



Charles N. Kahn III  
President and CEO

October 5, 2020

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

***RE: CMS-1739-P, Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage***

Dear Administrator Verma:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care across settings in both urban and rural areas. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals. They provide a wide range of acute, post-acute, emergency, children's, cancer care, and ambulatory services. Approximately 90 percent of FAH member hospitals serve a significant number of low-income patients and therefore qualify for Medicare disproportionate share hospital (DSH) payments under 42 U.S.C. § 1395ww(d)(5)(F). We appreciate the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with our views in response to the proposed rule on the Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage, 85 Fed. Reg. 47,723 (August 6, 2020) (Proposed Rule).

## EXECUTIVE SUMMARY

***The FAH strongly opposes adoption of the Proposed Rule, which would effectively reinstate CMS’s vacated 2004 rule and expand its retroactive effect to cover all dates of service prior to October 1, 2014 (including dates of service prior to the effective date of the 2004 rule).*** CMS has tried in vain to impose the proposed policy for 16 years, and these efforts have been repeatedly rebuffed by the Federal courts. Instead, the courts have consistently recognized CMS’s pre-2005 practice of excluding Part C days from the Medicare fraction of the disproportionate patient percentage (DPP). Thus, the only lawful option now available to CMS is to calculate and make DSH payments in accordance with its original, pre-2005 practice and the plain text of the statute. Retroactive rulemaking cannot cure the defects in the vacated 2004 rule, and CMS’s limited authority to retroactively change rules does not authorize retroactive rulemaking here.

In addition, the public interest favors prompt payment using the pre-2005 DSH payment methodology because the inclusion of Part C days in the Medicare fraction would, in fact, impose a substantial, multi-billion dollar economic cost on hospitals that provide a vital safety net for Medicare beneficiaries. Prompt and proper payment of these long withheld DSH funds is particularly vital in the context of the present public health emergency due to novel coronavirus 2019 (COVID-19). DSH hospitals have incurred additional costs planning, preparing for, and treating patients presenting with COVID-19 symptoms at the same time that their revenue has declined due to the delay and cancellation of non-emergency procedures. The economic crisis that has accompanied this public health emergency has also resulted in unprecedented job and health coverage losses, which has in turn magnified the financial burden on DSH hospitals treating growing numbers of uninsured patients. Although the Department of Health and Human Services (HHS) has made critical emergency relief funds appropriated by Congress available to help mitigate the financial hardships associated with the current public health emergency, hospitals continue to face an uncertain financial outlook. As a general matter, the public interest is undermined by CMS’s continued withholding of appropriate DSH payments, contrary to Congress’s detailed and self-executing statutory scheme for DSH payments, and this adverse impact is particularly acute in the context of the COVID-19 public health emergency.

***The FAH urges CMS to comply with the binding decisions of the D.C. Circuit and the Supreme Court by calculating and making DSH payments in accordance with its pre-2005 practice of excluding Part C days from the Medicare fraction and including Part C days in the Medicaid fraction. CMS cannot and should not finalize its proposal to readopt its previously vacated Part C days policy on a retroactive basis.***

### **I. CMS Lacks Retroactive Rulemaking Authority**

CMS, having attempted since 2005 to exclude Part C days in the Medicare fraction, now proposes to adopt this same policy on a retroactive basis for all dates prior to October 1, 2014 (including dates prior to the invalidated 2005 final rule). “Retroactivity is not favored in the law,” *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988), and the Proposed Rule simply does not fit within CMS’s “limited authority to make retroactive ‘substantive change[s]’”

in policy under 42 U.S.C. § 1395hh(e)(1)(A).<sup>1</sup> CMS endeavors to fit the Proposed Rule into this narrow grant of retroactive rulemaking authority, but the attempt to retroactively adopt a policy that has been repeatedly rejected by the courts fails.

