final Administrative Decision of the Secretary of Health and Human Services is articulated.

DECISION

The Administrator determines that the days associated with Medicare patients who are enrolled in a Part C plan are to be included in the numerator and denominator of the Medicare fraction for the Providers’ cost years involved in this case.

On July 25, 2017, the Court of Appeals for the District of Columbia issued a provider-friendly decision in *Allina Health Services v. Price*, Case No. 16-5255 (D.C. July 25, 2017) (commonly known as *Allina II*) (Exhibit C-9), reversing the negative decision the hospitals received at the district court level. The appeals court's reversal stems from its reasoning that the "pre-2004 standard of excluding Part C days from Medicare fractions remains the baseline practice" until the 2014 effective date of CMS's properly promulgated rule pertaining to the location of Medicare Advantage ("MA") days in the Medicare Disproportionate Share Hospital ("DSH") calculation. The court noted that the "pre-2004 standard of excluding Part C days from Medicare fractions remains the baseline practice." The court remanded the case back to the District Court for proceedings consistent with its opinion.

On June 3, 2019, the U.S. Supreme Court issued an opinion in *Azar v. Allina Health Services*, 139 S.Ct. 1804 (2019), affirming the Court of Appeals for the District of Columbia’s decision in *Allina II*. (See Exhibit C-11.) In its opinion, the Supreme Court determined that CMS’s policy of including Part C days in the Medicare fraction “establishes or changes a substantive legal standard” requiring notice and comment as set forth in Section 1395hh(a)(2) of the Medicare Act. Still, the Court narrowed the scope of its opinion, and did not expand the ruling beyond the policy change at issue.

Subsequent to the Supreme Court’s decision in *Azar v. Allina*, the Secretary proposed a new rule that “would create a policy governing the treatment of days associated with beneficiaries enrolled in Medicare Part C for discharges occurring prior to October 1, 2013”. 85 Fed. Reg. 47723 (August 6, 2020) (Exhibit C-12). Referring to the vacatur of the FY 2005 final rule, the Secretary stated:

Because the FY 2005 IPPS final rule was vacated, the Secretary “has no promulgated rule governing” the treatment of Part C days for fiscal years before 2014.” (See Allina Health Servs. v. Price, 863 F.3d 937, 939 (D.C. Cir. 2017).) As a result, in order to comply with the statutory requirement to calculate Medicare DSH payments, CMS must determine whether beneficiaries enrolled in Part C are “entitled to benefits under part A” and so must be included in the Medicare fraction (and excluded from the numerator of the Medicaid fraction), or are not so entitled and so must be excluded from the Medicare fraction (and included in the numerator of the Medicaid fraction, if dually eligible). The Secretary has therefore determined that, in order to comply with the statutory requirement to make DSH payments, **it is necessary for CMS to engage in retroactive rulemaking to establish a policy** to govern whether individuals enrolled in MA plans under Part C should be included in the Medicare fraction or in the numerator of the Medicaid fraction, if dually eligible, for fiscal years before 2014. *Id*. at 47725. (Emphasis added.)

**4. CMS officially readopted the policy of counting M+C (Part C) days in the Medicare fraction in the August 19, 2013 Federal Register, effective October 1, 2013.**

The participants have a June 30, 2017 Fiscal Year End and includes service dates after October 1, 2013. CMS reiterated its policy on the counting of M+C (Part C) days in the Medicare fraction of the Disproportionate Patient Percentage (DPP) in the August 19, 2013 Federal Register (Exhibit C-10). In this Federal Register, CMS stated:

We also believe that our policy of counting patients enrolled in MA plans in the Medicare fraction was a logical outgrowth of the FY 2004 IPPS proposed rule, and, accordingly, have appealed the decision in *Allina.* However, in an abundance of caution and for the reasons discussed above, in the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27578), we proposed to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP. (78 FR 50,615)

This Federal Register discusses the background of this issue at length and addresses the many comments received in response to the FY 2014 IPPS/LTCH PPS proposed rule. CMS formally readopted the policy of counting the days of patients enrolled in M+C (Part C) plans in the Medicare fraction of the DPP for FY 2014 and subsequent years.

