PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D19

PROVIDER –
QRS 1999-2003 DSH Medicare Part C Days Groups

Provider No.: Various

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/ Noridian Administrative Services, LLC; National Government Services, LLC; TrailBlazer Health Enterprises, LLC; and Wisconsin Physicians Service

DATE OF HEARING -
February 26, 2009

Cost Reporting Periods Ended -
Various

CASE NOs.: 09-0003GC, 04-2135G, 04-2136G, 04-2137G, 06-1907G, 06-1906G, 08-2753GC, 08-2757GC, 08-2847GC

INDEX

	Page No.
Issue	**2**
Medicare Statutory and Regulatory Background	**2**
Statement of the Case and Procedural History	**7**
Parties' Contentions	**8**
Findings of Fact, Conclusions of Law and Discussion	**10**
Decision and Order	**12**

ISSUE:

Whether the Intermediary should include dual-eligible, Medicare + Choice (M + C) patient days in the numerator of the Medicaid proxy in determining Medicare reimbursement for disproportionate share hospital (DSH) payments in accordance with the Medicare statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)(II).

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

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

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

Medicare DSH Payment

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

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

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

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

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

The statute defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter....

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

The statute defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added). The fiscal intermediary determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare part A, and divides that number by the total number of patient days in the same period. 42 C.F.R. § 412.l06(b)(4).

Medicare+Choice Program

The Medicare program permits its beneficiaries to receive services from managed care organizations. The managed care statute implementing payments to health maintenance

organizations (HMOs) and competitive medical plans (CMPs) is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter …" Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days. Payments for medical services for Medicare beneficiaries enrolled in HMOs and CMPs were funded from Part A of the Medicare program.

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

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

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

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

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

CMS Policy for Managed Care Days in DSH Calculation

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

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

Id.

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

> 8. Medicare+Choice (M+C) Days
>
> Under § 422.1, an M+C plan "means health benefits coverage offered under a policy or contract by an M+C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan." Generally, each M+C plan must provide coverage of all services that are covered by Medicare Part A and Part B (or just Part B if the M+C plan enrollee is only entitled to Part B).
>
> We have received questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation. The question stems from whether M+C

> plan enrollees are entitled to benefits under Medicare Part A since M+C plans are administered through Medicare Part C.
>
> We note that, under § 422.50, an individual is eligible to elect an M+C plan if he or she is entitled to Medicare Part A and enrolled in Part B. However, once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A.
>
> Therefore, we are proposing to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's [sic] days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.

Id. (Emphasis added).

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

> 4. Medicare+Choice (M+C) Days
>
> Under existing § 422.1, an M+C plan means "health benefits coverage offered under a policy or contract by an M+C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan." Generally, each M+C plan must provide coverage of all services that are covered by Medicare Part A and Part B (or just Part B if the M+C plan enrollee is only entitled to Part B).
>
> We have received questions whether the patient days associated with patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation. The question stems from whether M+C plan enrollees are entitled to benefits under Medicare Part A since M+C plans are administered through Medicare Part C.
>
> We note that, under existing regulations at § 422.50, an individual is eligible to elect an M+C plan if he or she is entitled to Medicare Part A and enrolled in Part B. However, once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A. In the proposed rule of May 19, 2003 (68 FR 27208), we proposed that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary would not be included in the Medicare fraction of the DSH patient percentage. Under our proposal, these patient days would be

> included in the Medicaid fraction. The patient days of dual-eligible M+C beneficiaries (that is, those also eligible for Medicaid) would be included in the count of total patient days in both the numerator and denominator of the Medicaid fraction.
>
> *Comment:* Several commenters indicated that they appreciated CMS's attention to this issue in the proposed rule. The commenters also indicated that there has been insufficient guidance on how to handle these days in the DSH calculation. However, several commenters disagreed with excluding these days from the Medicare fraction and pointed out that these patients are just as much Medicare beneficiaries as those beneficiaries in the traditional fee-for-service program.
>
> *Response:* Although there are differences between the status of these beneficiaries and those in the traditional fee-for-service program, we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction. As noted previously, if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at §412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.

