No. 20-1312

In the Supreme Court of the United States

XAVIER BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

EMPIRE HEALTH FOUNDATION, FOR VALLEY HOSPITAL MEDICAL CENTER

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOINT APPENDIX

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PETITION FOR A WRIT OF CERTIORARI FILED: MAR. 19, 2021
CERTIORARI GRANTED: JULY 2, 2021

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Docket No. 18-35845

EMPIRE HEALTH FOUNDATION, FOR VALLEY HOSPITAL MEDICAL CENTER, PLAINTIFF-APPELLEE

v.

ALEX M. AZAR II, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEFENDANT-APPELLANT

DOCKET ENTRIES

DATE	DOCKET NUMBER	PROCEEDINGS
10/12/18	1	DOCKETED CAUSE AND ENTERED APPEARANCES OF COUNSEL. SEND MQ: Yes. The schedule is set as follows: Mediation Questionnaire due on 10/19/2018. Transcript ordered by 11/13/2018. Transcript due 12/10/2018. Appellant Alex M. Azar II opening brief due 01/22/2019. Appellee Empire Health Foundation answering brief due 02/22/2019. Appellant's optional reply brief is due 21 days after service of the answering brief. [11044958] (RT) [Entered: 10/12/2018 11:30 AM]

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
10/19/18	5	DOCKETED CAUSE AND ENTERED APPEARANCES OF COUNSEL. SEND MQ: Yes. Setting cross-appeal briefing schedule as follows: Mediation Questionnaire due on 10/26/2018. First cross appeal brief due 01/22/2019 for Alex M. Azar II. Second brief on cross appeal due 02/22/2019 for Empire Health Foundation. Third brief on cross appeal due 03/25/2019 for Alex M. Azar II. Optional cross appeal reply brief is due within 21 days of service of third brief on cross appeal [11053184] [18-35872, 18-35845] (JBS) [Entered: 10/19/2018 10:01 AM]
		* * * * *
4/11/19	16	Submitted (ECF) excerpts of record. Submitted by Appellant Alex M. Azar, II in 18-35845, Appellee Alex M. Azar, II in 18-35872. Date of service: 04/11/2019. [11260797] [18-35845, 18-35872] (Marcus, Stephanie) [Entered: 04/11/2019 12:16 PM]
4/11/19	17	Submitted (ECF) First Brief on Cross-Appeal for review. Submitted by Appellant Alex M. Azar, II in 18-35845, Appellee Alex M.

DATE	DOCKET NUMBER	PROCEEDINGS
		Azar, II in 18-35872. Date of service: 04/11/2019. [11261303] [18-35845, 18-35872] (Marcus, Stephanie) [Entered: 04/11/2019 03:48 PM]
4/11/19	18	Filed clerk order: The first brief on cross-appeal [17] submitted by Alex M. Azar, II is filed. Within 7 days of the filing of this order, filer is ordered to file 7 copies of the brief in paper format, accompanied by certification (attached to the end of each copy of the brief) that the brief is identical to the version submitted electronically. Cover color: blue. The Court has reviewed the excerpts of record [16] submitted by Alex M. Azar, II. Within 7 days of this order, filer is ordered to file 4 copies of the excerpts in paper format securely bound on the left side, with white covers. The paper copies shall be submitted to the principal office of the Clerk. [11261316] [18-35845, 18-35872] (SML) [Entered: 04/11/2019 03:55 PM]

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
6/12/19	23	Submitted (ECF) Second Brief on Cross-Appeal for review. Submitted by Appellee Empire Health Foundation in 18-35845, Appellant Empire Health Foundation in 18-35872. Date of service: 06/12/2019. [11328934] [18-35845, 18-35872]—[COURT UPDATE: Attached corrected brief. 6/13/2019 by TYL] (Sherman, Teresa) [Entered: 06/12/2019 03:06 PM]
6/12/19	24	Submitted (ECF) supplemental excerpts of record. Submitted by Appellee Empire Health Foundation in 18-35845, Appellant Empire Health Foundation in 18-35872. Date of service: 06/12/2019. [11328943] [18-35845, 18-35872] (Sherman, Teresa) [Entered: 06/12/2019 03:08 PM]
6/14/19	25	Filed clerk order: The second brief on cross-appeal [23] submitted by Empire Health Foundation is filed. Within 7 days of the filing of this order, filer is ordered to file 7 copies of the brief in paper format, accompanied by certification (attached to the end of each copy of the brief) that the brief is identical to the version submitted electronically. Cover color:

DATE	DOCKET NUMBER	PROCEEDINGS
		red. The Court has reviewed the supplemental excerpts of record [24] submitted by Empire Health Foundation. Within 7 days of this order, filer is ordered to file 4 copies of the excerpts in paper format securely bound on the left side, with white covers. The paper copies shall be submitted to the principal office of the Clerk. [11332545] [18-35845, 18-35872] (SML) [Entered: 06/14/2019 04:20 PM]
		* * * * *
8/9/19	30	Submitted (ECF) Third Brief on Cross-Appeal for review. Submitted by Appellant Alex M. Azar, II in 18-35845, Appellee Alex M. Azar, II in 18-35872. Date of service: 08/09/2019. [11393127] [18-35845, 18-35872] (Marcus, Stephanie) [Entered: 08/09/2019 04:13 PM]
8/9/19	31	Submitted (ECF) supplemental excerpts of record. Submitted by Appellant Alex M. Azar, II in 18-35845, Appellee Alex M. Azar, II in 18-35872. Date of service: 08/09/2019. [11393166] [18-35845, 18-35872]

DATE	DOCKET NUMBER	PROCEEDINGS
		(Marcus, Stephanie) [Entered: 08/09/2019 04:41 PM]
8/12/19	32	Filed clerk order: The third brief on cross-appeal [30] submitted by Alex M. Azar, II is filed. Within 7 days of the filing of this order, filer is ordered to file 7 copies of the brief in paper format, accompanied by certification (attached to the end of each copy of the brief) that the brief is identical to the version submitted electronically. Cover color: yellow. The Court has reviewed the supplemental excerpts of record [31] submitted by Alex M. Azar, II. Within 7 days of this order, filer is ordered to file 4 copies of the excerpts in paper format securely bound on the left side, with white covers. The paper copies shall be submitted to the principal office of the Clerk. [11393836] [18-35845, 18-35872] (SML) [Entered: 08/12/2019 10:05 AM]
		* * * * *
9/30/19	40	Submitted (ECF) Cross-Appeal Reply Brief for review. Submitted by Appellee Empire Health Foundation in 18-35845, Appellant Empire Health Foundation in

DATE	DOCKET NUMBER	PROCEEDINGS
		18-35872. Date of service: 09/30/2019. [11449368] [18-35845, 18-35872]—[COURT UPDATE attached corrected PDF of cross-appeal reply brief. 10/01/2019 by KT] (Hettich, Daniel) [Entered: 09/30/2019 06:33 PM]
10/1/19	41	Filed clerk order: The cross-appeal reply brief [40] submitted by Empire Health Foundation is filed. Within 7 days of the filing of this order, filer is ordered to file 7 copies of the brief in paper format, accompanied by certification (attached to the end of each copy of the brief) that the brief is identical to the version submitted electronically. Cover color: gray. The paper copies shall be submitted to the principal office of the Clerk. [11450227] [18-35845, 18-35872] (KT) [Entered: 10/01/2019 01:50 PM]
		* * * * *
2/6/20	46	ARGUED AND SUBMITTED TO MILAN D. SMITH, JR., N. RANDY SMITH and JOHN R. TUNHEIM. [11587896] [18-35845, 18-35872] (KRK) [Entered: 02/06/2020 11:38 AM]

DATE	DOCKET NUMBER	PROCEEDINGS
		* * * * *
5/5/20	48	FILED OPINION (MILAN D. SMITH, JR., N. RANDY SMITH and JOHN R. TUNHEIM) AFFIRMED AND REMANDED. Judge: MDS Authoring. FILED AND ENTERED JUDGMENT. [11680465] [18-35845, 18-35872]—[Edited 05/06/2020 (attached corrected PDF—typo corrected) by AKM] (AKM) [Entered: 05/05/2020 08:01 AM]
		* * * * *
7/14/20	51	Filed (ECF) Appellant Alex M. Azar, II in 18-35845, Appellee Alex M. Azar, II in 18-35872 petition for rehearing en banc (from 05/05/2020 opinion). Date of service: 07/14/2020. [11753029] [18-35845, 18-35872] (Marcus, Stephanie) [Entered: 07/14/2020 04:15 PM]
8/5/20	52	Filed order (MILAN D. SMITH, JR., N. RANDY SMITH and JOHN R. TUNHEIM) Plaintiff-Appellee is ordered to file a response to Defendant-Appellant's petition for rehearing en banc, filed with this court on July 14, 2020 (Dkt. [51]). The response

DATE	DOCKET NUMBER	PROCEEDINGS
		shall not exceed 20 pages, and shall be filed within 21 days of the date of this order. [11778471] [18-35845, 18-35872] (WL) [Entered: 08/05/2020 01:36 PM]
		* * * * *
9/16/20	57	Filed (ECF) Appellee Empire Health Foundation in 18-35845, Appellant Empire Health Foundation in 18-35872 response to Petition for Rehearing En Banc (ECF Filing), Petition for Rehearing En Banc (ECF Filing) for rehearing by en banc only (all active, any interested senior judges). Date of service: 09/16/2020. [11827002]. [18-35845, 18-35872] (Hettich, Daniel) [Entered: 09/16/2020 07:46 PM]
10/20/20	58	Filed order (MILAN D. SMITH, JR., N. RANDY SMITH and JOHN R. TUNHEIM) Judge M. Smith voted to deny the petition for rehearing en banc, and Judges N.R. Smith and Tunheim so recommended. The full court has been advised of the petition for rehearing en banc and no judge has requested a vote on whether to rehear the matter en banc. Fed. R.

DATE	DOCKET NUMBER	PROCEEDINGS
		App. P. 35. The petition for rehearing en banc is DENIED. [11865271] [18-35845, 18-35872] (WL) [Entered: 10/20/2020 11:14 AM]
10/28/20	59	MANDATE ISSUED. (MDS, NRS and JRT) [11873840] [18-35845, 18-35872] (JFF) [Entered: 10/28/2020 08:55 AM]

* * * * *

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WASHINGTON
(SPOKANE)

Case No. 2:16-cv-00209-RMP

EMPIRE HEALTH FOUNDATION FOR VALLEY HOSPITAL MEDICAL CENTER, PETITIONER

v.

SYLVIA MATTHEWS BURWELL, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; THOMAS E. PRICE MD, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEFENDANTS

DOCKET ENTRIES

DATE	DOCKET NUMBER	PROCEEDINGS
6/9/16	1	COMPLAINT for Judicial Review Under the Medicare Act against Sylvia Matthews Burwell (Filing fee $ 400; Receipt # 0980-2356554) Filed by Empire Health Foundation. (Attachments: # 1 Exhibit Exhibit A to Complaint, # 2 Summons, # 3 Civil Cover Sheet) (Sherman, Teresa) (Entered: 06/09/2016)
		* * * * *
6/14/16	4	Summons Issued as to Sylvia Matthews Burwell. (SK, Case

DATE	DOCKET NUMBER	PROCEEDINGS
		Administrator) (Entered: 06/14/2016)
		* * * * *
12/5/16	11	MOTION to Dismiss for Lack of Jurisdiction by Sylvia Matthews Burwell. Motion Hearing set for 1/27/2017 Without Oral Argument before Judge Rosanna Malouf Peterson. (Attachments: # 1 Exhibit, # 2 Exhibit, # 3 Exhibit, # 4 Text of Proposed Order) (Bickford, James) (Entered: 12/05/2016)
		* * * * *
1/13/17	15	RESPONSE to Motion re 11 MOTION to Dismiss for Lack of Jurisdiction filed by Empire Health Foundation. Motion Hearing set for 2/28/2017 at 10:00 AM Spokane Courtroom 901 before Judge Rosanna Malouf Peterson. (Attachments: # 1 Text of Proposed Order) (Sherman, Teresa) (Entered: 01/13/2017)
2/3/17	16	REPLY MEMORANDUM re 11 MOTION to Dismiss for Lack of Jurisdiction filed by Sylvia Matthews Burwell. (Bickford, James) (Entered: 02/03/2017)

DATE	DOCKET NUMBER	PROCEEDINGS
2/28/17	17	Minute Entry for proceedings held before Judge Rosanna Malouf Peterson: Motion Hearing held on 2/28/2017 re 11 MOTION to Dismiss for Lack of Jurisdiction filed by Sylvia Matthews Burwell. (Reported/Recorded by: Ronelle F. Corbey) (MF, Courtroom Deputy) (Entered: 02/28/2017)
		* * * * *
9/1/17	22	ORDER GRANTING PLAINTIFF'S MOTION TO SUPPLEMENT THE RECORD 19 AND DENYING DEFENDANT'S MOTION TO DISMISS 11. Signed by Judge Rosanna Malouf Peterson. (VR, Courtroom Deputy) (Entered: 09/01/2017)
		* * * * *
9/20/17	26	ANSWER to Complaint by Thomas E Price MD. (Bickford, James) (Entered: 09/20/2017)
		* * * * *
1/26/18	34	MOTION for Summary Judgment by Empire Health Foundation. Motion Hearing set for **6/14/2018** at **10:00 AM** in Spokane Courtroom 901 before Judge Ro-

DATE	DOCKET NUMBER	PROCEEDINGS
		sanna Malouf Peterson. (Sherman, Teresa) (Entered: 01/26/2018)
		* * * * *
3/13/18	38	MOTION to Amend/Correct Administrative Record, MOTION to Vacate Briefing Schedule by Thomas E Price MD. Motion Hearing set for 4/12/2018 Without Oral Argument before Judge Rosanna Malouf Peterson. (Attachments: # 1 Text of Proposed Order) (Bickford, James) (Entered: 03/13/2018)
		* * * * *
3/13/18	40	TEXT-ONLY ORDER (no PDF will issue) granting ECF No. 38, Motion to Amend/Correct Administrative Record, Motion to Vacate Briefing Schedule, and ECF No. 39, Motion to Expedite hearing of the same. Defendant shall produce the missing rulemaking record to Plaintiff no later than March 23, 2018. The current summary judgment briefing schedule as outlined in the Court's text-order at ECF No. 37 is vacated, and a new briefing

DATE	DOCKET NUMBER	PROCEEDINGS
		schedule will be set after consultation between the attorneys. This text-only entry constitutes the Court's ruling on these matters. Signed by Judge Rosanna Malouf Peterson. (MS, Judicial Assistant) (Entered: 03/13/2018)
		* * * * *
5/9/18	46	Cross MOTION for Summary Judgment by Thomas E Price MD. Motion Hearing set for 7/10/2018 at 01:30 PM in Spokane Courtroom 901 before Judge Rosanna Malouf Peterson. (Attachments: # 1 Text of Proposed Order) (Bickford, James) (Entered: 05/09/2018)
5/9/18	47	RESPONSE to Motion re 34 MOTION for Summary Judgment filed by Thomas E Price MD. (Bickford, James) (Entered: 05/09/2018)
6/8/18	48	REPLY MEMORANDUM re 46 Cross MOTION for Summary Judgment, 34 MOTION for Summary Judgment filed by Empire Health Foundation. (Sherman, Teresa) (Entered: 06/08/2018)
6/29/18	49	REPLY MEMORANDUM re 46 Cross MOTION for Summary Judgment filed by Thomas E

DATE	DOCKET NUMBER	PROCEEDINGS
		Price MD. (Attachments: # 1 Exhibit Memorandum Opinion in Stringfellow v. Azar) (Bickford, James) (Entered: 06/29/2018)
		* * * * *
7/10/18	53	Minute Entry for proceedings held before Judge Rosanna Malouf Peterson: Motion Hearing held on 7/10/2018 re 46 Cross MOTION for Summary Judgment filed by Thomas E Price MD, 34 MOTION for Summary Judgment filed by Empire Health Foundation. (Reported/Recorded by: Allison R. Stovall) (MF, Courtroom Deputy) (Entered: 07/10/2018)
		* * * * *
8/3/18	55	APPENDIX (Rulemaking Record) by Thomas E Price MD. (Bickford, James) (Entered: 08/03/2018)
8/3/18	56	APPENDIX (PRRB Record) by Thomas E Price MD. (Bickford, James) (Entered: 08/03/2018)
8/13/18	57	ORDER GRANTING IN PART AND DENYING IN PART 34 PLAINTIFFS MOTION FOR SUMMARY JUDGMENT, AND DENYING 46 DEFENDANTS

DATE	DOCKET NUMBER	PROCEEDINGS
		MOTION FOR SUMMARY JUDGMENT. Case is CLOSED. Signed by Judge Rosanna Malouf Peterson. (LR, Case Administrator) (Entered: 08/13/2018)
81/3/18	58	JUDGMENT IN A CIVIL ACTION in favor of Plaintiff. (LR, Case Administrator) (Entered: 08/13/2018)
		* * * * *
10/11/18	59	LODGED NOTICE OF APPEAL from District Court decision as to 58 Clerk's Judgment, 57 Order on Motion for Summary Judgment, by Thomas E Price MD. Filing fee $505, receipt number WAIVED. (Bickford, James) (Entered: 10/11/2018)
10/11/18	60	NOTICE OF APPEAL from District Court decision as to 58 Clerk's Judgment filed 8/13/18 57 Order on Motion for Summary Judgment filed 8/13/18 by Thomas E Price MD cc: Court Reporter: Ronelle Corbey, Allison Stovall. (VR, Courtroom Deputy) Modified on 10/12/2018 (**9CCA No. 18-35845**) (VR, Courtroom Deputy). (Entered: 10/11/2018)

DATE	DOCKET NUMBER	PROCEEDINGS
		* * * * *
10/17/18	64	NOTICE OF CROSS APPEAL from District Court decision as to 58 Clerk's Judgment, 57 Order on Motion for Summary Judgment, by Empire Health Foundation. Filing fee $505, receipt number 0980-3012047. (Sherman, Teresa) Modified on 10/19/2018 (**9CCA No. 18-35872**) (VR, Courtroom Deputy). (Entered: 10/17/2018)
		* * * * *
5/5/20	68	9CCA Slip Opinion: Decision of the District Court is Affirmed & Remanded. 9CCA Case No. 18-35845 & 18-35872. (SG, Case Administrator) (Entered: 05/05/2020)
		* * * * *
10/28/20	71	MANDATE from 9CCA as to 60 Notice of Appeal, filed by Thomas E Price MD and 64 Notice of Cross Appeal, filed by Empire Health Foundation. Decision of the District Court is Affirmed and Remanded. 9CCA: 18-35845 & 18-35872. (SG, Case Administrator) (Entered: 10/28/2020)

DATE	DOCKET NUMBER	PROCEEDINGS
11/30/20	72	MOTION to Enforce Judgment of Mandate of the Court of Appeals by Empire Health Foundation. Motion Hearing set for **1/21/2021** Without Oral Argument before Judge Rosanna Malouf Peterson. (Sherman, Teresa) (Entered: 11/30/2020)
		* * * * *
1/8/21	78	MEMORANDUM in Opposition re 72 MOTION to Enforce Judgment of Mandate of the Court of Appeals filed by Thomas E Price MD. (Bickford, James) (Entered: 01/08/2021)
1/25/21	79	REPLY MEMORANDUM re 72 MOTION to Enforce Judgment of Mandate of the Court of Appeals filed by Empire Health Foundation. (Hettich, Daniel) (Entered: 01/25/2021)
3/12/21	80	ORDER GRANTING IN PART AND DENYING IN PART 72 PLAINTIFF'S MOTION TO ENFORCE MANDATE OF THE COURT OF APPEALS; Court REMANDS to the Provider Reimbursement Review Board. Case Management Deadline set for 9/13/2021. Signed by Judge Rosanna Malouf Peterson.

DATE	DOCKET NUMBER	PROCEEDINGS
		(SG, Case Administrator) (Entered: 03/12/2021)

* * * * *

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WASHINGTON

No.

EMPIRE HEALTH FOUNDATION FOR VALLEY HOSPITAL MEDICAL CENTER MEDICARE COST REPORT 09/30/2008, PLAINTIFF

v.

SYLVIA MATTHEWS BURWELL SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEFENDANT

Filed: June 9, 2016

COMPLAINT FOR JUDICIAL REVIEW UNDER THE MEDICARE ACT

The above-named Plaintiff, by and through their undersigned counsel, state the following in the form of this Complaint against SYLVIA MATTHEWS BURWELL, Secretary of the United States Department of Health and Human Services (the "Secretary"):

I. INTRODUCTION

1. Plaintiff (also referred to hereinafter as the "Hospital") was, at all relevant times, a not-for-profit hospital that participated in the Medicare and Medicaid programs. The Hospital challenges the Secretary's policy of treating patient days for which no payment was received under Medicare Part A as nonetheless "entitled to benefits under part A" for purposes of calculat-

ing both fractions of the Disproportionate Share Hospital ("DSH") payment adjustment. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi) (the "Medicare DSH Statute"). If the Secretary's treatment of unpaid Part A days as "days entitled to benefits under part A" is upheld, the Hospital contends that the Secretary must at least apply that interpretation of the word "entitled" consistently by also treating days for which no supplemental security income payments were received as days "entitled to supplemental security income benefits" under 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).

As explained below, the Secretary's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring) ("HHS thus interprets the word "entitled" differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this term is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); *see also Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets. . . . ").

II. JURISDICTION AND VENUE

2. This action arises under Title XVIII of the Social Security Act, as amended ("Medicare Act") (42 U.S.C.

§§ 1395 et. seq.), and the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 551 et seq.

3. This Court has jurisdiction under 42 U.S.C. § 1395oo(f)(1), to review a final decision of the Provider Reimbursement Review Board ("PRRB"). The final decision of the PRRB, granting expedited judicial review, was issued April 8, 2016 under PRRB Case No. 15-3126GC, a copy of which is attached hereto as Exhibit "A." This decision was received by the Hospital several days after it was issued and this action is therefore timely pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1801.

4. Pursuant to 42 U.S.C. § 1395oo(f)(1), venue is proper in the judicial district in which the provider is located. Plaintiff is located in the judicial district for Eastern Washington.

III. PARTIES

5. Plaintiff, Empire Health Foundation, acquired the assets consisting of any outstanding Medicare reimbursement owed to Valley Hospital Medical Center for the Medicare cost year at issue. Valley Hospital Medical Center operated a short-term acute care hospital assigned Medicare Provider No. 50-0119, with this action covering its Medicare fiscal year ending September 30, 2008. At all relevant times, Plaintiff had a Medicare provider agreement and was eligible to participate in the Medicare Program.

6. Defendant, SYLVIA MATTHEWS BURWELL is the Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington D.C. 20201, the federal agency responsible for

the administration of the Medicare and Medicaid Programs. Defendant BURWELL is sued in her official capacity. References to the Secretary herein are meant to refer to her, to her subordinates, and to her official predecessors or successors as the context requires.

7. The Center for Medicare and Medicaid Services ("CMS") is a component of the Department of Health and Human Services ("HHS") with responsibility for day-to-day operations and administration of the Medicare program. References to CMS herein are meant to refer to the agency and its predecessors.

IV. THE MEDICARE PROGRAM

8. Congress enacted the Medicare Program (Title XVIII of the Social Security Act) in 1965. As originally enacted, Medicare was a public health insurance program that furnished health benefits to the aged, blind and disabled. Over the years, the scope of benefits and covered individuals has been expanded.

9. Among the benefits covered by Medicare are inpatient hospital services. For cost reporting years beginning prior to October 1, 1983, the Medicare Program reimbursed inpatient hospital services on a "reasonable cost" basis. 42 U.S.C. § 1395f(b). Effective with cost reporting years beginning on or after October 1, 1983, Congress adopted a prospective payment system ("PPS") to reimburse most acute care hospitals, including Plaintiff, for inpatient operating costs. 42 U.S.C. § 1395ww(d). Under PPS, hospitals are paid a fixed amount for services rendered based upon diagnosis-related groups ("DRGs"), subject to certain payment adjustments, such as the DSH payment at issue here.

