CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Exempla Lutheran Medical Center	**Reimbursement Determination for Cost Reporting Periods ending: 12/31/04**
Provider	
vs.	
Wisconsin Physician Services	**Review of: PRRB Dec. No. 2011-D32 Dated: June 3, 2011**
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 parties were notified of the Administrator's intention to review the Board's decision. The Provider commented, requesting that the Board's decision be affirmed. The Center for Medicare (CM) commented, requesting that the Administrator reverse the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUES AND BOARD DECISION

The issue as stated by the Board was whether the Intermediary properly disallowed the Provider's entire Medicare disproportionate share hospital (DSH) payment. The Board held that the Intermediary's sampling methodology and the exclusion of Medicare+Choice (M+C) days (prior to October 1, 2004) from the numerator of the Medicaid fraction used to calculate the DSH payment were improper.

First, with respect to the Intermediary's sampling methodology, the Board found that the use of the RAT-STATS program was acceptable if properly applied.

However, in this case the Board found several errors in its application. First, the Board found that the sample size selected by the Intermediary was too small. The Board found that sampling less than 30 patients in a stratum was contrary to CMS policy and inadequate to eliminate the entire DSH payment.

Second, the Board found no reasonable rational justification for all the stratifications of the sample. While the Board agreed with the stratification of patients who did not match to the State eligibility database and the 100 percent review of the patients with length of stays over 47 days, the Board did not see a relationship between allowable DSH days and length of stay. Therefore, the Board found the breakdown of two strata based on length of stays less than ten days and stays 10-47 days unnecessary. Finally, the Board found that the results of the sample did not support the Medicaid days eliminated in the audit adjustment. Thus, based on the sampling results, the Board concluded that there was no basis to disallow any patient day beyond the lesser of the upper confidence interval or the total population less those actually audited and determined to be non-allowable.

Next with respect to Medicaid Eligible M+C days, the Board noted that, under the managed care statue in § 1876 of the Social Security Act (Act), as well as, the Balance Budget Act of 1997 (BBA'97) (§1851 of the Act), a beneficiary must first be entitled to benefits under Medicare Part A to enroll in a Medicare managed care plan.[1] However, once enrolled in the plan, that beneficiary would no longer be entitled to benefits under Parts A or B. The Board found significant the statutory use of the disjunctive "or", noting that once that election is made, the beneficiary is entitled to benefits under one or the other, but not both. Hence, the Board claimed, if a beneficiary is enrolled in an M+C plan, that beneficiary is not entitled to benefits under Medicare Part A.

---

[1] The Board noted that in prior decisions, it had 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 Manage Care and Medicaid Eligible Days Group v. Blue Cross Blue shield Association/Noridian Administrative Services*, PRRB Dec. No. 2009-D3, Dec. 17, 2008, CMS Administrator declined to review, Feb. 6. 2009. However, the Board noted it was convinced it stopped too short in its analysis of statute, and that as the District court in *Northeast Hospital Corporation v. Sebelius*, 699 F.Supp.2d 81 (D.D.C. Mar. 29, 2010(, pointed out, the statute 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.

In addition, the Board noted that, in the August 2004 Inpatient Prospective Payment Systems (IPPS) Final Rule[2] CMS indicated that, although 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. CMS did not articulate how, or in what sense, beneficiaries might be covered by both Parts A and C, and that the clear language of the statute cannot be overcome by commentary made by CMS in the preamble to a final rule.

The Board stated that the intent of Congress was clear when one reviews the statute at § 1851(i)(1) of the Act, which states that payments under a contract with an M+C organization with respect to an individual electing an M+C plan shall be made instead of the amounts which would otherwise be payable under Parts A and B for services furnished to the individual. The Board found that, similar to the election of benefits, the payments made under the M+C plan replaced 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 found that the plain language of the Medicare DSH statute required the inclusion of M+C days in the numerator of the Medicaid fraction, and that it agreed with the holdings of two recent district court cases. The courts in *Northeast Hospital Corp. v. Sebelius*[3] and *Metropolitan Hospital, Inc. v. U.S. Dept. of Health and Human Services*[4] have both held that, as used 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 questions. The Board agreed with the Provider's argument and the district court's holding in *Northeast Hospital* that once an individual has enrolled in a M+C 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.

