PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2011-D37

PROVIDERS –
Partners 2002 – 2004 DSH
Medicare+Choice Groups
See Appendix

Provider Nos.: See Appendix

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
NHIC Corp., c/o National Government
Services, Inc.

DATE OF HEARING –
April 7, 2011

Cost Reporting Periods Ended:
September 30, 2002; September 30, 2003;
and September 30, 2004

CASE NOs.: 06-0867GC; 08-2122GC;
and 08-1592GC

INDEX

ISSUE:

Should patient days attributable to Medicare beneficiaries who elected to enroll in a Medicare+Choice (M+C) plan be included in the numerator of the Medicaid fraction that was used to calculate each of the Providers' Disproportionate Share Hospital (DSH) payments under Section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)), and 42 C.F.R. § 412.106 for the cost reporting periods at issue?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due providers of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. *See* 42 U.S.C. §§ 1395 *et seq*. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FIs) or Medicare administrative contractors (MACs). FIs and MACs[1] determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. *See* 42 U.S.C. § 1395h and §1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show costs incurred during the fiscal year and the portion of those costs allocated to Medicare. 42 C.F.R. § 413.20. The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 - 405.1837.

Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (PPS). *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412. Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. *Id.*

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients. *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

[1] FIs and MACs are hereinafter referred to as intermediaries.

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (DPP). *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l). As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital. *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

The DPP is defined as the sum of two fractions expressed as percentages. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi). Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute defines the Medicare/SSI fraction as:

> the 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 this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, 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 this subchapter …

42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added). The Medicare/SSI fraction is computed annually by CMS, and the intermediaries use CMS' calculation to compute a hospital's DSH payment adjustment. 42 C.F.R. § 412.106(b)(2)-(3).

The statute defines the Medicaid fraction as:

> the 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 plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, 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) (emphasis added). The intermediary determines 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. 42 C.F.R. § 412.l06(b)(4).

Medicare+Choice Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations (HMOs) and competitive medical plans (CMPs) is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for

individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter …" Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In 1997, Congress amended the Medicare statute by adding a new part C for Medicare beneficiaries enrolled in managed care organizations after 1999. *See* Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, §4001, 111 Stat. 251, 270 (codified at 42 U.S.C. § 1395w-21). Part C governs the Medicare+Choice (M+C) program. This statute provides that a Medicare beneficiary may elect to receive Medicare benefits through one of two means:

> Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this subchapter –
>
> (A) through the original [M]edicare fee-for-service program under parts A and B of this subchapter, or
>
> (B) through enrollment in a Medicare+Choice plan under this part…

42 U.S.C. § 1395w-21(a)(1) (emphasis added); *see also* 42 C.F.R. § 422.50; 63 Fed. Reg. 34968 (June 26, 1998). A "Medicare+Choice eligible individual" means an individual who is entitled to benefits under part A and enrolled under part B of the Medicare statute. 42 U.S.C. § 1395w-21(a)(3)(A).

Once a beneficiary elects to enroll in an M+C plan, however, the beneficiary receives Medicare benefits under part C and the Secretary makes payment to the contracted M+C plan. *See* 42 U.S.C. § 1395w-21(a)(1)(B), (i). Subject to certain exceptions that are not pertinent here, the statute requires the Secretary to make payments to the M+C plan under part C "instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B [of the Medicare statute] for items and services furnished to the individual" and provides that "only the Medicare+Choice organization shall be entitled to receive payments from the Secretary under this subchapter for services furnished to the individual." 42 U.S.C. § 1395w-21(i)(l)-(2) (emphasis added).

More recently, the Medicare Modernization Act of 2003 (MMA) (P.L. No. 108-173) established the Medicare Advantage (MA) program as part C of Title XVIII of the Act replacing the M+C program. This change is effective for cost reporting periods subsequent to September 30, 2004.

CMS Policy for Managed Care Days in DSH Calculation

In 1990, CMS published a statement in the Federal Register indicating that Medicare HMO days had been counted in the Medicare Fraction. 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990). It states in relevant part:

> *Comment:* One commenter believes that the disproportionate share adjustment calculation should be expanded to include days that Medicare patients utilize

> health maintenance organizations (HMOs) since these beneficiaries are entitled to Part A benefits.
>
> *Response:* Based on the language of section 1886(d)(5)(F)(vi) of the Act, which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A", we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs and, therefore, were unable to fold this number into the calculation. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time, we have been including HMO days in SSI/Medicare percentage.

