October 1, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-1850

Re: CMS-1739-P Medicare Program: Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Share Percentage

Submitted electronically via http://www.regulations.gov

Dear Administrator Verma,

Trinity Health appreciates the opportunity to comment on the proposed policy changes set forth in CMS-1739-P. Our comments and recommendations to the Centers for Medicare and Medicaid Services (CMS) reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. Trinity Health includes 94 hospitals as well as 106 continuing care locations that include PACE, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns $1.2 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with graduate medical education (GME) programs providing training for more than 2,000 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 123,000 colleagues, including more than 6,800 employed physicians and clinicians, and have more than 15,000 physicians and advanced practice professionals committed to 16 Clinically Integrated Networks (CINs) that are accountable for approximately 1.5 million lives across the country through alternative payment models.

Trinity Health participates in 11 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes five markets partnering as an MSSP Track 3 ACO. We also have three markets partnering as a Next Generation ACO and 2 participating in CPC+. In addition, we have 33 hospitals participating in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative, and three hospitals in the Comprehensive Care for Joint Replacement (CJR) program. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

**Proposed treatment of Medicare Part C Day in the Calculation of Disproportionate Share Hospital (DSH) allotment**

The proposed rule would alter the treatment of MA patient days in the calculation of a hospital's disproportionate patient percentage (DPP) and thereby their DSH payments. This rule was issued in response to HHS/CMS loss in the U.S. Supreme Court in the *Allina* case, and is CMS' attempt to use retroactive rulemaking to implement the same policy that was vacated by the Court. After the CMS first loss in the string of *Allina* cases, at the District Court level in late 2012, resulted in the FFY 2005 rule being vacated, CMS issued a proposed and final rule for FFY 2014 to cure the errors found by the Court in the FFY 2005 rulemaking process. Now, CMS wants to use that FFY 2014 rule and apply it to all prior years, through retroactive rulemaking. This is CMS' second attempt to apply this policy retroactively prior to FFY2014.

**Trinity Health vigorously opposes CMS' proposal to apply their rule on including Part C days in the SSI fraction retroactively and the attempt to avoid the impact of the Supreme Court's decision that determined prior attempts at the policy were invalid.**

**Through this proposed rule, CMS is exceeding its authority in attempting to codify a policy already decided by the Supreme Court that would take away funds owed to hospitals**. In addition, publication of *CMS Ruling 1739 R* immediately binds Medicare Contractors, the Provider Reimbursement Review Board and other Medicare appeal entities to the policies outlined in the proposed rule. Publication of the ruling prior to the regulatory comment and final process is outside of the scope of CMS goes against that Administrative Procedures Act.

**Trinity Health objects CMS's claim that retroactively applying this policy is appropriate. Retroactive rulemaking should not allow an agency to circumvent a contrary Supreme Court ruling. Further it is not in the public's best interest to cause further delay and deprive hospitals of Medicare reimbursement owed to them.**

The Allina case through well-established judicial precedent and the Supreme Court's decision restores the status quo or prior policy which excluded Part C Days from the Medicare fraction and included such Dual Eligible Days in the Medicaid fraction.

**For these reasons and the judicial precedents established below, the proposed rule should not apply to any hospital that has properly pending appeals on the Allina Part C Day issue.**

**Additional Legal Arguments**

*Legal Ambiguity*

This proposed rule is effective for cost reporting periods starting before FFY 2014. For purposes of calculation of the Disproportionate Share (DSH) adjustment, CMS proposes to include the Medicare Part C (Medicare Advantage) patient days in the Supplemental Security Income Percentage (SSI%), also known as the Medicare Fraction, and exclude them from the Medicaid percentage, also known as the Medicaid Fraction. CMS states that this will result in minimal dollar impact to the Program, since the current proposed rule is the methodology used to pay Providers during the period in question. **CMS feels that this approach will avoid legal ambiguity. Trinity Health points out that legal ambiguity is already resolved in this case by following the precedent of the**

***Northeast Hospital* case, *Northeast Hospital Corp. v. Sebelius*, 657 F.3d. (D.C. Cir. 2011)**. In the subsequent case *Alegent Health-Immanuel Medical Center et al. v. Kathleen Sebelius*, 1:2011cv00139 (D.D.C. 2012) the court order states that "the parties agree that *Northeast Hospital* is controlling in both cases before this Court, and further agree that the cases should be remanded to HHS for recalculation of the reimbursement amounts owed to plaintiffs, 'which is the relief to which Plaintiffs would be entitled if they were to prevail on the merits here.' St. Anthony's v. Sebelius, Case No. 11-1932, Defendant's Motion to Dismiss and Remand at 2, ECF No. 10." **In 2012, CMS agreed in court that for fiscal years prior to the FFY 2005 vacated rule, that the *Northeast Hospital* case was controlling, and there was no legal ambiguity. That same *Northeast Hospital* case should be controlling through the effective date of the FFY 2014 rule.**