The Board noted that it could 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

---

[2] 69 Fed. Reg. 48,916, 49,099 (Aug. 11, 2004).

[3] *Northeast Hospital Corporation v. Sebelius*, 699 F.Supp.2d 81 (D.D.C. Mar. 29, 2010)(appeal pending).

[4] *Metropolitan Hospital, Inc. v. U.S. Dept. of Health and Human Services,* Case No. 1:09-cv-128 D.Mich. (Apr. 5, 2010) (Granting Plaintiff Hospital's Motion for Summary Judgment and Denying Defendant HHS's Motion for Summary Judgment); and (Nov. 4, 2010) (Judgment in Favor of Plaintiff)

A" regardless of whether or not Medicare actually makes payments for the days at issue. The Board stated that there was a similar unexplained distinction evident in CMS' treatment of Part A days for determining a hospital's payment for graduate medical education (GME). Finally, the Board noted, that CMS' current interpretation of "entitled to benefits under part A" as used in the DSH statute under subparagraph (F) of § 1886(d)(5) of the Act 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.

The Board also found that the exclusion of the M+C days contrary to the DSH regulation that was in effect during the periods at issue, stating that the regulation in effect interpreted the statutory phrase "entitled to benefits under part A" to mean "covered" by Medicare Part A. The Part A coverage regulations define "covered" to mean "services for which the law and regulations authorize Medicare payment."[5] The Board found that this was consistent with CMS' calculation of the Medicare/SSI fraction for periods before the 2004 change in policy.[6] The Board found the evidence persuasive that CMS' actual practice was not to count the M+C days in the SSI fraction prior to 2004, and that this combined with CMS' numerous statements on not counting the days as Part A days persuaded it that CMS did not have a long-standing policy of counting Part C days as Part A days for DSH purposes.

Thus, the Board found that the Intermediaries improperly excluded the M+C days from the numerator of the Medicaid fraction used to calculate the DSH payment, and ordered the Intermediaries to revise the Provider's DSH calculations for each cost reporting period under appeal.[7]

COMMENTS

The CM commented, requesting that the Administrator reverse the Board's decision to include Medicare Part C days in the Medicaid fraction of the DSH calculation. The CM noted that the Board's interpretation of statutory language that suggests that beneficiaries are entitled to either Part A or Part C misconstrues the plain language of the statute. CM stated that the statute explicitly establishes

---

[5] 42 C.F.R. § 409.3.

[6] 69 Fed. Reg. 48,916, 49,098 (Aug. 11, 2004).

[7] The Board also considered whether the case was within the scope of the Secretary's Ruling No.: CMS-1498-R (April 28, 2010), but determined that although the category of days in issue may arguably be included as "non-covered" days, the Ruling did not explicitly include M+C or other managed care days in its directive of those to be remanded.

that entitlement to Part A benefits is a prerequisite for enrollment in a Part C plan, but that under the Board's circular reasoning, beneficiaries enrolled in a Part C plan are not entitled to Part A benefits and therefore would not be eligible to enroll in a Part C plan under the statute.

The CM noted that it is longstanding Medicare policy to include in the DSH adjustment days those Medicare patients that utilize health maintenance organizations (HMOs) since these beneficiaries are entitled to Part A benefits. The CM referred to both the FFY 1991 Final IPPS Rule and the FFY 2005 Final IPPS Rule for support of its position. The CM stated that this position is based on Congress' understanding of "entitled to benefits under Part A". The CM also noted that the statutory framework establishing Part C plans contemplates that enrollment in a Part C plan is effective for a period of one calendar year, at which point a beneficiary must reenroll in a Part C plan or return to their Part A benefits.[8] The CM argued that the Board's reasoning inaccurately suggests that Part C enrollees are no longer entitled to return to their benefits under Part A. They also argued that the Board's interpretation conflicts with Congress' understanding of "entitled to benefits under Part A", citing as examples 42 U.S.C. § 1395b, which defines a category of beneficiaries entitled to Part A benefits but not enrolled in Part C. This language would be a redundant statement under the Board's interpretation. In addition, 42 U.S.C. § 1395(a)(8)(B)(i), creates benefits for beneficiaries entitled to benefits under Part A but for whom Part A does not make payment, suggesting that "entitled" to benefits under Part A does not require payment by Part A.

