CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12513	**Date: February 21, 2024**
	Change Request 13294

SUBJECT: Change Request (CR) to Implement the Medicare Program Final Action: Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide guidance for the treatment of Medicare Part C days in the calculation of a provider's Medicare Disproportionate Share Hospital adjustment.

EFFECTIVE DATE: March 25, 2024
**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: March 25, 2024- NOTE: MACs shall begin work once this CR is placed on their contract.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 12513	Date: February 21, 2024	Change Request: 13294

SUBJECT: Change Request (CR) to Implement the Medicare Program Final Action: Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage

EFFECTIVE DATE: March 25, 2024
**Unless otherwise specified, the effective date is the date of service*

.

IMPLEMENTATION DATE: March 25, 2024- NOTE: MACs shall begin work once this CR is placed on their contract.

I. GENERAL INFORMATION

A. Background: The summary below is intended to provide background on the Supreme Court decision Azar v. Allina Health Services, 139 S. Ct. 1804 (June 3, 2019) (hereinafter referred to as Allina II) and the handling of cost reports for periods prior to October 1, 2013 and that use a 2013 or prior SSI ratio.

In the FY 2004 IPPS proposed rule (68 FR 27208), in response to questions about whether the patient days associated with patients enrolled in a Medicare Advantage (MA) plan (then called a Medicare+Choice (M+C) plan) should be counted in the Medicare fraction or the Medicaid fraction of the disproportionate patient percentage (DPP) calculation, CMS proposed that once a beneficiary enrolls in an MA plan, patient days attributable to the beneficiary would not be included in the Medicare fraction of the DPP. Instead, those patient days would be included in the numerator of the Medicaid fraction, if the patient was also eligible for Medicaid. In the FY 2004 IPPS final rule (68 FR 45422), CMS did not respond to public comments on this proposal, due to the volume and nature of the public comments CMS received, and the agency indicated that it would address those comments later in a separate document. In the FY 2005 IPPS proposed rule (69 FR 28286), CMS stated that it planned to address the FY 2004 comments regarding MA days in the IPPS final rule for FY 2005. After considering comments on this proposal (68 FR 27208), CMS decided not to implement the policy as proposed.

Instead, in the FY 2005 IPPS final rule (69 FR 49099), CMS determined that, under § 412.106(b)(2)(i) of the regulations, MA patient days should be counted in the Medicare fraction of the DPP calculation. CMS explained that, even where Medicare beneficiaries enroll in a MA plan, they are still entitled to benefits under Medicare Part A. Therefore, it was noted that if a MA beneficiary is also an SSI recipient, the patient days for that beneficiary would be included in the numerator of the Medicare fraction and not in the numerator of the Medicaid fraction.

In 2012, a district court vacated the final policy adopted in the FY 2005 final rule on the basis that the final rule was not a "logical outgrowth" of the proposed rule. In 2014, the United States Court of Appeals for the D.C. Circuit upheld the district court's 2012 holding, vacating the FY 2005 final part C days rule. In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50614), CMS re-adopted the policy of including MA patient days in the Medicare fraction prospectively for FY 2014 and subsequent fiscal years.

In Allina II, the Supreme Court considered a challenge to the agency's inclusion of MA patient days in the Medicare fractions that it published for FY 2012. Section 1871(a)(2) of the Act requires notice-and-comment rulemaking for any Medicare "rule, requirement, or other statement of policy" that "establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits." The Supreme Court held that section 1871(a)(2) of the Act required CMS to engage in notice-and-comment rulemaking

before adopting its "avowedly gap-filling" policy regarding treatment of inpatient days for beneficiaries enrolled in MA plans for purposes of calculating the DPP.

Because the FY 2005 IPPS final rule was vacated, the Secretary had no promulgated rule governing the treatment of Part C days for fiscal years before 2014. (See Allina Health Servs. V. Price, 863 F.3d 937, 939 (D.C. Cir. 2017)) Section 1871(e)(1)(A) of the Act authorizes CMS to engage in retroactive rulemaking when the Secretary determines that such retroactive application is necessary to comply with statutory requirements or that a failure to apply a policy retroactively would be contrary to the public interest.

On August 6, 2020, CMS issued the proposed rule: Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage (85 FR 47723). The Secretary determined that, in order to comply with the statutory requirement to make DPP payments, it was 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 periods before federal fiscal year 2014. Absent such a retroactive rule, the Secretary would be unable to calculate and confirm proper DSH payments for time periods before FY 2014, which would be contrary to the public interest of providing additional payments to hospitals that serve a significantly disproportionate number of low-income patients, as expressed in the DSH provisions of the Medicare statute.