10. The Secretary has delegated much of the responsibility for administering the Medicare Program to CMS, which was formerly known as the Health Care Financing Administration. The Secretary, through CMS, contracted out many of the audit and payment functions for inpatient hospital care furnished to Medicare program beneficiaries to organizations known as fiscal intermediaries or Medicare administrative contractors ("Medicare contractor"). 42 U.S.C. § 1395h.

11. At the close of the fiscal year, a hospital provider of services must submit to its Medicare contractor a cost report showing the allowable costs incurred and amounts due from Medicare for the fiscal year and the payments received from Medicare. The Medicare contractor is required to audit the cost report and inform the hospital provider of a final determination of the amount of Medicare reimbursement through a Notice of Program Reimbursement ("NPR"). 42 CFR §405.1803.

12. A hospital provider dissatisfied with its Medicare contractor's determination may file an appeal to the Provider Reimbursement Review Board ("PRRB") as long as the amount in controversy is $10,000 or more and the request for hearing is within 180 days of the date the hospital provider receives the NPR. 42 U.S.C. § 1395oo(a). The PRRB was established by the Social Security Amendments of 1972 (Pub. L. 92-603) as a national, independent forum for hearing and deciding payment disputes between hospital providers and their Medicare contractors.

13. Upon filing a timely hearing request, a hospital provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the PRRB within no later than 60 days after the

expiration of the applicable 180-day period to file the initial hearing request. 42 C.F.R. § 405.1835(e).

14. Pursuant to PRRB Rule 16 a hospital provider may transfer a specific issue from an individual appeal to an existing group appeal when there is a single common issue to be resolved. The PRRB Rules set out the documentation requirements for such a transfer.

15. The decision of the PRRB is a final administrative decision, unless the Secretary, through the Administrator of CMS, reviews the PRRB's decision; the Administrator may reverse, affirm or modify the PRRB's decision. 42 U.S.C. § 1395oo(f). When the PRRB grants a hospital provider's request for expedited judicial review ("EJR") because it has jurisdiction over an appeal but lacks the authority to grant the relief requested, the Administrator of CMS may only review the jurisdictional component of the PRRB's EJR decision. The Administrator of CMS may not review the PRRB's determination of its authority to decide the legal question. 42 C.F.R. § 405.1842(g)(1)(i) and (ii).

16. A hospital provider has the right to obtain judicial review of any final decision of the PRRB, or of the Secretary, by filing a civil action within 60 days of the date on which notice of any final decision by the PRRB, or of any reversal, affirmance, or modification by the Secretary, is received. 42 U.S.C. § 1395oo(f). Pursuant to 42 C.F.R. § 405.1801 the date of receipt for a decision of the PRRB is presumed to be 5 days after the date of issuance of such decision. If the PRRB grants EJR, the hospital provider may file a complaint in Federal district court in order to obtain review of the legal question. 42 C.F.R. § 405.1842(g)(2).

V. THE MEDICARE DISPROPORTIONATE SHARE PAYMENT ADJUSTMENT

17. In 1986, Congress amended Title XVIII of the Social Security Act to require the Secretary to make additional payments to hospitals that serve "a significantly disproportionate number of low-income patients . . . " 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Eligibility for these "disproportionate share" (DSH) payments, and the level of these payments, is based on the calculation of a "disproportionate share percentage" that considers the number of low-income patients a hospital serves. See 42 U.S.C. §§ 1395ww(d)(5)(F)(v) and (vi).

18. As the Ninth Circuit observed in *Portland Adventist Medical Ctr. v. Thompson*, 399 F.3d 1091, 1095 (9th Cir. 2005) (quoting *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996)):

> Congress "overarching intent" in passing the [Medicare] disproportionate share provision was to supplement the prospective payment system payments of hospitals serving "low income" persons . . . Congress intended the Medicare and Medicaid fractions to serve as a proxy for all low-income patients.

19. To be eligible for the DSH payment, a hospital must meet certain systemic criteria, including a disproportionate patient percentage that exceeds the threshold. The amount of the DSH payment then depends upon the extent to which the disproportionate patient percentage exceeds the threshold.

20. The disproportionate patient percentage is statutorily defined as the sum of two fractions expressed as a percentage for a hospital's cost reporting period.

These fractions are commonly known as the "SSI fraction" and the "Medicaid fraction," respectively, and are defined as follows:

> (I) The fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such dates) 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 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 title,
>
> . . .
>
> (II) The fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient 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 of this chapter, 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's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi) (emphasis added).

21. As set forth in the statutory language above, the numerator of the Medicaid fraction consists of days of patients who were both *eligible* for medical assistance under Title XIX, or Medicaid, and *not entitled* to benefits under Part A of Title XVII, or Medicare. The denominator for the Medicaid fraction is the hospital's total patient days for the period. The statutory language

defines the SSI fraction as consisting solely of days for patients who were "*entitled* to benefits under part A" of Medicare. The denominator of the SSI fraction includes all Part A days, and the numerator includes only those Part A days for patients who are also *entitled* to social security income ("SSI") benefits.

22. The Secretary implemented the Medicare DSH provisions through 42 C.F.R. § 412.106. The portion of the regulation which applies to the SSI fraction, prior to the change in language in 2008, states:

> (b) *Determination of a hospital's disproportionate patient percentage—*
>
> (1) *General Rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
>
> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) Determines the number of **covered** patient days that—
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;
>
> (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 associate with discharges that occur during that period; and

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

(emphasis added to the word "**covered**"). The change to the regulation which first appeared in the 2008 regulations, but allegedly effective October 1, 2004, omits the word "covered":

(b) *Determination of a hospital's disproportionate patient percentage—*

(1) *General Rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(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 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 supplementation;

(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 associate with discharges that occur during that period; and

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

23. While the Secretary attempted to enshrine her policy in regulation by amending 42 C.F.R. § 412.106(b)(2) through rulemaking as described above, she has now acquiesced to the D.C. Circuit's decision in *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014) ("*Allina*") that her rulemaking process violated the APA. Since all hospitals have recourse to the D.C. Circuit for their Medicare reimbursement appeals, the Secretary conceded that "the 2004 Final Rule has ceased to exist." *See* Def's Response to the Court's Sept. 29, 2014 Minute Order at 2, *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012), *aff'd in part, rev'd in part*, 746 F.3d at 1111 (No. 1:14-cv-01415-RMC), ECF No. 13 ("Because the D.C. Circuit upheld [the vacat[ur] of the 2004 Final Rule] . . . , the 2004 Final Rule has ceased to exist"); *see also* 42 U.S.C. § 1395hh(a)(4) (stating that when a final Medicare rule is not the logical outgrowth of a proposed rule that it "shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation").

That recently invalidated regulation, however, was clearly relied upon in establishing the Hospital's DSH percentage for its 2008 cost reporting period and was

relied upon in the final decision of the Secretary in this case. *See* Exhibit A.

While the Hospital believes that the reliance on the invalidated regulation was error, it is nonetheless true that the Secretary continues to consider an individual to be "entitled to benefits under Part A," regardless of whether the days were "covered" or not "covered" by Medicare Part A, even in the absence of the invalidated regulation.

In other words, it is the Secretary's policy that non-covered categories of Medicare Part A days—for example, days for which Part A benefits have been exhausted, days for which payment was made under Part C and not Part A, and days for which Medicare Part A was a secondary payor and therefore made no payments, are included in the SSI fraction and, even if Medicaid eligible, excluded from the Medicaid fraction.

24. Despite the Secretary's policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS has at all times required that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be included in the numerator of the SSI fraction as a day "entitled to supplemental security income benefits." The Secretary, therefore, does not include days in the numerator of the SSI fraction when individuals were eligible for SSI but did not receive SSI payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee problems, Medicaid paying for more than 50% of the cost of care in a medical facility, or the period of hospitalization is during the first month of eligibility before a cash pay-

ment is made. This policy ultimately reduces the Secretary's DSH payment obligation, as does the Secretary's wholly inconsistent policy of treating unpaid Part A days as days entitled to benefits under Part A.

25. Of more than 100 Social Security Administration payment status codes, the Secretary only uses C01, M01, and M02, to identify SSI entitled individuals. 75 Fed. Reg. 50280-50281 (August 16, 2010).

The Secretary is aware of other payment codes, as identified in the August 16, 2010 Federal Register, that could be used to determine the numerator of the SSI fraction, but has adopted a policy of including only codes reflecting actual SSI cash payments. *Id.*

26. The Secretary has a consistent practice of limiting and paying out as little money as possible to hospitals. An analysis of CMS Administrator decisions (Exhibit P-4 to Plaintiff's Position Paper filed with the PRRB) demonstrates the Secretary's bias and record of ruling against hospitals in appeals for Medicare reimbursement.

27. In sum, the Secretary contends that "the phrase 'entitled to benefits under part A' applies to all individuals who meet the statutory criteria in 42 U.S.C. § 426(a) and (b) for receiving 'hospital insurance benefits under Part A,'" *Northeast Hosp. Corp.*, 657 F.3d at 20 n.1, but does not interpret the analogous phrase "entitled to supplemental security income benefits" as encompassing all individuals who meet the statutory criteria in 42 U.S.C. § 1382(a) for receiving supplemental security income benefits. Because these contradictory interpretations reduce the Secretary's DSH payment obligation, they can only be reconciled with the Secretary's interest in

"paying out as little money as possible." *Id.* The Secretary has, therefore, arbitrarily and capriciously adopted two conflicting interpretations of the same word in the same sentence.

VI. THE HOSPITAL'S ADMINISTRATIVE APPEAL

28. On August 10, 2012, the Medicare contractor, Wisconsin Physicians Services, issued a NPR for the Hospital's cost reporting period ending September 30, 2008 ("FYE 9/30/2008").

29. This NPR for FYE 9/30/2008 was timely appealed to the PRRB on November 1, 2012 by written request for hearing. The PRRB assigned Case No. 13-0059 for the hearing request.

30. The Hospital timely added additional issues to PRRB Case No. 13-0059, including the issue currently before this Court, and subsequently transferred the issue to the group that was the subject of the PRRB's EJR decision at issue here.

31. The Hospital then filed Requests to Transfer some of the issues to existing group appeals pursuant to the Board's Rules. The DSH SSI percentage Systemic Errors issue was transferred to Case. No. 15-3126GC.

32. In a related decision for the only other provider in PRRB Case 15-3126GC, Deaconess Medical Center fiscal year end 9/30/2008, the PRRB found it did not have jurisdiction over Deaconess's appeal because of unique procedural circumstances that are not applicable to the Hospital here. The PRRB therefore dismissed Deaconess's appeal on February 23, 2016 and Empire Health Foundation filed a Complaint for Judicial Review of that final decision on April 27, 2016 under Cause No. 2:16-cv-00135-RMP in this Court.

33. By decision dated April 8, 2016, the PRRB found that it had jurisdiction over the Hospital's appeal but lacked the authority to grant the relief requested by the Hospital and therefore granted the Hospital's request for EJR on the group appeal issue in PRRB Case No. 15-3126GC. A copy of this decision is attached as Exhibit "A".

VII. ASSIGNMENT OF ERRORS

34. The applicable provisions of the APA provide that the "reviewing court shall . . . hold unlawful and set aside agency action . . . found to be . . . (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; . . . (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right; (D) without observance of procedure required by law; [or] (E) unsupported by substantial evidence[.]" 5 U.S.C. §706(2).

35. The Secretary's determination to treat days for which no Part A payments were made as nonetheless "entitled to benefits under part A" is arbitrary and capricious and otherwise contrary to law because it is:

a) inconsistent with the plain language of the Medicare statute and conflates the statutory term "entitled" with the statutory term "eligible";

b) inconsistent with the plain language of the controlling pre-2004 regulation, which explicitly included only "covered," i.e., "paid," Part A days and that pre-2004 is controlling since CMS admitted that its attempt to amend that 2004 regulation was procedurally invalid and "ceased to exist";

c) inconsistent with the Secretary's longstanding interpretation of "entitled to benefits under Part

A" to mean "entitled to payment under Part A," *see* 55 Fed. Reg. 35990, 35996 ("entitle[ment] to benefits under part A" ceases when "[e]ntitlement to payment under part A ceases"); and

d) inconsistent with the Secretary's longstanding interpretation of "entitled to supplemental security income benefits" as including only SSI days for which payment was actually made, *see, e.g.,* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010) (stating that "[e]ntitlement to" receive SSI benefits [requires that an individual] 'be paid benefits by the Commissioner of the Social Security'. . . . ").

36. The Secretary's interpretation of "entitled to supplemental security income benefits" under 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) as including only days for which actual SSI payments were made is arbitrarily and capriciously inconsistent with her policy described above of treating *un*paid Part A days as "entitled to benefits under part A" and arbitrarily assigns two different meanings to the same term "entitled."

In addition, because the purpose of the DSH adjustment is to provide additional payment to hospitals that incur higher costs in treating low-income patients, an agency interpretation that does not take into account SSI payment status codes associated with *eligible* SSI individuals is also unreasonably and impermissibly inconsistent with the legislative history and purpose of the Medicare DSH Statute.

37. For the reasons set forth above, the Secretary's amendment of the regulation, and policy in its applica-

tion, conflicts with the Medicare DSH Statute and is otherwise arbitrary and capricious, as well as an abuse of discretion.

WHEREFORE the Hospital requests an order:

(a) Declaring invalid and enjoining the Secretary from applying her policy that unpaid Medicare Part A days are "days entitled to benefits under part A" for purposes of the DSH SSI and Medicaid fractions or, in the alternative, directing the Secretary to include unpaid SSI eligible patient days in the numerator of the SSI percentage utilizing SSI payment status codes that reflect the individuals' eligibility for SSI—even if the individuals did not receive SSI payments;

(b) Directing the Secretary to calculate the Plaintiff Hospital's DSH payment consistent with that Order and to make prompt payment of any additional amounts due to the Plaintiff Hospital plus interest calculated in accordance with 42 U.S.C. § 1395oo(f)(2); and

(c) For Plaintiff's costs and reasonable attorney's fees, and for such other and further relief as the Court deems appropriate.

Dated this 9th day of June, 2016.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 409, and 489

Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services

AGENCY: Health Care Financing Administration (HCFA), HHS

ACTION: Final rule.

* * * * *

E. Hospitals with Disproportionate Numbers of Low Income Patients or Medicare Beneficiaries or Both

Section 1886(d)(5)(C)(i) authorizes adjustments to the propsective payment rates in consideration of the special needs of certain classes of hospitals that incur additional costs because they serve a significantly disproportionate number of low income patients or Medicare Part A beneficiaries or both. We did not make special provisions for these hospitals in the regulations (§ 405.476) because our current data do not show that an adjustment is warranted.

Comment—A number of commenters stated that hospitals with disproportionate numbers of low income patients or Medicare beneficiaries or both should receive special treatment because of the excess cost of providing health care to this group resulting from additional staffing, supplies and lengths of stay. The commenters believe that a review and analysis of bad debt and charity cases should be undertaken in addition to the studies of Medicaid recipients which may vary from State to State.

Response—We have previously responded to this issue in the following documents:

Interim final notice on Schedules of Limits on Hospital Inpatient Operating Costs (47 FR 43296);

Final notice on Schedule of Limits on Hospital Inpatient Operating Costs (48 FR 39426); and

Interim final rules on Prospective Payment for Medicare Inpatient Hospital Services (48 FR 39752).

We direct you to our responses published in these documents for a complete discussion of the reasons for our decision not to make special provision in such cases.

In summary and after a careful review of all comments received, we repeat that the data now available to us do not indicate that Medicare cost is generally affected by disproportionate numbers of low income patients or Part A beneficiaries. Therefore, there is not a sufficient basis for providing for an exception or adjustment at this time for hospitals that treat these patients. These hospitals may have a problem with bad debts. However, under the Act and long-standing regulations, Medicare is prohibited from reimbursing for bad debts other than uncollectible deductible and coinsurance amounts attributable to Medicare beneficiaries. This part of the law was not altered by Pub. L. 98-21.

We are continuing to examine this issue further to determine what action may be appropriate with respect to these types of hospitals. After consultation with industry representatives, we have agreed to an independent study of our data. As of this date, the study is still ongoing. Preliminary analysis of 487,706 1980 discharges across the nation's large urban hospitals is

yielding results which differ greatly from other studies. Our preliminary work shows that:

- Large urban non-public general hospitals have an average length-of-stay for their Medicare patients that is 63 days greater than the average length-of-stay for Medicare patients at a public general hospital.

- Nineteen out of the 20 most common DRGs at large urban hospitals had greater Medicare average lengths-of-stay at the non-public general hospitals than at the public general hospitals.

- For the DRGs where discharge data is available, the majority of the DRGs have a longer Medicare average length-of-stay at the large non-public general urban hospitals compared to the public general hospitals.

- The percentage of Medicare average length-of-stay long-stay cases to hospital discharges is greater at the large non-public general urban hospitals compared to the public general hospitals. This conclusion was consistent across five separate definitions of long-stay case boundaries.

Our preliminary data analysis is using 1980 data from MEDPAR, the Medicare Cost Reports, the Office of Civil Rights hospital survey and other previously generated HCFA data such as the Medicare Case-Mix Index, the Bureau of Labor Statistics hospital wage index and the ratio of interns and residents to beds. These data are the best available data we have to conduct our analysis. We will evaluate the results once the final report is completed. If this evaluation shows there is a need and basis for an adjustment, we will take appropriate action.

Comment—One commenter suggested that the study we are conducting should not examine public general hospitals as a group, but rather those hospitals (both public general hospitals and private hospitals) which have a disproportionate number of low-income patients.

Response—Our current public general hospital analysis has examined a hospital's percentage of Medicaid admissions as an indicator of its proportion of low-income patients. This is the best surrogate variable available to use as an indicator of a hospital's proportion of low-income patients. Our current study results to date show that a significantly higher percentage of Medicaid patients are served by the public general hospitals compared to the other large urban hospitals. This finding leads us to believe that the public general hospitals as a group treat a higher proportion of low-income patients than do the private hospitals. We have not pursued a study which specifically examines low income patients independent of their Medicaid status because we do not have a measure of patients' incomes.

Comment—One commenter stated, that in their study, hospitals serving disproportionate numbers of low-income patients or Medicare beneficiaries have the following characteristics:

- Municipal hospitals have a greater concentration of more complex cases attributable to the variety of diagnoses within DRG's.

- Voluntary hospitals perform more surgery; however, the performance of surgery is not automatically associated with a higher level of complexity.

- A significantly greater proportion of outlier admissions occur through public hospital emergency rooms

and these may be associated with a significantly larger average length-of-stay.

- Cost alone may be inadequate to measure the special need of low-income patients. Additional focus is required on the needs of these patients, not merely the costs.

Response—Contrary to this commenter's study, preliminary findings from our current analysis indicate the following:

- Our 1980 national data for large urban hospitals has shown that the Medicare Case-Mix Index (MCMI) at the public general hospitals is 1.114. The MCMI at the other non-public general hospitals is 1.111. This difference is slight and was not statistically significant.

- Our study of large urban hospitals using 1980 data concludes that the non-public general hospitals have a longer Medicare average length-of-stay than the public general hospitals do. Our data show that these non-public general hospitals had an average length-of-stay of 11.59 days for their Medicare patients compared to the average length-of-stay for Medicare patients of 10.96 days at the public general hospitals. Our data also show that Medicare length-of-stay long-stay cases represent a higher percentage of Medicare discharges at the non-public general hospitals compared to the public general hospitals.

- The study is also looking at Medicare average cost per case and Medicare average length-of-stay. However, other "need" variables such as a hospital's percentage of patients having surgery, and the percentage of a hospital's inpatients admitted from the emergency room are being examined descriptively. As

many low-income patient resource need variables as are available are included in our current research.

* * * * *

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 413

[CMS–1470–P]

RIN 0938–AL89

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates

AGENCY: Centers for Medicare and Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

* * * * *

7. Dual-Eligible Patient Days

As described above, the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits. If a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction. This is consistent with the language of section 1886(d)(5)(F)(vi)(II) of the Act, which specifies that patients entitled to benefits under Part A are excluded from the Medicaid fraction.

This policy currently applies even after the patient's Medicare coverage is exhausted. In other words, if a

dual-eligible patient is admitted without any Medicare Part A coverage remaining, or the patient exhausts Medicare Part A coverage while an inpatient, his or her patient days are counted in the Medicare fraction before and after Medicare coverage is exhausted. This is consistent with our inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.

We are proposing to change our policy, to begin to count in the Medicaid fraction of the DSH patient percentage the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage has expired. We note the statute referenced above stipulates that patient days attributable to patients entitled to benefits under Medicare Part A are to be excluded from the Medicaid fraction, while the statute specifies the Medicaid fraction is to include patients who are eligible for Medicaid.

As noted above, our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted. We believe this interpretation is consistent with the statutory intent of section 1886(d)(5)(F)(vi)(II) of the Act. However, we recognize there are other plausible interpretations. In addition, on a more practical level, we recognize it is often difficult for fiscal intermediaries to differentiate the days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the States, which may vary from one State to the next. Some States identify all dual-eligible beneficiaries in their lists of Medicaid patient days provided to the hospitals, while in other States the fiscal intermediary must

identify patient days attributable to dual-eligible beneficiaries by matching Medicare Part A bills with the list of Medicaid patients provided by the State. The latter case is problematic when Medicare Part A coverage is exhausted because no Medicare Part A bill may be submitted for these patients. Thus, the fiscal intermediary has no data by which to readily verify any adjustment for these cases in the Medicaid data provided by the hospital. Currently, the fiscal intermediaries are reliant on the hospitals to identify the days attributable to dual-eligible beneficiaries so these days can be excluded from the Medicaid patient days count.

Therefore, in order to facilitate consistent handling of these days across all hospitals, we are proposing that the days of patients who have exhausted their Medicare Part A coverage will no longer be included in the Medicare fraction. Instead, we are proposing these days should be included in the Medicaid fraction of the DSH calculation. (We note that not all SSI recipients are Medicaid eligible. Therefore, it will not be automatic that the patient days of SSI recipients will be counted in the Medicaid fraction when their Part a coverage expires.)

Under this proposed change, before a hospital could count patient days attributable to dual-eligible beneficiaries in the Medicaid fraction, the hospital must submit documentation to the fiscal intermediary that justifies including the days in the Medicaid fraction after the Medicare Part A benefits have been exhausted. That is, if the State provides data on all the days associated with all dual-eligible patients treated at a hospital, regardless of whether the beneficiary had Medicare Part A coverage, the hospital is responsible for providing

documentation showing which days should be included in the Medicaid fraction because Medicare Part A coverage was exhausted.

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 to-

tal 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.

D. Medicare Geographic Classification Review Board (MGCRB) Reclassification Process (§ 412.230)

With the creation of the MGCRB, beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). Implementing regulations in subpart L of part 412 (§§ 412.230 *et seq.*) set forth criteria and conditions for redesignations for purposes of the wage index or the average standardized amount, or both, from rural to urban, rural to rural, or from an urban area to another urban area, with special rules for SCHs and rural referral centers.

Effective with reclassifications for FY 2003, section 1886(d)(10)(D)(vi)(II) of the Act provides that the MGCRB must use the average of the 3 years of hourly wage data from the most recently published data for the hospital when evaluating a hospital's request for reclassification. The regulations at § 412.230(e)(2)(ii) stipulate that the wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. To evaluate applications for wage index reclassifications for FY 2004, the MGCRB used the 3-year average hourly wages published in Table 2 of the August 1, 2002 IPPS final rule

(67 FR 50135). These average hourly wages are taken from data used to calculate the wage indexes for FY 2001, FY 2002, and FY 2003, based on cost reporting periods beginning during FY 1997, FY 1998, and FY 1999, respectively.