Id.

CMS did not publish any further guidance regarding Medicare managed care days until it addressed the treatment of M+C patient days in the DSH calculation in 2003 and 2004. In proposed regulations, 68 Fed. Reg. 27154, 27208 (May 19, 2003), CMS indicated that M+C days should not be counted in the Medicare fraction. CMS also proposed to permit hospitals to count these days in the numerator of the Medicaid fraction when an M+C enrollee is also eligible for Medicaid. It stated in relevant part:

> 8. Medicare+Choice (M+C) Days
>
> Under § 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 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 § 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 [sic] days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.

Id.

In 2004, however, CMS reconsidered its position and decided to count M+C days in the Medicare fraction. 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004). It stated in relevant part:

> 4. Medicare+Choice (M+C) Days
>
> 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.

Id.

In the instant case, the parties dispute where the M+C days should be counted in the DSH calculation.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case involves three (3) Common Issue Related Party (CIRP) group appeals, collectively known as the Partners 2002 – 2004 DSH Medicare+Choice Days Groups (Providers).[2] The Providers are members of the Partners Healthcare System, which is an integrated healthcare system of hospitals, community health centers, and other health-related entities located in the Boston, Massachusetts area. NHIC Corp., c/o National Government Services, Inc. (Intermediary) is the fiscal intermediary for the Providers within the Partners Healthcare System and is the lead intermediary for each of the three consolidated groups.

The Providers and Intermediary stipulated to the following pertinent facts concerning the procedural history of this case:[3]

1. This appeal involves three (3) different Providers and cost reporting periods 2002 through 2004. Two hospitals (The General Hospital and Brigham & Women's Hospital) have appeals for all three cost reporting periods; North Shore Medical Center is in the appeal for 2004 only.

2. Each of the Providers in these group appeals is an acute care facility in the Commonwealth of Massachusetts that received payments under Medicare part A for

[2] Although the consolidation correspondence and parties' position papers reference four group appeals, Case No. 08-1889, applicable to fiscal year 2001, was withdrawn by the Provider by letter dated September 10, 2010, and closed by the Board on September 16, 2010.
[3] *See* Stipulations dated December 17, 2010.

services provided to Medicare beneficiaries for the cost reporting periods at issue. Each Provider is reimbursed by Medicare under the [Inpatient Prospective Payment System] IPPS as a short-term acute hospital

3. There are no jurisdictional issues.

4. The issue presented in these appeals is:

> Should patient days attributable to Medicare beneficiaries who elected to enroll in a Medicare+Choice ("M+C") plan be included in the numerator of the Medicaid fraction that was used to calculate each of the Providers' Disproportionate Share Hospital ("DSH") payments under Section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)), and 42 C.F.R. § 412.106 for the cost reporting periods at issue?

5. Each of the Providers in these group appeals qualified for the Medicare DSH payment adjustment for each of the cost reporting periods for which they are included in the group appeal.

6. The patient days of the dual-eligible patients at issue were, for all cost reporting years, excluded from the numerator of the Medicaid DSH fraction as part of the final audit adjustment of Medicaid-eligible days for the Providers.

The Providers have appealed the exclusion of the M+C patient days to the Board and met the jurisdictional requirements of 42 U.S.C. § 1395oo(a). The Providers were represented by Gary A. Rosenberg, Esq., and Edward D. Kalman, Esq., of Behar & Kalman, LLP. The Intermediary was represented by Arthur E. Peabody, Jr., Esq. of Blue Cross Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers contend that patients who are enrolled in an M+C plan under Medicare part C are not "entitled to benefits under part A," for purposes of the DSH payment calculation. Therefore the exclusion of the M+C days from the numerator of the Providers' Medicaid fractions is incorrect and must be reversed.