*Retroactive Rulemaking*

In the lead-up to its discussion of the need for retroactive rulemaking in this instance, CMS states that "the Supreme Court held that section 1871(a)(2) of the Act required CMS to engage in notice-and-comment rulemaking before adopting its policy regarding treatment of inpatient days for beneficiaries enrolled in MA plans for purposes of calculating the DPP." While CMS is paraphrasing the Supreme Court decision in *Allina*, with a bent towards supporting the need for retroactive rulemaking, the actual Supreme Court language was "We hold simply that, when the government establishes or changes an avowedly 'gap'-filling policy, it can't evade its notice-and-comment obligations under §1395hh(a)(2) on the strength of the arguments it has advanced in this case." *Azar, Secretary of Health and Human Services v. Allina Health Services*, 139 S. Ct. 1804 (2019). **The Supreme Court was *not* directing CMS to utilize retroactive rulemaking to reinstitute the same policy whose vacatur was just upheld 7-1 by the Court. The Court clarified to establish or *change* a substantive policy, CMS must properly engage in notice-and-comment rulemaking**. The *Northeast* case also turned on the fact that CMS was attempting to *change* their existing approach to excluding the Medicare Advantage days from the Medicare Fraction (SSI%), per the *Northeast* opinion opening, "We nonetheless affirm the district court on the alternative ground that the Secretary must be held to the interpretation that guided her approach to reimbursement calculations during fiscal years 1999 – 2002, an interpretation that differs from the view she now advances. Under her previous approach, the hospital would have prevailed on its claim for a larger reimbursement." In both cases, the courts are stating that CMS needs to engage in notice-and-comment rulemaking in order to make a change.

Without the notice-and-comment rulemaking, the existing approach that was enforced by the *Alegent Health-Immanuel Medical Center* order and agreed to by CMS at the time that *Northeast* controlled, should continue, that the Medicare Advantage patient days are to be excluded from the Medicare Fraction (SSI%). This should apply to all fiscal years prior to the FFY 2015 notice-and-comment rulemaking change, effective 10/1/14**.** The logical conclusion then would be the alternative considered in section D of this proposed rule, which is the *Northeast* and *Alegent* methods, excluding Medicare Advantage days from the Medicare Fraction, and including them in the Medicaid Fraction.

CMS references Section 1871(e)(1)(A) of the Act as authorizing CMS to engage in retroactive rulemaking under two circumstances, when necessary to comply with statutory requirements or where failure to apply a policy retroactively would be contrary to the public interest. In the first instance, statutory requirements, CMS states that they must determine whether beneficiaries enrolled in Part C are "entitled to benefits under Part A" or not, in order to determine which fraction they belong in order to comply with the DSH statute, Section 1886(d)(5)(F). **The D.C. Circuit Court of Appeals in *Northeast* and the D.C. District Court in *Alegent* read the current DSH regulation as**

**being compliant with the DSH statute 42 CFR 412.106(b)(2)(i), with the Medicare Advantage days being excluded from the Medicare Fraction under the Secretary's previous interpretation. Therefore, retroactive rulemaking would not be necessary to comply with the statute.** In the second instance, public interest, CMS makes reference to the hundreds of outstanding cost reports for periods prior to the FFY 2014 rule. CMS again paraphrases the Supreme Court from the Allina case, stating "[b]ecause the Supreme Court has held that CMS cannot resolve this issue except by notice-and-comment rulemaking, we have concluded that the only way for CMS to resolve this issue and properly calculate DSH payments for time periods before FY 2014 is to establish a new regulation that would apply retroactively to the determination of Medicare and Medicaid fractions for this time period. **However, the Supreme Court did not say the only way for CMS to resolve this would be through retroactive rulemaking. The Supreme Court stated the only way that CMS could initiate or *change* a policy is through notice-and-comment rulemaking. We come back to the *Northeast* and *Alegent* cases ruling that what CMS is proposing is a change from the existing practice of excluding the Medicare Advantage days from the Medicare Fraction.**

**If CMS persists in its belief that retroactive rulemaking is the only option in this issue, then Trinity Health recommends that the decision-making be based solely on statutory interpretation and not consider the dollar impacts of one option over the other. Retroactive rulemaking when the dollar impacts are known interferes with the integrity of the process.** The statutory paragraphs specific to the Medicare and Medicaid fractions of the DSH calculation are SSA Section 1886(d)(5)(F)(vi)(I) Medicare Fraction and (II) Medicaid Fraction. The Medicare Fraction language references "… patients who (for such days) were entitled to benefits under part A of this title…." While the Medicaid Fraction references "… patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX…." The Medicare Part C (Medicare Advantage) option for beneficiaries was created as part of the Balanced Budget Act of 1997 (BBA). The BBA amended several items in clause (5)(F), but specifically did NOT amend the Medicare fraction references to Medicare Part A to include Medicare Part C. The BBA also did not specifically exclude Medicare Part C from the Medicaid fraction, as the Medicare Part A is specifically excluded. As evidenced by the BBA section 4622 – Payment to hospitals of indirect medical education costs for Medicare+Choice enrollees, Congress did not assume Part C was synonymous with Part A to the point that it would not exclude the need to specifically mention Part C. Part C was cited several times in the IME section of the BBA, but not the DSH section. **Therefore, if Part C was not specifically excluded from the Medicaid fraction, it should be included in the Medicaid fraction, not the Medicare fraction.**

The U.S. Supreme Court, in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), identified two questions to be addressed when a court reviews an agency's construction of a statute. "First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." Chevron.