After consideration of the public comments we received, we are finalizing our proposal to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP for FY 2014 and subsequent years. We continue to believe this policy is most consistent with the language of the statute, congressional intent, and the structure of the DSH calculation. (78 FR 50,620)

**5. The FLORIDA HEALTH SCIENCES CENTER case**

In its Preliminary Position Paper, on pages 21-22, the Providers reference the case of *Florida Health Sciences Center vs Becerra:*

The Provider(s) hereby incorporate the full record of *Florida Health Sciences Center vs Becerra 1:19-cv-03487-RC FLORIDA HEALTH SCIENCES CENTER, INC. et al v. AZAR,* of which a copy of the Providers’ complaint is included herewith as Exhibit P-1*.*

The Providers’ Conclusion on page 23, includes:

The Providers are requesting that this case be held in abeyance pending the decision in the Florida Health Sciences Center case.

The MAC notes that the case cited by the Provider has not been resolved and therefore, reliance on this case is improper and premature. Thus, the MAC will not make any comments regarding this case.

**C. Conclusion**

The CMS policy of counting M+C days in the Medicare fraction was properly promulgated in the August 19, 2013 Federal Register, effective October 1, 2013. The cost reporting period at issue in this appeal began after that effective date. Therefore, the Board should affirm the MAC’s exclusion of these M+C days from the Medicaid fraction of the Providers’ DSH adjustment calculation as proper. The MAC has properly adjusted to use the CMS issued SSI ratio, which properly includes these M+C days in the Medicare fraction.

**IV. CITATION OF PROGRAM LAWS, REGULATIONS, AND INSTRUCTIONS**

**United States Statutes:**

42 U.S.C. § 426(a);42 U.S.C. § 1395w-21(a)(1)(B);42 U.S.C. § 1395w-21(a)(3)(A);42 U.S.C. § 1395w-23(f);42 U.S.C. § 1395hh(a)(2);42 U.S.C. § 1395ww(d)(5)(F)(i)(I);42 U.S.C. §;1395ww(d)(5)(F)(v);42 U.S.C. § 1395ww(d)(5)(F)(vi)(I);42 U.S.C. § 1395ww(d)(5)(F)(vi)(II);Balanced Budget Act of 1997 (Pub. L. 105-33, § 4001)

**Regulations:**

42 C.F.R. § 412.106;42 C.F.R. § 422.1;42 C.F.R. § 422.50

**Federal Register:**

68 FR 27,208 (May 19, 2003);68 FR 45,422 (August 1, 2003);69 FR 49,093, 49,099 (August 11, 2004);78 FR 27,578 (May 10, 2013);78 FR 50,614 – 50,620 (August 19, 2013);85 FR 47723 – 47728 (August 6, 2020)

**Judicial Decisions:**

*Allina Health Serv’s v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014);*Allina Health Services v. Price*, Case No. 16-5255 (D.C. July 25, 2017);*Azar v. Allina Health Services*, 139 S.Ct. 1804 (2019);*Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013);*Chevron U.S.A.*, Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837 (1984)

**Agency Decisions:**

Administrator’s decision *Allina Health Serv’s, et al*., Civil Nos. 1:10-cv-01463, 1:12-cv-00328 (December 1, 2015)

**V. EXHIBITS**

C-1. Schedule of Providers from OH CDMS

C-2. 42 C.F.R. § 412.106

C-3. 68 FR 27,208 (May 19, 2003)

C-4. 68 FR 45,422 (August 1, 2003)

C-5. 69 FR 49,093 – 49,099 (August 11, 2004)

C-6. *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013)

C-7. *Allina Health Serv’s v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014)

C-8. Administrator’s decision *Allina Health Serv’s, et al*., Civil Nos. 1:10-cv-01463, 1:12-cv-00328 (December 1, 2015)

C-9. *Allina Health Services v. Price*, Case No. 16-5255 (D.C. July 25, 2017)

C-10. 78 FR 50,614 – 50,620 (August 19, 2013)

C-11. *Azar v. Allina Health Services*, 139 S.Ct. 1804 (2019)

C-12. 85 FR 47723 – 47728 (August 6, 2020)

C-13. PRRB letter approving the merger of 21-0799GC and 21-0801GC