First, the Providers contend that the Intermediary's exclusion of the M+C days at issue is contrary to the plain meaning of the DSH statute. The Providers state that CMS and the Intermediary erroneously used the terms "eligible" and "entitled" interchangeably by construing the DSH statute to mean that M+C beneficiaries remain entitled to Medicare part A simply by meeting the eligibility criteria for enrolling in Medicare part A. However, the Providers take the position that for the periods under appeal, a beneficiary could elect to receive Medicare benefits either through the original fee-for-service program under Medicare parts A and B, or through enrollment in an M+C plan under part C. 42 U.S.C. § 1395w-21(a)(1); 42 C.F.R. § 422.50. Once the individual elected to enroll under part C, he or she is no longer entitled to have payment made on his or her behalf under Medicare part A; instead payment is made under part C. 42 U.S.C. § 1395w-21(i)(1).

Second, the Providers contend that CMS has changed its interpretation of the statute. In its proposed IPPS rule for fiscal year (FY) 2004, CMS agreed with the Providers' analysis by stating that M+C days should not be included within the Medicare fraction and should be included in the Medicaid fraction. 68 Fed. Reg. 27154, 27208 (May 19, 2003). This proposal was not acted on by CMS in its final IPPS rule for FY 2004, but in its final IPPS rule for fiscal year 2005, CMS reversed the previous interpretation and explicitly stated that it was adopting a prospective policy to include M+C days in the Medicare fraction. 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004). The Providers argue that CMS' current policy is contrary to Medicare statutes and regulations that were in effect for the cost reporting periods at issue, and further, may not be retroactively applied to the periods prior to the October 1, 2004 effective date.

Finally, the Providers contend that two recent United States District Court rulings provide useful guidance. The district court in *Northeast Hosp. Corp. v. Sebelius*, held that:

> Congress, then, explicitly concluded that M+C patients are not "entitled to benefits under [Medicare] part A" as that phrase is defined in the Medicaid statute. Hence, the Secretary erred by excluding patient days attributable to such individuals from the numerator of the Hospital's Medicaid fraction.

699 F.Supp.2d 81, 93 (D.D.C. 2010).

The Providers point out that the court also held that, even if the statute had been ambiguous, "the Secretary's conclusion that M+C patients remain 'entitled to benefits under [Medicare] part A' directly conflicts with her interpretation of identical language elsewhere in the Medicare statute." *Id*. at 93. The Secretary has interpreted this phrase, for purposes of 42 U.S.C. § 1395ww(d)(5)(G), to mean that an individual's entitlement to benefits under part A ceases when the individual has exhausted his or her right to have payments made under part A. *See* 55 Fed. Reg. 35990, 35996 (Sept. 4, 1990) ("Entitlement to payment under part A ceases after the beneficiary has used 90 days in a benefit period and has either exhausted the lifetime reserve days or elected not to use available lifetime reserve days."). Therefore, "[w]ere the Secretary's prior interpretation applied to the Medicare DSH provision at issue here, the Hospital's M+C patient days would be included in the numerator of the Medicaid fraction, as such patients are 'no longer entitled to payment under [Medicare] part A.' " *Northeast*, 699 F.Supp.2d 94.

The Providers note that the district court's holding in *Metropolitan Hosp., Inc. v. U.S. Dept. of Health and Human Services*, 702 F.Supp.2d 808, 824-825 (W.D. Mich. 2010) further supports the conclusion that a beneficiary is "entitled to" part A benefits only if payments may be made on behalf of the individual for inpatient care. The Providers argue that the same definition should be used here, and accordingly, patients who have elected an M+C plan are not entitled to Medicare part A because they no longer have a right to payment from Medicare part A for the hospital stay.

INTERMEDIARY'S CONTENTIONS:

The Intermediary notes that the Board has ruled in favor of the Intermediary and CMS' position to exclude M+C days from the Medicaid fraction, finding that such days should be included in the Medicare fraction of the DSH calculation. *See e.g., St. Joseph's Hospital v. BlueCross BlueShield Association*, 2007 WL 3341630; *Beverly Hospital v. BlueCross BlueShield Association*, 2008 WL 7256679; and *SRI 1998 DSH Medicare Part C Days Group v. BlueCross BlueShield Association, 2009 WL 3231754*. The CMS Administrator has consistently upheld the Board. *See e.g., St. Joseph's Hospital v. BlueCross BlueShield Association*, 2007 WL 4861952; *Beverly Hospital v. BlueCross BlueShield Association*, 2008 WL 6468518[4]; and *SRI 1998 DSH Medicare Part C Days Group v. BlueCross BlueShield Association, 2009 WL 4522056*.