Id. (Emphasis added).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case involves ten group appeals, collectively referred to as QRS DSH Medicare Part C Days Groups (the Providers). All of the Providers in each of the groups are acute care facilities that received payment under Medicare Part A for services to Medicare beneficiaries for the cost reporting periods from 1999 through 2003. The Intermediaries for each of the Providers did not include in the numerator of the Medicaid fraction the days attributable to patients who were eligible for Medicaid and enrolled in a Medicare + Choice managed care plan during their inpatient hospital stays. All of the Providers in each group seek to include in the numerator of the Medicaid fraction the days attributable to those patients who were eligible for Medicaid and enrolled in a Part C Medicare + Choice managed care plan during their inpatient hospital stays.

The Providers were represented by Mr. Alan J. Sedley, Esq. of Alan J. Sedley Law Offices. The Intermediaries were represented by Bernard M. Talbert, Esq. of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Intermediaries contend that CMS policy has consistently dictated that Medicare managed care days are to be included in the Medicare fraction. *See* 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990). With respect to M + C beneficiaries, CMS considered including their inpatient days in the Medicaid fraction, but following re-evaluation of the question, CMS determined that such days should remain in the Medicare fraction. In the August 11, 2004 Final Rule, *See* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004), CMS indicated that even though Medicare beneficiaries may elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A and should be included in the Medicare fraction of the DSH calculation.

The Intermediaries note that the Board found that M + C days should be included in the Medicare DSH fraction in *St. Joseph's Hospital and St. John's Northeast Hospital v. Blue Cross BlueShield Association/Noridian Government Services*, PRRB Decision No. 2007-D68, September 14, 2007, *aff'd*, CMS Administrator Decision, November 13, 2007. In affirming the Board's decision in that case the CMS Administrator stated the following.

> In this case, while the Provider agreed with the Board's determination that M+C days must be included in the Provider's DSH calculation, the Provider argued that the M+C days belong in the numerator of the Medicaid fraction instead of the Medicare fraction. The Administrator agrees with the Board's finding that the dual-eligible M+C days should be included in the Medicare DSH calculation.

The Intermediaries also note that the Board ruled that HMO managed care days should be included in the Medicare fraction because a beneficiary must first be entitled to benefits under Medicare Part A to enroll in a Medicare managed care plan. *See QRS 1994 DSH Managed Care and Medicaid Eligible Days Group v. Blue Cross Blue Shield Association/Noridian Administrative Services*, PRRB Dec. No. 2009-D3, December 17, 2008, *declined rev.* CMS Administrator, February 6, 2009 (*QRS 1994 DSH Managed Care and Medicaid Eligible Days Group*).

The Providers contend that all days associated with dual-eligible Medicare managed care days (all of which are post-1999 M + C days) should be included in the numerator of the Medicaid fraction in the DSH formula.

The Providers rely on the explicit language in Section 4001 of the BBA of 1997, in which Congress amended the Medicare Act by adding a new Part C for benefits provided through Medicare HMOs. 42 U.S.C. §1395w-21. Under subsection (a)(3)(A) it provides that in order to be eligible to enroll in a Medicare HMO, an individual must be entitled to benefits

under Medicare parts A and B. But, once an individual elects to enroll in a Medicare HMO, he or she is "entitled to receive benefits under [the Medicare statute] . . . through enrollment in a Medicare + Choice plan under this part [i.e., Part C]." (emphasis added) 42 U.S.C. §1395w-21(a)(1)(B). Therefore, once enrolled in a Medicare HMO, payments for Medicare HMO enrollees are made from Medicare Part C, rather than Parts A or B.[2]

The Providers further point out that the DSH and graduate medical education (GME) statutes have similar language regarding "entitled to benefits under part A" and "with respect to whom payment may be made under part A". *See* 42 U.S.C. §1395ww(d)(5)(F)(vi)(I) and §1395ww(h)(3)(C). CMS, through its preamble to the 1989 implementing rule, specifically construes the GME statute to exclude Medicare HMO days from the calculation of the Medicare patient load category because Medicare HMO days "are recorded as *non-Medicare* days" for all Medicare payment purposes. 54 Fed. Reg. 40,286, 40,294-5 (September 29, 1989) (emphasis added).[3]