Last year, we received a comment suggesting that we allow for the correction of inaccurate data from prior years as part of a hospital's bid for geographic reclassification (67 FR 50027). The commenter suggested that not to allow corrections to the data results in inequities in the calculation in the average hourly wage for purposes of reclassification. In the August 1, 2002 IPPS final rule, we responded:

"Hospitals have ample opportunity to verify the accuracy of the wage data used to calculate their wage index and to request revisions, but must do so within the prescribed timelines. We consistently instruct hospitals that they are responsible for reviewing their data and availing themselves to the opportunity to correct their wage data within the prescribed timeframes. Once the data are finalized and the wage indexes published in the final rule, they may not be revised, except through the mid-year correction process set forth in the regulations at § 412.63(x)(2). Accordingly, it has been our consistent policy that if a hospital does not request corrections within the prescribed timeframes for the development of the wage index, the hospital may not later seek to revise its data in an attempt to qualify for MGCRB reclassification.

"Allowing hospitals the opportunity to revise their data beyond the timelines required to finalize the data used to calculate the wage index each year would lessen the importance of complying with those deadlines. The

likely result would be that the data used to compute the wage index would not be as carefully scrutinized because hospitals would know they may change it later, leading to inaccuracy in the data and less stability in the wage indexes from year to year."

Since responding to this comment in the FY 2003 IPPS final rule, we have become aware of a situation in which a hospital does not meet the criteria to reclassify because its wage data were erroneous in prior years, and these data are now being used to evaluate its reclassification application. In addition, in this situation, the hospital's wage index was subject to the rural floor because the hospital was located in an urban area with an actual wage index below the statewide rural wage index for the State, and it was for a time period preceding the requirement for using 3 years of data. Therefore, the hospital contends, it had no incentive to ensure its wage data were completely accurate. (However, we would point out that hospitals are required to certify that their cost reports submitted to CMS are complete and accurate. Furthermore, inaccurate or incomplete reporting may have other payment implications beyond the wage index.)

While we continue to have all of the concerns we expressed in last year's final rule, we now more fully understand this particular hospital's situation. Although we do have administrative authority to establish a policy allowing corrections for this particular set of circumstances, we are concerned about establishing a precedent that could reduce the importance of ensuring that the final wage data published in the annual IPPS final rule are complete and accurate. As we indicated in our response last year, we are concerned this could lead to

less accuracy and stability in the wage indexes from year to year.

However, we are soliciting comments on whether it may be appropriate to establish a policy whereby, for the limited purpose of qualifying for reclassification based on data from years preceding the establishment of the 3-year requirement (that is, cost reporting years beginning before FY 2000), a hospital in an urban area that was subject to the rural floor for the period during which the wage data the hospital wishes to revise were used to calculate the wage index, a hospital may request that its wage data be revised.

* * * * *

7. Dual-Eligible Patient Days

We are proposing to change our policy for counting days for patients who are Medicare beneficiaries and also eligible for Medicaid, to begin to count in the Medicaid fraction of the DSH patient percentage the patient days of these dual-eligible Medicare beneficiaries whose Medicare coverage has expired. Our current policy regarding dual-eligible patient days is they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient has no Medicare Part A coverage or coverage has been exhausted. However, we recognize it is often difficult for fiscal intermediaries to differentiate the days for dual-eligible patients whose Part A coverage has been exhausted. We believe the impact of this proposed change would be minimal, both because situations where dual-eligible patients exhaust their Medicare benefits occur infrequently, and because, due to the administrative difficulty separately identifying these days, in many cases they are already included

in the hospital's Medicaid fraction. Accordingly, we do not have data available to allow us to quantify the impact of this proposed change precisely.

* * * * *

MERCY Hospital

July 2, 2003

Thomas Scully, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1470-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: Medicare Program: Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates (Proposed Rule, 68 *Federal Register*), May 19, 2003.

Dear Mr. Scully,

On behalf of Mercy Hospital, a large urban short-term acute hospital located in Miami, Florida, I appreciate the opportunity to comment on the Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Federal Fiscal Year 2004 as published in the *Federal Register* dated May 19, 2003. Specifically, I will comment on proposed rules that will affect the Wage Index, Disproportionate Share payments, Indirect Medical Education payments, and the Transfer Payment Policy.

* * * * *

Issues Influencing Disproportionate Share Payments

We oppose the proposed rule for disproportionate share payments related to dual-eligible patients and we believe the comments regarding the Medicare+

Choice days are unclear. We continue to believe that providers should be given access to the patient detail that comprises the SSI fraction in order to verify and to assess proposed changes to it.

- ***We do not support the proposal to remove Part A exhausted days from the SSI percentage.***

  We are uncomfortable with the removal of any item from the SSI percentage, as the details of the fraction have never been available to providers. It is unclear whether the removal of these days will result in revision to both the numerator and denominator of the SSI percentage and to what extent this will impact disproportionate share payments. Since we are not aware of the extent of Part A exhausted days included in the SSI fraction, we cannot accurately assess the financial impact.

  We can make the assumption that the days will only be removed from the numerator of the SSI fraction and added to the numerator of the Medicaid fraction. The result will be a loss ranging from approximately ($500,000) to ($800,000) for each 1,000 days adjusted based on a varied Medicaid eligibility percentage from 100% to 0%. Depending on the magnitude of the days removed and the Medicaid eligible percentage of the displaced days; this will definitely result in financial loss and is likely to be significant. Additionally, since providers will not be given a patient detailed list of Part A exhausted days removed; it will be improbable to capture all of the Medicaid eligible days from the population excluded from the SSI fraction.

* * * * *

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July 7, 2003

Mr. Thomas Scully
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1470-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: Comments on Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates; Proposed Rule

Dear Mr. Scully:

We have the following comments on the proposed rule for changes to the hospital inpatient prospective payment system (IPPS) for fiscal year 2004, published in the May 19, 2003, Federal Register.

* * * * *

Dual Eligible Days - Page 27207

CMS proposes to change its policy to include in the Medicaid percentage the patient days of dual eligible Medicare beneficiaries whose Medicare coverage has expired. We agree with the proposed change to include in the Med-

icaid percentage the patient days of dual eligible Medicare beneficiaries whose Medicare coverage has expired.

However, we recommend eliminating the requirement that the hospital submit documentation to the fiscal intermediary that justifies including the days in the Medicaid fraction. As indicated in the preamble, to identify these days is very difficult since these are usually patients that have exhausted their Part A benefits before entering the hospital. As a result, the hospital has identified these patients as Medicaid only. These patient days would already be counted as Medicaid.

* * * * *

HANYS
HEALTHCARE ASSOCIATION OF NEW YORK STATE

Representing New York State's Not-For-Profit Hospitals, Health Systems, and Continuing Care Providers

Daniel Sisto, President

July 7, 2003

The Honorable Thomas A. Scully
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room C5-14-03
Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1470-P; Medicare Program, Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2004 Rates; (68 *Federal Register* 96), May 19, 2003

Dear Administrator Scully:

The Healthcare Association of New York State (HANYS), on behalf of our more than 550 hospitals, nursing homes, home health agencies, and other health care providers, welcomes the opportunity to comment on the proposed rule related to the Medicare Prospective Payment System (PPS) for inpatient admissions.

* * * * *

Dual-Eligible Patient Days

CMS states that it is often difficult for fiscal intermediaries to differentiate the days for dual-eligible patients whose Part A coverage has been exhausted. Some states are able to report all dual-eligible beneficiaries in the lists of Medicaid days provided to hospitals, while in other states the intermediary must identify them by matching Medicare claims to the list of Medicaid patients provided by the state. In these cases, there may be no Medicare claim submitted for patients who have exhausted their Part A coverage. Currently, the intermediary must rely on the hospital to identify dual-eligible days for exclusion from the Medicaid count.

CMS is proposing that the days of dual-eligible patients who have exhausted their Medicare Part A coverage no longer be included in the Medicare fraction. Instead, these days would be included in the Medicaid fraction of the Disproportionate Share Hospital (DSH) calculation. Under this proposal, hospitals would be required to submit information to the fiscal intermediary documenting the days included in the Medicaid fraction after the Medicare Part A benefits have been exhausted.

The proposal will result in a redistribution of DSH funds. This would be justifiable if it resulted in more equitable payments. However, CMS did not make this proposal based on policy considerations. Instead, the proposal is based on practical considerations aimed at making determinations of the DSH days easier and more uniform. In fact, the proposal does not improve the process for identifying the days to be used in the DSH calculation. Currently, hospitals must provide the fiscal intermediary with a report of all dual-eligible days for exclusion from the Medicaid count. Under the proposal, hospitals would

instead be required to report the days incurred by dual-eligible patients after exhausting Part A coverage to include in the Medicaid count. This will be at least as difficult for hospitals to collect and for intermediaries to verify. Moreover, it will be difficult for hospitals to provide the data required under this proposal.

In addition, fiscal intermediaries now have a process and criteria in place to collect and review the required information for this calculation. The proposal would require major changes in the data required to determine Medicaid days. Because data are provided by state Medicaid programs and individual hospitals, this will be a complicated process for everyone involved. Given that the proposal serves no policy objective and the practical benefits are doubtful, we urge that CMS not change the rules for counting dual-eligible days.

* * * * *

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July 7, 2003

[By Federal Express]

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1470-P
Room 443-G
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: CMS-1470-P
Hospital Inpatient PPS Proposed Rule for FFY 2004
Disproportionate Share Payments
Treatment of Dual-Eligible Patients Who Have Exhausted Part A Coverage

Dear Sir or Madam:

These comments relate to CMS' preamble discussion in the proposed inpatient hospital PPS rule for federal fiscal year 2004 of how it will count in the disproportionate share payment formula the days of inpatient services furnished to patients who are dual-eligible but who have exhausted their Medicare Part A coverage.

We support the proposal to count dual-eligible days in the Medicaid fraction when a patient has exhausted the days of Part A coverage during a spell of illness. We disagree, however, that CMS' description of its past practice is correct, and believe that the proposed policy must also be applied retrospectively to all open cost reporting periods.

In the preamble, CMS summarizes the current treatment of days for a dual-eligible patient when the patient has exhausted his or her Part A coverage of inpatient days for a spell of illness by saying:

> If a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction. [68 Fed. Reg. 27207, col. 3]

This description of past practice is at odds with the plain language of the regulation. The regulation describes the Medicare fraction as including "covered patient days" only. 42 C.F.R. § 412.106(b)(2)(i). A day of care furnished to a Medicare beneficiary who has exhausted his or her Part A benefits is not a "covered patient day" and thus could not be properly included in the past or future in the Medicare fraction. Moreover, not all dual-eligible patients are entitled to SSI benefits. To the extent that dual-eligible patients were not entitled to SSI benefits, under CMS' regulation and the statute, they should not have been included in the Medicare fraction. Thus, CMS' description of its past practice is irreconcilable with the wording of the law and regulation.

Apart from the limitations of the law and regulation, CMS' description of its past practice is factually unsupportable. First, CMS could not have included days in the Medicare fraction for dual-eligible patients who were not entitled to SSI benefits since those patients could not have been included in the SSI data furnished by the Social Security Administration to CMS. Second, it is our understanding that the MedPAR data that is matched with SSI data furnished by the Social Security Administration does not include data for noncovered services furnished after patients have exhausted days of coverage in a spell of illness. Finally, the information emerging in pending appeals on the Medicare fraction shows that such days were not included in the fraction.

If CMS chooses to stand by the preamble statements that are factually and legally incorrect, it will squander its credibility with the courts and sets itself up not only to lose as the issue is litigated but to subject itself to paying attorney fees and other sanctions.

The proposed policy should be applied retrospectively to all open cost reports.

* * * * *

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Jordan J. Cohen, M.D., President

July 8, 2003

Thomas A. Scully, Administrator
Centers for Medicare & Medicaid Services
Humbert H. Humphrey Building
Room 443-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMSA-1470-P**

Dear Administrator Scully:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services" (CMS or the Agency) proposed rule entitled "*Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates.*" 68 Fed. Reg. 27154 (May 19, 2003). The AAM:C represents approximately 400 major teaching hospitals and health systems; all 126 accredited U.S. medical schools; 96 professional and academic societies; and the nation's medical students and residents.

A primary focus of this letter is to comment on proposed changes to the regulations for Medicare direct graduate medical education (DGME) and indirect medical educa-

tion (IME) payments that, if finalized, would dramatically and fundamentally change the purpose of these payments.

We also believe the cost threshold under the Medicare outlier payment methodology must be reduced substantially below that published in proposed rule. In fact, we believe that as a result of the changes in the outlier final rule published on June 9, 2003 (68 Fed. Reg. 34494), the outlier threshold for Federal fiscal year (FY) 2004 must be set below the FY 2003 level in order to ensure that the statutorily mandated level of outlier payments is achieved.

We also believe other aspects of the proposed rule must be addressed, including:

- Withdrawing the proposal to expand the post-acute care transfer policy,
- Clarifying the initial residency period for specialties requiring a general clinical training year,
- Reconsidering the nursing and allied health proposals,
- Withdrawing proposals relating to counting beds and patient days for Medicare IME and disproportionate share (DSH) payment methodologies, and
- Addressing wage index, new technology, and drug-eluting stent payment policies.

* * * * *

VII. THE PROPOSALS AFFECTING PATIENT DAY COUNTS FOR MEDICARE DSH PAYMENTS SHOULD BE MODIFIED IN THE FINAL RULE

The methodology for calculating Medicare disproportionate share (DSH) payments involves two fractions: 1) inpatient days associated with Medicare patients receiving supplemental security income (SSI) divided by total Medicare inpatient days, and 2) inpatient days associated with Medicaid patients divided by total inpatient days. Patient days associated with patients eligible for both Medicare and Medicaid (so called "dual eligibles") currently are included in the Medicare SSI inpatient day count and not the Medicaid count.

A. Dual-Eligible Patient Days

The proposed rule would include the patient days of dual eligible Medicare patients whose Medicare coverage has expired in the Medicaid fraction of the DSH methodology. They currently are included in the Medicare fraction.

CMS acknowledges that the current policy is consistent with statutory intent (68 Fed. Reg. at 27208). Thus, it appears that the proposed rule change is due solely to practical considerations regarding fiscal intermediaries' abilities in obtaining data on Medicare SSI beneficiaries.

We find CMS' rationale for making this change unconvincing particularly given the new administrative burden it will place on hospitals to provide documentation to fiscal intermediaries that a patient's Medicare Part A coverage has been exhausted.

* * * * *

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July 8, 2003

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W. Room 443-G
Washington, DC 20201

RE: TECHNICAL ADDENDUM

Ref: CMS-1470-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2004 Rates; Proposed Rule (68 *Federal Register* 27154), May 19, 2003.

Dear Mr. Scully:

On behalf of our nearly 5,000 member hospitals, health care system, networks and other providers of care, the American Hospital Association (AHA) appreciates the opportunity to submit this technical addendum in addition to our comment letter of July 2, 2003 on the Centers for Medicare & Medicaid Services (CMS) proposed rule establishing new policies and payment rates for hospital inpatient services for fiscal year (FY) 2004. Specifically, we would like to provide additional comments related to the outlier threshold the post-acute care transfer policy,

and the counting of patient days for calculating Medicare disproportionate share hospital (DSH) payments.

* * * * *

Dual-Eligible Patient Days

The AHA opposes CMS's proposed change in the counting of dual-eligible patient days for the purpose of calculating the disproportionate share hospital (DSH) patient percentage.

The DSH patient percentage is a sum of two fractions: the "Medicare fraction," calculated as the number of patient days attributable to patients eligible for both Medicare Part A and SSI benefits divided by total Medicare days, and the "Medicaid fraction," calculated as the number of patient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits divided by total patient days. CMS is proposing a change to its treatment of dual eligible patients who have exhausted their Medicare coverage. Rather than continue to include these patients as part of the Medicare fraction, CMS is proposing to exclude them from the Medicare fraction and count them in the Medicaid fraction.

CMS provides no justified reason for making this change, and there are clear reasons <u>not</u> to make this change. First, CMS clearly states in the proposed rule that the current formula is consistent with statutory intent (page 27208). Second, the proposed change would place a significant new regulatory and administrative burden on hospitals. CMS indicates in the rule that "it is often difficult for fiscal intermediaries (FIs) to differentiate days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the States, which may vary from

one State to the next." The shift of this administrative burden to hospitals is unjustified, especially given the inability of hospitals to access this information. Government agencies, specifically the FIs and the States, have records regarding the Medicaid and Medicare status of patients as well as information regarding whether they have exhausted their benefits.

Additionally, it is likely that this proposed change would result in reduced DSH payments to hospitals. Any transfer of a particular patient day from the Medicare fraction (based on total *Medicare* patient days) to the Medicaid fraction (based on *total* patient days) will dilute the value of that day, and therefore reduce the overall patient percentage and the resulting DSH adjustment. **Thus the calculation of dual-eligible days must not be changed.**

* * * * *

Charles N. Kahn III
President

July 8, 2003

Mr. Thomas A. Scully
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: CMS-1470-P Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2004 Rates *(68 Federal Register 12153)*

Dear Administrator Scully:

The Federation of American Hospitals ("FAH") is the national representative of privately owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, and provide a wide range of acute and post-acute services. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") proposed

rule regarding changes to the hospital inpatient prospective payment system and FY04 rates.

* * * * *

F. Dual-Eligible Patient Days

The FAH also opposes CMS's proposed policy change regarding counting dually eligible patient days. Under current law, patients entitled to Medicare Part A and eligible for Supplement Security Income ("SSI") are included in the "Medicare fraction" for DSH payment purposes. (SSA § 1886(d)(5)(F)(vi)(I).) CMS's proposed policy change would affect patients that are entitled to Medicare Part A and SSI benefits, but do not have Medicare coverage for particular inpatient services because they have exhausted their allotment of covered days for such services under the Medicare Part A benefit ("Exhausted Days"). CMS proposes to remove Exhausted Days from the Medicare fraction. The Proposed Rule also appears to indicate that if a hospital provides sufficient and verifiable data, then CMS would include the Exhausted Days in the Medicaid fraction instead. (*See* SSA § 1886(d (5)(F)(vi)(II).)

From a reimbursement perspective, the proposed policy would result in a reduction of DSH payments when Exhausted Days are removed from the Medicare fraction, with the financial impact mitigated to some degree if the hospital can provide adequate data to include those days in the Medicaid fraction. Given the mechanics of the DSH payment formula, this means that under either scenario the hospital will receive lower DSH payments than what it currently receives. CMS does not expressly acknowledge this outcome, but the policy change seems driven by a desire to reduce DSH payments.

The FAH believes that CMS lacks statutory authority to implement the proposed policy regarding Exhausted Days. The Medicare fraction of the statutory DSH payment methodology includes patients that are entitled to both Medicare Part A and SSI benefits. In our view, Exhausted Days patients remain entitled to Medicare Part A benefits, although they have reached their coverage limit for inpatient hospital services. However, CMS's proposed policy would remove these patients from the Medicare fraction based on the unfounded premise that patients who exhaust their *coverage* are, as a result, no longer *entitled* to Medicare Part A benefits. This conclusion confuses concepts and is improper under the Medicare statute.

A patient who exhausts his/her coverage for inpatient hospital services remains entitled to all Medicare Part A benefits, and will still receive covered services under other Part A benefit categories. Under CMS's proposed interpretation of the DSH statute, it is impossible to reconcile the position that these patients are not entitled to Medicare Part A when they can receive other covered Part A services, such as skilled nursing services. Therefore, we find CMS s proposed policy to be an impermissible and untenable interpretation of the Medicare statute. The FAH strongly urges CMS not to finalize this policy, and to leave the Exhausted Days in the Medicare fraction as part of the Medicare Part A entitlement variable.

While concluding that CMS is without statutory authority to remove Exhausted Days from the Medicare fraction, the FAH also believes CMS lacks statutory authority to include Exhausted Days in the Medicaid fraction. The Medicare statute specifies that patients entitled to benefits under Medicare Part A are excluded from the

Medicaid fraction. (SSA § 1886(d)(5)(F)(vi)(II).) This result would be expected, given there needs to be a clearly drawn line between who qualifies for the Medicare and the Medicaid fractions under the DSH payment methodology. It is also logical to conclude that a patient who has exhausted his/her coverage under the inpatient hospital benefit has not lost his/her entitlement to Medicare Part A benefits.

In addition to the lack of statutory support, CMS's policy proposal would also impose a substantial record keeping burden on providers and drain valuable resources by forcing providers to collect and maintain data necessary to support a request to have Exhausted Days included in the Medicaid fraction. From our reading of the proposal, it does not appear that Exhaust ed Days would be subject to a direct reclassification from the Medicare fraction to the Medicaid fraction. Instead, it appears Exhausted Days would be automatically removed from the Medicare fraction but would only be included in the Medicaid fraction if the provider could present accurate and reliable supporting documentation identifying those days. If this policy proposal is finalized, CMS should clarify in the final rule whether our understanding of the mechanics of the proposed policy is correct.

Notably, the preamble concedes that CMS currently has no direct source of Exhausted Days data. So, the burden would fall onto hospitals to produce this information in order to receive the financial benefit of having these days included in the Medicaid fraction. In addition to the statutory authority concerns, we believe placing this burden on hospitals is inappropriate from a policy perspective and will be extremely burdensome for providers while producing minimal policy benefits for CMS.

We especially oppose any policy that would require hospitals to submit documentation to their fiscal intermediaries for approval *in advance* of counting the days. This process should not be governed by special rules but, instead, should be subject to the normal Medicare review and audit procedures, such that hospitals are required to maintain supporting documentation as part of their normal operations for potential later scrutiny.

The FAH is troubled by the dearth of reasons offered by CMS to support this proposed policy change. CMS has included Exhausted Days in the Medicare fraction for years, but now only offers that the agency "recognizes there are other plausible interpretations" when announcing its proposed policy change. (68 *Fed. Reg.* at 27,208.) While deciding whether there are other plausible interpretations is a separate issue, we find CMS's reason for the policy change announced in the Proposed Rule to be unpersuasive and inappropriate to support this significant change to a long standing Medicare policy.

CMS's proposed change to the IME and DSH regulations clearly present significant changes to current policy. Due to the substantive policy changes that would occur if the Proposed Rule is finalized, we strongly urge CMS to implement any policy changes prospectively. That is, CMS should indicate specifically in the final rule that such changes will only be applied to a provider's cost reporting period beginning on or after October 1, 2003. CMS should not apply its final policy to any prior cost reporting periods that remain open with, or unsettled by, Medicare, or are settled but potentially subject to reopening under the Medicare rules.

* * * * *

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

July 8, 2003

The Honorable Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Humbert H. Humphrey Building, Room 443-G
200 Independence Ave, SW
Washington, DC 20201

Re: CMS-1470-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates; Proposed Rule

Dear Mr. Scully:

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above-captioned proposed rule.[1] NAPH represents more than 100 metropolitan area safety net hospitals and health systems. NAPH members are significant providers of care to low-income and uninsured patients: approximately 40 percent of the patients served by these systems are Medicaid recipients; another 24 percent are uninsured. NAPH members also provide certain essential specialized services to their entire communities, such as emergency and

[1] 68 Fed. Reg. 27154 (May 19, 2003).

trauma care, burn care, and neonatal intensive care. Our members are multifaceted institutions, often operating facilities at multiple sites and frequently serving as major training centers for medical residents and interns. Because of all of these characteristics, the proposed rule changes would significantly impact day-to-day operations of NAPH members.

With respect to other provisions of the proposed rule that impact payment formulas, NAPH is concerned that a number of them will reduce Medicare payments to safety net hospitals at a time when they already provide care to the elderly at a significant loss. Recent analysis of NAPH member data from fiscal year 2000 (the most recent year available) indicates that NAPH members lost $420 million treating Medicare patients. Eighty-one percent reported losses on Medicare patients in 2000, up from 68 percent the year before. Safety net hospitals like NAPH members cannot continue to sustain losses like these and maintain their multiple missions of patient care to the low-income, specialized services to all, emergency preparedness, and educating our nation's physicians and other front-line providers. Changes like the ones contemplated in the proposed rule, particularly to the DSH, IME, DGME and outlier formulas will further jeopardize the situation of these providers.