***Retroactive Establishment of a New Policy.*** The Proposed Rule indicates that “it is necessary for CMS to engage in retroactive rulemaking to *establish a policy* to govern whether individuals enrolled in MA plans under Part C should be included in the Medicare fraction or in the numerator of the Medicaid fraction, if dually eligible, for fiscal years before 2014.”<sup>2</sup> ***Under the Medicare Act, however, CMS has no authority to retroactively establish or adopt new policies.*** The authority cited in the Proposed Rule—42 U.S.C. § 1395hh(e)(1)(A)—only permits retroactive application of a “substantive *change* in regulations, manual instructions, interpretive rules, statements of policy, or guidelines of general applicability” in limited circumstances.<sup>3</sup> In contrast, the same section of the Medicare Act separately references the adoption of rules that “establish[] or change[] a substantive legal standard,” indicating that Congress distinguishes between rules *establishing* policies and those *changing* policies.<sup>4</sup> Thus, the plain text of the statute confers CMS with limited authority to retroactively change policies but not to retroactively *establish* policies. Instead, CMS can only establish a substantive legal standard governing the payment for services on a prospective basis through notice-and-comment rulemaking in accordance with § 1395hh(a)(2).

On the other hand, if the proposal is treated as a proposed substantive change in policy (contrary to the text of the Proposed Rule), the Proposed Rule provides no rationale for its retroactive application under § 1395hh(e)(1)(A). CMS’s limited authority to retroactively apply a substantive change of policy only extends to situations where “retroactive application is necessary to comply with statutory requirements” or where “failure to apply the change retroactively would be contrary to the public interest.”<sup>5</sup> But the Proposed Rule wholly fails to provide any rationale as to why retroactive application of a *change* to CMS’s pre-2005 policy excluding Medicare Part C days from the Medicare fraction is necessary. Rather, the rule only purports to explain why the *establishment* of a policy would be necessary to comply with statutory requirements or in the public interest in the absence of any prior policy.

***Statutory Requirements.*** The Proposed Rule asserts that retroactive application of the proposal is necessary “in order to comply with the statutory requirement to make DSH payments,”<sup>6</sup> suggesting that DSH payments cannot be calculated or made for the applicable time period without retroactive rulemaking. This rationale, however, could only support the

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<sup>1</sup> *Azar v. Allina Health Svcs. (Allina II)*, 139 S. Ct. 1804, 1812 (2019).

<sup>2</sup> 85 Fed. Reg. at 47,725 (emphasis added). At other points, the Proposed Rule describes the proposed action as “adopt[ing] a policy,” *id.*, and at no point does the Proposed Rule refer to it as a substantive change in policy.

<sup>3</sup> 42 U.S.C. § 1395hh(e)(1)(A) (emphasis added).

<sup>4</sup> *Id.* at § 1395hh(a)(2).

<sup>5</sup> *Id.* at § 1395hh(e)(1)(A).

<sup>6</sup> 85 Fed. Reg. at 47,725.

retroactive establishment of a new policy (rather than a change in policy), and as explained above, CMS has no authority to retroactively establish new policies. Even putting that dispositive issue aside, CMS's assertion that DSH payments cannot be made without retroactive rulemaking is belied by CMS's past practice and contradicts judicial precedent.

Prior to 2005, CMS calculated and made DSH payments by excluding Part C days from the Medicare fraction. In fact, the Supreme Court noted that CMS calculated DSH payments and "did not include" Part C participants in the Medicare fraction before the 2004 rule.<sup>7</sup> CMS's obligation to make DSH payments thus cannot justify retroactive rulemaking. Rather, after over a decade of litigation, it is clear that CMS has in the past and can in the future properly make DSH payments for periods prior to October 1, 2014 by excluding Part C days from the Medicare fraction without any retroactive rulemaking.

In addition, we note that the Proposed Rule does not point to any provision of the DSH statute that would require retroactive rulemaking. Nor could it. The DSH statute at 42 U.S.C. 1395ww(d)(5)(F) makes no express or implied reference to retroactivity. As the D.C. Circuit observed in 2011, "We are aware of no statute that authorizes the Secretary to promulgate retroactive rules for DSH calculations."<sup>8</sup> This observation remains true today, and retroactive application of a Medicare Part C days DSH rule is not necessary to comply with any statutory requirement.