Finally, the CM noted that, under the current regulations, both Medicare exhausted benefit days and Medicare Secondary Payor (MSP) days are included in the Medicare fraction (42 C.F.R. § 412.106(b)(2)), and that such days have never been counted in the Medicaid fraction under the Medicare DSH regulations. The Administrator has previously ruled that these two categories of days cannot be included in the Medicaid fraction.

The Provider commented, requesting that the Administrator affirm the Board's decision for all the reasons stated in the Board's decision and in the Provider's post hearing brief, which is incorporated by reference herein. First, the Provider contended that the disallowance was based upon an extrapolated error rate from a sample which was derived from a judgmental sample, not a statistically valid random sample. Next, the Provider argued that the sampling error rate was derived from and inflated by an irrational stratification of the Provider's Medicaid patient population. Had the Intermediary not stratified its review and simply applied a single error rate from its revised sample, and added the 337 Medicaid days supported by Ernst & Young's audit that were not initially identified by the

[8] *See* 42 U.S.C. § 1395w-21(e).

Provider, the resulting number of days would have exceeded the number necessary for the Provider to qualify for the DSH payment. Finally, the Provider argued that even if the Intermediary's sampling methods are consistent with Medicare law and CMS policy, the disallowance must be overturned because nearly all of the sampled days disallowed by the Intermediary are attributable to patients who were eligible for Medicaid and were receiving Medicare benefits under Part C though enrollment in the M+C plan. The Intermediary's decision to exclude days attributable to these patients from the numerator of the Provider's Medicaid fraction is unlawful and contrary to the DSH statute.

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.

Relevant to the issue involved in this case, two Federal programs, Medicaid and Medicare involve the provision of health care services to certain distinct patient populations. The Medicaid program is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children.[9] The program is jointly financed by the Federal and State governments and administered by the States according to Federal guidelines. Medicaid, under Title XIX of the Social Security Act, establishes two eligibility groups for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.[10] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC)[11] and Supplemental Security Income or SSI.[12] Participating States may elect to provide for payments of medical services to those aged blind or disabled individuals known as "medically needy" whose incomes or resources, while exceeding the financial eligibility requirements for the categorically needy (such as an SSI recipient) are insufficient to pay for necessary medical care.[13]

In order to participate in the Medicaid program, a State must submit a plan for medical assistance to CMS for approval. The State plan must specify, *inter alia*, the categories of individuals who will receive medical assistance under the plan and

---

[9] Section 1901 of the Social Security Act (Pub. Law 89-97).
[10] Section 1902(a)(10) of the Act.
[11] 42 U.S.C. § 601 *et seq.*
[12] 42 U.S.C. § 1381, *et seq.*
[13] Section 1902(a)(1)(C)(i) of the Act.

the specific kinds of medical care and services that will be covered.[14] If the State plan is approved by CMS, under § 1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.

Within broad Federal rules, States enjoy a measure of flexibility to determine "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.[15] However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for "medical assistance" under the State plan.

In particular, § 1901 of the Social Security Act sets forth that appropriations under that title are "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services…." Section 1902 sets forth the criteria for State plan approval.[16] As part of a State plan, § 1902(a)(13)(A)(iv) requires that a State plan provide for a public process for determination of payment under the plan for, *inter alia*, hospital services which in the case of hospitals, take into account (in a manner consistent with § 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs. Notably, § 1905(a) states that for purposes of this title "the term 'medical assistance' means the payment of part or all of the costs" of the certain specified "care and medical services" and the identification of the individuals for whom such payment may be made.

Section 1923 of the Act implements the requirements that a State plan under Title XIX provides for an adjustment in payment for inpatient hospital services furnished by a disproportionate share hospital. A hospital may be deemed to be a Medicaid disproportionate share hospital pursuant to § 1923(b)(1)(A), which addresses a hospital's Medicaid inpatient utilization rate, or under paragraph (B), which addresses a hospital's low-income utilization rate. The latter criterion relies, *inter*

---

[14] *Id.* § 1902 *et seq.*, of the Act.