COMMENTS ON PROPOSED CHANGES TO THE FY 2004 INPATIENT PROSPECTIVE PAYMENT RULE

I. Counting of Patient Days for Purposes of Calculating Medicare DSH Payments

NAPH strongly opposes a proposed change in the counting of patient days for the purpose of calculating the Medicare DSH patient percentage, a key component of the DSH payment formula. The DSH patient percentage is a sum of two fractions, which the proposed rule refers to as the "Medicare fraction" and the "Medicaid fraction." CMS is proposing a change to its treatment of dual eligible patients who have exhausted their Medicare coverage, so that such patients would no longer be considered part of the Medicare fraction and instead would be counted in the Medicaid fraction. In addition, the proposed change would place a new burden on hospitals to document a patient's status as having exhausted Medicare coverage. **This change will have the effect of reducing DSH payments across-the-board, while imposing costly new administrative burdens on hospitals, which they are not equipped to fulfill. At a time of increasing demand and shrinking public support for safety net hospitals, such a policy change is extremely ill-advised.**

The proposed change compounds fundamental flaws with the current Medicare DSH formula. Medicare DSH payments are intended to ensure that Medicare beneficiaries have access to hospitals that, due to their disproportionate share of low income patients, are under more financial stress than the average facility. When originally enacted by Congress, the statutory formula identified eligible hospitals according to their share of low

income Medicare beneficiaries (i.e. SSI recipients) and Medicaid recipients. It did not include a measure of uninsured patients, because at that time (mid-1980s), those hospitals with high Medicaid volumes were generally the same hospitals with high uninsured volumes, thus Medicaid served as a reasonable proxy for low income care. That generalization is clearly no longer true in today's healthcare marketplace, and currently the most financially stressed hospitals are those with highest uninsured volumes (who may not be the same as those with high Medicaid volumes).

For many years, the Medicare Payment Assessment Commission or MedPAC has recommended that the formula be updated to incorporate uncompensated care so that all low-income care is reflected, not just Medicaid and Medicare/SSI. NAPH wholeheartedly supports MedPAC's approach to reforming Medicare DSH. Although we acknowledge that such a change would require an amendment to the statute, we are especially wary of any changes to the Medicare DSH formula which would have the effect of reducing DSH payments, because the formula is already so flawed and therefore inadequate to its intended purpose.

As CMS describes in the preamble to the Proposed Rule, the DSH patient percentage is equal to the sum of two fractions. The "Medicare fraction" is the number of patient days attributable to patients eligible for both Medicare Part A and SSI benefits divided by total Medicare days. The "Medicaid percentage" is the number of patient days attributable to patients eligible for Medicaid, but not entitled to Medicare Part A benefits divided by total days. CMS also explains that under current policy, patients entitled to both Medicare Part A

and SSI benefits who have exhausted their Medicare coverage are included in the Medicare fraction of the patient percentage, but not the Medicaid fraction. Moreover, CMS notes that "this interpretation is consistent with the statutory intent."

Nevertheless, despite express acknowledgement that the current interpretation is consistent with the intent of the statute, CMS is proposing to change its policy to one that by its own admission is merely a "plausible" interpretation of the language (with seemingly no regard to implementing congressional intent). CMS is proposing to shift these patient days associated with dual eligibles who have exhausted their Medicare coverage to the Medicaid fraction instead of the Medicare fraction. **NAPH strongly urges CMS to consider the ramifications of this change and to maintain its current policy**.

The proposed policy would have an across-the-board negative financial impact on all hospitals that receive Medicare DSH payment. The two fractions that comprise the DSH patient percentage are structured such that the Medicare fraction is always more heavily weighted than the Medicaid fraction. The denominator of the Medicare fraction is total Medicare patient days while the denominator of the Medicaid fraction is total patient days. Thus the transfer of any particular patient day from the Medicare to the Medicaid fraction will always dilute the value of that day and therefore reduce the overall patient percentage and the resulting DSH adjustment.

Moreover, **the proposed change would place a significant new regulatory and administrative burden on hospitals in order to receive payments for these patient days**. Under the proposed change, CMS would require hospitals to

submit documentation to their fiscal intermediaries to justify the inclusion in the Medicaid fraction of any days for patients who have exhausted their Medicare benefits. This shift of the burden onto hospitals is inappropriate given their relative lack of access to information as compared to the fiscal intermediary and the state regarding the Medicaid or Medicare status of their patients and whether they have exhausted benefits. Moreover, CMS does not even acknowledge this burden in its assessment in the preamble of the information collection and recordkeeping requirements it is imposing, as required by the Paperwork Reduction Act of 1995. While we acknowledge the practical difficulties of the current policy outlined in the preamble, we do not think that the solution to these practical difficulties lies in either the change in policy or the imposition of the entire burden of classification of patients onto hospitals. **Rather, NAPH urges CMS to develop uniform data collection and reporting requirements on the part of both the intermediaries and the state in order to facilitate accurate counting of patient days.**

Such a solution would be consistent with Congress' intent that states accurately identify Medicaid managed care days for purposes of the Medicare DSH formula (*see* 42 U.S.C. § 1396u-2(g)) and the current efforts in Congress to require fiscal intermediaries to provide certain data in connection with DSH payments (*see* Medicare Prescription Drug and Modernization Act of 2003, H.R. 1, § 951).

Ironically, CMS accurately notes that its *current* policy is consistent with its inclusion of Medicaid patient days in the Medicaid fraction even after a patient exhausts

his or her Medicaid coverage. Prior to 1997, the Secretary applied a policy that excluded from the Medicaid fraction of the Medicare DSH calculation the patient days associated with those patients eligible for Medicaid, but for which the hospital did not receive payment (because, for example, Medicaid benefits have been exhausted). That policy was soundly rejected by four United States Courts of Appeal. *See* Cabell v. Huntington Hosp. v. Shalala, 101 F.3d 984 (4th Cir. 1996); Legacy Emanuel Hosp. & Health Ctr. v. Shala, 97 F.3d 1261 (9th Cir. 1996) Deaconess Health Serv. Corp. v. Shalala, 83 F.3d 1041 (8th Cir. 1996); Jewish Hosp., Inc. v. Secretary of Health & Human Services, 19 F.3d 270 (6th Cir. 1994). It was only in response to these federal court decisions that CMS (then the Health Care Financing Administration ("HCFA")) implemented its current policy. *See* HCFA Ruling 97-2 (Feb. 27, 1999). Indeed, the litigation is still ongoing even with respect to the retroactive application of the mandated policy change. *See* Monmouth Medical Center v. Thompson, 257 F.3d 807 (D.C. Cir. 2001). **The new policy with regards to Medicare beneficiaries who have exhausted their Part A coverage will undoubtedly invite similarly lengthy legal challenges to which neither CMS nor the hospital industry should have to devote resources.**

If, despite these concerns, CMS decides to move forward with its new policy, we urge you to clarify that the new policy will enable hospitals to include certain days in the Medicaid fraction that previously were included in neither fraction. In particular, if SSI recipients who have exhausted their Medicare coverage are to be treated as not entitled to Medicare (and therefore included in the Medicaid fraction) than other, non-SSI Medicaid recipients who have exhausted their Medicare coverage

should also be included in the Medicaid fraction. Under the current policy, these individuals are included in neither fraction because they are considered to be entitled to Medicare (and therefore ineligible for the Medicaid fraction) but they are not SSI recipients (and therefore ineligible for the Medicare fraction). **CMS should clarify for hospitals and fiscal intermediaries that this new class of patient days will now be included in the DSH patient percentage.**

* * * * *

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July 8, 2003

CMS
Room 443-G
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200 Independence Avenue, SW
Washington, DC 20201

RE 2004 Proposed Regulations
File Code: CMS-1470-P

We would like to offer the following comments proposed regulations concerning the Medicare DSH calculation.

* * * * *

Dual Eligible Days

CMS' statement "the days of patients who have exhausted their Medicare Part A coverage will no longer be included in the Medicare fraction" is inconsistent with CMS' current actual practice with respect to the Medicare fraction. In our analysis of the SSI fraction, based on data received from CMS and the HHS Office of General Counsel, generally only covered Medicare days are included in the numerator and denominator of the SSI fraction. The published documentation for the SSI percentages also labels the denominator days as Covered Days. In addition, SCA has a letter from OGC

stating that only covered days are used in the SSI fraction. To say that these days "will no longer be included" may be a change in policy", but it is clearly not a change in "practice". That begs the question—What was the "policy"—what CMS professed or what it did?

SCA has found, on occasion, that more than covered days are included in the denominator of the SSI fraction, but these have always been errors on CMS's part. These errors include the inclusion of Medicare HMO days, exempt unit days, and inappropriate billings to Part A (which were voided on the PS&R, but remained in the SSI fraction). These errors are inconsistent from provider to provider, and from year to year.

In relation to the exhausted benefits issue is the question of a Medicare beneficiary where Medicare does not pay the claim. For example, if a Medicare beneficiary (who is also Medicaid eligible) is in an auto accident, then the auto insurance company will pay the hospital bill. In fact, Medicare is usually not even billed in this situation. However, the fiscal intermediaries are routinely removing these days from the Medicaid fraction of the DSH calculation because the patient is a Medicare beneficiary.

The purpose of the DSH calculation is to count the indigent population. A patient in the scenario described above would not be included in the DSH calculation under proposed rules. We submit that since the patient was not entitled to Medicare Part A and thus Medicare did not pay the claim and these days are not in the SSI fraction, a provider should be able to include these days in the Medicaid fraction of the DSH calculation, otherwise a portion of the indigent population is excluded

from the calculation. We request that CMS specifically allow patients with Medicare eligibility, but without entitlement (payment from Medicare Part A) to be included in the Medicaid fraction of the DSH calculation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 413

[CMS–1470–F]

RIN 0938–AL89

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates

AGENCY: Centers for Medicare and Medicaid Services (CMS), HHS.

ACTION: Final rule.

* * * * *

7. Dual-Eligible Patient Days

We are still reviewing the large number of comments received on the proposed provision relating to dual-eligible patient days in the May 19, 2003. Due to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document. We refer individuals who are interested in reviewing the background information and discussions regarding this policy to the May 19, 2003 proposed rule (68 FR 27207–27208).

* * * * *

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 412, 413, 418, 460, 480, 482, 483, 485, and 489

[CMS–1428–P]

RIN 0938–AM80

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates

AGENCY: Centers for Medicare and Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

* * * * *

2. Proposals for Available Beds and Patient Days for the DSH Adjustment

In our May 19, 2003 IPPS proposed rule for FY 2004 (68 FR 27201), we proposed changes to our policy on counting available beds and patient days for the purposes of the DSH adjustment. For the available beds policy we proposed changes to counting unoccupied beds and observation beds. In regard to patient days, we proposed changes to counting dual-eligible and Medicare+Choice (M+C) days. Due to the number and nature of the public comments received, we did not respond to the public comments on these proposals in the final rule for FY 2004 (68 FR 45415). We indicated that we would address those public comments in a sepa-

rate document. We plan to address the comments regarding unoccupied beds, observation beds, dual eligible days, and M+C days in the IPPS final rule for FY 2005.

* * * * *

American Hospital Association

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July 2, 2004

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Washington, DC 20201

Ref: CMS-1428-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 *Federal Register* 28196), May 18, 2004.

Dear Dr. McClellan:

On behalf of our nearly 5,000 member hospitals, health care systems, networks and other providers of care, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule establishing new policies and payment rates for hospital inpatient services for fiscal year (FY) 2005.

The rule is one of the most complicated and lengthy in the history of the Medicare program. It not only implements a number of provisions of the Medicare Modernization Act of 2003 (MMA), but also proposes a significant number of complex regulatory changes. The AHA is pleased that Congress acknowledged that Medicare payments to hospitals were inadequate and provided $25 billion in relief through the MMA. We are concerned, however, that the agency is proposing provisions that would reduce these gains. The Medicare Payment Advisory Commission (MedPAC) in its March 2004 report to Congress said that hospitals' overall Medicare margins had dropped from 4.1 percent in 2001 to 1.7 percent in 2002, the most recent year for which data is available. While the MMA was a good first step, we will continue to urge Congress to provide adequate Medicare reimbursement to hospitals, and, in our attached comments on this proposed rule, we encourage CMS to make changes that would prevent a further decline in Medicare payment.

* * * * *

Dual-Eligible Patient Days

The AHA would like to reiterate its opposition to CMS' proposed changes las year in the counting of dual-eligible patient days for the purpose of calculating the DSH patient percentage. CMS did not finalize its proposal last year, but indicates in this year's proposed rule that it will respond to last year's comments and make a decision in its FY 2005 final rule.

The DSH patient percentage is a sum of two fractions, the "Medicare fraction," calculated as the number of pa-

tient days attributable to patients eligible for both Medicare Part A and SSI benefits divided by total Medicare days, and the "Medicaid fraction," calculated as the number of patient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits divided by total patient days. CMS proposes changing how it treats dual eligible patients who have exhausted their Medicare coverage. Rather than continue to include these patients as part of the Medicare fraction, CMS proposes to exclude them from the Medicare fraction and count them in the Medicaid fraction.

There are important reasons <u>not</u> to make this change. First, CMS clearly states in the FY 2004 proposed rule that the current formula is consistent with statutory intent. Second, the proposed change would place a significant new regulatory and administrative burden on hospitals. CMS indicates, "it is often difficult for fiscal intermediaries (FIs) to differentiate days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the States, which may vary from one State to the next." The shift of this administrative burden to hospitals is unjustified, especially given the inability of hospitals to access this information. Government agencies, specifically the FIs and the states, have records regarding the Medicaid and Medicare status of patients as well as whether they have exhausted their benefits.

It also is likely that this proposed change would result in reduced DSH payments to hospitals. Any transfer of a particular patient day from the Medicare fraction (based on total *Medicare* patient days) to the Medicaid fraction (based on *total* patient days) will dilute the

value of that day, and therefore reduce the overall patient percentage and the resulting DSH adjustment. **The calculation of dual-eligible days must not be changed.**

Disproportionate Share Hospital Adjustment—Dual Eligible Patient Days

The Medicare disproportionate share hospital (DSH) adjustment is based in part on the DSH patient percentage. The DSH patient percentage is the sum of two fractions: the Medicare fraction and the Medicaid fraction. The Medicare fraction is the number of patient days attributable to patients entitled to both Medicare Part A and SSI benefits divided by the total number of days for all patients entitled to Medicare. The Medicaid fraction is the number of patient days attributable to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A. As we stated in the May 19, 2003 proposed rule (68 FR 27207), if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered a dual-eligible and the patient days are generally included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. This is consistent with the language of section 1886(d)(5)(F)(vi)(II) of the Act, which specifically excludes patients that are entitled to benefits under Part A from the Medicaid fraction.

In the May 19, 2003 proposed rule (68 FR 27207) we indicated, with respect to dual-eligibles, that the policy described above currently applies even after the patient's Medicare Part A coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A coverage remaining, or the patient exhausts Medicare Part A coverage while an inpatient,

the non-covered patient days are counted in the Medicare fraction. It has come to our attention, however, that this statement is not accurate. Our policy has been that only covered patient days are included in the Medicare fraction (42 CFR ? 412.106(b)(2)(i)).

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July 7, 2004

Mark McClellan, M.D., Ph.D.
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Ref: CMS-1428-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 *Federal Register* 28196), May 18, 2004.

Dear Dr. McClellan:

On behalf of our 73 member hospitals and health systems, the West Virginia Hospital Association appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule establishing new policies and payment rates for hospital inpatient services for fiscal year (FY) 2005.

The rule is one of the most complicated and lengthy in the history of the Medicare program. It not only implements a number of provisions of the Medicare Modernization Act of 2003 (MMA), but also proposes a significant number of complex regulatory changes. The Association is pleased that Congress acknowledged that Medicare payments to hospitals were inadequate and

provided $25 billon in relief through the MMA. However, we are concerned that the agency is proposing a number of provisions that would reduce these gains for West Virginia's hospitals.

The Association is concerned about the redistribution of hospital payments due to the proposed revisions to metropolitan statistical areas (MSAs), the implementation of an occupational mix adjustment and changes to geographic reclassification. The Office of Management and Budget, in releasing its revised standards for defining MSAs, cautions that the new definitions "should not be used to develop and implement Federal, State, and local nonstatistical programs and policies without full consideration of the effects of using these definitions for such purposes. These areas should not serve as a general-purpose geographic framework for nonstatistical activities, and they may or may not be suitable for use in program funding formulas." We question whether CMS has given full consideration regarding the effects that the revised MSA definitions will have on hospital payments. For example, while we support CMS' proposal to not adopt the OMB micropolitan statistical areas, for the same reason that CMS rejects these areas (the creation of a number of one-hospital micropolitan areas), it should also reject the movement of City Hospital in Martinsburg, WV, from its current MSA (Washington, D.C.) to the Hagerstown MSA. City Hospital would become the only hospital in that MSA subject to the IPPS, since the only other WV hospital in the MSA is a CAH, and the only remaining hospital is a Maryland hospital not subject to the IPPS. Its IPPS payments

would be reduced in excess of 10% due to this MSA change. * * *

* * * The rule discusses a potential change—but does not propose a change—in how CMS would "weight" the direct GME resident count for residents that pursue specialties requiring an initial year of broad-based training. Currently a number of programs, such as anesthesiology and radiology, require a year of generalized clinical training in internal medicine as a prerequisite to subsequent training in their chosen specialty. This requirement can be met by either spending the first year in internal medicine, pediatrics, or surgery, or participating in a one-year, freestanding "transitional year" program. CMS policy, however, bases direct GME payments on the resident's first year of training, without factoring in the specialty in which the resident ultimately seeks board certification. For example, an anesthesiologist who does a base year of generalized clinical training would be labeled with a three-year training period—which is the time required to be board eligible in internal medicine—rather than the four years it takes to be board eligible in anesthesiology. The result is that the resident is eligible for only partial direct GME reimbursement in the fourth year.

Current CMS policy violates the statute, does not reflect congressional intent, and results in inequitable payments to teaching hospitals for residents training in certain specialties. The MMA conference report language clearly states, "the initial residency period for any residency for which the Accreditation Council on Graduate Medical Education (ACGME) requires a preliminary or general

clinical year of training is to be determined in the resident's second year of training."

CMS discusses the possibility of reweighing these residents to allow hospitals their full direct GME payments. Given that it has been CMS' longstanding policy to allow an appropriate calculation of the full residency period for those residents training in "transitional year" programs, we also feel strongly that this interpretation should be extended to those spending their first year in internal medicine, pediatrics or surgery. **The AHA believes that this issue needs to be addressed and corrected in the final regulation.**

The Association is also opposed to CMS' proposed changes last year in the counting of dual-eligible patient days for the purpose of calculating the DSH patient percentage. CMS did not finalize its proposal last year, but indicates in this year's proposed rule that it will respond to last year's comments and make a decision in its FY 2005 final rule.

The DSH patient percentage is a sum of two fractions, the "Medicare fraction," calculated as the number of patient days attributable to patients eligible for both Medicare Part A and SSI benefits divided by total Medicare days, and the "Medicaid fraction," calculated as the number of patient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits divided by total patient days. CMS proposes changing how it treats dual eligible patients who have exhausted their Medicare coverage. Rather than continue to include these patients as part of the Medicare fraction, CMS proposes to exclude them from the Medicare fraction and count them in the Medicaid fraction.

There are important reasons <u>not</u> to make this change. First, CMS clearly states in the FY 2004 proposed rule that the current formula is consistent with statutory intent. Second, the proposed change would place a significant new regulatory and administrative burden on hospitals. CMS indicates, "it is often difficult for fiscal intermediaries (FIs) to differentiate days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the States, which may vary from one State to the next." The shift of this administrative burden to hospitals is unjustified, especially given the inability of hospitals to access this information. Government agencies, specifically the FIs and the states, have records regarding the Medicaid and Medicare status of patients as well as whether they have exhausted their benefits.

It also is likely that this proposed change would result in reduced DSH payments to hospitals. Any transfer of a particular patient day from the Medicare fraction (based on total *Medicare* patient days) to the Medicaid fraction (based on *total* patient days) will dilute the value of that day, and therefore reduce the overall patient percentage and the resulting DSH adjustment. **The calculation of dual-eligible days must not be changed.**

Finally, we are disappointed that the rule contains a proposal to further expand the post-acute care transfer policy, as a result of changing, less than a year after its last revision, the criteria that the agency uses in defining a DRG that qualifies for the transfer provision. There is no sound policy rationale for CMS' proposal to adopt a

new set of "alternative criteria." **This provision must be withdrawn.**

TOURO
INFIRMARY
LEADING HEALTHCARE FOR 150 YEARS

July 8, 2004

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1428-P
P.O. Box 8010
Baltimore, MD 21244-1850

Ref: CMS-1428-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 *Federal Register* 28196), May 18, 2004.

Dear Dr. McClellan:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule establishing new policies and payment rates for hospital inpatient services for fiscal year (FY) 2005.

We are pleased that Congress acknowledged that Medicare payments to hospitals were inadequate and provided $25 billion in relief through the Medicare Modernization Act of 2003 (MMA). We are concerned, however, that the agency is proposing provisions that would reduce these gains.

The adequacy and equity of Medicare payments to hospitals is essential, yet 39 percent of hospitals lost money providing inpatient services to Medicare patients in FY 2001, and preliminary estimates indicate that figure has jumped to almost 50 percent in FY 2002.

The economic viability of Touro Infirmary, a hospital that has been serving our community for over 150 years, and the only remaining not for profit hospital in New Orleans, is increasingly threatened. There is no question that Medicare reimbursement is less than our cost of proving services. Medicare reimbursement is less than 40% of our charges.

Our detailed comments are contained in the following sections of this letter and address CMS's proposed changes to the inpatient payment system, including those related to the wage index, outlier threshold, transfer policy, new technology, graduate medical education, critical access hospitals, and diagnosis-related groupings.

* * * * *

Dual-Eligible Patient Days

We oppose CMS' proposed changes last year in the counting of dual-eligible patient days for the purpose of calculating the DSH patient percentage. CMS did not finalize its proposal last year, but indicates in this year's proposed rule that it will respond to last year's comments and make a decision in its FY 2005 final rule.

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The calculation of dual-eligible days must not be **changed.**

* * * * *

LINCOLN GENERAL HOSPITAL
North Central Louisiana's Reginal Medical Center

July 8, 2004

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1428-P
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Baltimore, MD 21244-1850

Ref: CMS-1428-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 *Federal Register* 28196), May 18, 2004.

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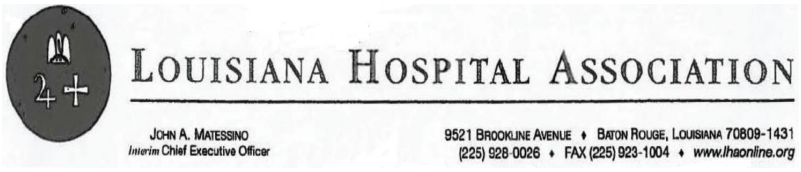

July 8, 2004

Mark McClellan, M.D., Ph.D.
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Baltimore, MD 21244-1850

Ref: CMS-1428-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 *Federal Register* 28196), May 18, 2004.

Dear Dr. McClellan:

On behalf of our 158 member hospitals the Louisiana Hospital Association (LHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule establishing new policies and payment rates for hospital inpatient services for fiscal year (FY) 2005.

We are pleased that Congress acknowledged that Medicare payments to hospitals were inadequate and provided $25 million in relief through the Medicare Modernization Act of 2003 (MMA). We are concerned, however, that the agency is proposing provisions that would reduce these gains.

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* * * * *

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
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July 8, 2004

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Washington, D.C. 20201

Ref: CMS-1428-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule.