**Public Interest.** The Proposed Rule also suggests that failure to apply a retroactive rule concerning the treatment of MA patient days in the Medicare and Medicaid fractions would be contrary to the public interest" because CMS cannot calculate Medicare fractions for open cost reports except through retroactive notice-and-comment rulemaking.<sup>9</sup> This argument is virtually indistinguishable from the argument that a retroactive rule is necessary to comply with a statutory requirement. Again, this rationale could only support the retroactive *establishment* of a new policy, and as explained above, CMS has only limited authority to apply *changes* to policies on a retroactive basis and has no authority to retroactively establish new policies under § 1395hh(e)(1)(A), regardless of the public interests at stake.

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<sup>7</sup> *Allina II*, 139 S. Ct. at 1810, *aff'g*, 863 F.3d 937, 939 (D.C. Cir. 2017) ("Before 2004, HHS had not treated Part C enrollees as entitled to benefits under Part A."); *see also Allina Health Svcs. v. Sebelius (Allina I)*, 746 F.3d 1102 (D.C. Cir. 2014) ("Prior to 2003, the Secretary treated Part C patients as not entitled to benefits under Part A . . . excluding Part C days from the Medicare fraction and including them in the Medicaid fraction."); *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 16-17 (D.C. Cir. 2011) (concluding that CMS had in place a "practice of excluding [Part C] days from the Medicare fraction" prior to the 2004 rulemaking). Along similar lines, in 2003, CMS characterized a proposed rule that would have excluded Part C days from the Medicare fraction as a mere "clarification" of its existing policy after observing that "once a beneficiary has elected to join [a Part C plan], that beneficiary's benefits are no longer administered under Part A." 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

<sup>8</sup> *Northeast Hosp.*, 657 F.3d at 17.

<sup>9</sup> 85 Fed. Reg. at 47,725.

Moreover, the suggestion that CMS “would be unable to calculate and confirm proper DSH payments for time periods before FY 2014” absent a retroactive rule is again ahistorical in light of CMS’s calculation of the Medicare fraction without the benefit of a rule prior to 2005. The Proposed Rule, however, ignores this past practice and misrepresents the Supreme Court’s holding in *Allina* when it states that “the Supreme Court has held that CMS cannot resolve this issue [*i.e.*, the establishment of Medicare fractions for the pre-2014 time period] except by notice-and-comment rulemaking.”<sup>10</sup> The Supreme Court concluded that CMS could not impose a policy of excluding Part C days from the Medicare fraction without notice-and-comment rulemaking, but it certainly did not endorse adoption of such a policy through retroactive rulemaking. In fact, the Supreme Court properly noted that § 1395hh(e)(1) only “gives the government *limited* authority to make retroactive ‘substantive *change[s]*’” in policies.”<sup>11</sup> The Court also noted CMS’s prior practice of excluding these days from the Medicare fraction.<sup>12</sup> To read the Court’s ruling concerning CMS’s procedurally improper attempt to apply a policy including Part C days in the Medicare fraction as an implicit endorsement of retroactive rulemaking is disingenuous at best. Rather, CMS’s past conduct, judicial precedent, and the plain text of the DSH statute all indicate that retroactive rulemaking is not required for CMS to apply its pre-2005 policy of excluding Part C days from the calculation of the Medicare fraction and properly make all outstanding DSH payments.

To the extent that the Proposed Rule suggests that retroactivity is in the public interest because Medicare DSH payments would be no more than the amount CMS has paid since 2005,<sup>13</sup> the public interest in fact also weighs strongly in favor of paying providers the full Medicare DSH amounts they are owed to compensate them for providing services to disadvantaged patients as called for under the plain dictate of the DSH statute. In enacting the DSH statute, Congress made clear its determination that compensating hospitals for providing often undercompensated care to economically disadvantaged patients is in the public’s interest. It is hardly “in the public interest” for CMS to craft an artificial rule depressing such statutorily guaranteed reimbursement on a retroactive basis.

