# CENTERS FOR MEDICARE AND MEDICAID SERVICES

## *Decision of the Administrator*

| **In the case of:** | **Claim for:** |
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| **SRI 1998 DSH Medicare Part C Days Group**<br>**Provider** | **Reimbursement Determination**<br>**Cost Reporting Periods ending:**<br>**Various** |
| **vs.** | |
| **Blue Cross Blue Shield Association/ Noridian Administrative Services** | **Review of:**<br>**PRRB Dec. No. 2009-D30**<br>**Dated: July 9, 2009** |
| **Intermediary** | |

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The Administrator notified the parties of the intent to review the Board's decision. The Centers for Medicare Management (CMM) submitted comments requesting that the Board's decision be upheld with clarification. Accordingly, this case is now before the Administrator for final agency review.

## ISSUE AND BOARD DECISION

The issue is whether the exclusion of patient days attributable to Medicare + Choice (M+C) enrollees from the Medicaid fraction in calculating the Providers' disproportionate patient percentage contravenes the statute and regulations.[1]

[1] The Providers submitted revised Exhibits P-8 and P-9 to exclude days for dates of service that pre-date the August 5, 1997 enactment of the Balanced Budget Act of 1997. *See* Provider's Post-Hearing Brief p.2, Revised Exhibits P-8 and P-9. The Providers further stated that they believed that these days were for M+C days but argued that if certain days were for patients that had not transitioned to the M+C Program, these were still individuals who derived their benefits under Part C or

The Board found that the Medicare fraction numerator consists of patient days for patients who were entitled to both Medicare Part A and SSI and the denominator is the number of patient days for patients entitled to Medicare Part A. Similarly, the Medicare + Choice statute provides that payments will be made to eligible organizations under this section for an individual entitled to benefits under Part A. Therefore a beneficiary can only receive benefits under M+C if entitled to benefits under Part A. The Board found that it was also clear that the M+C enrollees would be excluded from being counted in the Medicaid percentage by the explicit language in the DSH statute which limits inclusion in the Medicaid fraction to those eligible for medical assistance under a State plan under Title XIX and not entitled to benefits under Part A. The Board found that although CMS' own policy appeared to waiver over time and at times completely reverse, the clear language of the statute cannot be overcome. The Board concluded that the M+C patient days are properly excluded from the Medicaid fraction, but should be included in the Medicare fraction.

## COMMENTS

CMM stated that the Board properly found that the M+C days should not be included in the Medicaid fraction, but instead should be included in the Medicare fraction as such days are for individuals "entitled to benefits under Part A." However, CMM disagreed with the Board's characterization that such policy was established in 2004 and waivered over time and at times reversed completely. CMM pointed out that the policy has been to include M+C days (originally known as Medicare HMO days and currently referred to as Medicare Advantage days) in the Medicare fraction since 1987. In the September 4, 1990 Inpatient Prospective Payment System (IPPS) final rule CMS stated that based on the language of Section 1886(d)(5)(F)(vi) of the Act it was appropriate to include the days associated with Medicare patients who receive care at an HMO in the Medicare fraction. The CMS noted that, prior to December 1, 1987, the program was 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 in the Medicare provider analysis and review (MedPAR) file that allows CMS to isolate those HMO days that are associated with Medicare patients. Therefore, CMS was including HMO days in the SSI/Medicare percentage since 1987. CMM stated that the August 11, 2004 IPPS final rule merely reiterated and codified the policy to include M+C days in the Medicare fraction because the beneficiaries are in some sense "entitled to benefits under Medicare Part A" and, therefore, should be included in the Medicare fraction.

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Part D (not Part A or Part B.) For purposes of this case, the days at issue will be referred to as M+C days.

## DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

The Social Security Amendments of 1965[2] established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[3] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[4] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[5] Section 226 of the Social Security Amendments of 1972[6] added section 1876 to the Social Security Act to authorize Medicare payments to health maintenance organizations on a capitation basis. Prior to this legislation, Medicare reimbursement to HMOs for Part A and Part B services was not available on a capitation basis. Later in an effort to improve Medicare reimbursement methods for HMOs, Congress enacted section 114 of the Tax Equity & Fiscal Responsibility Act (TEFRA) of 1982, to provide for the inclusion of competitive medical plans.[7]

Concerned with increasing costs, Congress also enacted Title VI of the Social Security Amendments of 1983.[8] This provision added §1886(d) of the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[9]

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[2] Pub. Law No. 89-97.
[3] Section 1811-1821 of the Act.
[4] Section 1831-1848(j) of the Act.
[5] Under Medicare, Part A services are furnished by providers of services.
[6] Pub. Law No. 92-603.
[7] Pub. Law No. 97-248.
[8] Pub. Law No. 98-21.
[9] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimburse their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based on diagnosis related groups (DRG) subject to certain payment adjustments.

