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|  | Whether the Medicare Advantage (Part C) days should be excluded from the Medicare Part A/SSI fraction, and the Medicaid-eligible portion of these days included in the numerator of the Medicaid fraction, of the Medicare disproportionate share hospital (“DSH”) payment calculation for discharges on or after October 1, 2013. |

**A. Facts**

The Provider's 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.

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 a M+C plan, an individual must be entitled to benefits under Medicare Part A. Once an individual enrolls in a 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’s 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 M+C days from the Medicare (SSI) fraction. Whether or not M+C days may be included in the Medicaid fraction depends on whether patients enrolled in M+C plans were "entitled to benefits under Medicare Part A." This is because 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 may therefore be included in the Medicaid fraction and excluded from the Medicare fraction of the DSH formula.

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.

This appeal relates to cost reporting periods with discharges beginning on or after October 1, 2013. In the FFY 2014 Hospital Inpatient Prospective Payment System (IPPS) Final Rule, CMS re-adopted its policy of including dual eligible Medicare Part C days in the SSI fraction of the DSH calculation. 78 FR 50614-50620 (August 19, 2013). The Providers contend that the re-adoption of this rule violates the notice-and-comment rulemaking requirement under the Medicare Act and the Administrative Procedures Act (APA) and is otherwise arbitrary, capricious and an unreasonable interpretation of the DSH statute.

**B. Arguments**

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 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. The NPRM stated in pertinent part:

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 27208 at **Exhibit C-2, pg. 2.**

In August 2003, CMS announced that it was still reviewing comments (68 FR 45422). In August 2004, CMS announced in a Final Rule that M+C days would be included in the Medicare fraction of the DSH formula. 69 FR 49093, 49099 (**Exhibit C-3, pp. 3 & 9).** 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 49093)

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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 49099.)

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 fiscal years ending during calendar year 2014 (i.e. after the Final Rule was issued that announced the revision of 42 C.F.R. § 412.106(b)(2)(i)).

1. **The Regulation Requiring M+C Days to be 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 a 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 a 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 a 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 a 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 a 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 Provider may dispute that the DSH statute unambiguously states that individuals enrolled in M+C plans remain entitled to benefits under Part A, the Provider 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. 2013). 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*, 2013 WL 2476896 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*.

1. **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). The history of those proceedings can be found in the ensuing Administrator’s Decision dated December 1, 2015, **Exhibit C-4, pp. 2 and 3.**

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. The Final Administrative Decision of The Secretary of Health and Human Services is articulated at **Exhibit C-4, pg. 46**.

**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*, 863 F.3d 937, 939 (D.C. Cir. 2017) (commonly known as *Allina II*), 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 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*. 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.

1. **CMS Officially Readopted the Policy of Counting M+C Days in the Medicare Fraction in the FY 2014 IPPS Final Rule, Effective October 1, 2013.**

On November 15, 2012, the Federal District Court for the District of Columbia ruled in the case of *Allina Health Services v. Sebelius* that CMS’s policy of including dual eligible Medicare Part C days in the Medicare fraction of the DPP calculation was not a logical outgrowth of the FY 2004 proposed rule on the subject. The Court held that the interested parties had not been put on notice that the Secretary might adopt a final policy of counting the days in the Medicare fraction and were not provided an adequate further opportunity for public comment. In response to the Court’s ruling and in an abundance of caution[[1]](#footnote-1), CMS issued a Notice of Proposed Ruling Making on May 10, 2013. 78 FR 27578. In this proposed rule, CMS once again solicited comments regarding the proper placement of Part C days in the DPP calculation. Specifically, CMS stated,

However, in an abundance of caution and for the reasons discussed above, in this proposed rule, we are proposing to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP. We are seeking public comments from interested parties that may support or oppose the proposal to include the MA patient days in the Medicare fraction of the DPP calculation for FY 2014 and subsequent years.

78 FR 27578 at **Exhibit C-5, pg. 4**.

CMS received many comments on the proposed rule and addressed each one at length. In the August 19, 2013, FY 2014 IPPS Final Rule, CMS re-adopted its policy of counting Part C days in the Medicare fraction of the DPP. In this Final Rule, 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 50615 at **Exhibit C-6, pg. 2**.

Some commenters stated that CMS could not finalize its proposed policy for FY 2014 because CMS had not corrected the deficiencies cited by the court in *Allina*, and by doing so, CMS would be acting in an arbitrary and capricious manner in violation of the APA. These commenters argued that CMS did not give stakeholders a complete and thorough discussion on the policy “change” to allow them to fully respond. CMS responded that the proposed rule did not propose a change in policy, but rather readopted a policy that was finalized in FY 2005. As a result, commenters have had more than ample time to comment both in support of and in opposition of the proposal and CMS considered all comments received. As a result, 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 50620 at **Exhibit C-6, pg. 7**.