After the Secretary determined that he could not lawfully calculate the DPP fractions for discharges before October 1, 2013, until a notice-and-comment rule was in place to determine the treatment of Part C days, the CMS Administrator put a hold on all such calculations until a retroactive Part C days rule was finalized. In August 2020, CMS issued CMS Ruling 1739-R, which provided that "CMS and the Medicare contractors will not calculate the SSI fractions, Medicaid fractions, or DSH payment amounts that depend upon them, necessary for the DSH payment adjustment for discharges prior to October 1, 2013, until a new rule is promulgated through notice-and-comment rulemaking that addresses the treatment of MA days." It further provided that pending administrative appeals raising the "same issue that was raised in [Allina II] …whether patient days associated with patients enrolled in Part C should be included in the SSI fraction for discharges before FY2014," would be remanded to the relevant contractor so that the DSH adjustment could be calculated in accordance with the forthcoming rule. *See* CMS Ruling 1739-R at: https://www.cms.gov/regulations-and-guidanceguidancerulingscms-rulings/cms-1739-r.

Final Rule:

On June 9, 2023, CMS issued the final rule: Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage. This final rule establishes a policy concerning the treatment of patient days associated with persons enrolled in a Medicare Part C (also known as ''Medicare Advantage'') plan for purposes of calculating a hospital's DPP for cost reporting periods starting before FY 2014. (88 FR 37772)

Since the publication of the CMS proposed rule, the Supreme Court handed down its decision in Becerra v. Empire Health Foundation, 142 S. Ct. 2354, 1368 (June 24, 2022) (hereinafter referred to as "''Empire"''). In Empire, the Supreme Court held that the statutory text is clear that "being 'entitled' to Medicare benefits . . . means—in the [DSH] fraction descriptions, as throughout the statute—meeting the basic statutory criteria." (142 S. Ct. at 2362.) Part C enrollees, who by definition must be "entitled" to Part A benefits to enroll under Part C, necessarily meet the basic statutory criteria (essentially that they are over 65 or disabled). While Empire did not address Part C days specifically, it addressed the same statutory language that is the subject of the Part C days rule, i.e., the meaning of "entitled to benefits under Part A of [Medicare]." The Supreme Court held that the Secretary correctly interpreted that phrase to denote a legal status that does not turn on whether Medicare pays for any particular hospital day. The Supreme Court concluded that the "[t]ext, context, and structure all support calculating the Medicare fraction HHS's way. In that fraction, individuals "entitled to [Medicare Part A] benefits" are all those qualifying for the program." CMS believes it is now clear that the statute itself requires the Secretary to count Part C days in the Medicare fraction because Medicare beneficiaries remain "entitled to [Medicare Part A]" regardless of

whether they enroll in Part C, just as do beneficiaries who have exhausted their coverage for a spell of illness. Nonetheless, Empire did not address specifically whether Part C enrollees remain "entitled to Part A," and because the FY 2005 IPPS final rule was vacated in 2014, the Secretary ''has[d] no promulgated rule governing'' the treatment of Part C days for the fiscal years before 2014.

The Secretary therefore determined that, in order to comply with the statutory requirement to make DSH payments and to address any potential statutory gap, to the extent one might remain after Empire, it was necessary for CMS to engage in retroactive rulemaking to establish a policy to govern whether individuals enrolled in MA plans should be included in the Medicare fraction or in the numerator of the Medicaid fraction, if dually eligible, for fiscal years before 2014.

After considering comments from the public, CMS finalized its proposal that a patient enrolled in an MA plan remains entitled to benefits under Medicare Part A and will be counted in the Medicare fraction of the DPP and not counted in the numerator of the Medicaid fraction for cost reporting periods that include discharges before October 1, 2013. CMS did not adopt any change to the regulation text because the current text at § 412.106(b)(2)(i) reflects the policy adopted for fiscal years before FY 2014 in the prior, vacated rule.

B. Policy: Many challenges to CMS's treatment of Part C days in pre-2014 DPP calculations were filed in federal district court, and many were consolidated (and continue to be consolidated) before Judge Amy Berman Jackson. See In re Allina II-Type DSH Adjustment Cases, No. 19-mc-00190 (D.D.C. 2019) ("In re Allina II"). This district court and courts in other cases have remanded many of these claims to the Secretary or the PRRB, and the Administrator in turn has remanded them (and will continue to remand them) to the Office of Financial Management, with instructions to direct the relevant MACs to apply the final Part C days rule. And because the final Part C days rule is now effective, CMS Ruling 1739-R's hold on calculating and publishing SSI fractions and DSH payment amounts has expired by its own terms.

The purpose of this CR is for MACs to implement the requirements in the final rule: Medicare Program, Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage published on June 9, 2023. The final rule took effect August 8, 2023 and will require MACs to calculate and recalculate the DPP and to issue Notices of Program Reimbursement (NPR) or revised NPRs for all cost reports previously placed on hold due to CMS instructions or CMS Ruling 1739-R and for cost years remanded to MACs pursuant to court orders or pursuant to CMS Ruling 1739-R. The RNPRs (or NPRs for those providers who never received an NPR for the cost year at issue) shall set forth a DSH payment adjustment that accounts for Part C patient days in the calculation of the DPP in the manner set forth in the final Part C days rule. Please note that CMS has re-published SSI fractions for discharges before FY 2014 to reflect the Part C days policy adopted through notice-and-comment rulemaking, and for cost reports from that period held for issues relating to the SSI fraction, MACs are required to use the re-published SSI fractions to issue NPRs and revised NPRs.

