CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Baycare 2002 Medicare+Choice Days Group	**Provider Cost Reimbursement Determination for Cost Years Ending: June 6, 2002; December 31, 2002**
Provider	
vs.	**Review of:**
BlueCross BlueShield Association/ First Coast Service Options, Inc.	**PRRB Dec. No. 2011-D39 Dated: July 15, 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 mandated in § 1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. § 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The Providers commented, requesting that the Board's decision be affirmed. The Intermediary and the CMS' 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.

BACKGROUND

The Providers are part of a hospital chain located in Clearwater, Florida. The Providers sought to include in the numerators of the Medicaid fraction the days attributable to patients who were eligible for Medicaid and enrolled in a Medicare+Choice (M+C) managed care plan during their inpatient hospital stay. The Intermediary did not include those days in the numerator of the Medicaid fractions. The Providers appealed.

ISSUE

The issue was whether inpatient days for Medicaid-eligible patients who were enrolled in Medicare+Choice (M+C) plan under Part C of the Medicare statute were properly excluded from the numerator of the Medicaid fraction that is used to calculate the disproportionate share hospital (DSH) payment.[1]

BOARD'S DECISION

The Board concluded that the M+C days should be included in the Medicaid fraction used to calculate the DSH adjustment, and directed the Intermediary to revise the Providers' DSH calculations for each cost reporting period under appeal. 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.[2] 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.

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[1] The parties incorporated exhibits and transcripts of the concurrently held hearing in Southwest Consulting DSH Medicare+Choice Days Group, PRRB Dec No. 2010-D52, along with the consolidated position paper and post hearing briefs.

[2] 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[3] 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*[4] and *Metropolitan Hospital, Inc. v. U.S. Dept. of Health and Human Services*[5] 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 A" regardless of whether or not Medicare actually makes payments for the days at issue. The Board stated that there was a similar unexplained

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[3] 69 Fed. Reg. 48,916, 49,099 (Aug. 11, 2004).

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

[5] *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)

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."[6] The Board found that this was consistent with CMS' calculation of the Medicare/SSI fraction for periods before the 2004 change in policy.[7] 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 Intermediary improperly excluded the M+C days from the numerator of the Medicaid fraction used to calculate the DSH payment, and ordered the Intermediary to revise the Providers' DSH calculations for each cost reporting period under appeal.

SUMMARY OF 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.[8] 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 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.

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[6] 42 C.F.R. § 409.3.

[7] 69 Fed. Reg. 48,916, 49,098 (Aug. 11, 2004).

[8] Pursuant to the regulation, the 15 days, after a five day presumption of receipt, was August 16, 2011. The CMS building was closed on that day and the Office of the Attorney Advisor was not open to receive comments. The comments were filed on the first business day after the closure and, therefore, are considered timely.

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.[9] 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 Intermediary commented requesting that the Administrator review and revise the Board's determination in this case. The Intermediary noted that CMS policy as consistently dictated that Medicare managed care days be placed in the Medicare fraction. Even thought Medicare beneficiaries can elect Medicare Part C coverage, they are still, in some sense, eligible for Medicare Part A and should, therefore, be included in the Medicare fraction of the DSH calculation. Absent eligibility for Part A, no beneficiary could elect Medicare Part C coverage.

The Providers commented, requesting that the Administrator affirm the Board's decision for all the reasons stated in the Board's decision and in the Providers' filings with the Board, which are incorporated by reference herein. 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 at issue from the numerator of the Providers' Medicaid fractions is incorrect and must be reversed.

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[9] *See* 42 U.S.C. § 1395w-21(e).

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.[10] 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.[11] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC)[12] and Supplemental Security Income or SSI.[13] 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.[14]

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 the specific kinds of medical care and services that will be covered.[15] 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.[16] However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive

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

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.[17] 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 alia*, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.[18]

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[19] 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

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[17] 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."

[18] 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.