[15] *Id.*

[16] 42 C.F.R. § 200.203 defines a State plan as "a comprehensive written commitment by a Medicaid agency submitted under section 1902(a) of the Act to administer or supervise the administration of a Medicaid plan in accordance with Federal requirement."

alia, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.[17]

While Title XIX implemented medical assistance pursuant to a cooperative program with the States for certain low-income individuals, the Social Security Amendments of 1965[18] 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 payment reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[19] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[20] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[21] Section 226 of the Social Security Amendments of 1972[22] 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 payment 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.[23]

Concerned with increasing costs, Congress also enacted Title VI of the Social Security Amendments of 1983.[24] 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

---

[17] Congress has revisited the Medicaid DSH provision several times since its establishment. In 1993, Congress enacted further limits on DSH payments pursuant to section 13621 of Pub. Law 103-66 that took into consideration costs incurred for furnishing hospital services by the hospital to individuals who are either eligible for medical assistance under the State plan or have no health insurance (or other source of third part coverage for services provided during the year). The Medicaid DSH payments may not exceed the hospital's Medicaid shortfall; that is, the amount by which the costs of treating Medicaid patients exceeds hospital Medicaid payments plus the cost of treating the uninsured.

[18] Pub. L. No. 89-97.

[19] Section 1811-1821 of the Act.

[20] Section 1831-1848(j) of the Act.

[21] Under Medicare, Part A services are furnished by providers of services.

[22] Pub. L. No. 92-603.

[23] Pub. L. No. 97-248.

[24] Pub. L. No. 98-21.

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.[25]

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.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to § 1886(d) (5) (F) (i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…."[26] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[27] 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" or Medicaid/SSI fraction, and the "Medicaid low-income proxy" or Medicaid fraction, 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.

---

[25] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

[26] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). *See also* 51 Fed. Reg. 16,772, 16,773-16,776 (1986).

[27] The Pickle method is set forth at section 1886(d) (F) (i) (II) of the Act.

> (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 regulation at 42 C.F.R. § 412.106 explains the proxy method. The first computation, the Medicare/SSI fraction set forth at 42 C.F.R. § 412.106(b)(2)[28] 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]—
> (i) Determines the number of covered patient days that—
> (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, 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.

[28] This is the language used in the regulation in effect for the cost periods at issue. The regulation now specifically includes Medicare Advantage (Part C) patients. *See* 75 Fed. Reg. 50.042, 50,285 (Aug. 16, 2010).

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.
>
> 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.[29]

Section 4001 of the Balanced Budget Act (BBA) of 1997, established the M+C program known as Medicare + Choice[30] by adding a new Part C to Title XVIII of the Act pursuant to § 1851 through § 1859.[31] 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

---

[29] 55 Fed. Reg. 35,990.

[30] Now Medicare Advantage (MA). The MA program replaced the Medicare+Choice (M+C) program, while retaining most key features of the M+C program. The MA program was enacted in Title II of The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) on December 8, 2003. *See* 69 Fed. Reg. 46,866 (Aug. 3, 2004) and 70 Fed. Reg. 4,194 (Jan. 28, 2005).

[31] 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. *See* 63 Fed. Reg. 34,968 (June 26, 1998). Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) amended Title XVIII of the Social Security Act by establishing a new Part D: the Voluntary Prescription Drug Benefit Program. *See* 70 Fed. Reg. 4,194 (Jan. 28, 2005).

plan, an individual must be entitled to benefits under Medicare Part A. Section 1851 of the Act notes, in pertinent part:

> (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICARE+CHOICE PLANS.—
>
> (1) IN GENERAL.—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 title—
>
> (A) through the original medicare fee–for–service program under parts A and B, or
>
> (B) through enrollment in a Medicare+Choice plan under this part, and may elect qualified prescription drug coverage in accordance with section 1860D-1.
>
> ****
>
> (3) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—
>
> (A) In general.—In this title, subject to subparagraph (B), **the term Medicare+Choice eligible individual means an individual who is entitled to benefits under part A** and enrolled under part B.
>
> ****
>
> (i) EFFECT OF ELECTION OF MEDICARE+CHOICE PLAN OPTION.—
>
> (1) PAYMENTS TO ORGANIZATIONS.—Subject to sections 1852(a)(5), 1853(a)(4), 1853(g), 1853(h), 1886(d)(11), and 1886(h)(3)(D), **payments** under a contract with a Medicare+Choice organization under section 1853(a) with respect to an individual electing a Medicare+Choice plan offered by the organization **shall be instead of the amounts which** (in the absence of the contract) **would otherwise be payable under parts A and B** for items and services furnished to the individual.
>
> (2) ONLY ORGANIZATION ENTITLED TO PAYMENT.—Subject to sections 1853(a)(4), 1853(e), 1853(g), 1853(h), 1857(f)(2), 1858(h), 1886(d)(11), and 1886(h)(3)(D), only the Medicare+Choice organization shall be entitled to receive payments from the Secretary

> under this title for services furnished to the individual. (Emphasis added).

In 2003, the Secretary proposed to specifically address the proper method of treating M+C days for purposes of the DSH calculation. In pertinent part, the Secretary stated that:

> 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.[32]

In August, 2003, CMS announced that it was still reviewing comments.[33] However, in August of 2004, CMS announced in a final rule, that M+C days would to be included in the Medicare/SSI 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…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.
>
> ****

[32] 68 Fed Reg. 27,154, 27,208 (May 19, 2003).
[33] 68 Fed Reg. 45,346, 45,422 (Aug. 1, 2003).

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.

****

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.[34]

Thus, the Medicare policy has always been to include HMO days in the Medicare/SSI 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 and concluded that the days should not be included in the Medicaid fraction numerator, but instead similar to the treatment of HMO days, should be included in the Medicare/SSI fraction.

In this case, the Provider wants to include M+C days in the numerator of the Medicaid fraction for those Medicare beneficiaries that were also eligible for Medicaid. The Administrator finds that the M+C days should not be counted in the Medicaid fraction, but rather, as noted above, should be counted in the Medicare fraction. By statute, a beneficiary can only be eligible for M+C if "entitled to benefits" under Part A. As the Secretary previously has noted:

> Section 226 of the Act provides that an individual is automatically 'entitled' to Medicare Part A when the person reaches age 65 and is

[34] 69 Fed Reg. 48,916, 49,098-99 (Aug. 11, 2004).

> entitled to Social Security benefits under section 202 of the Act, or becomes disabled and has been entitled to disability benefits under section 223 of the Act for 24 calendar months…Once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. **Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual.** (Emphasis added.) [35]

Thus, one does not stop being "entitled to benefits" under Part A simply because the Medicare beneficiary "elect[s] to receive benefits…through enrollment in a Medicare+Choice plan"[36]. Indeed, a beneficiary is still "entitled to" Medicare Part A benefits even if Medicare does not pay for a patient day at all.[37]

The Provider and Board fail to distinguish between being "entitled to benefits", and being entitled to elect to have *payment made* for those benefits, through enrollment in a M+C plan, rather than through the original fee-for-service program under parts A and B.[38] While beneficiaries, by reason of "elect[ing] to receive benefits…through enrollment in" a M+C plan, may not be entitled to have *payment made* by Part A for services, they do not lose their entitlement to Part A benefits, and thus should be included in the Medicare fraction. Based on the plain language of the DSH statute[39] the Administrator finds that the statutory phrase in the

---

[35] 75 Fed. Reg. 50,041, 50,280-81 (Aug. 16, 2010).

[36] Section 1851(a)(1) of the Act.

[37] *See, Cf. Legacy Emanuel Hosp. & Health Ctr. v. Shalala*,97 F.3d 1261, 1266 (9th9th Cir. 1996) (concluding that, with respect to calculation of the Medicaid DSH adjustment, "[p]atients meeting the statutory requirement for Medicaid do not cease to be low-income patients on days that the state does not pay Medicaid inpatient hospital benefits.").