The Intermediary contends CMS policy has consistently dictated that Medicare managed care days are to be included in the Medicare fraction, and not in the Medicaid fraction. *See* 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990). With respect to M+C beneficiaries, CMS considered including these days in the Medicaid fraction, but following debate, CMS determined that the Medicare fraction should remain the proper placement for such days. In the August 11, 2004 Final Rule, CMS indicated that even though Medicare beneficiaries may elect Medicare part C coverage, they are still, in some sense, entitled to benefits under Medicare part A and should be included in the Medicare fraction of the DSH calculation. *See* 63 Fed Red. 48916, 49099 (Aug. 11, 2004).

The Intermediary contends that excluding M+C days from the Medicaid fraction is consistent with the statutory and regulatory scheme. The Intermediary states that an M+C enrollee is, by definition, entitled to benefits under Medicare part A. 42 U.S.C. § 1395w-21(a)(3)(A) ("In 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."). The Medicare statute also provides for automatic entitlement to Medicare part A benefits for "[e]very individual who … has attained the age of 65, and is entitled to monthly insurance benefits [i.e., monthly Social Security benefits] under section 402 of this title." 42 U.S.C. § 426(a). Therefore, based on a plain reading of the applicable statutory provision, the statutory phrase in the Medicaid proxy "but who were not entitled to benefits under Medicare part A" forecloses the inclusion of the days at issue in the numerator of the Medicaid proxy.

The Intermediary also argues that there is nothing in the statute to suggest that whether Medicare directly pays for a day instead of purchasing coverage from an HMO affects entitlement to Medicare part A. Because an individual who is enrolled in a Medicare HMO for a particular period would still be over 65 and entitled to monthly Social Security benefits, that individual is still "entitled to" Medicare part A benefits under the statute. Further, the statute speaks solely in terms of entitlement of the beneficiary, not payment to the provider.

Finally, the Intermediary contends that *Northeast Hospital*'s reliance on inconsistent interpretations of "entitled to benefits pursuant to part A" is misplaced since it ignores the

[4] The federal district court reversed. *See Northeast Hosp. Corp. v. Sebelius*, 699 F.Supp.2d 81 (D.D.C. 2010) (finding that selection of part C by a beneficiary makes the beneficiary no longer eligible for Part A or traditional Medicare; therefore the day should be included in the numerator of the Medicaid fraction).

context of the commentary, i.e., the determination of whether a facility is a Medicare dependent hospital.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions and evidence presented, the Board finds and concludes that the M+C days should be included in the Medicaid fraction used to calculate the DSH adjustment.

Under the managed care statute 42 U.S.C. § 1395mm, as well as the Balanced Budget Act of 1997, 42 U.S.C. § 1395w-21, a beneficiary must first be entitled to benefits under Medicare part A to enroll in a Medicare managed care plan.[5] However, once enrolled in the plan, that beneficiary would no longer be entitled to benefits under parts A or B. The statute provides that an M+C eligible beneficiary can elect to receive benefits through the traditional fee-for-service program under parts A and B, or enroll in an M+C plan under part C. *See* 42 U.S.C. § 1395w-21(a)(1). Significantly, the Medicare statute uses the disjunctive "or," stating that once that election is made, the beneficiary is entitled to receive benefits under one or the other, but not both. Hence, if a beneficiary is enrolled in an M+C plan, that beneficiary is not entitled to benefits under Medicare part A.[6]

The intent of Congress is also clear when one reviews the statute at 42 U.S.C. § 1395w-21(i)(1) which states that payments under a contract with an M+C organization with respect to an individual electing an M+C plan shall be instead of the amounts which would otherwise be payable under parts A and B for services furnished to the individual. Similar to the election of benefits, the payments made under the M+C plan replace payments under parts A and B. Therefore, once enrolled in the M+C program, the beneficiary is not entitled to payments under Medicare part A.