Re: DSH Adjustment; Graduate Medical Education; Revised MSAs

Dear Dr. McClellan:

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above-captioned proposed rule.[1] NAPH represents more than 100 metropolitan area safety net hospitals and health systems. Our members are significant providers of care to low-income and uninsured patients. For example, approximately 40 percent of the inpatient services provided by NAPH

[1] 69 Federal Register 28196 (May 18, 2004).

members is to Medicaid recipients and another 24 percent is provided to uninsured patients. NAPH members also provide certain essential specialized services to their entire communities, such as emergency and trauma care, burn care, and neonatal intensive care. Our members are multifaceted institutions, often operating facilities at multiple sites and frequently serving as major training centers for medical residents and interns. Because of all of these characteristics, the proposed rule changes would significantly impact day-to-day operations of NAPH members.

With regard to the FY 2005 IPPS proposed rule, NAPH is particularly concerned that a number of the changes contemplated by the Centers for Medicare and Medicaid Services (CMS) will reduce Medicare payments to safety net hospitals at a time when they already provide care to Medicare patients at a significant loss. Recent analysis of NAPH member data from fiscal year 2002 (the most recent year available) indicates that NAPH members lost $903 million treating Medicare patients. In total ninety percent of NAPH members reported losses on Medicare patients in 2002. Safety net hospitals like NAPH members cannot continue to sustain losses like these and maintain their multiple missions of patient care to the low-income, specialized services to all, emergency preparedness, and educating our nation's physicians and other front-line providers. * * *

* * * * *

I. Counting of Patient Days for Purposes of Calculating Medicare DSH Payments

NAPH strongly opposes a proposed change in the treatment of dual eligible patients who have exhausted their Medicare coverage for the purpose of counting patient days for the calculation of the Medicare DSH patient percentage. CMS is proposing that dual eligible patients who have exhausted their Medicare coverage would no longer be considered part of the Medicare fraction and instead would be counted in the Medicaid fraction. **This change will have the effect of reducing DSH payments across-the-board, while imposing costly new administrative burdens on hospitals, which they are not equipped to fulfill. At a time of increasing demand and shrinking public support for safety net hospitals, such a policy change is extremely ill-advised.**

In the preamble, CMS explains that under current policy, patients entitled to both Medicare Part A and SSI benefits who have exhausted their Medicare coverage are included in the Medicare fraction of the patient percentage, but not the Medicaid fraction. CMS notes that "this interpretation is consistent with the statutory intent." Despite express acknowledgement that the current interpretation is consistent with the intent of the statute, CMS is proposing to change its policy to one that by its own admission is merely a "plausible" interpretation of the language (with seemingly no regard to implementing congressional intent). CMS is proposing to shift these patient days associated with dual eligibles who have exhausted their Medicare coverage to the Medicaid fraction instead of the Medicare fraction. **NAPH strongly urges CMS to consider the ramifications of this change and to maintain its current policy.**

The proposed policy would have an across-the-board negative financial impact on all hospitals that receive Medicare DSH payments. The two fractions that comprise the DSH patient percentage are structured such that the Medicare fraction is always more heavily weighted than the Medicaid fraction. The denominator of the Medicare fraction is total Medicare patient days while the denominator of the Medicaid fraction is total patient days. Thus the transfer of any particular patient day from the Medicare to the Medicaid fraction will always dilute the value of that day and therefore reduce the overall patient percentage and the resulting DSH adjustment.

Moreover, the proposed change would place a significant new regulatory and administrative burden on hospitals in order to receive payments for these patient days. Under the proposed change, CMS would require hospitals to submit documentation to their fiscal intermediaries to justify the inclusion in the Medicaid fraction of any days for patients who have exhausted their Medicare benefits. This shift of the burden onto hospitals is inappropriate given their relative lack of access to information as compared to the fiscal intermediary and the state regarding the Medicaid or Medicare status of their patients and whether they have exhausted benefits. Moreover, CMS does not even acknowledge this burden in its assessment in the preamble of the information collection and recordkeeping requirements it is imposing, as required by the Paperwork Reduction Act of 1995. While we acknowledge the practical difficulties of the current policy outlined in the preamble, we do not think that the solution to these practical difficulties lies in either the change in policy or the imposition of the entire

burden of classification of patients onto hospitals. **Rather, NAPH urges CMS to develop uniform data collection and reporting requirements on the part of both the intermediaries. and the state in order to facilitate accurate counting of patient days.**

Such a solution would be consistent with Congress' intent that states accurately identify Medicaid managed care days for purposes of the Medicare DSH formula (*see* 42 U.S.C. § 1396u-2(g)) and the current efforts in Congress to require fiscal intermediaries to provide certain data in connection with DSH payments (*see* Medicare Prescription Drug and Modernization Act of 2003, H.R. 1, § 951).

Ironically, CMS accurately notes that its *current* policy is consistent with its inclusion of Medicaid patient days in the Medicaid fraction even after a patient exhausts his or her Medicaid coverage. Prior to 1997, the Secretary applied a policy that excluded from the Medicaid fraction of the Medicare DSH calculation the patient days associated with those patients eligible for Medicaid, but for which the hospital did not receive payment (because, for example, Medicaid benefits have been exhausted). That policy was soundly rejected by four United States Courts of Appeal. *See* Cabell v. Huntington Hosp. v. Shalala, 101 F.3d. 984 (4th Cir. 1996); Legacy Emanuel Hosp. & Health Ctr. v. Shalala, 97 F.3d 1261 (9th Cir. 1996); Deaconess Health Serv. Corp. v. Shalala, 83 F.3d 1041 (8th Cir. 1996); Jewish Hosp., Inc. v. Secretary of Health & Human Services, 19 F.3d 270 (6th Cir. 1994). It was only in response to these federal court decisions that CMS (then the Health Care Financing Administration ("HCFA")) implemented its current policy. *See* HCFA Ruling 97-2 (Feb. 27, 1999). Indeed,

the litigation is still ongoing even with respect to the retroactive application of the mandated policy change. *See* Monmouth Medical. Center v. Thompson, 257 F.3d 807 (D.C. Cir. 2001). **The new policy with regards to Medicare beneficiaries who have exhausted their Part A coverage will undoubtedly invite similarly lengthy legal challenges to which neither CMS nor the hospital industry should have to devote resources.**

If, despite these concerns, CMS decides to move forward with its new policy, we urge you to clarify that the new policy will enable hospitals to include certain days in the Medicaid fraction that previously were included in neither fraction. In particular, if SSI recipients who have exhausted their Medicare coverage are to be treated as not entitled to Medicare (and therefore included in the Medicaid fraction) than other, non-SSI Medicaid recipients who have exhausted their Medicare coverage should also be included in the Medicaid fraction. Under the current policy, these individuals are included in neither fraction because they are considered to be entitled to Medicare (and therefore ineligible for the Medicaid fraction) but they are not SSI recipients (and therefore ineligible for the Medicare fraction). **CMS should clarify for hospitals and fiscal intermediaries that this new class of patient days will now be included in the DSH patient percentage.**

Finally, we are deeply troubled by the recent web posting of a modification of these comments on the CMS website.[4] Our understanding is that this modification appeared with no formal notification by CMS and without the opportunity for provides to comment. The notification states:

> In the May 19, 2003 proposed rule (68 FR 27207) we indicated, with respect to dual-eligibles, that the policy described above currently applies even after the patient's Medicare Part A coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A coverage remaining, or the patient exhausts Medicare Part A coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. It has come to our attention, however, that this statement is not accurate. Our policy has been that only covered patient days are included in the Medicare fraction (42 CFR § 412.106 (b)(2)(i)).

Although CMS states "Our policy has been that only covered patient days are included in the Medicare fraction," we believe this is far from a settled issue. At the very least, CMS's unequivocal statement in the FY 2004 proposed rule that "a dual-eligible patient . . . [who] exhausts Medicare Part A coverage while an inpatient . . . [is] counted in the Medicare fraction before and after Medicare coverage is exhausted" clearly indicates

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[4] "Disproportionate Share Hospital Adjustment—Dual Eligible Patient Days," available at: http://www.cms.hhs.gov/providers/hipps/dual.asp; last modified July 7, 2005.

uncertainty within the agency about CMS's policy.[5] **Furthermore, a plain reading of the federal regulation cited by CMS in support of this web posting does not support the wholesale exclusion of non-covered days.** The regulation provides that the numerator of the Medicare fraction includes, *inter alia,* patient days "entitled to Medicare Part A . . ."[6] It is important to note that Medicare Part A benefit not only includes inpatient services but other services such as skilled nursing facility care, some home health services, and hospice care. **The regulation does NOT specify that patients included in the DSH Medicare Fraction numerator must be entitled to Medicare Part A *inpatient* services but rather Medicare Part A generally. We would assert that, at a minimum, a plain reading of the regulation requires that patients entitled to any Part A benefit be included in the DSH Medicare fraction numerator (regardless of whether they have exhausted their Medicare Part A inpatient benefit).** As discussed above, we also believe that such an interpretation is "consistent with the statutory intent" of the Social Security Act § 1886(d)(5)(F)(vi)(II) as CMS itself stated in the FY 2004 proposed rule.[7] Finally, as noted in the Medicaid fraction discussion above, federal courts are apt to interpret the requirement that patients are "eligible" or "entitled" to a government benefit to include patients that generally meet the criteria necessary to receive the benefit (e.g. age, disability status, income) but have exhausted their coverage.

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[5] 68 Fed Reg. 27207 (May 19, 2003).

[6] 42 CFR § 412.106(b)(2)(i)(B):

[7] 68 Fed Reg. 27207 (May 19, 2003).

Even more troubling is the manner in which CMS has chosen to release this "clarification." By obscurely posting this policy-change on the CMS website and providing very limited notification,[8] it is uncertain the degree to which providers are aware of the new policy. In addition, by posting it a few days before FY 2005 IPPS proposed rule comments are due, CMS has limited the ability of the provider community to properly analyze and comment on this policy in the context of the proposed rule.

For these reasons, we urge CMS to withdraw the notification and enter into a collaborative discussion with the provider community. At the very least, CMS should respond to comments submitted in relation to this year's and last year's IPPS proposed rules before formally adopting any policy excluding patients from the Medicare DSH calculation. **CMS must utilize the rule making process to adopt this new policy**.

* * * * *

[8] Notification was sent via email on the CMS Open Door Forum Hospital Acute list-serve, on Friday, July 9th at midnight two days before these comments were due.

July 8, 2004

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1428-P
P.O. Box 8010
Baltimore, MD 21244-1850

Ref: CMS-1428-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 *Federal Register* 28196), May 18, 2004

Dear Dr. McClellan:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule establishing new policies and payment rates for hospital inpatient services for fiscal year (FY) 2005.

We are pleased that Congress acknowledged that Medicare payments to hospitals were inadequate and provided $25 billion in relief through the Medicare Modernization Act of 2003 (MMA). We are concerned, however, that the agency is proposing provisions that would reduce these gains.

The adequacy and equity of Medicare payments to hospitals is essential, yet 39 percent of hospitals lost money providing inpatient services to Medicare patients in FY

2001, and preliminary estimates indicate that figure has jumped to almost 50 percent in FY 2002.

Our detailed comments are contained in the following sections of this letter and address CMS's proposed changes to the inpatient payment system, including those related to the outlier threshold, transfer policy and new technology.

* * * * *

Dual-Eligible Patient Days

We oppose CMS' proposed changes last year in the counting of dual-eligible patient days for the purpose of calculating the DSH patient percentage. CMS did not finalize its proposal last year, but indicates in this year's proposed rule that it will respond to last year's comments and make a decision in its FY 2005 final rule.

The DSH patient percentage is a sum of two fractions, the "Medicare fraction," calculated as the number of patient days attributable to patients eligible for both Medicare Part A and SSI benefits divided by total Medicare days, and the "Medicaid fraction," calculated as the number of patient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits divided by total patient days. CMS proposes changing how it treats dual eligible patients who have exhausted their Medicare coverage. Rather than continue to include these patients as part of the Medicare fraction, CMS proposes to exclude them from the Medicare fraction and count them in the Medicaid fraction.

There are important reasons not to make this change. First, CMS clearly states in the FY 2004 proposed rule that the current formula is consistent with statutory in-

tent. Second, the proposed change would place a significant new regulatory and administrative burden on hospitals. CMS indicates, "it is often difficult for fiscal intermediaries (FIs) to differentiate days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the States, which may vary from one State to the next." The shift of this administrative burden to hospitals is unjustified, especially given the inability of hospitals to access this information. Government agencies, specifically the FIs and the states, have records regarding the Medicaid and Medicare status of patients as well as whether they have exhausted their benefits.

It also is likely that this proposed change would result in reduced DSH payments to hospitals. Any transfer of a particular patient day from the Medicare fraction (based on total *Medicare* patient days) to the Medicaid fraction (based on *total* patient days) will dilute the value of that day, and therefore reduce the overall patient percentage and the resulting DSH adjustment. **The calculation of dual-eligible days must not be changed.**

* * * * *

Tennessee Hospital Association

July 8, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1428-P
P.O. Box 8010
Baltimore, MD 21244-1850

Ref: CMS-1428-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 *Federal Register* 28196), May 18, 2004

Dear Sirs:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule establishing new policies and payment rates for hospital inpatient services for fiscal year (FY) 2005. The Tennessee Hospital Association (THA), established in 1938, serves as an advocate for hospitals, health systems and other healthcare organizations and the patients they serve. THA represents over 200 healthcare facilities, including hospitals, home care agencies, nursing homes, and health-related agencies and businesses and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and the many health professionals. THA is the premi-

ere organization in Tennessee that promotes and represents the interests of all health careers, hospitals and health systems.

The proposed rule would increase a hospital's patient PPS rates by 3.3 percent in 2005, if the hospital submits data on 10 specific clinical measures of quality care. Hospitals that do not submit quality data would receive a reduced payment update to reflect market basket less 0.4 percentage points, or 2.9 percent

THA continues to urge adequate Medicare reimbursement to hospitals which reflects cost increases and applaud Congress and CMS for the full market basket increase for the upcoming year.

The THA is concerned about the redistribution of hospital payments due to the proposed revisions to metropolitan statistical areas (MSAs), the implementation of an occupational mix adjustment, and changes to geographic reclassification. **Specifically, the THA urges the agency to implement a 3-year "stop-loss provision" to protect those hospitals that would experience a decline in their wage Index value due to the revised MSAs.**

THA is greatly concerned about those critical access hospitals (CAHs) that now would be designated as "urban" hospitals due to the new geographic boundaries. It is essential that these facilities maintain their CAH status, even though they may no longer be located in extended to those spending their first year in internal medicine, pediatrics or surgery. **The THA believes that this Issue needs to be addressed and corrected in the final regulation.**

Dual-Eligible Patient Days

The THA is in opposition to CMS' proposed changes last year in the counting of dual-eligible patient days for the purpose of calculating the DSH patient percentage. CMS did not finalize its proposal last year, but indicates in this year's proposed rule that it will respond to last year's comments and make a decision in its FY 2005 final rule.

The DSH patient percentage is a sum of two fractions, the "Medicare traction," calculated as the number of patient days attributable to patients eligible for both Medicare Part A and SSI benefits divided by total Medicare days, and the "Medicaid fraction," calculated as the number of patient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits divided by total patient days. CMS proposes changing how it treats dual eligible patients who have exhausted their Medicare coverage. Rather than continue to include these patients as part of the Medicare fraction. CMS proposes to exclude them from the Medicare fraction and count them in the Medicaid fraction.

There are important reasons not to make this change. First, CMS clearly states in the FY 2004 proposed rule that the current formula is consistent with statutory intent. Second, the proposed change would place a significant new regulatory and administrative burden on hospitals. CMS indicates, "it is often difficult for fiscal intermediaries (FIs) to differentiate days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the States, which may vary from one State to the next." The shift of this administrative burden to hospitals is unjustified, especially given the inability of hospitals to

access this information. Government agencies, specifically the FIs and the states, have records regarding the Medicaid and Medicare status of patients as well as whether they have exhausted their benefits.

It also is likely that this proposed change would result in reduced DSH payments to hospitals. Any transfer of a particular patient day from the Medicare fraction (based on total *Medicare* patient days) to the Medicaid fraction (based on *total* patient days) will dilute the value of that day, and therefore reduce the overall patient percentage and the resulting DSH adjustment. **The calculation of dual-eligible days must not be changed**.

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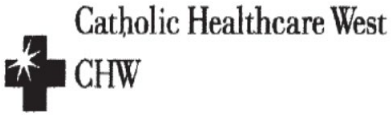

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* * * * *

July 9, 2004

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 443-G
Washington, D.C. 20201

Ref: CMS-1428-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Payment Rates; Proposed Rule (69 *Federal Register* 28196), May 18, 2004

Dear Dr. McClellan:

Catholic Healthcare West (CHW), on behalf of our 43 hospitals in California, Arizona and Nevada, is pleased to submit the following comments on the notice of proposed rulemaking (NPRM) on the Medicare Hospital Inpatient Prospective Payment System for Fiscal Year 2005, as published in the May 18, 2004 *Federal Register* (Vol. 69, No. 96, page 28196). In addition to proposing rates of increase for hospital payments and updates to

Diagnosis Related Groups (DRG) weights and calibrations for FY 2005, the proposed rule includes potential changes to regulations governing several important areas affecting the care we provide to Medicare beneficiaries.

Our comments will address the following issues:

- Proposed increase in the Medicare fixed-loss cost outlier payment threshold;
- Proposed expansion of DRGs subject to the Medicare post-acute transfer policy;
- Proposed changes to counting of dual-eligible patient days in calculating Disproportionate Share Hospital (DSH) patient percentage

In addition to these comments, we also support the comments and recommendations of the American Hospital Association, the Catholic Health Association, Premier, Inc. and the California Healthcare Association.

Dual-Eligible Patient Days

Last year, CMS proposed changes in the counting of dual eligible patient clays for the purpose of calculating the DSH patient percentage. CMS did not finalize this proposal last year, but indicates in this year's proposed rule that it will respond to last year's comments and make a decision in its FY 2005 final rule. **CHW strongly opposes these proposed changes in the counting of dual-eligible patient days for the purpose of calculating the DSH patient percentage.**

The DSH patient percentage is a sum of two fractions, the "Medicare fraction," calculated as the number of patient days attributable to patients eligible for both Medicare Part A and SSI benefits divided by total Medicare

days, and the "Medicaid fraction," calculated as the number of patient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits divided by total patient days. CMS proposes changing how it treats dual eligible patients who have exhausted their Medicare coverage. Rather than continue to include these patients as part of the Medicare fraction, CMS proposes to exclude them from the Medicare fraction and count them in the Medicaid fraction.

There are important reasons <u>not</u> to make this change. First, CMS clearly states in the FY 2004 proposed rule that the current formula is consistent with statutory intent. Second, the proposed change would place a significant new regulatory and administrative burden on hospitals. CMS indicates, "it is often difficult for fiscal intermediaries (FIs) to differentiate days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the states, which may vary from one state to the next." The shift of this administrative burden to hospitals is unjustified, especially given the inability of hospitals to access this information. Government agencies, specifically the FIs and the states, have records regarding the Medicaid and Medicare status of patients as well as whether they have exhausted their benefits.

Further, it is likely that this proposed change would result in reduced DSH payments to hospitals. Any transfer of a particular patient day from the Medicare fraction (based on total Medicare patient days) to the Medicaid fraction (based on total patient days) will dilute the value of that day, and therefore reduce the overall patient percentage and the resulting DSH adjustment.

Therefore, CHW makes the following recommendation with regard to the proposed changes to the counting of dual-eligible patient days:

CHW respectfully requests that CMS not change the calculation of dual-eligible days for the purpose of calculating the DSH patient percentage.

Illinois Hospital Association

July 9th, 2004

Dr. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.,
Washington, D.C. 20201

ATTN.: CMS-1428-P

Re: Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates; Proposed Rule, Federal Register, Volume 69, No. 96, Tuesday, May 18th, 2004

Dear Dr. McClellan:

On behalf of our approximately 190 member hospitals or health care systems, the Illinois Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule establishing new policies and payment rates for hospital inpatient services for fiscal year 2005. The FY 2005 rule is one of the most lengthy and complicated since the inception of the Medicare program; it not only proposes a significant number of complex regulatory changes, but also implements a number of provisions of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. IHA commends the Centers for Medicare and Medicaid Services (CMS) for its exhaustive and thorough analyses that are presented in this rule. However, the Illinois Hospital

Association is concerned that some of the financial relief that hospitals received through the MMA will be compromised with some of the provisions of the proposed rule. Therefore, the Illinois Hospital Association presents the following comments for your consideration.

* * * * *

> **Change in the DSH calculation-Counting Dual-eligible days:** The proposed rule contains a provision whereby CMS is changing its treatment of "dual-eligible" patient days in the payment formula for the purposes of calculating a hospital's specific Medicare disproportionate share patient percentage. Specifically, the agency is proposing to include patient days applicable to Medicare-Medicaid cases when the patients have exhausted their Medicare Part A benefits in the Medicaid fraction of the formula as opposed to the Medicare SSI fraction. **The Illinois Hospital Association urges CMS not to make this change for the following reasons**:
>
> 1. The current Medicare disproportionate share payment formula is consistent with statutory intent.
> 2. This change would require additional recordkeeping on the part of hospitals to determine the number of patient days to include in the Medicaid fraction. Currently, the CMS database includes, by hospital, the number of dual eligible days to include as part of the Medicare SSI fraction. This data is reported to the individual hospitals by the Medicare Part A fiscal

intermediaries as part of the Medicare SSI percentage and is one less documentation burden on the shoulders of hospitals. Implementing this change places even more of a reporting burden on hospitals, a result undoubtedly unintended given CMS' willingness to examine cost reporting "streamlining" in the future.

3. There is no estimate as to the financial impact of this change on aggregate Medicare payments; hence, there is no information as to whether implementation of this change results in more or less cumulative Medicare payments to hospitals. The final rule must include an estimate as to the impact of this change, which, at a minimum, should be budget-neutral.

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Jewish Hospital
HealthCare Services

July 9, 2004

Mark McClellan, M.D., Ph.D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1428-P
P.O. Box 8010
Baltimore, MD 21244-1850

Dear Dr. McClellan:

On behalf of Jewish Hospital Healthcare Services (JHHS) we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule establishing new policies and payment rates for hospital inpatient services for the federal fiscal year 2005. The following are our comments:

* * * * *

III. Dual-Eligible Patient Days

It is our understanding that CMS will make a decision in the final rule regarding the counting of dual-eligible days for disproportionate share (DSH) purposes. We oppose CMS's proposal to include dual-eligible days where Pert A coverage has been exhausted in the "Medicaid fraction". The current methodology has proven consistent with regulations; and, shifting the burden of proof to the providers and intermediaries will only make the task of determining eligible days more burdensome and costly to the facility. The result of this shift will be lower DSH

payments due to a greater decrease in the SSI ratio than the resulting increase in the Medicaid ratio. The SSI ratio is only subject to Medicare days in the denominator while the Medicaid ratio is subject to all days in its denominator. **We believe CMS mut abandon this proposal.**

* * * * *

July 9th, 2004

Dr. Mark B. McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1428-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: CMS 1428-P—Medicare Program; Changes to the Inpatient Prospective Payment System and FY 2005 Rates; Proposed Rule, May 18, 2004 *Federal Register*

Dear Dr. McClellan:

On behalf of its 143 member hospitals, the Michigan Health and Hospital Association welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services regarding the proposed rule for the FY 2005 Inpatient Prospective Payment System, released on the CMS website on May 11, 2004 and published in the May 18, 2004 *Federal Register.* Although this rule provides a 3.3 percent market basket increase for hospitals that participate in the CMS quality initiative project, we are very concerned about other policy changes which will result in significant payment decreases for some hospitals.