[38] While the Medicare program does not pay hospitals directly for services provided to patients enrolled in M+C plans, the Part C payment is made from funds from the Medicare Part A trust fund. *See* § 1853(f) of the Social Security Act. Moreover, where the scope of benefits under Part A expands beyond certain costs thresholds, payment will be made directly from Medicare Part A. *See* § 1851(i)(1) of the Act. *See also* § 1853(h)(2) regarding payment for hospice care, which is paid by the Secretary.

[39] *See* 75 Fed. Reg. 50,041, 50,286 (Aug. 16, 2010), which states, "In the statutory section which sets forth the Medicare DSH fraction, the phrase 'entitled to benefits under [P]art A' refers to individuals who are entitled to Part A benefits under Part A pursuant to section 226, section 226A, section 1818, or section 1818A (42 U.S.C.

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.

In this case, the majority of the days disallowed were associated with M+C patients. The record shows that the Intermediary used a stratified sampling plan in which the universe was divided into multiple, non-overlapping categories (strata) and selected patient files (i.e., entire stays), as the sampling unit. The Intermediary used the RAT-STATS variable appraisal module to determine the sample sized sufficient to obtain 20 percent precision at a 90 percent confidence level, and to generate the random number for selecting the specific sample. The Provider argued that the Intermediary's disallowance of the DSH payment for the fiscal period in dispute should be reversed because the Intermediary's disallowance is derived from a judgmental sample, which is not a statistically valid random sample.

The Administrator does not agree. The Administrator finds that the judgment of the auditor to stratify and extrapolate the finding to the population is acceptable. The audit instructions for conducting audits of Medicare cost reports are found in CMS Pub 100-6, chapter 8. This chapter provides general instructions on sampling techniques and the application of audit findings. Specifically § 60.6 states "If the results of testing your sample that was selected using a statistical method indicate probable errors in the universe, document your decision to project the error to the universe/population."[40] The record shows that the Intermediary used a statistical sampling software program developed by the OIG (RATSTATS). This program identifies sample sizes for each stratum used by the Intermediary and generated random samples selections from each respective stratum. From these samples, the Intermediary found errors in certain stratums. The Intermediary computed an error rate for each stratum and projected that error rate to its stratum. Base upon the sampled population the sample size was verified to be sufficient. The

---

426, 42 U.S.C. 426–1, 42 U.S.C. 1395i–2, or 42 U.S.C. 1395i– 2(a), respectively). We note that the statute uses mandatory language, unambiguously stating that qualifying individuals 'shall be entitled to benefits under [P]art A.' Patients who have…enrolled in Medicare Advantage still meet the statutory criteria for entitlement to Medicare Part A benefits, even though Medicare Part A does not directly pay for a particular inpatient day…With respect to the days of patients enrolled in Medicare Advantage plans, we believe that the sections of the Social Security Act which create Part C clearly demonstrate that Part C enrollees remain entitled to Medicare Part A benefits, and we do not believe that Congress intended to alter the calculation of the DSH payment adjustment when it enacted Medicare Part C."

[40] Intermediary Exhibit I-5.

Administrator finds that this current procedure is in compliant with these instructions and is satisfied with the results they have produced.[41]

[41] Transcript (TR. at page 84). *See also*, Intermediary Exhibit 24. During the hearing Board member Bowers requested a recalculation of the extrapolation based on patient stays to be submitted post-hearing. To adjust the extrapolation calculation in this manner resulted in an increase of 199 allowable days (7447 less 7328 per stipulation #18), which is still 382 days short of the necessary amount of 7,829 days needed to qualify for the DSH payment.

Moreover, despite the Provider's contention that the Intermediary's method was flawed, and that even excluding these days the Provider met the necessary patient day threshold, the Provider's Ernest and Young audit (Exhibit 6) did not attempt to identify the M+C days and the Provider's attempt to extrapolate those days itself relies on the Provider's further manipulation of that same alleged flawed Intermediary sampling.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

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

Date: 7/27/11 /s/

Marilyn Tavenner
Principal Deputy Administrator and Chief Operating Office
Centers for Medicare & Medicaid Services