The Board finds that the plain language of the Medicare DSH statute requires the inclusion of M+C days in the numerator of the Medicaid fraction. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Board agrees with the holdings of the two district courts that have recently addressed this precise issue, the meaning of the phrase, "entitled to benefits under part A," as used in the DSH statute. The courts in *Northeast Hospital* and *Metropolitan Hospital* have both held that, as used

[5] In prior decisions, the Board found the statutory language dispositive of the question because to enroll in a Medicare+Choice plan under part C, a beneficiary was first required to be "entitled" to Part A benefits. *See e.g. QRS 1994 DSH Managed Care and Medicaid Eligible Days Group v. Blue Cross Blue Shield Association/Noridian Administrative Services*, PRRB Dec. No 2009-D3, Dec. 17, 2008, *declined rev*. CMS Administrator, Feb 6, 2009. The Board is now convinced it stopped too short in its analysis of the statute. As the District Court in *Northeast Hospital* pointed out, the statute also expressly links "entitlement" to the right to receive payment and further provides that once a beneficiary elects a Medicare +Choice plan, payment is no longer made under part A, but is made under part C. 699 F.Supp.2d. at 81.

[6] In the August 2004 Final Rule, which was published after the fiscal year at issue in this case, CMS indicated that though Medicare beneficiaries may elect Medicare part C coverage, they are still, "in some sense" entitled to benefits under Medicare part A and should be included in the Medicare fraction. *See* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004). CMS did not articulate how, or in what sense beneficiaries might be covered by both parts A and C. However, the clear language of the statute cannot be overcome by commentary made by CMS in the preamble to a final rule or in its policy shifts.

in the context of the Medicare DSH statute, the term “entitled to benefits under part A” means the right to have payment made under part A for the inpatient hospital days in question. *See Northeast Hosp.*, 699 F.Supp.2d at 93; *Metropolitan Hosp.*, 702 F.Supp.2d at 823. The Board agrees with the Providers' argument and the district court's holding in *Northeast Hospital* that once an individual has enrolled in a Medicare+Choice plan under part C, he or she is no longer “entitled to benefits under part A,” because he or she is no longer entitled to have payment made under part A for the days at issue. *See Northeast Hosp.*, 699 F.Supp.2d at 93 (finding that Congress has "explicitly concluded that M+C patients are not 'entitled to benefits under [Medicare] part A' as that phrase is defined in the Medicaid [sic] statute").

The Board can discern no rational explanation for CMS' inconsistent interpretation of the term "entitled" as used in the same sentence within the DSH statute. On one hand, CMS states that SSI beneficiaries are "entitled to supplemental security income benefits" only when entitled to payment for the specific days at issue, while at the same time finding that any individual who is eligible for benefits under Medicare part A is also "entitled to benefits under part A," regardless of whether or not Medicare actually makes payment for the days at issue.

This same unexplained distinction is also evident in CMS’ treatment of part A days for determining a hospital’s payment for graduate medical education (GME). The M+C days that CMS insists are part A days for purposes of the DSH payment, are treated as *not* being part A days for purposes of the GME payment. The Board agrees with the Providers that Congress clearly manifested its intent in the GME statute that M+C patients should not be regarded as patients who are "entitled to benefits under part A." Otherwise, there would have been no need for Congress to establish additional GME and IME payments for patients enrolled in M+C plans.

Similarly, CMS' current interpretation of "entitled to benefits under part A," as used in the DSH statute under subparagraph (F) of section 1395ww(d)(5), conflicts with the agency's interpretation of the same phrase as used in the very next subparagraph (G) of the statute. Under subsection G, CMS interprets entitlement to cease once payment cannot be made on the beneficiary’s behalf. *See* 55 Fed. Reg. 35990, 35996 (Sept. 4, 1990).

The district court in *Northeast Hospital* found CMS' failure to acknowledge or explain its departure from established agency precedent to be arbitrary and capricious. *See* 699 F.Supp.2d at 94-95; *see also FCC v. Fox TV Stations, Inc.*, 129 S.Ct. 1800, 1811 (2009) (agencies "may not ... depart from a prior policy *sub silentio* or simply disregard rules that are still on the books"); *accord Dillmon v. Nat'l Trans. Safety Bd.*, 588 F.3d 1085, 1089 (D.C. Cir. 2009) ("Reasoned decision making, therefore, necessarily requires the agency to acknowledge and provide an adequate explanation for its departure from established precedent.").