In the end, the Proposed Rule represents a continuation of CMS’s 16-year effort to include Part C days in the Medicare fraction and is fundamentally unfair to DSH hospitals that have successfully litigated this issue for years. CMS’s renewed effort to reduce the DSH payments rightfully owed to DSH hospitals cannot be credibly characterized as being in the public interest. In the end, retroactive application of CMS’s proposal is unlawful and improper. The FAH strongly urges CMS to decline to finalize the proposal and to instead prioritize the prompt and full payment of outstanding Medicare DSH amounts.

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<sup>10</sup> *Id.*

<sup>11</sup> 139 S. Ct. at 1812 (emphasis added).

<sup>12</sup> *Id.* at 1810.

<sup>13</sup> 85 Fed. Reg. at 47,726.

## II. Medicare Part C Days Must be Excluded from the Medicare Fraction

Rulemaking—retroactive or otherwise—is wholly unnecessary for appropriately calculating and making DSH payments because the statute provides clear and detailed direction to CMS.<sup>14</sup> In particular, Congress provided explicit direction as to the calculation of the DPP fractions, providing that the numerator of the Medicare fraction must consist of “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 . . . and were entitled to supplementary security income benefits, (excluding any State supplementation).*”<sup>15</sup> In contrast, the numerator of the Medicaid fraction must include “the number of the hospital’s patient days for such period which consists of patients who (for such days) were eligible for [Medicaid], but who were *not entitled to benefits under part A.*”<sup>16</sup> Thus, by statute, CMS is required to calculate the DPP by excluding Part C days from the Medicare fraction and including Part C days in the Medicaid fraction, and CMS has no authority to vary from Congress’ specific direction. In short, faced with a self-executing statute, CMS need not undertake rulemaking to appropriately calculate and make DSH payments as required by law.

In an effort to shoehorn the proposed policy into this statutory language, the Proposed Rule suggests that a Medicare beneficiary that elects Part C benefits is still somehow “entitled” to Part A benefits.<sup>17</sup> It is certainly true that eligibility to enroll in Medicare Part C is restricted to those individuals that are entitled to Part A benefits,<sup>18</sup> and that Medicare Part C coverage must cover certain items and services “for which benefits are available under part A and B to individuals entitled to benefits under part A and enrolled under part B.”<sup>19</sup> But, it does not follow from these observations that a beneficiary can be entitled to both Medicare Part A and Part C benefits for the same services *on the same patient day.*<sup>20</sup> Rather, once a beneficiary elects Part C coverage, that election eliminates the patient’s “entitlement” to receive benefits through Medicare Part A.<sup>21</sup> As then Judge (now Justice) Kavanaugh observed, “Medicare beneficiaries must choose between government-subsidized private insurance plans under Part C and government-administered insurance under Part A, and after they choose, they are obviously not

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<sup>14</sup> See 42 U.S.C. § 1395ww(d)(5)(F).

<sup>15</sup> *Id.* at § 1395ww(d)(5)(F)(vi)(I) (emphasis added).

<sup>16</sup> *Id.* at § 1395ww(d)(5)(F)(vi)(II) (emphasis added).

<sup>17</sup> 85 Fed. Reg. at 47,725.

<sup>18</sup> 42 U.S.C. § 1395w-21(a)(3); *see also* 42 U.S.C. § 426(a) (describing individuals that are “entitled to hospital insurance benefits under part A”).

<sup>19</sup> *Id.* at § 1395w-22(a)(1)(B)(i).

<sup>20</sup> Congress explicitly specified that the numerator of the Medicare fraction is restricted to those individuals “entitled to benefits under part A” for the actual “days” of such individual’s hospital stay. *Id.* at § 1395ww(d)(5)(F)(vi)(I).