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

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,[20] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[21] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[22] Section 226 of the Social Security Amendments of 1972[23] 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.[24]

Concerned with increasing costs, Congress also enacted Title VI of the Social Security Amendments of 1983.[25] 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.[26]

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

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[20] Section 1811-1821 of the Act.
[21] Section 1831-1848(j) of the Act.
[22] Under Medicare, Part A services are furnished by providers of services.
[23] Pub. L. No. 92-603.
[24] Pub. L. No. 97-248.
[25] Pub. L. No. 98-21.
[26] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

significantly disproportionate number of low-income patients…."[27] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[28] 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.
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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 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)[29] 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

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[27] 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).

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

[29] 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).

> 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.

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.[30]

[30] 55 Fed. Reg. 35,990.

Section 4001 of the Balanced Budget Act (BBA) of 1997, established the M+C program known as Medicare + Choice[31] by adding a new Part C to Title XVIII of the Act pursuant to § 1851 through § 1859.[32] 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. Section 1851 of the Act notes, in pertinent part:

> (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICARE+CHOICE PLANS.—
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> (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—
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> (A) through the original medicare fee–for–service program under parts A and B, or
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> (B) through enrollment in a Medicare+Choice plan under this part, and may elect qualified prescription drug coverage in accordance with section 1860D-1.
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> (3) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—
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> (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.
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[31] 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).

[32] 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).

> (i) EFFECT OF ELECTION OF MEDICARE+CHOICE PLAN OPTION.—
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> (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.
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> (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.
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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.[33]

In August, 2003, CMS announced that it was still reviewing comments.[34] 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

[33] 68 Fed Reg. 27,154, 27,208 (May 19, 2003).
[34] 68 Fed Reg. 45,346, 45,422 (Aug. 1, 2003).

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.[35]

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 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. 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:

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[35] 69 Fed Reg. 48,916, 49,098-99 (Aug. 11, 2004).

> Section 226 of the Act provides that an individual is automatically 'entitled' to Medicare Part A when the person reaches age 65 and is 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.) [36]

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"[37].

The Providers 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

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[36] 75 Fed. Reg. 50,041, 50,280-81 (Aug. 16, 2010).

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

[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. 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

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.

The Secretary also restated the existing process for calculating the Medicare fraction in the FFY 2006 final IPPS rule,[40] 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.[41]

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.[42]

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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] 70 Fed. Reg. 47,278 (Aug. 12, 2005).

[41] Id. at 47,438-39.

[42] Id. at 47,439. 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 47,440-41. The preamble's reference that the use of the MedPAR ensures that the MCO days are included in

For the cost years at issue, the MedPAR data was intended to include the Medicare HMO-type days, as it had in the past, and it is the MedPAR data which is used for the purpose of calculating the Medicare fraction.

However, the Providers asserted that the days at issue are not already included in the Medicare fraction, and used that as further evidence of CMS "policy" to exclude these days from the Medicare fraction.[43] The Administrator finds that, to the extent any M+C days were not included in the Medicare fraction, this would have been due to inadvertent data system error, and is not evidence that CMS' affirmative policy was to exclude these days from the Medicare fraction. The Providers have not requested that, in the alternative, any alleged missing days should be included in the Medicare fraction, and thus, that issue is not addressed here.

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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.

[43] Moreover, for this claim, the Providers relied on parts of the record developed in Southwest Consulting DSH Medicare + Choice Days Group, PRRB Decision No. 2010-D52. The Providers asserted that the days at issue are not already included in the Medicare fraction and that this is evidence of CMS' policy. A witness in that case submitted data relating to hospitals not involved in this case to support his claim that the M+C days were not included in the DSH calculation. The providers in Southwest argued that the M+C days were not included for certain of the witnesses' other clients and part of the analysis was for cost years not contemporaneous with those in this case. Hence, the Providers in this case now before the Administrator (nor for the providers in Southwest) did not submit documentation specific to each Provider to demonstrate that the M+C days were not included in the DSH calculation, but rather claimed the total number of M+C days for the dual eligible beneficiaries for each Provider to be included in the Medicaid fraction. The Administrator finds that such documentation, based on other providers' data, is not sufficient evidence of the exclusion of the days from the DSH calculation in this case for this cost year.

DECISION

The decision of the Board is reversed consistent with the foregoing opinion.

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

Date: 9/14/11

/s/
Marilynn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services