The adequacy of Medicare payments to cover the cost of services provided is crucial for ensuring the future viability of Michigan's nonprofit hospitals. Based on the latest data available, **44 percent** of Michigan hospitals experienced a negative margin on Medicare inpatient services while **74 percent** experienced a negative margin on Medicare outpatient services. As such, we are gravely concerned about the consequences of the additional negative financial impact of the proposed changes, particularly implementation of the new Core Based Statistical Areas based on the 2000 Census data, the increased outlier threshold, expansion of the post-acute transfer policy, and the long term care hospital changes. These changes will further threaten the future viability of hospitals and access to healthcare services for Medicare beneficiaries and other residents of the state of Michigan.

* * * * *

Dual-Eligible Patient Days

The MHA would like to reiterate its opposition to the CMS' proposed changes in the FY 2004 rule regarding the counting of dual-eligible patient days for the purpose of calculating the DSH patient percentage. Although the CMS did not finalize its proposal last year, in this year's proposed rule the agency indicates that it will respond to last year's comments and make a decision in its FY 2005 final rule.

The DSH patient percentage is a sum of two fractions, the "Medicare fraction," calculated as the number of patient days attributable to patients eligible for both Medicare Part A and SSI benefits divided by total Medicare

days, and the "Medicaid fraction," calculated as the number of patient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits divided by total patient days. CMS proposes changing how it treats dual eligible patients who have exhausted their Medicare coverage. Rather than continue to include these patients as part of the Medicare fraction, CMS proposes to exclude them from the Medicare fraction and count them in the Medicaid fraction.

There are important reasons <u>not</u> to make this change. First, CMS clearly states in the FY 2004 proposed rule that the current formula is consistent with statutory intent. Second, the proposed change would place a significant new regulatory and administrative burden on hospitals. The CMS indicates, "it is often difficult for fiscal intermediaries to differentiate days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the States, which may vary from one State to the next." The shift of this administrative burden to hospitals is unjustified, especially given the inability of hospitals to access this information. Government agencies, specifically the fiscal intermediaries and the states, have records regarding the Medicaid and Medicare status of patients as well as whether they have exhausted their benefits.

It also is likely that this proposed change would result in reduced DSH payments to hospitals. Any transfer of a particular patient day from the Medicare fraction (based on total *Medicare* patient days) to the Medicaid fraction (based on *total* patient days) will dilute the value of that day, and therefore reduce the overall patient percentage and the resulting DSH adjustment. **The**

MHA strongly believes that the calculation of dual-eligible days must not be changed.

* * * * *

Marc D. Smith, Ph.D., President

July 9, 2004

Mark McClellan
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Room 443-G
Washington, D.C. 20201

Ref: CMS-1428-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 *Federal Register* 28196), May 18, 2004.

Dear Dr. McClellan:

On behalf of our member hospitals, health care systems, networks and other care providers, the Missouri Hospital Association appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule establishing new policies and payment rates for hospital inpatient services for fiscal year 2005.

The rule is one of the most complicated and lengthy in the history of the Medicare program. It not only implements a number of provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 but also proposes a significant number of complex

regulatory changes. MHA is pleased with Congress' acknowledgement that Medicare payments to hospitals were inadequate and provided $25 billion in relief through this bill. However, we are concerned the CMS is proposing provisions that would reduce these gains. In its March 2004 report to Congress, the Medicare Payment Advisory Commission said that hospitals' overall Medicare margins had dropped from 4.1 percent in 2001 to 1.7 percent in 2002, the most recent year for which data is available. Although the act was a good first step, we will continue urging Congress to provide adequate Medicare reimbursement to hospitals. In our following comments on this proposed rule, we encourage CMS to make changes that would prevent a further decline in Medicare payment.

MHA is concerned about the redistribution of hospital payments because of proposed revisions to metropolitan statistical areas, the implementation of an occupational mix adjustment and changes to the geographic reclassification. **Specifically, MHA urges CMS to implement a three-year "stop-loss provision" to protect those hospitals that would experience a decline in their wage index value of 5 percent or more because of the revised MSAs.**

Dual-Eligible Patient Days

MHA would like to reiterate its opposition to last year's proposed changes from CMS in the counting of dual-eligible patient days for the purpose of calculating the DSH patient percentage. CMS did not finalize its proposal last year but in this year's proposed rule indicates it will respond to last year's comments and make a decision in its FY 2005 final rule.

The DSH patient percentage is a sum of two fractions—the "Medicare fraction" and the Medicaid fraction. The "Medicare fraction" is calculated as the number of patient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income benefits divided by total Medicare days—and the "Medicaid fraction," calculated as the number of patient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits divided by total patient days. CMS proposes changing how it treats dual-eligible patients who have exhausted their Medicare coverage. Rather than continuing to include these patients as part of the Medicare fraction, the CMS proposes to exclude them from the Medicare fraction and count them in the Medicaid fraction.

There are important reasons <u>not</u> to make this change. First, in the FY 2004 proposed rule CMS clearly states the current formula is consistent with statutory intent Second, the proposed change would place a significant new regulatory and administrative burden on hospitals. CMS indicates "it is often difficult for fiscal intermediaries to differentiate days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the states, which may vary from one state to the next." The shift of this administrative burden to hospitals is unjustified, especially given the hospitals' inability to access this information. Government agencies, specifically the fiscal intermediaries and the states, have records regarding the Medicaid and Medicare status of patients, as well as if they have exhausted their benefits.

It also is likely that this proposed change would result in reduced DSH payments to hospitals. Any transfer of

a particular patient day from the Medicare fraction (based on total Medicare patient days) to the Medicaid fraction (based on total patient days) will dilute the day's value, which reduces the overall patient percentage and the resulting DSH adjustment. **The calculation of dual-eligible days must not be changed.**

* * * * *

July 12, 2004

Mark B. McClellan, M.D., Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1428-P
Room 443-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-1428-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 *Federal Register* 28196), May 18, 2004.

Dear Dr. McClellan:

The California Healthcare Association (CHA), on behalf of its nearly 500 member hospitals, health systems and ancillary providers, respectfully submits its comments regarding the proposed inpatient prospective payment system (IPPS). We want to thank the Centers for Medicare & Medicaid Services (CMS) for the extraordinary effort that was clearly invested in preparing the proposed rule and implementing the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 provisions in a timely fashion.

* * * * *

DSH ADJUSTMENT

In the 2004 IPPS rule, CMS proposed changing the treatment of dual eligible patients who had exhausted their Medicare coverage. Currently, the DSH patient percentage is the sum of two fractions: the "Medicare traction," calculated as the number of patient days attributable to patients eligible for both Medicare Part A and SSI benefits, divided by total Medicare days; and the "Medicaid fraction," calculated as the number of patient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits, divided by total patient days. Rather than continue to include these patients as part of the Medicare fraction, CMS proposed excluding them from the Medicare fraction and counting them in the Medicaid fraction.

There are important reasons not to make this change. First, CMS clearly states in the FY 2004 proposed rule that the current formula is consistent with statutory intent. Second, the proposed change would place a significant new regulatory and administrative burden on hospitals. CMS indicates, "it is often difficult for fiscal intermediaries (FIs) to differentiate days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the States, which may vary from one State to the next." The shift of this administrative burden to hospitals is unjustified, especially given the inability of hospitals to access this information. Government agencies, specifically the FIs and the states, have records regarding the Medicaid and Medicare status of patients as well as whether they have exhausted their benefits.

It is also likely that this proposed change would result in reduced DSH payments to hospitals. Any transfer

of a particular patient day from the Medicare traction (based on total *Medicare* patient days) to the Medicaid fraction (based on *total* patient days) will dilute the value of that day and therefore reduce the overall patient percentage and the resulting DSH adjustment. The calculation of dual-eligible days must not be changed.

* * * * *

Orchestra Place
3663 Woodward Ave., Suite 200
Detroit, MI 48201-2403

ATTACHMENT 4 TO #284

July 12, 2004

Centers for Medicare and Medicaid Services
Room C5-14-03
Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1428-P
Hospital Inpatient PPS Proposed Rule for FY 2005
DSH Adjustment

Dear Sir or Madam:

The Detroit Medical Center (DMC) Hospitals—Children's Hospital of Michigan, Detroit Receiving Hospital, Harper-Hutzel Hospital Huron, Valley-Sinai Hospital, Rehabilitation Institute of Michigan and Sinai-Grace Hospital are submitting this comment in connection with the notice of proposed rulemaking (the "NPRM") addressing proposed changes to the inpatient prospective payment system for Federal Fiscal Year 2005. Specifically, this comment relates to the proposed implementation of changes to the methodology for calculating the disproportionate share hospital ("DSH") pa-

tient percentage. In connection with a proposal initially set forth last year, the Centers for Medicare and Medicaid Services ("CMS") has proposed to shift patient days attributable to dual-eligible patients who have exhausted their Medicare Part A coverage from the Medicare Proxy to the Medicaid Proxy. The DMC strongly disagrees with this policy and urges CMS to withdraw it.

DSH payments are payments to hospitals that serve a disproportionate share of low-income patients. DSH payments are paid based on the sum of two computations. The first computation, which is referred to as the Medicare Proxy, is calculated by taking the number of patient days that are furnished to patients entitled both to Medicare Part A and Supplemental Security Income and dividing this number by the total number of patient days attributable to patients entitled to benefits under Medicare Part A. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The second computation, which is referred to as the Medicaid Proxy, is calculated by taking the number of patient days that are furnished to patients eligible for Medicaid but who are not entitled to benefits under Medicare Part A and dividing this number by total patient days. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The proposal in the NPRM relates to dual-eligible patients, referring to Medicare beneficiaries who are also eligible for Medicaid. Patient days attributable to these patients are now included in the Medicare Proxy numerator. However, the NPRM proposes to include these days in the Medicaid Proxy numerator when the dual-eligible patient has exhausted his or her Medicare Part A coverage.

CMS has offered little justification for this policy in its NPRM. CMS does not assert that its proposal reflects a better interpretation of the statute than present policy or one mandated by recent court decisions or changes in the applicable statute, but rather that its proposal reflects a "plausible" interpretation. 69 Fed. Reg. at 27208. Its primary purpose in suggesting this revision is to alleviate difficulties for its fiscal intermediaries, who may have difficulty identifying dual eligible patients who have exhausted their Part A benefits and verifying that hospitals furnishing Medicaid Proxy data have not included patient days relating to these patients. *Id.* Ostensibly, the intermediaries face this difficulty because hospitals do not submit claims to their intermediaries for dual eligible patients who have exhausted their Part A coverage. *Id.*

The DMC asserts that this proposal runs counter to the law and is otherwise inequitable to hospitals receiving DSH funding. As CMS has acknowledged in the NPRM, it is consistent with the statute to include in the Medicare Proxy numerator days attributable to dual eligible patients with exhausted Part A benefits. Indeed, even under the proposed policy, CMS would still include in the Medicare Proxy numerator days attributable to patients who have exhausted their Part A benefits if these patients are *not eligible* for Medicaid. However, CMS offers no basis in the statute for treating these similarly situated groups differently. Furthermore, CMS has not claimed that it intends to remove from the Medicare Proxy denominator days attributable to dual eligible patients with exhausted Part A benefits. Thus, the policy would result in an impermissible mismatching of data.

The proposal is also entirely inequitable to providers. Essentially, the genesis of the policy is the difficulty intermediaries face verifying which Medicaid patients are also Medicare beneficiaries who have exhausted their Part A benefits. It remains unclear why CMS believes that hospitals will be better able to access this information. Intermediaries have access to CMS databases that collect information about beneficiaries over the course of their participation in Medicare. Hospitals only have access to information about the patient's admissions to that hospital or information otherwise self-reported by their patients. As is apparent, intermediaries have access to a greater wealth of information. While hospitals are thus in a weaker position to collect this data, the consequences of being inaccurate can be severe, ranging from overpayment liability to potential False Claims Act allegations. Such consequences are unacceptable, given that CMS and its intermediaries can take the alternative approach of refining their systems to allow for a more accurate system of matching Medicare beneficiary names against names on Medicaid beneficiary lists furnished by the States. This inequity militates in favor of discarding this policy.

Not only is this an unwarranted shifting of an administrative burden that is more appropriately borne by CMS' intermediaries, this policy would also result in a decrease in reimbursement. Since the denominator of the Medicaid Proxy is larger than the denominator of the Medicare Proxy, the days in question will have a more diluted effect if shifted to the Medicaid Proxy. Thus, merely for the sake of administrative convenience for the intermediaries, CMS is proposing to reduce reimbursement to hospitals in violation of the applicable statutory provisions.

At a minimum, even if CMS were to implement this policy (which it clearly should not), it should clarify that it intends to subtract the corresponding days from the Medicare Proxy denominator. Otherwise, it would be compounding the inequities inherent in this policy through further distorting the Medicare Proxy.

* * * * *

July 12, 2004

Dr. Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS Proposed Rule with Comment Period, Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, Federal Register (May 18, 2004)

Dear Administrator McClellan:

The Federation of American Hospitals ("FAH") is the national representative of privately owned or managed community hospitals and health systems throughout the United States. Our members are full service community hospitals, teaching and non-teaching, urban and rural, who provide critical health care services across the ambulatory, acute, and post-acute spectrum. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") proposed

rule regarding changes to the hospital inpatient prospective payment system and fiscal year ("FY") 2005 rates. Attached as Exhibit A to this letter, FAH has set forth a list of all major issues commented upon in this letter (and the corresponding page number where discussion of each issue begins).

* * * * *

Dual-Eligible Patient Days

In the May 19, 2003 Proposed Rule (68 Fed. Reg. at 27207-08), CMS proposed to "change" the treatment, for DSH purposes, of days attributable to patients who are eligible for both Medicare Part A and Medicaid , but who are admitted as an inpatient without any Medicare Part A coverage remaining or who exhaust Medicare Part A coverage while admitted ("Part A Exhausted/Noncovered Days"). CMS stated that these days had historically been counted in the Medicare fraction of the DSH calculation and then proposed to change their treatment, so that prospectively such days would be counted in the Medicaid fraction. This change has not yet been implemented. Instead, in the August 1, 2003 Final Rule (68 Fed. Reg. at 45421), CMS stated that it was still reviewing the large number of comments that it received on this issue and would address those comments in a separate document. In the current Proposed Rule, CMS stated that it would address this issue in the Final Rule for FY 2005 (69 Fed. Reg. at 28286).

In response to the May 19, 2003 Proposed Rule, FAH submitted comments on this issue (pages 15 to 17 of its July 8, 2003 comment letter). Information has come to FAH's attention which has caused a reconsideration of those comments. Accordingly, FAH is submitting these

additional comments pertaining to this issue and requests that, in light of the delay in implementation of the May 19, 2003 proposal, these comments be taken into consideration. (As noted in the following paragraph, CMS published some misinformation in its May 19, 2003 Proposed Rule. Thus, CMS should continue to accept comments on this issue.)

When drafting its comments for FY 2004, FAH took at face value CMS's statement that, historically, Part A Exhausted/Noncovered Days have been included in the Medicare fraction. Assuming that this was true, and concerned that, if moved to the Medicaid fraction, the burden would be on the provider to identify these days, which might result in a lower number of days counted, FAH argued for a continuation of the existing policy to include these days in the Medicare percentage. Since submitting those comments, however, FAH has been informed that at least one knowledgeable fiscal intermediary, and possibly members of CMS staff, have indicated that further research has confirmed that such days are, in fact, not currently (and never were) included in the Medicare percentage. This possibility makes sense, because it is FAH's understanding that the Medicare fraction (i.e., the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and supplemental security income ("SSI") benefits) is calculated by matching a tape from the Social Security Administration (containing SSI eligibility data) with Medicare Provider Analysis & Review ("MedPAR") files. Since MedPAR only contains patient days that have been paid by Medicare, FAH questions how days that are unpaid due to the exhaustion or noncoverage of Part A benefit were being accounted for in the calculation.

Indeed, as discussed below, CMS admitted in a July 7, 2004 bulletin that it had been mistaken in its assertion that Part A Exhausted/Noncovered Days were in the Medicare percentage. Thus, CMS has confirmed FAH's suspicion.

FAH also notes that CMS's previously published assertion that all Part A Exhausted/Noncovered Days are being currently included in the Medicare fraction could only be accurate if all dual eligible recipients (i.e., eligible for Medicare Part A and Medicaid) whose Part A hospital benefits were exhausted were also eligible for SSI FAH believes there may be certain dual eligibles who are receiving Medicaid but not SSI and questions how Part A Exhausted/Noncovered Days associated with such patients are being treated.

FAH notes that CMS has just recently issued a bulletin, on July 7, 2004, stating that it had previously made an inaccurate statement when it indicated that Part A Exhausted/Noncovered Days have historically been included in the Medicare fraction. This finally confirms FAH's belief that these days had not been included in the Medicare fraction.

Part A Exhausted/Noncovered Days must be counted in the DSH calculation. If, in the future, Part A Exhausted/Noncovered Days are counted in the Medicare fraction, CMS should publish an explanation of how such days will be included in the calculation, so that providers can have assurances that they will be included. If such days are not counted in the Medicare fraction, then the days must be counted in the Medicaid fraction.

Regardless of how CMS ultimately elects to treat Part A Exhausted/Noncovered Days in the future, CMS should take action to address how such days have been counted in the past. Previously, CMS had instructed intermediaries to deny these days if a provider claimed them as part of the Medicaid fraction, on the grounds that the days were already counted in the Medicare fraction. Since CMS now acknowledges that this was not accurate, **it must take affirmative action** to allow providers to claim Part A Exhausted/Noncovered Days for past, open or reopenable fiscal years.

* * * * *

July 12, 2004

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Room 443-G
Washington, DC 20201

Ref: CMS-1428-P—Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 *Federal Register* 28196), May 18, 2004.

Dear Dr. McClellan:

On behalf of our 109 member hospitals, and health care systems, networks and other providers of care, the New Jersey Hospital Association (NJHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule establishing new policies and payment rates for hospital inpatient services for fiscal year (FY) 2005.

The rule is one of the most complicated and lengthy in the history of the Medicare program. It not only implements a number of provisions of the Medicare Modernization Act of 2003 (MMA), but also proposes a significant number of complex regulatory changes. NJHA is pleased that Congress acknowledged that Medicare

payments to hospitals were inadequate and provided $25 billion in relief through the MMA. We are concerned, however, that the agency is proposing provisions that would reduce these gains. The Medicare Payment Advisory Commission (MedPAC) in its March 2004 report to Congress said that hospitals' overall Medicare margins had dropped from 4.1 percent in 2001 to 1.7 percent in 2002 the most recent year for which data is available. In New Jersey our own analysis shows that hospitals receive on average just 90 cents on the dollar for the services they provide to Medicare beneficiaries. While the MMA was a good first step, we will continue to urge Congress to provide adequate Medicare reimbursement to hospitals, and, in our attached comments on this proposed rule, we encourage CMS to make changes that would prevent a further decline in Medicare payment.

NJHA is encouraged that previously the OMB and now CMS (through the proposed rule) recognize that commuting, settlement and employment patterns change over time and therefore so should the labor markets used to calculate the Medicare wage index. New Jersey is uniquely positioned between the first and fifth largest cities in the country. Wage index parity in this market will allow New Jersey hospitals to fairly compete for the scarce labor resources available.

NJHA is however concerned about the redistribution of hospital payments due to the proposed revisions to metropolitan statistical areas (MSAs), the implementation of an occupational mix adjustment. And that only discharges involving ESRD Medicare beneficiaries who have *received a dialysis treatment* during an inpatient hospital stay would be counted toward qualifying for this adjustment, rather than all ESRD discharges. These

payments were established because of the higher cost of treating patients who are critically ill, even though they may not receive a dialysis treatment during their inpatient admission. The adjustment is used to help defray the extra costs of treating ESRD patients in their entirety, not just to defray dialysis costs. CMS has not explained why it proposes the change in policy, nor presented a sound argument for doing so—except to say that the effect of the change would be reduced Medicare program expenditures. This is a real cut to hospitals treating these very ill and costly patients. NJHA opposes any change to this provision, which was put in place to protect access to care for Medicare beneficiaries and help offset the financial losses associated with hospitals treating a high concentration (10 percent or more of a hospitals total Medicare discharges) of dialysis patients.

Dual-Eligible Patient Days

NJHA would like to reiterate its opposition to CMS' proposed changes last year in the counting of dual-eligible patient days for the purpose of calculating the DSH patient percentage. CMS did not finalize its proposal last year, but indicates in this year's proposed rule that it will respond to last year's comments and make a decision in its FY 2005 final rule.

The DSH patient percentage is a sum of two fractions. the "Medicare fraction," calculated as the number of patient days attributable to patients eligible for both Medicare Part A and SSI benefits divided by total Medicare days, and the "Medicaid fraction," calculated as the number of patient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A bene-

fits divided by total patient days. CMS proposes changing how it treats dual eligible patients who have exhausted their Medicare coverage. Rather than continue to include these patients as part of the Medicare fraction, CMS proposes to exclude them from the Medicare fraction and count them in the Medicaid fraction.

There are important reasons <u>not</u> to make this change. First, CMS clearly states in the FY 2004 proposed rule that the current formula is consistent with statutory intent. Second, the proposed change would place a significant new regulatory and administrative burden on hospitals. CMS indicates, "it is often difficult for fiscal intermediaries (FIs) to differentiate days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the States, which may vary from one State to the next." The shift of this administrative burden to hospitals is unjustified, especially given the inability of hospitals to access this information. Government agencies, specifically the FIs and the states, have records regarding the Medicaid and Medicare status of patients as well as whether they have exhausted their benefits.

It also is likely that this proposed change would result in reduced DSH payments to hospitals. Any transfer of a particular patient day from the Medicare fraction (based on total *Medicare* patient days) to the Medicaid fraction (based on *total* patient days) will dilute the value of that day, and therefore reduce the overall patient percentage and the resulting DSH adjustment. **The calculation of dual-eligible days must not be changed**.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 412, 413, 418, 460, 480, 482, 483, 485, and 489

[CMS–1428–F]

RIN 0938–AM80

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates

AGENCY: Centers for Medicare and Medicaid Services (CMS), HHS.

ACTION: Final rule.

* * * * *

I. Background

A. Summary

1. Acute Care Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system (PPS). Under these PPSs, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located; and if the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the IPPS (known as the indirect medical education (IME) adjustment). This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies or medical services that have been approved for special add-on payments. To qualify, a new technology or medical service must demonstrate that it is a substantial clinical improvement over technologies or services otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology or medical service add-on adjustments.

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of FY 1982, FY 1987, or FY 1996) or the IPPS rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries (although MDHs receive only 50 percent of the difference between the IPPS rate and their hospital-specific rates if the hospital-specific rate is higher than the IPPS rate).

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services "in accordance with a prospective payment system established by the Secretary." The basic methodology for determining capital prospective payments is set forth in our regulations at 42 CFR 412.308 and 412.312. Under the capital PPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Similar adjustments are also made for

IME and DSH as under the operating IPPS. In addition, hospitals may receive an outlier payment for those cases that have unusually high costs.

The existing regulations governing payments to hospitals under the IPPS are located in 42 CFR part 412, subparts A through M.

* * * * *

3. Counting Beds and Patient Days for Purposes of Calculating the IME Adjustment (§ 412.105(b)) and DSH Adjustment ((§ 412.106(a)(1)(i))

As stated in section IV.K.1 of the preamble, § 412.105 of our existing regulations specifies that the calculation of the IME adjustment is based on the IME adjustment factor, which is calculated using hospitals' ratios of residents to beds. The determination of the number of beds is based on available bed days. This determination of the number of available beds is also applicable for other purposes, including the level of the disproportionate share hospital (DSH) adjustment payments under § 412.106(a)(1)(i).