<sup>21</sup> *Id.* at § 1395w-21(a)(1) (A beneficiary “is entitled to elect to receive benefits . . . (A) through the original medicare fee-for-service program under parts A and B, *or* (B) through enrollment in a [Medicare Advantage] plan under [part C].”) (emphasis added).

entitled on the same ‘patient day’ to benefits from both kinds of plans.”<sup>22</sup> It is not enough that a Part C beneficiary could be viewed as “entitled” to Part A benefits in some general sense, nor is it enough that the beneficiary was entitled in the past, or that s/he can be entitled again in the future. Rather, the DSH statute requires evaluating entitlement on the particular “patient day” at issue, and the Proposed Rule fails to reconcile the inclusion of Part C days in the Medicare fraction with the DSH statute’s “for such days” requirement.<sup>23</sup> Thus, the Proposed Rule once again fails to adequately explain how or why the inclusion of Part C days in the Medicare fraction could be consistent with the plain language of the DSH statute, even after having engaged hospitals in decades of litigation and failed rulemaking on this precise question.

Nor does the Proposed Rule provide any credible explanation for deviating from CMS’s pre-2005 policy. Rather, the Proposed Rule largely disregards the fact that prior to FY 2005, CMS followed a policy that was more consistent with the alternative model included in the Proposed Rule. As the courts and CMS have previously observed, prior to FY 2005, CMS did not consider Part C patients to be entitled to Part A benefits and excluded these patients from the numerator of the Medicare fraction.<sup>24</sup> Without any credible explanation for the proposed deviation from CMS’s prior policy and proposed application of that new policy on a retroactive basis, finalization of the Proposed Rule would be unlawful and arbitrary.

### **III. The Proposed Rule Does not Accurately Account for the Financial Impact of Properly Excluding Part C Days from the Medicare Fraction and Including Them in the Medicaid Fraction**

The Proposed Rule includes a “Detailed Economic Analysis” that purports to model the economic impact associated with the “alternative approach” of excluding Part C days from the Medicare fraction and including those days in the Medicaid fraction. This analysis is, however, wholly inadequate—it excludes any analysis of years other than 2013, does not draw from actual dual-eligible data available to the agency, and is inconsistent with the methodology described in

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<sup>22</sup> *Northeast Hosp.*, 657 F.3d at 18 (Kavanaugh, J., concurring).

<sup>23</sup> Then Judge (now Justice) Kavanaugh emphasized this textual point in his concurring opinion in *Northeast Hospitals*, concluding that “a Part C beneficiary is not ‘entitled’ to Part A benefits for a specific patient day.” *Id.* at 21.

<sup>24</sup> *See, Allina II*, 139 S. Ct. at 1810 (noting that CMS “did not include” Part C participants in the Medicare fraction before the 2004 rule), *aff’g*, 863 F.3d 937, 939 (D.C. Cir. 2017) (“Before 2004, HHS had not treated Part C enrollees as entitled to benefits under Part A.”); *Allina I*, 746 F.3d 1102 (D.C. Cir. 2014) (“Prior to 2003, the Secretary treated Part C patients as not entitled to benefits under Part A . . . excluding Part C days from the Medicare fraction.”); *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 16 -17 (D.C. Cir. 2011) (determining that CMS had in place a “practice of excluding [Part C] days from the Medicare fraction” prior to the 2004 rulemaking); Fed. Reg. 27,154, 27,208 (May 19, 2003) (observing that “once a beneficiary has elected to join [a Part C plan], that beneficiary’s benefits are no longer administered under Part A”); *see also* C.F.R. § 412.106(b)(2)(i) (2003) (defining the Medicare fraction to include only “the number of *covered* patient days”) (emphasis added); 42 C.F.R. § 409.3 (2003) (defining “covered” as services for which payment is authorized).

the Proposed Rule. In light of these defects, commenters are unable to meaningfully engage with CMS concerning the economic impact of the proposal or alternatives and cannot replicate CMS's analysis.