In 1997, Congress, presumably aware of CMS' existing policy of recording Medicare HMO days as non-Medicare days, enacted legislation providing for a separate, additional medical education payment specifically for hospitals that treat Medicare managed care patients. *See* Section 4624 of the BBA of 1997, 42 U.S.C. §1395ww(h)(3)(D)(i). The Providers argue that if Congress had intended Medicare HMO patients to be counted as patients who are "entitled to benefits under Medicare Part A," then Medicare HMO patients would have been included in the calculation of the standard GME payment under the pre-existing statutory and regulatory scheme. And it follows, that if that were the intent, Congress would simply have directed the Secretary to count Medicare HMO days in the GME payment calculation specified under the pre-existing law.[4]

Instead, Congress' enactment of a separate GME payment for Medicare HMO patient days manifests an intent that Medicare HMO enrollees not be regarded as patients "with respect to whom payment may be made under part A." 42 U.S.C. §1395ww(h)(3)(C). Like the GME statute, which fixes the GME payment on a hospital's number of patient days attributable to patients who are entitled to payment under Medicare Part A, the DSH statute also defines the Medicare fraction as consisting of a hospital's number of days attributable to patients who are "entitled to benefits" under part A. The Secretary's position that Medicare HMO days should be included in the Medicare fraction for DSH, the Providers argue, conflicts with the intent of Congress and results in the unexplained inconsistent treatment of HMO days for all other payment purposes. Consequently, it is arbitrary and capricious.

The Providers note that CMS clarified in the Federal Register, 68 Fed. Reg. 27154, 27208 (May 19, 2003), that once the patient elects a Part C managed care plan, their benefits are no longer administered under Part A. It follows that the patient is not entitled to benefits under Part A during the period of enrollment in a Part C managed care plan. *See* 42 U.S.C. §1395w-21. The Providers state that when one applies this logic to the definition of the

[2] See Tr. at 26-27.
[3] See Tr. at 21-22.
[4] Tr. at 22-24.

Medicaid fraction, it is clear that the numerator shall be comprised, in part, of patients who were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were *not entitled to benefits under Part A*. Managed care patient days under Part C should therefore not be counted as days for which payment is being made under Medicare Part A.

The Providers acknowledge that CMS changed its position in 2004 and adopted a policy that these days should be counted in the Medicare fraction. Because this policy was not adopted until 2004, and the fiscal years at issue in all of these cases were before the policy was adopted, they argue it should not apply retroactively to any of the Providers in this group.

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

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

The Board has recently considered this same issue in *Southwest Consulting DSH Medicare+Choice Days Groups v BlueCross BlueShield Association/NHIC Corp. c/o National Government Services, Wisconsin Physicians Service, and Noridian Administrative Services*, PRRB Dec. No. 2010-D52, September 30, 2010, Medicare and Medicaid Guide (CCH) ¶ 82,679 (*Southwest*) . The rationale is equally applicable here.

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

[5] In decisions prior to *Southwest*, the Board found the statutory language dispositive of the question because to enroll in a Medicare+Choice plan under part C, a beneficiary was first required to be "entitled" to Part A benefits. *See e.g. QRS 1994 DSH Managed Care and Medicaid Eligible Days Group, supra*. The Board is now convinced it stopped too short in its analysis of the statute. The District Courts in *Northeast Hosp. Corp. v. Sebelius*, 699 F.Supp.2d 81, 93 (D.D.C. 2010) (*Northeast Hosp.*) and *Metropolitan Hosp., Inc. v. U.S. Dept. of Health and Human Services*, 702 F.Supp.2d 808, 823 (W.D. Mich. 2010) (*Metropolitan Hosp.)* have recently held that 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.

[6] In the August 2004 Final Rule, which was published after most of the fiscal years at issue in this case, CMS indicated that though Medicare beneficiaries may elect Medicare part C coverage, they are still, "in some sense" entitled to benefits under Medicare part A and should be included in the Medicare fraction. *See* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004). CMS did not articulate how, or in what sense beneficiaries might