In the FY 2004 IPPS proposed rule (68 FR 27201 through 27208, May 19, 2003), we proposed changes to our policy on determining the number of beds and patient days as it pertains to both the IME and DSH adjustments. In the FY 2004 IPPS final rule (68 FR 45415 through 45422), we indicated that, due to the nature and number of public comments we received on the proposed policies regarding unoccupied beds, observation beds for patients ultimately admitted as inpatients, dual-eligible patient days, and Medicare+Choice (M+C) days, we would address the comments in a separate document. In the May 18, 2004 proposed rule, we stated that we

planned to respond to comments in this final rule. Under section IV.L.3. of this preamble, we are responding to public comments received on the proposals in the May 19, 2003 and the May 18, 2004 proposed rules as they relate to both the IME and DSH payment adjustments and finalizing our policies in these four areas.

* * * * *

L. Payment to Disproportionate Share Hospitals (DSHs) (Section 402 of Pub. L. 108-173 and § 412.106 of Existing Regulations)

1. Background

Section 1886(d)(5)(F) of the Act provides for additional payments to subsection (d) hospitals that serve a disproportionate share of low-income patients. The Act specifies two methods for a hospital to qualify for the Medicare disproportionate share hospital (DSH) adjustment. Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients. These hospitals are commonly known as "Pickle hospitals." The second method, which is also the most commonly used method for a hospital to qualify, is based on a complex statutory formula under which payment adjustments are based on the level of the hospital's DSH patient percentage, which is the sum of two fractions: the "Medicare fraction and the Medicaid fraction." The Medicare fraction is computed by dividing the number of patient days that

are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the total number of patient days furnished to patients entitled to benefits under Medicare Part A. The Medicaid fraction is computed by dividing the number of patient days furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A by the number of total hospital patient days in the same period.

$$\text{DSH Patient Percentage} = \frac{\text{Medicare, SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non - Medicare Days}}{\text{Total Patient Days}}$$

* * * * *

3. Counting Beds and Patient Days for the IME and DSH Adjustments

In the May 19, 2003 IPPS proposed rule for FY 2004 (68 FR 27201), we proposed changes to our policy on counting beds and patient days for the purposes of the DSH and IME adjustments. We proposed changes to the way unoccupied beds are counted. We also proposed to clarify how observation beds and swing-beds are counted, as well as our policy regarding nonacute care (that is, a level of care that would not generally be payable under the IPPS) beds and days. In regard to patient days, we proposed changes to the way observation days, dual-eligible days and M+C days are counted.

* * * * *

Due to the number and nature of the public comments received on the proposals regarding the counting of available beds and patient days in the May 19, 2003 proposed rule, we did not respond to the public comments on some of the proposals in the final rule for FY 2004

(August 1, 2003 final rule (68 FR 45415)). We indicated in that final rule that we would address public comments regarding unoccupied beds, observation beds, dual-eligible days, and M+C days in a separate document. In the May 18, 2004 proposed rule, we indicated that we planned to address the comments in this IPPS final rule for FY 2005.

a. Provisions of the FY 2004 Proposed Rule, Responses to Public Comments, and Provisions of the FY 2005 Final Rule

* * * * *

The final categories of patient days addressed in the proposed rule of May 19, 2003 were the dual-eligible patient days and the Medicare+Choice (M+C) days. We proposed in the rule that the days of patients who are dually-eligible, (that is, Medicare beneficiaries who are also eligible for Medicaid) and have exhausted their Medicare Part A coverage will not be included in the Medicare fraction. Instead, we proposed that these days should be included in the Medicaid fraction of the DSH calculation. In regard to M+C days, we proposed that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. The patient days should be included in the count of total patient days in the denominator of the Medicaid fraction, and if the M+C beneficiary is also eligible for Medicaid, the patient's days would be included in the numerator of the Medicaid fraction as well.

In the August 1, 2003 final rule (68 FR 45346), we finalized some of these proposals. For the proposals we did not finalize, we indicated that we would address the

comments in a separate document. The proposals for nonacute care beds and days, observation and swing-bed days, LDP beds and days, and days for 1115 demonstration projects were finalized in the August 1, 2003 final rule. 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.

As we did in the IPPS proposed rule of May 19, 2003 and the August 1, 2003 IPPS final rule, we are combining our discussion of policies for counting beds and patient days in relation to the calculations at §§ 412.105(b) and 412.106(a)(1) which relate to the IME and DSH payment adjustments, because the underlying concepts are similar, and we believe they should generally be interpreted in a consistent manner for both purposes. Specifically, we clarified that beds and patient days that are counted for these purposes should be limited to beds or patient days in hospital units or wards that would be directly included in determining the allowable costs of inpatient hospital care payable under the IPPS on the Medicare cost reports. As a preliminary matter, beds, and patient days associated with these beds, that are located in units or wards that are excluded from the IPPS (for example, psychiatric or rehabilitation units, or outpatient areas), and thus from the determination of allowable costs of inpatient hospital care under the IPPS on the Medicare cost report, are not to be counted for purposes of §§ 412.105(b) and 412.106(a)(1)(ii).

The remainder of this discussion pertains to beds and patient days in units or wards that are not excluded from the IPPS and for which costs are included in determining the allowable costs of inpatient hospital care under the IPPS on the Medicare cost report.

* * * * *

We received numerous comments on our May 19, 2003 and May 18, 2004 proposals and our responses and final policies are included in this preamble.

* * * * *

3. Dual-Eligible Patient Days

As described above, the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits. If a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction. This is consistent with the language of section 1886(d)(5)(F)(vi)(II) of the Act, which specifies that patients entitled to benefits under Part A are excluded from the Medicaid fraction.

It has come to our attention that we inadvertently misstated our current policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 (68 FR 27207). In that proposed rule, we indicated that a dual-eligible beneficiary

is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. Our policy has been that only covered patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.

Comment: We received numerous comments that commenters were disturbed and confused by our recent Web site posting regarding our policy on dual-eligible patient days. The commenters believed that this posting was a modification or change in our current policy to include patient days of dual-eligible Medicare beneficiaries whose Medicare Part A coverage has expired in the Medicaid fraction of the DSH calculation. In addition, the commenters believed that the information in this notice appeared with no formal notification by CMS and without the opportunity for providers to comment.

Response: The notice that was posted on our Web site was not a change in our current policy. Our current policy is, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction. This is consistent with the language of section 1886(d)(5)(F)(vi)(II) of the Act, which specifies that patients entitled to benefits under Medicare Part A are excluded from the Medicaid fraction.

The Web site posting is a correction of an inadvertent misstatement made in the May 19, 2003 proposed rule (68 FR 27207). This Web site posting was not a new proposal or policy change. As a result, we do not believe it is necessary to utilize the rule making process in correcting a misstatement that was made in the May 19, 2003 proposed rule regarding this policy.

In the proposed rule of May 19, 2003 (68 FR 27207), we proposed to change our policy to begin to count in the Medicaid fraction of the DSH patient percentage the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage has expired. We note that the statutory provision referenced above stipulates that the Medicaid fraction is to include patients who are eligible for Medicaid. However, the statute also requires that patient days attributable to patients entitled to benefits under Medicare Part A are to be excluded from the Medicaid fraction.

Comment: Numerous commenters opposed our proposal to begin to count in the numerator of the Medicaid fraction of the DSH patient percentage, the patient days of dual-eligible Medicare beneficiaries whose Medicare inpatient coverage has expired. They objected that the proposal would result in a reduction of DSH payments when the exhausted coverage days are removed from the Medicare fraction and included in the Medicaid fraction. According to these commenters, any transfer of a particular patient day from the Medicare fraction (based on total Medicare patient days) to the Medicaid fraction (based on total patient days) would dilute the value of that day and, therefore, reduce the overall patient percentage and the resulting DSH payment adjustment.

One commenter observed that a patient who exhausts coverage for inpatient hospital services still remains entitled to other Medicare Part A benefits. This commenter found it difficult to reconcile the position that these patients are not entitled to Medicare Part A benefits when they can receive other covered Part A services, such as SNF services.

In addition, some commenters stated that these days should not be included in either the Medicare or Medicaid fraction. They indicated that the days should not be included in the Medicare fraction because that computation includes the number of patient days actually furnished to patients who were entitled to both Medicare Part A and SSI benefits. The commenters stated that the days should also be excluded from the Medicaid fraction because that computation excludes hospital patient days for patients who, for those days, were entitled to benefits under Medicare Part A.

Commenters also indicated that the proposal would put an increased administrative burden on the hospitals to support including these patient days in the Medicaid fraction. They recommended that if we finalize this policy, the requirement that hospitals submit documentation justifying the inclusion of the days in the Medicaid fraction should be removed.

Response: We proposed this change to facilitate consistent handling of these days across all hospitals, in recognition of the reality that, in some States, fiscal intermediaries are reliant upon hospitals to identify days attributable to dual-eligible patients whose Medicare Part A hospitalization benefits have expired. We believe it is important that all IPPS policies be applied consistently for all hospitals around the country.

However, we acknowledge the point raised by the commenter that beneficiaries who have exhausted their Medicare Part A inpatient coverage may still be entitled to other Part A benefits. We also agree with the commenter that including the days in the Medicare fraction has a greater impact on a hospital's DSH patient percentage than including the days in the Medicaid fraction. This is necessarily so because the denominator of the Medicare fraction (total Medicare inpatient days) is smaller than the denominator of the Medicaid fraction (total inpatient days). However, we note that we disagree with the commenter's assertion that including days in the Medicaid fraction instead of the Medicare fraction always results in a reduction in DSH payments. For instance, if a dual-eligible beneficiary has not exhausted Medicare Part A inpatient benefits, and is not entitled to SSI benefits, the patient days for that beneficiary are included in the Medicare fraction, but only in the denominator of the Medicare fraction (because the patient is not entitled to SSI benefits). The inclusion of such patient days in the Medicare fraction has the result of decreasing the Medicare fraction in the DSH patient percentage.

For these reasons, we have decided not to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, we are adopting a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage. If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective

for discharges occurring on or after October 1, 2004. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual-eligible beneficiaries in the Medicare fraction of the DSH calculation.

* * * * *

■ 15. Section 412.106 is amended by

* * * * *

■ C. Revising paragraph (b)(2)(i) introductory text.

* * * * *

to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(b) * * *

(2) * * *

(i) Determines the number of patient days that—

* * * * *

I. Impact of Policy Changes for Available Beds and Patient Days Used in the IME and DSH Adjustments

Under the IPPS, the IME and the DSH adjustments utilize statistics regarding the number of beds and patient days of a hospital to determine the level of the respective payment adjustment. For IME, hospitals receiving this adjustment want to minimize their number of beds in order to maximize their resident-to-bed ratio. For DSH, urban hospitals with 100 or more beds qualify

for a higher payment adjustment, so some hospitals have an incentive to maximize their bed count to qualify for higher payments. Existing regulations specify that the number of beds is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period.

In this final rule, we finalized our policy regarding unoccupied beds, observation beds of patients ultimately admitted as inpatients, dual-eligible patient days, and Medicare+Choice patient days. We do not anticipate that these policy changes will have a significant impact on payments. Based on an analysis from our actuarial staff, we anticipate the impact of all four of these policy changes to be less than $50 million for FY 2005.

* * * * *

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 415, 424, 440, 441, 482, 485, and 489

[CMS-1498-Fand CMS-1498-IFC; CMS-1406-F]

RIN 0938-APS0; RIN 0938-AP33

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services; Medicaid Program: Accreditation for Providers of Inpatient Psychiatric Services

* * * * *

We are committed to continue working with SSA to ensure that the file we receive from SSA for the purposes of the SSI fraction data matching process is complete and comprehensive and includes all individuals who are entitled to SSI. To our knowledge, there are no omissions or data errors on the SSI file that we receive from SSA. If we become aware of any such omissions or errors, we will work with SSA to correct them as quickly as possible. With respect to obtaining an SSN for each record in the EBD that does not have an SSN, we remind the commenters that "of the more than 100 million records in the EDB, less than 0.07 percent (that is, fewer than 7 of every 10,000 records) relate to individuals for whom the EDB does not include a SSN for the person." There are valid reasons that a person in the EDB may not have an SSN. For example, as we noted in the proposed rule, a person could live in a country other than

the United States, but be entitled to Medicare benefits through his or her spouse. Another example of a record in the EDB that may validly lack an SSN is if the person filed for a spouse's or widower's benefit prior to the 1980's because SSA did not require that the person filing for benefits have an SSN at that time. There may be other valid reasons that a record in the EDB does not have an SSN, and as we previously stated, less than 0.07 percent of records in the EDB lack an SSN. We do not believe that it is possible to add an SSN for every record if the person became entitled to Title II or Medicare benefits without ever applying or receiving an SSN. However, we note that the EDB is populated by SSA on a frequent basis; to the extent that a record is added to the EDB, the SSN that SSA has on file for that person should be included in the EDB as well. Moreover, even if there were instances in which a record in the EDB was missing an SSN, the lack of an SSN for certain records in the EDB should have no effect on the data matching process because, in order to be entitled to SSI benefits, an individual must have an SSN. That is, a person who does not have an SSN, by definition, cannot be entitled to SSI (We refer readers to the proposed rule language at 75 FR 24003 that states: "However, if an applicant for SSI benefits does not already have a SSN, SSA then assigns a SSN to the person.") Thus, in the SSI eligibility data that SSA provides to CMS, each individual identified in those data should have a unique SSN. Additionally, as we stated under Step 2 of the proposed data matching process, if an individual is entitled to SSI benefits and Medicare benefits, the new format of the SSI eligibility file will contain up to 10 Title II numbers and, if they have not already been captured, each of those numbers will be included in our revised

match process. Even if an individual does not have a SSN in the EDB, this second step should ensure that our revised match process will include that individual.

In response to the comment that CMS share the SSI file data with hospitals, the SSI program is under the authority of SSA and CMS is not authorized to share SSA data. Additionally, CMS is only permitted to use the SSI data for the sole purpose of conducting the data match process and calculating the SSI fractions. To the extent that a third party wishes to obtain direct access to the SSI file, it must contact SSA directly and meet SSA's requirements to become an authorized user.

Comment: One commenter stated that CMS uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but uses paid SSI days in the numerator of the SSI fraction. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI fraction. The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data matching process. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:

- E01 and E02
- N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
- P01
- S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
- T01, T20, T22, and T31

Response: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "entitled to supplemental security income benefits (excluding any State supplementation)" (emphasis added).[19] Consistent with this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to" receive SSI benefits. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis

[19] As a side note, we have used the phrase "SSI-eligible" interchangeably with the term "SSI-entitled" in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.

On the other hand, 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 (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4) of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.

Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), 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. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.

In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether any of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.

Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.

Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.

As we have described above, none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used. SSI entitlement can change from time to time, and we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits.

After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay.

* * * * *

QUALITY REIMBURSEMENT SERVICES, INC.
Healthcare Consultants

PRRB Case No. 15-3126GC

Feb. 8, 2016

Mr. Michael W. Harty, Chairman
Department of Health and Human Services
Provider Reimbursement Review Board
2520 Lord Baltimore Dr.—Suite L
Baltimore, Maryland 21244-2670

RE: QRS Empire Health 2008 SSI Percentage CIRP Group—NPR Based PRRB Case No. 15-3126GC
Provider Nos.: 50-0044 and 50-0119
FYE: 09/30/2008
Request for EJR

Dear Mr. Harty:

I accordance with PRRB Rule 42 I am writing to request Expedited Judicial Review for the above referenced case number 15-3126GC. The request to form this Common Issue Related Party group appeal was received by the Board on August 3, 2015. The Board issued an acknowledgement letter on August 6, 2015 assigning the above referenced case number.

The Board also issued a Critical Due Dates letter on August 6, 2015. Subsequently, per the Group representatives' request, the Board revised the critical due dates.

Per the revised Critical Due Dates notice the Group Representative sent the Schedule of Providers and supporting documentation with a cover letter to the Board

demonstrating that the Board has jurisdiction over the providers named in the group appeal. The Group Representative also sent a complete copy of the Schedule of Providers with all supporting documentation to the Lead Intermediary. A preliminary position paper has also been submitted to the Lead Intermediary. The Lead Intermediary in this case is Wisconsin Physicians Service.

The Issue For Which EJR Is Requested

The Provider is challenging the validity of CMS's regulation, 42 CFR § 412.106(b)(2), specifically the application of "entitled" to the denominator of the SSI fraction for DSH purposes. Effective October 1, 2004 CMS amended section 412.106 to change the previous language "(i) Determines the number of covered patient days" to "(i) Determines the number of patient days." That is, CMS amended the regulation to remove the word "covered" so that any days for which CMS considers the individual to be "entitled to benefits under part A" (e.g., exhausted days, Part C days, MSP days), regardless of whether the days were covered or paid by Medicare Part A will be included in the denominator of the SSI fraction. However, the change only affected the denominator. For purposes of the numerator, CMS requires that beneficiary was paid SSI benefits during the period of his or her hospital stay in order for such days to be included in the numerator. *See* 75 Fed. Reg. 50280-81. The Provider challenges the regulation as contrary to Medicare Statute and arbitrary and capricious because CMS is not permitted to have two different meanings of "entitled" within the SSI Fraction—either CMS is incorrect in applying a stricter standard

with respect to entitled to SSI for purposes of the numerator or CMS's change to its regulation to place exhausted days, MSP days and Part C days in the denominator regardless of whether they were paid or covered by Medicare Part A is invalid.[1]

There Are No Factual Issues In Dispute

EJR is appropriate because the above-referenced appeal challenges CMS' revised/changed interpretation (effective October 1, 2004) of the term "entitled" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).

There is no dispute that CMS changed its regulation at 42 CFR 412.106(b)(2) effective October 1, 2004 by eliminating the word 'covered' when referring to days used in calculating SSI fractions. There is also no dispute that effective October 1, 2004 CMS stopped using 'covered' days in the denominator of the SSI fraction and began using 'total' days instead.

Effective October 1, 2004 the Secretary began including 'covered', 'non-covered', 'exhausted benefit', 'Medicare secondary payer' and Medicare 'Part C' days in the denominator of the SSI fraction calculations. Previously only 'covered' / 'paid' Medicare Part A days were included in both the numerator and denominator of the SSI fraction. The Secretary, effective October 1, 2004, began including days in the denominator that were 'not covered' / 'not paid' by Medicare Part A, yet continued requiring that only 'paid' SSI days be included in the numerator.

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[1] The Provider notes that, as applied to Part C days, the 2004 amendment to section 412.106(b)(2) has been vacated. *See Allina Health Servs, v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).

There is also no dispute that CMS will include 'covered', 'non-covered', 'exhausted benefit', 'Medicare secondary payer' and Medicare 'Part C' days in the numerator of the SSI fraction calculations, but only if the individual(s) also received SSI cash payments. CMS made it clear in the Federal Register that only days for which SSI payments were actually made will be included in the numerator. 75 Fed. Reg. 50042, 50280-81 Aug. 16, 2010 CMS does not include days in the numerator when individuals were eligible for SSI but were not due a payment.

There is no dispute that **only** Social Security Administration payment status codes ('PSC's) C01, M01 and M02 are utilized to identify individuals whose patient days will be included in the numerator of the SSI fraction. On April 29, 2003 Pat Cribbs, a team leader for the database analysis section at the Social Security Administration, with 24 years of experience, testified at a PRRB evidentiary hearing related to PRRB Case Nos. 96-1882, 97-1579, 98-1827, and 99-2061 (*Baystate*). Ms. Cribbs worked with the preparation of the SSI file that was sent to CMS for the purpose of developing the SSI fractions for hospitals. In her testimony Ms. Cribbs stated that in order for an individual to be included in the file that SSA sent to CMS, the individual would have to have been active with one of three SSA payment status codes (C01, M01 or M02) and have been paid at least a penny for the month in question.

CMS reaffirmed their position to only include payment status codes C01, M01 and M02 in their response to a comment letter related to proposed rule 1498-P in the Federal Register/Vol. 75, No. 157/Monday, August 16, 2010 on pages 50280 and 50281 when it stated:

" . . . we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits." There is no dispute that CMS does not include and has no intention of including any other PSCs in determining the numerator of the SSI fraction. The following are some additional excerpts from CMS' response in the Federal Register referenced above.

"Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSJ benefits."

"Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits."

"Code "EOI" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment."

"Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (I) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the

month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits. "

"As we have described above, none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used"

The Controlling Law

42 U.S.C. § 1395ww(d)(5)(F)(vi) is controlling, and is printed below:

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(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 subchapter and were entitled to supplementary 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, and

(II) 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 pa-

> tients who (for such days) 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 of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

(emphasis added)

CMS's Regulation(s)

Section 42 CFR 412.106, which applied to the SSI Percentage **prior to the 10/1/2004 change**, is reprinted below:

42 CFR § 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(b) *Determination of a hospital's disproportionate patient percentage—*

(1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

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

> (i) Determines the number of covered patient days that—
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medi-

care Part A and SSI, excluding those patients who received only State supplementation; (emphasis added)

(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.

Section 42 CFR 412.106, which applies to the SSI Percentage **after to the 10/1/2004 change**, is reprinted below:

Determination of a hospital's disproportionate patient percentage.

(1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(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 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 supplementation;

(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. (emphasis added)

Why The Board Does Not Have Authority To Decide The Legal Question

The Board does not have authority in this case to give the Provider the relief it seeks because it is challenging the validity of the 2004 regulation. The Provider challenges the regulation as contrary to Medicare Statute and arbitrary and capricious because CMS is not permitted to have two different meanings of "entitled" within the SSI Fraction—either CMS is incorrect in applying a stricter standard with respect to entitled to SSI for purposes of the numerator or CMS's change to its regulation to place exhausted days, MSP days and Part C days in the denominator regardless of whether they were paid or covered by Medicare Part A is invalid

Attached is a Schedule of Providers along with copies of all necessary jurisdictional documents as required by PRRB Rule 42.

Also attached is an analysis of the patient days used to determine Valley Hospital Medical Center's SSI fraction for Federal Fiscal Year ending September 30, 2008. Redacted Social Security Administration records are included documenting patient days not included in the numerator of the SSI fraction for specific individuals that

were eligible for SSI however were not due SSI payments. The redacted Social Security Administration records, for these individuals, reflect the assignment of PSC codes CMS refuses to recognize in the numerator of the SSI fraction (per the response she provided in the above referenced Federal Register).

Should you have any questions or require additional documentation please feel free to call me at (509) 924-3824.

Sincerely

/s/ DELBZERT NORD
DELBERT NORD
Associate

Encl

Cc: Byron Lamprecht, Wisconsin Physicians Service, Omaha, NE

SDX Payment Status Codes

The first position of the payment status code indicates the status of SSI/SS payment eligibility and the second and third positions indicate the reasons for the status.

C Indicates recipient is eligible for SSI/SS payment.

E Indicates eligibility for Federal and/or State benefit based on the eligibility computation but no payment is due based on the payment computation.

H Indicates a case in hold status, final disposition pending.

M Indicates case under manual control. Case is known as "force payment" although a payment may not be involved.

N Indicates applicant is not eligible for SSI/SS payment or that a previously eligible recipient is no longer eligible.

P Indicates suspension with the probability of reinstatement.

S Indicates recipient may still be eligible for SSI/SS but payment is being withheld.

T Indicates SSI/SS eligibility is terminated.

C01 Current pay status.

E01 Eligible for Federal and/or State benefits based on eligibility computation, but no payment is due based on payment computation.

H10 Living arrangement change is in process.

H20 Marital status change in process.

H30 Resource change in process,

H40 Student status change in process.

H50 Head of Household change in process.

H60 Hold pending receipt of date of death.

H70 Hold pending transmission of one-time payment data

H80 Early input.

H90 Systems limitation involved. SSA District office (DO) must manually compute and input payment amount.

M01 Force Payment—Recipients may be in payment or nonpayment status. See SSI Gross Payable Amount field or State Supplemental Gross Payable Amount field for eligibility amount. These fields will contain zeros if in non-payment status.

M02 Payment status posted to indicate that the record is under "force due" control.

N01 Non-pay Recipient's countable income exceeds Title XVI payment amount and his/her State's payment standard.

N02 NONPAY recipient is inmate of public institution.

N03 NONPAY recipient is outside U.S.

N04 NONPAY recipient's nonexcludable resources exceed Title XVI limitations.