DeBrunner & Associates (DeBrunner) conducted various examinations and probing of data to understand CMS's economic impact analysis.<sup>25</sup> This analysis identified significant shortcomings that precluded replication of CMS's model and call the accuracy of the impact analysis into serious question. For example, DeBrunner's analysis shows that the public use file (PUF) accompanying the Proposed Rule models the alternative approach as *increasing* the numerator of the Medicare fraction for more than 300 hospitals and *increasing* the denominator of the Medicare fraction for nearly 150 hospitals. This is inconsistent with CMS's description of its methodology for analyzing the alternative approach, which states that CMS *subtracted* the subset of SSI/Medicare Days attributable to individuals enrolled in Medicare Advantage from the numerator of the Medicare fraction and *subtracted* the subset of Medicare Days attributable to individuals enrolled in Medicare Advantage from the denominator of the Medicare fraction, but does not indicate that any days were added to the Medicare fraction. In addition, although CMS indicates that the number of days subtracted from the Medicare fraction numerator was the same as the number of days added to the Medicaid fraction numerator, the PUF data shows that these numbers were modeled differently for many hospitals. In fact, the PUF models a change in the Medicare numerator that differs from the change in the Medicaid numerator by at least +/-100 days for nearly 500 hospitals, and the discrepancy was in excess of +/-1000 days for several hospitals.

CMS also fails to adequately explain its unreasonable use of proxy data rather than actual Part C data for dually eligible beneficiaries. The Proposed Rule states that proxy data (consisting of Medicare Advantage SSI days) was used because CMS did "not have readily available specific data on Medicaid eligibility for beneficiaries [sic] who are eligible for SSI benefits."<sup>26</sup> CMS, however, had available to it the State Medicare Modernization Act (MMA) File of Dual Eligible Beneficiaries, which identifies dually eligible beneficiaries enrolled in Medicare Advantage plans.<sup>27</sup> The Proposed Rule provides no explanation for disregarding this data source and using proxy data in the form of Medicare Advantage SSI days. Moreover, DeBrunner's analysis indicates that the proxy data used by CMS significantly undercounts the number of dual eligible Part C days at affected hospitals, rendering the reliance of proxy data rather than the MMA file unreasonable and unreliable.

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<sup>25</sup> See the attached DeBrunner report, *Treatment of Medicare Advantage Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage* (Attachment A).

<sup>26</sup> 85 Fed. Reg. at 47,727.

<sup>27</sup> In fact, CMS identified the MMA file as "the *most current* and *most accurate*" source of information on dually eligible Medicare-Medicaid enrollees in its 2017 document entitled *Defining Medicare-Medicaid Enrollees in CMS Data Sources* (Feb. 16, 2017), available at [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO\\_DualEligibleDefinition.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_DualEligibleDefinition.pdf).



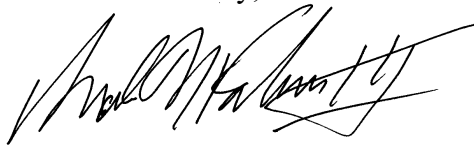
Lastly, the Proposed Rule's financial impact analysis and accompanying PUF data is not sufficient for meaningful stakeholder comment. The analysis only covers a single year (FY 2013), even though CMS is proposing retroactive application for all years prior to FY 2014. In addition, the financial impact analysis does not identify hospitals that would either become eligible for or lose eligibility for DSH under the alternative model. These deficiencies prevent stakeholders from meaningfully assessing the financial impact of the alternative approach on individual hospitals or subgroups of hospitals and providing meaningful comments. These shortcomings are particularly acute in light of the data discrepancies described above and the use of proxy data in lieu of more accurate, direct data sources (*i.e.*, the MMA file).

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The FAH appreciates the opportunity to submit these comments, and strongly opposes the improper, retroactive reinstatement of the Part C days policy first vacated 14 years ago in *Allina I*. Instead, the FAH urges CMS to comply with the decisions of the Federal courts and the applicable statutory requirements by calculating and paying Medicare DSH payments to hospitals under its pre-2005 policy of excluding Part C days from the Medicare fraction and including them in the Medicaid fraction.

If you have any questions, please contact me at 202-624-1534, or Steve Speil, Executive Vice President Policy, at [sspeil@fah.org](mailto:sspeil@fah.org) or 202-624-1529.

Sincerely,

A handwritten signature in black ink, appearing to read "Steve Speil", written in a cursive style.