The Board further finds that CMS' current interpretation of the DSH statute applied in these cases improperly conflates the statutory terms "entitled" and "eligible" as used in a single sentence within the DSH statute. CMS' current interpretation construes these terms to have the same meaning, violating the elementary principle of statutory construction that Congress does not intend the same meaning when it uses different terms in different parts of the same statute. *See, e.g., Russello* v. *United States*, 464 U.S. 16, 23 (1983). The Board agrees with the *Metropolitan Hospital* court's holding that the statutory terms "entitled" and "eligible" are

"conceptually and practically distinct and not to be used interchangeably." 702 F.Supp.2d at 825. The distinctions between these two terms and the impropriety of conflating them as having the same meaning has been established for over a decade. *See Jewish Hosp. Inc*., 19 F.3d at 274-75; *Cabell Huntington Hosp.,* 101 F.3d at 988 (4th Cir. 1996); *Legacy Emanuel Hosp. and Health Ctr.,* 97 F.3d at 1265-66 (9th Cir. 1996).

The Board finds that the exclusion of the M+C days at issue is contrary to the DSH regulation that was in effect during the periods at issue. The regulation in effect interpreted the statutory phrase "entitled to benefits under part A" to mean "covered" by Medicare part A, *see, e.g.*, 42 C.F.R. § 412.106(b)(2)(i) (1997), and the part A coverage regulations define "covered" to mean "services for which the law and regulations authorize Medicare payment." 42 C.F.R. § 409.3 (1997). This interpretation of the regulation is consistent with the Secretary's statements of intent at the time she adopted the DSH regulation in 1986, 51 Fed. Reg. 31454, 31460-61, in subsequent litigation before multiple federal courts of appeals, *see* Provider Ex. 37-39, and in the Administrator's 1996 decision in *Presbyterian Med. Ctr. of Philadelphia v. Aetna Life Ins. Co.*, CMS Administrator, November 29, 1996, Medicare and Medicaid Guide (CCH) ¶45,032, at 4. This is also consistent with CMS's calculation of the Medicare/SSI fraction for periods before the 2004 change in policy. *See* 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004).

The Board finds the evidence persuasive that CMS' actual practice was to not count the M+C days in the SSI fraction prior to 2004. *See* PRRB Decision 2010-D52, *Southwest Consulting DSH Medicare+Choice Days Groups v. BlueCross BlueShield Association,* September 30, 2010, at 14. When this is combined with CMS' numerous statements on not counting the days as part A days, the Board is further convinced that CMS did not have a long-standing policy of counting part C days as part A days for DSH purposes. The Board nevertheless concludes that CMS' conflicting interpretations, its motivation, and whether or not the Providers would benefit from a particular interpretation are not dispositive of the statutory construction question at the heart of this dispute. The Board finds that question to have been properly answered by the federal court cases discussed above.[7]

DECISION AND ORDER:

The Intermediary improperly excluded the Medicare+Choice days at issue from the numerator of the Medicaid fraction used to calculate the DSH payment. The Intermediary is directed to revise the Providers' DSH calculations for each cost reporting period under appeal.

[7] The Board also considered whether these cases are within the scope of the Secretary's Ruling No.: CMS-1498-R (April 28, 2010). That Ruling provides that certain categories of days must be recalculated for DSH under the policy set out in the Ruling and that the Board's jurisdiction to take any further action on the case is suspended except for remanding the case. Although the category of days in issue here may arguably be included as "non-covered" days, the Ruling does not explicitly include M+C or other managed care days in its directive of those to be remanded, and remand under the Ruling was not raised by the Intermediary in any of the proceedings.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, CPA
John Gary Bowers, CPA
Michael W. Harty

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: June 30, 2011

APPENDIX

List of Appeals and Providers

Partners 2002 DSH M+C Group, Case No. 06-0867G (FYE: 09/30/2002)

1. Brigham & Women's Hospital (Provider #22-0110)
2. The General Hospital Corporation
   d/b/a Massachusetts General Hospital (Provider #22-0071)

Partners 2003 DSH M+C Group, Case No. 08-2122G (FYE: 09/30/2003)

1. Brigham & Women's Hospital (Provider #22-0110)
2. The General Hospital Corporation
   d/b/a Massachusetts General Hospital (Provider #22-0071)

Partners 2004 DSH M+C Group, Case No. 08-1592G (FYE: 09/30/2004)

1. Brigham & Women's Hospital (Provider #22-0110)
2. The General Hospital Corporation
   d/b/a Massachusetts General Hospital (Provider #22-0071)
3. North Shore Medical Center (Provider #22-0035)