CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Lifespan SWC 2003 DSH Medicare+Choice Days Group	**Provider Cost Reimbursement Determination for Cost Year Ending: 9/30/2003**
Providers	
vs.	**Review of:**
National Government Services/ Blue Cross Blue Shield Association	**PRRB Dec. No. 2012-D6**
Intermediary	**Dated: January 18, 2012**

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 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. CMS' Center for Medicare (CM) commented, requesting that the Administrator vacate the Board's decision and remand the matter to the Intermediary for revised payment determinations to include the disputed Medicare+Choice days in the Medicaid fraction. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Providers in this case are an integrated healthcare system of five partner hospitals located in the State of Rhode Island. The Common Issue Related Party (CIRP) group appeal includes three acute care facilities within this system. Each facility received payment under Medicare Part A for services to Medicare beneficiaries for cost reporting periods ending September 30, 2003. 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 those determinations and met the jurisdictional requirements. The

parties stipulated that the material facts and legal issues in this group appeal are the same in all pertinent respect to those presented in *Southwest Consulting DSH Medicare+Choice Days Group*.[1] The Providers adopted the Consolidated position paper sent on May 4, 2010 and the post-hearing brief sent on August 20, 2010, both sent in connection with *Southwest Consulting*, as their final position paper in this case, and the Intermediary adopted the final position paper filed on May 5, 2010 in connection with *Southwest Consulting* as its final position paper in this case.[2] A hearing on the record was held by the Board.[3]

ISSUE AND BOARD'S DECISION

The issue, according to the Board, was whether inpatient days for Medicaid-eliglbe patients who were enrolled in a 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. The Board concluded that the Intermediary improperly excluded the M+C days at issue from the numerator of the Medicaid fraction used to calculate the DSH payment, 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 statute in § 1876 of the Social Security Act, as well as the Balanced 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.[4] However, once enrolled in the plan, that beneficiary would no longer be entitled to benefits under Parts A or B. The statute provides that an M+C eligible beneficiary can elect to receive benefits through the traditional fee-for-service program under Parts A and B, or enroll in an M+C plan under Part C. The Board found significance in the statute's use of the disjunctive "or", noting that once that election is made, the beneficiary is entitled to benefits

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[1] PRRB Dec. No. 2010-D52 (Sept. 30, 2010).

[2] *See* Stipulations, dated June 6, 2011, and supporting attachments.

[3] *See* Notice of Hearing on the Record, dated August 10, 2011.

[4] 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 Managed 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 the 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.

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.

The Board stated that the intent of Congress is also 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 replace payments under Parts A and B, and 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 requires 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*[5] and *Metropolitan Hospital, Inc. v. U.S. Dept. of Health and Human Services*[6] 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 stated that it agreed with the Providers' 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 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 pointed out that the district court in Northeast Hospital found CMS'

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

[6] *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).

failure to acknowledge or explain its departure from established agency precedent to be arbitrary and capricious.[7]

The Board also found 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, 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."[8] The Board found that this was consistent with CMS' calculation of the Medicare/SSI fraction for periods before the 2004 change in policy.[9] 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. The Board nevertheless concluded that CMS' conflicting interpretations and its motivation are not dispositive of the statutory construction question at the heart of this dispute, and found that the question has been properly answered by the Federal courts.

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 Providers' DSH calculations for each cost reporting period under appeal.[10]

SUMMARY OF COMMENTS

The Provider commented, arguing that the Board's decision was correct for all the reasons the Board stated, for the reasons stated by the Providers in its position paper, and for the reasons stated by the Court of Appeals in *Northeast Hospital Corp. v. Sebelius*.[11] The Provider noted that the case involves cost reporting periods ending prior to October 1, 2004, and that accordingly, the Court of Appeals' decision in *Northeast Hospital* is dispositive.

CMS' Center for Medicare (CM), commented, requesting that the Administrator vacate the Board's decision and remand the matter to the Intermediary for revised payment determinations to include the disputed M+C days in the Medicaid fractions. The CM noted

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[7] 699 F.Supp. 23 at 94-95.
[8] 42 C.F.R. § 409.3.
[9] 69 Fed. Reg. 48,916, 49,098 (Aug. 11, 2004).
[10] 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.
[11] 657 F.3d 1 (D.C. Cir. 2011).

that it disagreed with the Board's decision finding that the plain language of the statute requires the inclusion of the M+C days in the numerator of the Medicaid fraction. However, CM recognized that this case is affected by the recent decision of the D.C. Circuit Court of Appeals in Northeast Hospital, as this appeal only includes patient discharged prior to October 1, 2004. The CM also stated that it continued to believe that it was the Secretary's longstanding policy to exclude M+C days from the Medicaid fraction for the cost reporting periods at issue.

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.[12] 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.[13] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC)[14] and Supplemental Security Income or SSI.[15] 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.[16]

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.[17] If the State plan is approved by CMS, under §1903 of the Act, the State is thereafter eligible to receive matching payments from

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

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.[18] 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.[19] 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.[20]

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[18] *Id.*

[19] 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."

[20] 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

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[21] 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,[22] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[23] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[24] Section 226 of the Social Security Amendments of 1972[25] 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.[26]

Concerned with increasing costs, Congress also enacted Title VI of the Social Security Amendments of 1983.[27] 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.[28]

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

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shortfall; that is, the amount by which the costs of treating Medicaid patients exceeds hospital Medicaid payments plus the cost of treating the uninsured.

[21] Pub. Law No. 89-97.

[22] Section 1811-1821 of the Act.

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

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

[25] Pub. Law No. 92-603.

[26] Pub. Law No. 97-248.

[27] Pub. Law No. 98-21.

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

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…."[29] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[30] 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) states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, [CMS]—

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[29] 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).

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

(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.

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.[31]

[31] 55 Fed. Reg. 35,990.

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

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

[33] 68 Fed Reg. 27,208 (May 19, 2003).

[34] 68 Fed Reg. 45,422 (Aug. 1, 2003).

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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.

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.[35]

While the Administrator continues to believe that the Medicare policy has always been to exclude M+C days from the Medicaid fraction numerator, the Administrator concedes that it is bound by the District of Columbia Circuit Court's decision in *Northeast Hospital Corp. v. Sebelius*.[36] The Circuit Court concluded that while the statute does not foreclose the Secretary's interpretation that a Medicare beneficiary enrolled in Medicare Part C still qualifies as a person "entitled to benefits" under Medicare Part A, and that the days should thus be included in the numerator of the Medicare fraction, the Circuit Court held that the Secretary could not apply this interpretation to patient discharges prior to October 1, 2004.

Thus, because this case involves only patient discharges prior to October 1, 2004, the Administrator finds that the case should be remanded to the Intermediary for revised payment determinations to include the disputed M+C days in the Medicaid fractions.

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[35] 69 Fed Reg. 49,098-99 (Aug. 11, 2004).
[36] 657 F.3d 1 (D.C. Cir. 2011).

Accordingly, the Administrator vacates the decision of the Board, and orders:

THAT this case is remanded to the Intermediary;

THAT, on remand, the Intermediary will revise the payment determinations to include the disputed M+C days in the Medicaid fractions; and

THAT any such revised final payment determinations will be subject to the provisions of Section 1878 of the Social Security Act and 42 C.F.R. 405.1801 *et seq*.

Date: 2/29/12

/s/
Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services