To be eligible for the DSH payment, an IPPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage. Relevant to this case, §1886(d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" and the "Medicaid low-income proxy", respectively, and are defined as follows:

> (I) 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 title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act and the denominator of which is the number of such hospital's patients day for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this title.
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> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patients days for such period which consists of patients who (for such days) were eligible for medical assistance under a State Plan approved under title XIX, but who were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital patients days for such period.

The Secretary implemented the provisions of the Act at 42 C.F.R. §412.106. The regulation explains the proxy method. The first computation, the "Medicare fraction" or "Clause I" set forth at 42 C.F.R. 412.106(b) (2) states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, [CMS]—
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> (i) Determines the number of covered patient days that—
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> (A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementations:

(ii) Adds the results for the whole period; and

(iii) Divides the number determined under paragraph (b) (2) (ii) of this section by the total number of patient days that—

(A) Are associated with discharges that occur during that period: and

(B) Are furnished to patients entitled to Medicare Part A.

In addition, the second computation, the "Medicaid fraction", or "Clause II", is set forth at 42 C.F.R. §412.106(b) (4) and provides that:

> Second computation. The fiscal intermediary determines, for the hospital's cost reporting period, the number of patient days furnished to patients entitled to Medicaid but not to Medicare Part A, and divides that number by the total number of patient days in the same period. (Emphasis added.)

The Secretary responded to commenters concerns regarding the treatment of Medicare HMO days in the calculation of the DSH patient percentage. In the September 4, 1990 IPPS final rule, the Secretary stated that:

> 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.
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> 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.[10]

[10] 55 Fed. Reg. 35990.

Section 4001 of the Balanced Budget Act (BBA) of 1997, established the M+C program known as Medicare + Choice by adding a new Part C to Title XVIII of the Act pursuant to §1851 through §1859.[11] As enacted by §4001 of the BBA of 1997, §1851 of the Act, 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. Because of various changes in the statutory basis for "HMO" payments, the Secretary again examined the proper method of treating these types of days for purposes of the DSH payment. In 2003, the Secretary proposed to specifically address the policy with respect to M+C days. In pertinent part, the Secretary stated that:

> We note that under §422.50, an individuals is eligible to elect an M+C plan if he or she is entitle to Medicare Part A and enrolled in Part B. However, once a beneficiary has elected to join an M+C plan, that beneficiary benefits are no longer administered under Part A.
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> 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.[12]

In August, 2003, CMS announced that it was still reviewing comments.[13] However, in August of 2004, CMS announced in a final rule, that M+C days would to be included in the Medicare fraction of the DSH calculation. The Secretary stated that:

> The final categories of patient days addressed in the proposed rule of May 19, 2003 were the dual-eligible patient days and the Medicare+Choice (M+C) days. We proposed in the rule that the days of patients who are dually-eligible, (that is, Medicare beneficiaries who are also eligible for Medicaid) and have exhausted their Medicare Part A coverage will not be included in the Medicare fraction. Instead, we proposed that these days should be included in

[11] The existing Part C of the statute, which included provisions in section 1876 of the Act governing existing Medicare HMO contracts, was redesignated as Part D.
[12] 68 Fed Reg. 27208 (May 19, 2003).
[13] 68 Fed Reg. 45422 (August 1, 2003).

the Medicaid fraction of the DSH calculation. 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.

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However, due to the large number of comments we received on our proposals for unoccupied beds, observation beds for patients ultimately admitted as inpatients, dual-eligible patient days, and M+C days, we decided to address the comments on these proposed policies in a separate final document. In this IPPS final rule, we are addressing those comments, as well as some additional comments that we received in response to the May 18, 2004 proposed rule, and finalizing the policies.

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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.
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> 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.
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> 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.[14]

Thus, the Medicare policy has always been to include HMO days in the Medicare fraction where captured by the MEDPAR data, and not to include these days in the Medicaid fraction. Upon the enactment of the M+C Program, the Secretary again examined the appropriateness of this policy with respect to the similar M+C program days and concluded that the days should not be included in the Medicaid fraction numerator.

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[14] 69 Fed Reg. 49098-49099 (August 11, 2004).

In this case, the Providers are seeking to add M+C days to the numerator of the Medicaid fraction for those Medicare beneficiaries that were also eligible for Medicaid.[15] The Board held that the M+C days should not be counted in the Medicaid fraction, but rather should be counted in the Medicare fraction. The Board concluded that a beneficiary can only be eligible for Part C if "entitled to benefits" under Part A. Therefore, since the Medicaid fraction's numerator excludes 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, M+C days cannot be included in the numerator of the Medicaid fraction.