Since the final rule is the controlling policy for fiscal years before FY 2014, any previously issued instructions related to the inclusion of Part C days in the Medicaid fraction for any of those fiscal years are no longer valid. Consistent with §405.1885(c)(2), the final rule retroactively adopting the policy at §412.106(b)(2)(i) for fiscal years before FY 2014 is not a basis for reopening final settled cost reports.

The final rule provides that the MAC will issue an RNPR where a provider has received an NPR that issued prior to the final rule (and so challenges a DPP that was calculated in the absence of a valid rule governing the treatment of Part C days) when the final rule's application to the provider's Medicare fraction does not change that fraction numerically. (88 FR 37788)

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13294.1	**Report Cost Reports on Hold That Have Not Received an Initial NPR** -The MAC shall identify the number of cost report settlements placed on hold pending instruction on the treatment of Part C days in DSH payments that have not received an initial NPR at the time of the issuance of this CR. This list of providers and FYEs shall be forwarded to DPAOQuestions@cms.hhs.gov within 30 days of the date of this Change Request.	X								
13294.2	**Report Pending Appeals That Have Been Remanded for Cost Reporting Periods Starting Before 10/01/2004** - The MAC shall identify the number of cost reports with pending appeals or appeals that were remanded that challenge the treatment of Part C days in DSH payments for cost reporting periods starting before October 1, 2004. The list of providers and FYEs shall be forwarded to DPAOQuestions@cms.hhs.gov within 30 days of the date of this Change Request.	X								
13294.3	**Report Pending Appeals or Appeals That Have Been Remanded for Cost Reporting Periods Starting on or After 10/01/2004 and Before 10/01/2013 -** The MACs shall identify the number of cost reports with pending appeals or appeals that were remanded that challenge the treatment of Part C days in DSH payments for cost reporting periods starting on or after October 1, 2004 and before October 1, 2013. The list of providers and FYEs shall be forwarded to DPAOQuestions@cms.hhs.gov within 30 days of the date of this Change Request.	X								
13294.4	**Cost Reports on Hold That Have Not Received an Initial NPR**- The MAC shall issue an NPR within 6 months from the effective date of this Change Request for all cost reports on hold pending instruction on the traetment of Part C days in DSH payments that have not received an initial NPR, using a DPP determined in accordance with § 412.106(b).	X								
13294.5	**Reopenings on Hold –** The MAC shall issue an RNPR within 6 months from the effective date of this Change Request for all cost reports that had a Notice of Reopening issued to the provider for the purpose of holding the cost report open pending the results of the Allina II decision, using a disproportionate patient	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	percentage determined in accordance with the final rule. Any cost report with a pending reopening, that also has a pending PRRB appeal that has been or will be remanded, shall receive a reopening denial and the RNPR shall be issued under the remand.									
13294.5.1	**Reopenings on Hold not specific to Allina II –** The MAC shall issue an RNPR within 6 months from the effective date of this Change Request for all pending reopenings that were placed on a general DPP hold pending rule-making for the treatment of Part C days in DSH payments, where the reopening was for issues related to the Medicaid fraction of the DPP.	X								
13294.6	**Pending Appeals and Remands for Cost Reports Beginning Before 10/01/2004 –** For cost reporting periods starting before 10/01/04, with DSH payment-related appeals that have been or will be remanded by the CMS Administrator or PRRB, the MAC shall issue an RNPR within the later of 12 months from the date of this Change Request if the remand has already been issued by the date of this CR's issuance or 6 months from the date of the remand for remands received after the issuance of this CR, using a DPP determined in accordance with the final rule.	X								
13294.6.1	Upon receiving the remand from the PRRB, the MAC shall create the remand entry in the System for Tracking Audit & Reimbursement (STAR) with the SSI%-Part C Issue selected along with all other normally required data entry items.	X								
13294.6.2	For remands on hold related to Labor and Delivery days in the DPP, if providers failed to supply the requested labor and delivery day listings, the MAC shall issue a denial letter to the provider as previously instructed within 6 months of the issuance of this CR.	X								
13294.6.3	For remands on hold for cost reporting periods prior to 1999, this CR does not apply since Medicare+Choice was not effective until 1999. MACs shall not keep cost reports prior to 1999 on hold and shall continue processing NPRs or revised NPRs.	X								
13294.7	**Pending Appeals or Remands for Cost Reports Beginning on or After 10/01/2004 and Before 10/01/2013 –** For cost reporting periods starting on or	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	after 10/01/04 and before 10/1/13, with DSH payment-related appeals that have been or will be remanded by the CMS Administrator or PRRB, the MAC shall issue an RNPR within the later of 12 months from the date of this Change Request if the remand has already been issued by the date of this CR's issuance or 6 months from the date of the remand for remands received after the issuance of the CR, using a DPP determined in accordance with the final rule.									
13294.7.1	Upon receiving the remand from the PRRB, the MAC shall create the remand entry in the STAR reopening screen with the SSI%-Part C Issue selected along with all other normally required data entry items.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13294.8	CR as Provider Education: MACs shall use the content in the CR to develop relevant education material. Provide a link to the entire instruction in the education content. You can also supplement with local information that would help your provider community bill and administer the Medicare Program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0