As the FY 2014 Final Rule was properly subject to notice and comment period and properly promulgated, effective October 1, 2013, Part C days are properly included in the Medicare fraction of the DPP calculation, as confirmed by the District Court for the District of Columbia decision in *Florida Health Sciences Center, Inc. v. Becerra*, No. CV 19-3487 (RC), 2021 WL 2823104 (D.D.C. July 7, 2021)[[2]](#footnote-2) (*See* **Exhibit C-7**).

The Court in *Florida Health Sciences Center* ruled in favor of the Secretary on each of the same arguments raised by the Group in its preliminary position paper. With regard to the Providers’ argument that the Secretary did not acknowledge or explain its change in policy regarding the calculation of Medicare Part C days, the Court concluded “that by both acknowledging agency precedent and providing a reasoned explanation for its current action, the Secretary has met this ‘core requirement’ for rulemaking. Accordingly, the 2013 Rule is not arbitrary and capricious on this ground.” (**Exhibit C-7, pg. 17**) The Court also ruled that “the potential financial implications of the 2013 Rule were not relevant to the agency’s statutory analysis. Accordingly, the Court holds that Plaintiffs have failed to show, as is their burden, that the 2013 Rule was arbitrary and capricious on this basis.” (**Exhibit C-7, pp. 29-30**) Lastly, the Court addressed the Secretary’s purported inconsistencies in its interpretation of the phrase “entitled to benefits” in the DSH statute and concluded that “the Secretary properly addressed comments about the alleged ‘inconsistency’ in the statutory interpretation of the Medicare fraction in the 2013 Rule such that the agency did not act in an arbitrary or capricious manner.” (**Exhibit C-7, pg. 38**)

**C. Conclusion**

The CMS policy of counting M+C days in the Medicare fraction was properly promulgated in the FY 2014 IPPS Final Rule, effective October 1, 2013. The cost reporting periods at issue in this appeal began after the effective date of the Final Rule. Therefore, the Board should affirm the MAC’s exclusion of the M+C days from the Medicaid fraction of the Providers’ DSH payment calculations. The MAC has utilized the CMS-issued SSI percentages, which properly include the M+C days, in the Medicare fraction of the DPP calculation.

IV. LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

Law:

42 U.S.C. § 426(a) Entitlement to hospital insurance benefits;

42 U.S.C. § 1395hh(a)(2) Authority to prescribe regulations;

42 U.S.C. § 1395w-21(a) Eligibility, election, and enrollment;

42 U.S.C. § 1395w-23(f) Payments to Medicare +Choice organizations;

42 U.S.C. § 1395ww(d)(5)(F) Payments to hospitals for inpatient hospital services;

Pub. L. 105-33, Section 4001 Balanced Budget Act of 1997;

Regulations:

42 C.F.R. § 412.106;Special treatment: Hospitals that serve a disproportionate share of low-income patients

Federal Register Notices:

68 FR 27208 May 19, 2003;

68 FR 45422 August 1, 2003;

69 FR 49093 - 49099 August 11, 2004;

78 FR 27578 May 10, 2013;

78 FR 50614 - 50620 August 19, 2013;

Case Law:

*Allina Health Services. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014);

*Allina Health Services v. Burwell,* Civil Nos. 1:10-cv-01463, 1:12-cv-00328: CMS Administrator Remand Decision, December 1, 2015;

*Allina Health Services v. Price*, 863 F.3d 937, 939 (D.C. Cir. 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);

*Florida Health Sciences Center, Inc. v. Becerra*, No. CV 19-3487 (RC), 2021 WL 2823104 (D.D.C. July 7, 2021);

V. EXHIBITS

C-1. Final Schedule of Providers

C-2. 68 FR 27208 (May 19, 2003)

C-3. 69 FR 49091-49099 (August 11, 2004)

C-4. *Allina Health Services v. Burwell*, Civil Nos. 1:10-cv-01463, 1:12-cv-00328: CMS Administrator Remand Decision, December 1, 2015

C-5. 78 FR 27486, 27577-27578 (May 10, 2013)

C-6. 78 FR 50614-50620 (August 19, 2013)

C-7. Florida Health Sciences Center, Inc. v. Becerra, No. CV 19-3487 (RC), 2021 WL 2823104 (D.D.C. July 7, 2021)

1. The MAC notes that references to *Allina* have no relevance to this case because *Allina* was only applicable to FFY’s 2004-2013. [↑](#footnote-ref-1)
2. The Plaintiffs in *Florida Health Sciences Center* appealed to the United States Court of Appeals for the District of Columbia Circuit on September 3, 2021, where the case remains pending. [↑](#footnote-ref-2)