Applying the relevant law and program policy to the foregoing facts, the Administrator agrees with the Board's determination that the M+C days are properly not included in the Medicaid fraction as CMS has consistently determined after an initial evaluation and later a reevaluation of the statutory basis for HMO type days, that the days should not be included in the Medicaid fraction numerator. The Administrator agrees with the Board's determination that a beneficiary can only be eligible for M+C if "entitled to benefits" under Part A. After reading the DSH statute and the implementing regulations, along with the M+C statute, the Administrator agrees that the M+C days are properly excluded from the Medicaid fraction. Based on the plain language of the statute the Administrator finds that the statutory phrase in the Medicaid proxy "but who were not entitled to benefits under Medicare Part A of this title" forecloses the inclusion of the days at issue in this case in the numerator of the Medicaid proxy. Thus, the Intermediary's calculation of the Providers' DSH adjustment was proper.[16]

With respect to the Board ruling that the days should be included in the Medicare fraction, the Administrator agrees that the policy provides for the inclusion of these types of days in the Medicare fraction. The record is not clear whether the

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[15] The Providers testified that the days at issue were already included in the denominator of the Medicaid fraction. See e.g, Transcript of Oral Hearing, pp. 25, 51. The Providers' Exhibits P-11, P-12 and P-13 do not show that, in calculating the effect of the days in the Medicaid fraction, the Provider excluded the days from the Medicare fraction. *See e.g.* Tr. at 84.

[16] Moreover, as the Providers are located in Arizona, which has a Medicaid program and a State only program, it is not clear that these days are for patients that are also eligible for Medicaid or whether these days include "State only" assistance patients. As the days cannot be included in the Medicaid fraction, the Administrator concludes that this issue need not be addressed at this time.

Providers continue to seek this alternative relief in the Medicare fraction[17] The Secretary restated the existing process for calculating the Medicare fraction in the FFY 2006 final IIPPS rule,[18] where the Secretary again stressed the role of the MedPAR data. The Secretary stated that:

> In order to determine the numerator of this fraction for each hospital, CMS obtains a data file from the Social Security Administration (SSA). CMS matches personally identifiable information from the SSI file against its Medicare Part A entitlement information for the fiscal year to determine the number of Medicare/SSI days for each hospital during each fiscal year. These data are maintained in the MedPAR Limited Data Set (LDS)…. The number of patient days furnished by the hospital to Medicare beneficiaries entitled to SSI is divided by the hospital's total number of Medicare days (the denominator of the Medicare fraction). CMS determines this number from Medicare claims data; hospitals also have this information in their records…… Under current regulations at §412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year.[19]

The Secretary noted that:

> The MedPAR LDS contains a summary of all services furnished to a Medicare beneficiary, from the time of admission through discharge, for a stay in an inpatient hospital or skilled nursing facility, or both; SSI eligibility information; and enrollment data on Medicare beneficiaries.[20]

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[17] While the Provider raised this as an alternative relief in its original briefs, the Provider did not restate this request in the Pos-Hearing Brief.

[18] 70 Fed. Reg. 47278 (Aug. 12, 2005)

[19] Id. at 47438-39.

[20] Id. at 47439. With respect to the use of the MedPAR data, the Secretary stated that: "We believe it is appropriate to continue to use the MedPAR for Medicare DSH calculations. Principally, as documented in the Federal Register, the MedPAR system has been the Medicare Part A data source for the Medicare DSH calculation since the implementation of the DSH adjustment….. The MedPAR system contains utilized days and the PS&R contains days paid to the provider by Medicare. The PS&R does not contain certain types of days that should be included in the denominator of the Medicare fraction, such as covered days that were paid by a Medicare managed care organization ( "MCO") *Id.* at 47440-41. The preamble's

For the cost years at issue, the MedPAR data was to include the Medicare HMO-type days and it is the MedPAR data which is used for the purpose of calculating the Medicare fraction. Further, the record does not otherwise demonstrate that the Medicare fraction should be modified to include these days. The Provider did not demonstrate that the days at issue are not already included in the Medicare fraction or that, if they were not already included in the Medicare fraction, it was due to error as the M+C claims had been timely processed.[21] Thus, the Administrator declines to rule that, in the alternative, the Medicare fraction should be modified.

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reference that the use of the MEDPAR ensures that the MCO days are included in the denominator is consistent with the scope of the preamble's response which was not addressing the specific issue of Medicare/SSI days for the dually eligible but rather the more general issue of Medicare Part A days in the Medicare fraction.

[21] The Provider testified that it had not identified or excluded the days that were already included in the Medicare fraction. *See, e.g.*, Tr. 84. The Provider also did not show that, even assuming *arguendo,* if the days had not initially been part of the Medicare fraction, the inclusion in the numerator and the denominator of the Medicare fraction would affect the numerator and denominator disproportionally and, thus, would actually result in an increase in the Medicare patient percentage and the DSH payment.

## DECISION

The Administrator modifies the Board's decision consistent with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 9/09/09

/s/
Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services