SM 01601.805 Payment Status codes in Computation History—List

Code	Status	Explanation
BLANK		Disability determination pending, an edit condition exists or verification is pending.
C01	CURRENT PAY	Systems generated payment currently, or FO transmitted PSC01
E01		Eligibility for Federal and/or State benefits based on the eligibility determination but no payment is due based on the payment computation (not applicable before 4/82). FLA-D or PCI is equal to FBR.
E02	NONPAY	Eligible for benefits but not due a payment (applies to first month of eligibility only)
H10	HOLD	Living arrangements change in process
H20	HOLD	Martial status change in process
H30	HOLD	Resource change in process
H40	HOLD	Student status change in process

H50	HOLD	Head of Household change in process
H60	HOLD	Hold Pending receipt of date of death
H70	HOLD	One-time payment or other PE data to be transmitted
H80	HOLD	Early input
H90	HOLD	Systems limitation regarding computation; FO must manually compute and input payment amounts
M01		Force payment case, recipient may be in current payment or nonpayment status, depending on payment history (PMTR)
M02		Force Due Case (FO controls case through MSSICS), recipient may be in current payment or nonpayment status, depending on payment history (PMTH)
N01	NONPAY	Recipient's countable income exceeds title XVI, FBR and OSS if applicable

N02	NONPAY	Recipient is inmate of public institution
N03	NONPAY	Recipient is outside U.S.
N04	NONPAY	Recipient's nonexcludable resources exceed title XVI limitations
N05	NONPAY	Field Office is unable to determine eligibility for some period of nonpayment or failure to provide information for children overseas
N06	NONPAY	Recipient failed to file for other benefits
N07	NONPAY	Cessation of recipient's disability
N08	NONPAY	Cessation of recipient's blindness
N09	NONPAY	Recipient refused vocational rehabilitation without good cause
N53	NONPAY	Deleted from State rolls after 12/73 payment
N54	NONPAY	Denied—Whereabouts unknown (obsolete)
P01	PROVISIONAL	Possible reinstatement ending development of SGA (obsolete)

S04	SUSPENDED	System is awaiting disability determination input (system generated)
S05	SUSPENDED	Prerequisite payment month development pending to determine eligibility for special 1619(a) payments to disabled individuals
S06	SUSPENDED	Recipient' address unknown
S07	SUSPENDED	Returned checks for other than death, identification, address, death of payee or duplicate check (systems generated)
S08	SUSPENDED	Representative payee development pending
S09	SUSPENDED	Temporary Institutionalization Suspense (system generated)
S10	SUSPENDED	Recipient has a bank account and refuses to receive payments via direct deposit
S20	SUSPENDED	The recipient is presumptively disabled or blind and has received 6 months payments (FO input)

S21	SUSPENDED	The recipient is presumptively disabled or blind and has received 6 months payments (system generated)
S90	SUSPENDED	PR1 change in process
S91	SUSPENDED	PR1 change in process
T01	TERMINATED	Death of recipient
T20	TERMINATED	Received a duplicate payment based on two different numbers: (applied by FO or CO 1719B input)
T22	TERMINATED	Received duplicate payment based on the same number on different SSRs or on two different numbers: (applied internally by the system)
T30	TERMINATED	Manual termination
T31	TERMINATED	Systems generated termination (payment previously made or refund on record)
T32	TERMINATED	Automated systems termination of a paid record that has exceeded certain size limitation

T33	TERMINATED	Manual termination (through MSSICS)
T50	TERMINATED	Manual termination (no previous payment made)
T51	TERMINATED	Systems generated termination (no previous payment made)
*		Data transmitted in error. Surface edit in PS field on 450SI

PAYMENT STATUS CODES (PS)
SM 01305.001
SM 01601.805

The following list includes abbreviated definitions. Complete instructions and definitions may be found in SM 01305.001. The PS Code is found in the PSY field and CMPH segment of SSI2, SSID, QUJ, QUS, and the PSY field of the SSI3 and SSIF query.

Code	Explanation
C01	Current pay
E01	Eligible but no payment due
H10	Living arrangement change pending
H20	Martial status change pending
H30	Resource change pending
H40	Student status change pending
H50	Head of household change pending
H60	Hold for PE input to post death
H70	Hold for subsequent PE input
H80	Hold for early input (allowance/denial pending)
H90	Systems limitation regarding computations
M01	Force payment case
N01	Nonpay—excess income
N02	Nonpay—inmate of public institution
N03	Nonpay—outside of US
N04	Nonpay—excess resources

N05	Nonpay—unable to determine if eligibility exists
N06	Nonpay—failed to file for other benefits
N07	Nonpay—medical cessation of disability
N08	Nonpay—medical cessation of blindness
N09	Nonpay—refused VR without good cause
N10	Nonpay—failure to comply with treatment plan for DAA
N11	Nonpay—benefit sanction month due to noncompliance DAA
N12	Nonpay—voluntary withdrawal
N13	Denial—not a citizen or eligible alien
N14	Denial—aged claim, denied for age
N15	Denial—blind claim, denied not blind (obsolete)
N16	Denial—disability claim, denied not disabled (obsolete)
N17	Denial—failure to pursue
N18	Denial—failure to cooperate
N19	Denial—voluntary termination
N20	Nonpay—failure to provide requested report of evidence
N27	Termination due to SGA
N30-N40	Disability Denials—No Visual Impairments
N30	Denial—slight impairment medical consideration only

N31	Denial—capacity for SGA—customary work
N32	Denial—capacity for SGA—other work
N33	Denial—engaging in SGA
N34	Denial—lack of severity and duration
N35	Denial—lack of duration
N36	Denial—insufficient or no medical evidence submitted
N37	Denial—refused consultative examination
N38	Denial—discontinue development claimant's request
N39	Denial—willful failure to follow prescribed treatment
N40	Denial—impairment(s) does not meet or equal listings—DC under age 18 only

QUALITY REIMBURSEMENT SERVICES
Healthcare Consultants

June 9, 2010

CERTIFIED MAIL—RETURN RECEIPT REQUSTED

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS 1498-P
P.O. Box 8011
Baltimore, MD 21244-1850

REF: CMS 1498-P/April 23, 2010/Proposed Rules

To Whom It May Concern:

Subject: Comments regarding section IV, Other Decisions and Proposed Changes to the IPPS for Operating Costs and GME Costs, part G, Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs): Supplemental Security Income (SSI) Fraction, of CMS 1498-P proposed rules.

My name is Delbert Nord. I am an associate at Quality Reimbursement Services, a company that specializes in Medicare Disproportionate Share payments and represents hospitals across the country. As an interested party, I am compelled to write this letter and comment on the proposed rule change because it is my belief that an obvious and material inequity exists between the numerator of the SSI fraction and the denominator of the SSI fraction.

SUMMARY

At its inception, the SSI fraction was to include only paid days. The numerator required an SSI payment to be

made for the days to be included, and only days paid by Medicare Part A were included in the denominator. While payment continues to be a requirement for the numerator of the SSI fraction, the denominator changed effective October 1, 2014 such that total days began being used. Thus the denominator, by current definition, includes covered (paid) days, non-covered (not paid) and exhausted days (not paid). Medicare Part A payment· is no longer a requirement for days to be included in the denominator. In other words, only paid SSI days are being included in the numerator while both paid and not paid Medicare Part A days are being included in the denominator. The restriction of the numerator to only paid days is an obvious and material inequity. To compare "apples to apples" it is necessary to include both paid and not paid SSI days in the numerator. Action to correct the numerator of the SSI fraction to include all paid and not paid SSI days is required by CMS such that in implementing the newly proposed matching process, accurate and fair SSI percentages are calculated.

The other alternative would be to stop including not paid days in the denominator of the SSI fraction.

BACKGROUND

From the inception of the DSH adjustment in 1986, CMS stated that the SSI fraction would include days paid by Medicare, consistent with CMS' original policy regarding the composition of the Medicaid fraction before the issuance of HCFA Ruling 97-2. *See, e.g.,* 51 Fed. Reg. 31454, 31460 (Sep. 3, 1986). In defending its original policy concerning the Medicaid fraction, CMS represented to several federal courts that the Medicare/SSI fraction counts only Medicare paid days. *See,*

e.g., Legacy Emanuel Hospital & Health Center v. *Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996).

The Secretary's regulation that was in effect for the time periods beginning before October 1, 2004 stated that the Medicare/SSI fraction includes only "covered patient days." 42 C.F.R. § 412.106(b)(2)(i) (1998). However, CMS Ruling 1498-R requires that the Medicare fraction include "inpatient days where the patient was entitled to Part A benefits but the inpatient hospital stay was not covered under Part A." Therefore, the CMS ruling is inconsistent with the language of the regulation in effect during the time periods prior to October 1, 2004.

Denominator:

While CMS repeatedly stated that the SSI fraction would only include inpatient days paid by Medicare Part A, CMS changed 42 CFR 412.106 removing the word "covered" ("covered" and "paid" are considered synonymous terms) from the regulation. Now the regulation simply refers to total days being used in the denominator (i.e. paid and not paid).

CMS 1498-P states, " . . . CMS determines the denominator of the hospital's SSI fraction by calculating the sum of the number of the hospital's inpatient days for patients entitled to benefits under Medicare Part A (regardless of SSI eligibility) that are included in the hospital's inpatient claims for the period." Ruling 1498-R states, "More specifically, we believe that the inpatient days of an individual who was entitled to Part A belong in the DSH SSI fraction even if the inpatient stay was not covered under Part A or the patient's Part A

hospital benefits were exhausted." Thus, based on CMS rules and regulations, **entitled=paid and not paid.**

Numerator:

On April 29, 2003 Pat Cribbs, a team leader for the database analysis section at the Social Security Administration, with 24 years of experience, testified at a PRRB evidentiary hearing related to PRRB Case Nos. 96-1882, 97-1579, 98-1827, and 99-2061. Ms. Cribbs worked with the preparation of the SSI file that was sent to CMS for the purpose of developing the SSI percentages for hospitals. In her testimony Ms. Cribbs stated that in order for an individual to be included in the file that SSA sends to CMS (the very file CMS 1498-P claims it will use in the proposed matching process), the individual would have to have been active with one of three pay codes (CO-1, MO-1 or MO-2) and have been getting **paid** at least a penny for the month in question.

CMS 1498-P states, " . . . CMS determines the numerator of the hospital's SSI fraction (that is, the number of the hospital's inpatient days for all its patients who were simultaneously **entitled** to Medicare Part A benefits and SSI benefits) . . . " It follows then that if CMS interprets the term "entitled" to include both paid and not paid patient days in the denominator of the SSI fraction that the numerator of the SSI fraction should also include both paid and not paid patient days.

THE PROBLEM

The proposed new matching process is to be implemented and used to finalize open cost reports for cost reporting periods beginning prior to October 1, 2010 as well as properly pending appeals and then be used in the

forthcoming 2011 fiscal year. CMS 1498-P does not address the inequity of the composition of the fraction which has existed since the regulation changed effective October 1, 2004 when total days began being used in the denominator.

While I commend CMS on their attempt to correct the SSI matching process to more accurately capture all **entitled** patient days in the numerator; CMS needs to go a step further to capture and include all not paid SSI patient days in the numerator as well. It often takes two to three years or more for SSI determinations to be made. The additional time CMS proposes to allow for retroactive SSI determinations and lifting of payment suspensions to be recognized is inadequate, and it continues to focus upon the necessity of SSI payment rather than focusing upon SSI eligibility.

The proposed rules talk a great deal about matching SSI **eligibility** records with MedPAR data (i.e. **"**CMS matches the Medicare records and SSI **eligibility** records for each hospital's patients. . . . " "The data underlying the match process are drawn from: (a) the . . . MedPAR data file; and (b) SSI eligibility data . . . " "The SSI eligibility data that CMS receives from SSA contain monthly indicators to denote which month(s) each person was eligible for SSI benefits . . . " "CMS' Proposed Process for Matching Medicare and SSI Eligibility Data"). In the final count of SSI days however CMS is still restricting the numerator of the SSI fraction to actual payment.

CMS has defined the term **entitled** when referencing the denominator to include both paid and not paid patient days. It only makes sense to apply the same definition

to the numerator. Otherwise, the fraction is not an equal or useful comparison.

CMS includes Medicare Part A exhausted days (for which there was no Medicare payment made) in the denominator of the SSI percentage—thus shouldn't SSI days be included in the numerator for SSI patients that are eligible for SSI but did not receive a SSI payment? There are a number of other status codes used by the Social Security Administration besides the C-01, M-01 and M-02 codes identified by Pat Cribbs that indicate the individual was eligible for or entitled to SSI benefits, however payment was not made.

For example: Per Pat's testimony, the individual has to be active to be counted (i.e. C-01, M-01 or M-02). Pat said the patient must have received at least a penny to be included in the file being sent over from SSA to CMS. What if a SSI patient were in a skilled nursing facility and did not receive their SSI payment simply because Medicaid covered the cost of the skilled nursing care provided? The patient would be eligible for SSI; however would not receive their SSI payment because another form of Federal payment was made in place of it. As soon as this patient is discharged from the skilled nursing facility their SSI payments will resume. The individual is still a low-income patient which the Medicare DSH program seeks to measure. What's the difference between this type of SSI patient and the Part A patient that exhausted their benefits whereupon Medicaid stepped in and mad payment in place of Medicare Part A?

There are other SSA Status codes that should be included in the numerator of the SSI percentage besides the few that restrict the numerator to requiring payment. If the denominator includes non-covered days and exhausted days—(i.e. payment is no longer required), then the numerator needs to be changed to allow days where the patient is not receiving a SSI check.

Additional code that should be counted in the numerator include suspended codes such as S-06 where the payment was suspended because, "recipient's address is unknown" and S10, "Recipient has a bank account and refuses to receive payments via direct deposit." Clearly, these patients are entitled to SSI and should be counted in the numerator even though they are not receiving payment. These patients are low-income whether SSA knows their address or not and whether they have direct deposit or not. It is my belief, position, and recommendation that all suspended SSA status codes be included in the numerator of the SSI percentage regardless of whether the payment suspensions are ever lifted or not. More specifically status codes S-04, S-05, S-06, S-07, S-08, S-09. S-10, S-20, S-21, S-90, and S-91 should be included in the numerator of the SSI fraction.

I also recommend that SSA status codes E-01 and E-02, "Eligibility for Federal and/or State benefits based on the eligibility determination but no payment is due based on the payment computation," and, "Eligible for benefits but not due a payment," respectively should be included. The explanation of these codes alone indicates the individuals were eligible for SSI benefits, however payment was not made.

Furthermore; there are several "Terminated" status codes that should be counted or at least considered for

inclusion. These include T-01, "Death of Recipient." A deceased recipient will have their SSI payment terminated, however this does not discount the fact that they were an SSI entitled individual at the time services were rendered. Other terminated status codes deserving of consideration for inclusion involve duplicate payments and payments previously made, T-20, T-22, and T-31.

Finally, there are many SSA status codes where the explanations are less clear, but what is clear is that if these are in fact SSI eligible patients not receiving payment, then they should be included and, counted in the numerator of the SSI fraction. For instance, Non-Pay codes N-06, "Recipient failed to file for other benefits," and N-18, "Failure to cooperate," indicate payment was not made for reasons other than the individuals eligibility for SSI benefits. These individuals are still low-income regardless of whether they file for other benefits or cooperate. Additional codes deserving of serious consideration are: N-10, N-11, N-35, N-39, N-42, N-43, N-50, N-54, and P-01.

IN SUMMARY

The current restriction of the SSI numerator to SSA status codes C-01, M-01 and M-02 needs to be expanded to include all SSI status codes for which individuals are eligible for SSI benefits however are not receiving payment. An obvious inequity exists. If the denominator of the SSI fraction includes days that were not paid by Medicare, namely non-covered and exhausted days, then the numerator of the SSI fraction should include not paid SSI days as well. Although improving the matching process is a much needed improvement, it is not enough, nor is the additional time CMS proposes to allow for the lifting of payment suspensions. The SSI

fraction needs to be a fair and equal comparison. In order to achieve this, the new data matching process needs to include the following:

- A provision to include all SSI eligible patient days in the numerator of the SSI percentage, including but not limited to the following codes:
  - E01, E02.
  - N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
  - P01
  - S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
  - T01, T20, T22, and T31

The other alternative is to go back to the use of the term "covered" in the regulation and stop including days for which Medicare failed to make payment.

I urge that the above stated be added to the public record for discussion in regards to Section IV, part G, Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs): Supplemental Security Income (SSI) Fraction, of CMS 1498-P proposed rule change.

Respectfully,

/s/ DELBERT NORD
DELBERT NORD
Associate
Quality Reimbursement Services

Program Operations Manual System (POMS)

Effective Dates: 04/25/2013 - Present

GN 02210.008 Cross Program Recovery (CPR) from Monthly Title II, Title VIII, and Title XVI Benefits to Recover Other Program Overpayments

Citations: Social Security Act § 1147
Social Security Act § 808
20 CFR § 404.530, 20 CFR § 416.572, 20 CFR § 408.930

A. Authority for mandatory (CPR) from Social Security administered program benefits

Section 210 of the Social Security Protection Act of 2004 expanded the Social Security Administration's (SSA) authority to conduct CPR. The 2004 amendment of Section 1147 of the Social Security Act (Act) permits SSA to recover Social Security (title II), Special Veterans Benefits (title VIll), and Supplemental Security Income (title XVI) overpayments from a debtor by decreasing any amount payable to that debtor under title II, title VIII, or title XVI. With the change in the law. a debtor does not have to provide permission for SSA to collect the overpayment from any program benefit due the debtor.

In general, CPR may recover only ten percent of a monthly benefit paid.

The law limits the amount of CPR recovery from regularly due monthly title XVI benefits to the lesser of:

- the amount of that monthly benefit or
- ten percent of the debtor's income for that month. Such income includes the monthly benefit but excludes payments under title II when we are recovering a title n overpayment from title II benefits and income excluded under section 1612(b) of the Act

In addition, the law provides that none of the above limits on CPR recovery apply if the debtor requests a greater CPR recovery or if the debtor, or the spouse of the debtor, was involved in willful misrepresentation or concealment of material information in connection with the overpayment amount.

B. General rules for CPR from monthly title II benefits

1. If we terminated or suspended the title II benefit retroactively, the overpayment recovery for the other program **ceases as of the current operating month (COM)**. Any amount with title II benefit used to reduce the other program debt effective with the retroactive termination month of is a **title II overpayment**
2. Cessation or suspension of the title II benefit precludes cross program recovery of benefits not regularly paid due to the suspension or cessation. See SM 00610.815 if the ledger account file (LAF) status of the debtor changes from current pay to a non-pay status. Initiate a new CPR action if the debtor becomes eligible again.
3. CPR applies nationwide. However, special procedures apply, effective November 21, 2000, to members of the Ellender Class (certain Supplemental Security Income (SSI) recipients who

resided in New York State who had title XVI overpayments from the 1980's), see SI 02220.020A.8.

We must send all class members notices which advise them:

- the time periods during which overpayment of SSI benefits arose;
- the amount of overpayment in each time period and in total;
- the amount of any prior repayments;
- the reason for overpayment;
- that the recipient has a right to appeal or reconsideration;
- that under specified conditions, the recipient may have the right to waive repayment and
- that the time period in which the Government should have collected the overpayments may have passed, but if the recipient pays back any installment or writes a letter acknowledging the overpayment the Government's right to collect may be revived (i.e., the statute of limitations may have run, but partial repayment or a written acknowledgment by the debtor may revive the claim).

C. Recovery of title VIII overpayments from monthly title II and title XVI benefits

Under Social Security Act § 808(e), we recover title VII overpayments by decreasing a beneficiary's monthly title II benefits or title XVI payments by CPR. For information about CPR recovery of title VIII overpayments from title II and title XVI benefits, see VB 02005.101.

D. Recovery of title XVI overpayments from monthly title II benefits

The Recovery and Collection of Overpayments (RECOOP) system automatically selects title XVI debts for CPR from title II benefits. For the automated process, see SI 02220.0208. Process Non-RECOOP cases manually per SI 02220.020C.

E. Recovery of title XVI overpayments from monthly VIII benefits

Title XVI and title VIII are two separate programs, but both utilize the Social Security Record (SSR) for record keeping and systems processing. Prior to July 5, 2002, the SSR limited refund of the overpayment efforts to recover title XVI overpayments from title VIII benefits. See VB 02020.005 for CPR recovery of title XVI overpayments from title VIII benefits.

F. Recovery of title II overpayments from monthly title VIII Benefits

Recovery of title II overpayments from monthly title VIII benefits is a manual process; for the recovery procedures, see SM 01311.320.

G. Recovery of title II overpayments from monthly title XVI benefits

Recovery of title II overpayments from monthly title XVI benefits is a manual process; for the recovery procedures, see SM 00610.820 and SM 01311.320.

H. References

- SI 02220.020 Cross Program Recovery (CPR) of SSI Overpayment from Monthly Title II Benefits
- SM 00610.815 A LAF Status Change in a Cross-Program Recovery Case
- SM 00610.820 Recovery of a Title II Overpayment from Title XVI Benefits
- SM 01311.320 Recovery of Title II Overpayment from Monthly SSI Benefits and Special Veterans Benefits
- VB 02005.101 SVB Overpayments—Overview
- VB 02020.005 Collection of SSI Overpayments From Special Veterans Benefits

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WASHINGTON

Case No. 2:16-cv-00209-RMP

EMPIRE HEALTH FOUNDATION FOR VALLEY HOSPITAL MEDICAL CENTER, MEDICARE COST REPORT 09/30/2008, PLAINTIFF

v.

ALEX M. AZAR II, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEFENDANT

Filed: May 9, 2018
Noted: July 10, 2018 1:30 p.m.
With Oral Argument

DEFENDANT'S COMBINED CROSS-MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

* * * * *

The challenged regulation provides that all "patient days" for Medicare Part A beneficiaries, 42 C.F.R. § 412.106(b)(2)(i), are to be counted as days on which the hospitalized patient is "entitled to benefits under [Medicare] part A," 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). Until 2004, only "covered patient days" were so counted. *See* 42 C.F.R. § 412.106(b)(2)(i) (2003). The difference between these phrases is that days on which a Medicare Part A beneficiary is hospitalized but Medicare will not

pay for his care, for one of several reasons discussed below, are "patient days," but not "covered patient days." Empire Health challenges the current regulatory provision because, on its view, only covered patient days are days on which a patient is "entitled to benefits under [Medicare] part A" and days for which Medicare did not pay should not be included in the Medicare fraction. Empire Health is mistaken; entitlement to Medicare part A is a status that does not change from day-to-day. Medicare beneficiaries are always "entitled to benefits under [Medicare] part A," regardless of whether Medicare covered a particular patient day. The Sixth Circuit has upheld the Secretary's regulation on both substantive and procedural grounds, *Metro. Hosp. v. U.S. Dep't of Health & Human Servs.,* 712 F.3d 248, 269-70 (6th Cir. 2013), and the D.C. Circuit has said that it contains "the better" reading of the statutory language, *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 920 (D.C. Cir. 2013). This aspect of the regulation is valid, and should be upheld.

The challenged regulation also provides that patients who participate in Medicare Advantage, and therefore receive their Medicare benefits (which they would otherwise receive through Parts A and B) through a private health insurance plan under Part C of the statute, are "entitled to benefits under [Medicare] part A." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). *See* 42 C.F.R. § 412.106(b)(2)(i)(B), (iii)(B). However, this part of the regulation has been vacated by the D.C. Circuit as procedurally invalid, *Allina Health Servs. v. Sebelius*, 146 F.3d 1102, 1111 (D.C. Cir. 2014) *("Allina I"),* and the Secretary has acquiesced to that vacatur. This Court should therefore remand this case to the Provider Reimbursement Review Board so that it can determine

whether these Part C days should be included in the Medicare fraction, without reference to 42 C.F.R. § 412.106(b)(2)(i)(B) or (iii)(B).

* * * * *