Congress did directly speak to the issue of Medicare Advantage by creating Medicare + Choice under Part C as an alternative to Medicare Part A, in the BBA. As part of the overall legislation which implemented Medicare + Choice, the BBA, Congress made several amendments to the statutory wording of Social Security Act§1886(d)(5)(F), the section that describes the DSH adjustment. This section of the Act specifically includes Medicare Part A in the Medicare fraction and specifically excludes Medicare Part A from the Medicaid fraction. Looking at the plain language of the statute in light of the fact that Medicare patient days can fall into one of three categories, Part A, Part B, or Part C, it is clear and unambiguous that Congress did not intend Medicare Advantage to be excluded from the Medicaid fraction.

Section 4001 of the BBA (SSA §1851(a)(3)(A)) states, to be Medicare + Choice eligible, an individual must be "entitled to benefits under Part A and enrolled under Part B." However, once Medicare + Choice eligible, SSA§1851(a)(1) states that individual "…is entitled to elect to receive benefits under this title—(A) through the original Medicare fee-for-service program under Parts A and B, or (B) through enrollment in a Medicare + Choice plan under this Part [Part C]." Once that individual makes the election of Part C over Parts A and B, they would not be entitled to the specific benefits under Part A, but rather would be entitled to the specific benefits under Part C. The statute defines the days in the Medicare fraction specifically as "…the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this title", SSA§1886(d)(5)(F)(iv)(I). The plain meaning of the statute is that the patient must be entitled to Part A during that particular inpatient stay, if they are Part C, that encounter is not entitled to payment under Part A. CMS believes that the Part C beneficiary is still entitled to benefits under Medicare Part A. **We argue the "plain language" rule does not give deference to the CMS belief when faced with three distinct categories such as Part A, Part B, and Part C.**

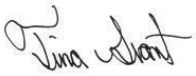
An argument discussed by the Court in the *Jewish Hospital* case, *Jewish Hospital Inc. v. Secretary of HHS*, 19 F.3d 270, US Court of Appeals (6th Cir, 1994), as well as other courts, distinguished between the terms "entitled" and "eligible" as used in the relevant statute. The Court states "furthermore, Congress spoke of 'eligibility' in the Medicaid proxy and 'entitlement' in the Medicare proxy. See 42 U.S.C. § 1395ww(d)(5)(F). The Secretary would have this Court conflate eligibility with entitlement. Adjacent provisions utilizing different terms, however, must connote different meanings. To be entitled to some benefit means that one possesses the right or title to that benefit. Thus, the Medicare proxy fixes the calculation upon the absolute right to receive an independent and readily defined payment." *Jewish Hospital*. The statute states that the Medicare fraction numerator is the number of "patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this title…." Once the individual makes the choice for Part C, they are no longer "entitled" to bring a claim under Part A, until they terminate their Part C election. The ensuing patient days that result from an inpatient hospital stay are not entitled to benefits under Part A, but rather are entitled to benefits under Part C. Since these are not "such days" under Part A, they are not to be included in the Medicare fraction and are not to be excluded from the Medicaid fraction. Therefore, the Medicare Advantage dual eligible days would be included in the Medicaid fraction. This distinction between "entitled" and "eligible" is echoed by the Court in *Emma Bohlen v. Richardson*, US Dist Ct, ED PA, (6/19/72), *Legacy Emanuel Hosp v. Shalala*, US Ct of Appeals, 9th Cir (10/9/96) and *Cabell Huntington Hosp v. Shalala*, US Ct of Appeals, 4th Cir (11/27/96). A more recent case, *Empire Health Foundation v. Azar*, No. 18-35845 (9th Cir. 2020) makes reference to *Legacy Emanuel Hosp*, calling it "clearly a *Chevron* step one decision." The *Empire Health* court goes on to say "[w]e interpreted the word 'entitled' to mean that a patient has an 'absolute right… to

payment.' In contrast, we interpret the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria…." In footnote 16, the court states "We note that then-Judge Kavanaugh's concurring opinion in *Northeast Hospital* agreed with the interpretation of 'entitled to [Medicare]' we announced in *Legacy Emanuel*. *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 (D.C. Cir. 2011)." **Given the statutory interpretation of the 9th Circuit Court of Appeals in *Empire Health* and other referenced opinions above, that statutory interpretation does not support CMS's view of "entitled" to part A, or that Part C is "in some sense" entitled to Part A, as CMS stated in the FFY 2005 IPPS final rule.**

**Conclusion**

We appreciate CMS's ongoing efforts to improve payment systems across the delivery system; however, this rule far exceeds CMS authority and should not be finalized. If you have questions on our comments, please feel free to contact me at granttw@trinity-health.org or 734-343-1375.

Sincerely,



Tina Weatherwax Grant, JD
Vice President, Public Policy and Advocacy
Trinity Health