American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

October 5, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

RE: CMS-1739-P, Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage: Proposed Rule (Vol. 85, No. 152), August 6, 2020.

Dear Administrator Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule regarding treatment of Medicare Advantage (MA)/Medicare Part C data in calculating a hospital's disproportionate patient percentage (DPP) for fiscal years preceding fiscal year (FY) 2014. **As we have previously communicated to CMS, the AHA opposes the inclusion of MA/Part C days into the Medicare fraction of the DPP. In addition, we do not believe that the current proposal meets the criteria for retroactive application.**

The DPP (also referred to as the disproportionate share hospital (DSH) calculation) is a sum of two fractions. The "Medicare fraction" is the number of patient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI) benefits divided by total Medicare days. The "Medicaid fraction" is the number of patient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits divided by total patient days.

In the inpatient prospective payment system (PPS) final rule for FY 2005, CMS did not finalize its previously proposed policy to count MA/Part C patient days in the *Medicaid* fraction; instead, the agency finalized counting MA/Part C patient days in the *Medicare* fraction, which had not been proposed. In addition, the agency did not endeavor to modify the governing regulations to reflect such policy until FY 2008. The process by

which CMS finalized and codified incorporating MA/Part C patient days into the Medicare fraction has been challenged in the courts for many years. Specifically, hospitals argued that CMS did not engage in proper notice-and-comment before adopting a substantive change in policy for FY 2005.

Indeed, in 2014, the Court of Appeals for the District of Columbia Circuit affirmed the district court's holding that CMS' policy to include MA days in the Medicare fraction was not a logical outgrowth of the agency's proposed rule and it therefore should be vacated. In addition, hospitals challenged CMS' inclusion of MA days in the Medicare fraction for FY 2012, arguing that the agency again did not engage in notice and comment, as the Medicare Act requires. In June 2019, the Supreme Court agreed, holding in *Azar v. Allina Health Services* that the policy to include MA days in the Medicare fraction must be vacated for the period of time prior to Oct. 1, 2013. While the FY 2005 change in policy was being challenged in the courts, CMS finalized counting MA/Part C patient days in the Medicare fraction of the DPP for FY 2014 (i.e., beginning Oct. 1, 2013) and subsequent years through regular rulemaking.

Under this proposed rule, CMS would retroactively apply a policy of counting MA/Part C patient days in the Medicare fraction of the DSH calculation for discharges occurring prior to Oct. 1, 2013. CMS asserts, in part, that it is responding to the *Azar v. Allina Health Services* ruling. **As we have previously commented, the AHA opposes CMS' proposal and urges the agency to exclude MA patient days from the Medicare fraction of the DSH calculation. We further object to the agency's proposal to apply this policy retroactively, as we do not believe the proposal would meet the criteria for retroactive rulemaking under either the Medicare Act or Administrative Procedure Act.**

Under statute, the Medicare fraction of the DSH calculation includes only individuals "entitled to benefits under Part A." In previous rulemaking, CMS has stated that individuals enrolled in a MA plan are entitled to benefits under Part A because, in order to enroll in MA, a beneficiary must be entitled to the benefits under Part A. The agency also has stated that once enrolled in MA, the plan must provide the benefits the beneficiary is entitled to under Part A, and that under certain circumstances and for certain beneficiaries, Part A pays for care furnished to individuals enrolled in MA.

The AHA disagrees that individuals enrolled in MA are "entitled" to benefits under Part A. In examining the statute and CMS' own regulations, it is clear that MA enrollees are not entitled to benefits under Part A and, thus, should continue to be excluded from the Medicare fraction of the DSH calculation. First, § 226(c)(1) of the Social Security Act states that "entitlement of an individual to hospital insurance benefits for a month [under Part A] shall consist of entitlement to have payment made under, and subject to the limitations in, [P]art A." In addition, § 1851(a)(1) of the Social Security Act states that persons eligible for MA are "entitled to elect to receive benefits" either "through the original [M]edicare fee-for-service program under [P]arts A and B, or through enrollment

in a [Medicare Advantage] plan under [Part C].” Finally, § 1851(i)(1) states that “payments under a contract with a [Medicare Advantage] organization… with respect to an individual electing a [Medicare Advantage] plan… shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under [P]arts A and B…”

Based on the statute, individuals who enroll in a MA plan do not receive benefits under Part A; rather, they receive benefits under Part C. Thus, MA enrollees cannot be “entitled” to benefits under Part A, because they can no longer receive benefits under Part A. Rather, they can receive benefits under Part C only.

The AHA also disagrees with CMS’ use of retroactive rulemaking to rectify the agency’s previous lack of adequate notice and comment. We do not believe that the proposal meets the criteria to engage in retroactive rulemaking under the Medicare Act, for two main reasons. First, the proposed rule is not "necessary to comply with statutory requirements." DSH payments to hospitals for periods prior to Oct. 1, 2013 must be calculated under the policy in effect before the agency unlawfully adopted the FY 2005 rule, which was vacated by the courts. That policy excludes Part C days from the Medicare fraction and is the policy in effect after vacating the FY 2005 rule. Second, CMS has not shown that "failure to apply the change retroactively would be contrary to the public interest." **Contrary to what CMS said, there is a way to calculate DSH payments on open cost reports for periods prior to Oct. 1, 2013 without going through notice and comment rulemaking: that is for CMS to use the policy in effect before the adoption of the now vacated FY 2005 rule.**

We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Erika Rogan, AHA senior associate director for policy, at (202) 626-2963 or erogan@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President