The intent of Congress is also clear when one reviews the statute at 42 U.S.C. §1395w-21(i)(1) which states that payments under a contract with an M+C organization with respect to an individual electing an M+C plan shall be instead of the amounts which would otherwise be payable under parts A and B for services furnished to the individual. Similar to the election of benefits, the payments made under the M+C plan replace payments under parts A and B. Therefore, once enrolled in the M+C program, the beneficiary is not entitled to payments under Medicare part A. The Board concludes that the plain language of the Medicare DSH statute requires the inclusion of M+C days in the numerator of the Medicaid fraction. *See* 42 U.S.C. §1395ww(d)(5)(F)(vi). The Board is also persuaded by decisions of two district courts that have recently addressed this precise issue: the meaning of the phrase, "entitled to benefits under part A," as used in the DSH statute. The courts in *Northeast Hospital* and *Metropolitan Hospital* 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 question. *See Northeast Hosp.,* 699 F.Supp.2d at 93; *Metropolitan Hosp.,* 702 F.Supp.2d at 823. In *Northeast Hospital* the court found that once an individual has enrolled in a Medicare+Choice plan under part C, he or she is no longer "entitled to benefits under part A," because he or she is no longer entitled to have payment made under part A for the days at issue. *See Northeast Hosp.,* 699 F.Supp.2d at 93 (finding that Congress has "explicitly concluded that M+C patients are not 'entitled to benefits under [Medicare] part A' as that phrase is defined in the Medicaid [sic] statute").

The Board can discern no rational explanation for CMS' inconsistent interpretation of the term "entitled" as used in the same sentence within the DSH statute. On one hand, CMS states that SSI beneficiaries are "entitled to supplemental security income benefits" only when entitled to payment for the specific days at issue, while at the same time finding that any individual who is entitled to benefits under Medicare part C is also "entitled to benefits under part A."

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

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

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be covered by both parts A and C. However, the clear language of the statute cannot be overcome by commentary made by CMS in the preamble to a final rule or in its policy shifts.

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

The Board further finds that CMS' current interpretation of the DSH statute applied in these cases improperly conflates the statutory terms "entitled" and "eligible" as used in a single sentence within the DSH statute. CMS' current interpretation construes these terms to have the same meaning, violating the elementary principle of statutory construction that Congress does not intend the same meaning when it uses different terms in different parts of the same statute. *See, e.g., Russello* v. *United States,* 464 U.S. 16, 23 (1983). The Board agrees with the *Metropolitan Hospital* court's holding that the statutory terms "entitled" and "eligible" are "conceptually and practically distinct and not to be used interchangeably." 702 F.Supp.2d at 825. The distinctions between these two terms and the impropriety of conflating them as having the same meaning has been established for over a decade. *See Jewish Hosp. Inc*., 19 F.3d at 274-75; *Cabell Huntington Hosp.,* 101 F.3d at 988 (4th Cir. 1996); *Legacy Emanuel Hosp. and Health Ctr.,* 97 F.3d at 1265-66 (9th Cir. 1996).

The Board further finds that the exclusion of the M+C days at issue is contrary to the DSH regulation that was in effect during the periods at issue. The regulation in effect interpreted the statutory phrase "entitled to benefits under part A" to mean "covered" by Medicare part A, *see, e.g.,* 42 C.F.R. § 412.106(b)(2)(i) (1997), and the part A coverage regulations define "covered" to mean "services for which the law and regulations authorize Medicare payment." 42 C.F.R. § 409.3 (1997).

The Board finds the evidence persuasive that CMS' actual practice was to not count the M+C days in the SSI fraction prior to 2004. When this is combined with CMS' numerous statements on not counting the days as part A days, we are also persuaded that CMS does not have a long-standing policy of counting part C days as part A days for DSH purposes. Regardless of CMS' position, we find the statutory language dispositive.

DECISION AND ORDER:

The Intermediaries improperly excluded the dual-eligible, Medicare+Choice days at issue from the numerator of the Medicaid fraction used to calculate the DSH payment. This case is remanded to the Intermediaries to revise the Providers' DSH calculations for each cost reporting period under appeal consistent with this opinion.[7]

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

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
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John Gary Bowers, CPA

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: March 16, 2011

in its directive of those to be remanded, and remand under the Ruling was not raised by the Intermediary in any of the proceedings. The parties have further stipulated that all final jurisdictional documents, data and schedules previously provided to the Board and to the Intermediaries relating to each of the above mentioned group appeals shall be admitted into evidence and attached as part of the record thereto, without foundational requirement or explanation. In the event that the Providers should prevail, in whole or in part for the relief sought, the Intermediaries shall have the right to audit any such relevant data provided, and request that additional data be provided as needed, including but not limited to state verification of Medicaid eligibility.