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SUMMARY

Medicare Disproportionate Share Hospital Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction

On February, 28, 2023, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule (CMS-1788-P) in the *Federal Register* (88 FR 12623) that would change CMS' policies on how the Medicare disproportionate share (DSH) adjustment is determined. The change relates to the counting of days associated with individuals eligible for certain benefits provided by section 1115 demonstrations in the Medicaid fraction of a hospital's disproportionate patient percentage (DPP). **The public comment period will end on May 1, 2023.**

CMS proposes that for a section 1115 demonstration inpatient day to be included in the numerator of the Medicaid fraction, the patient must:

1. Receive health insurance authorized by the section 1115 demonstration that provides inpatient hospital benefits; or
2. Buy health insurance with premium assistance provided to them under a section 1115 demonstration, where state expenditures to provide the health insurance or premium assistance receives federal matching funds.

Under CMS' proposal, patients whose inpatient hospital costs are paid for with funds from an uncompensated care pool authorized by a section 1115 demonstration are not patients "regarded as" eligible for Medicaid. The days of such patients may not be included in the DPP Medicaid fraction numerator for purposes of calculating hospitals' Medicare DSH payments.

CMS' proposal would be effective for discharges occurring on or after October 1, 2023.

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I. Disproportionate Share (DSH) and Uncompensated Care (UC) payments

A. Background

Medicare makes DSH and UC payments to inpatient prospective payment system hospitals that serve more than a threshold percentage of low-income patients. To be eligible for these payments, the hospital's DPP must meet a minimum percentage. The DPP is the sum of two fractions:

- Medicare Fraction: The proportion of inpatient days for Medicare eligible patients receiving Supplemental Security Income (SSI) over total Medicare inpatient days.
- Medicaid Fraction: The proportion of inpatient days for Medicaid patients not eligible for Medicare over total inpatient days.

Prior to fiscal year (FY) 2014, CMS made only DSH payments, not UC payments. Beginning in FY 2014, the Affordable Care Act (ACA) required that DSH equal 25 percent of the payments that would otherwise be made under the statutory formula in effect before the ACA. The remaining 75 percent of the amount that would have been paid under the pre-ACA formula is adjusted for reductions in the uninsured population and distributed to each hospital based on its share of uncompensated care costs.

This proposed rule does not concern either UC payments or the Medicare fraction of the DPP. It only addresses inpatient days included in the numerator of the Medicaid fraction.

B. History of 1115 Waiver Days in the Medicaid Fraction

For an inpatient day to be included in the Medicaid fraction, the patient must be eligible for inpatient benefits under Medicaid. Not all patients that are Medicaid eligible receive inpatient benefits. Other low-income people may not be eligible for Medicaid at all. Through a section 1115 demonstration project, some states will extend inpatient benefits to patients and to populations that could not have been made eligible for medical assistance under the Medicaid state plan.

CMS reviews the history of its policy on when section 1115 inpatient days could be included in the numerator of the Medicaid fraction. Prior to 2000, CMS only included section 1115 inpatient days for patients that could have been made eligible for Medicaid under the Medicaid state plan. Inpatient days for expansion populations made eligible for Medicaid under a section 1115 demonstration not otherwise eligible for Medicaid were not included in the numerator of the Medicaid fraction.

In 2000, CMS changed that policy to include in the DPP Medicaid fraction numerator all patient days of demonstration expansion groups made eligible for matching funds under title XIX, regardless of whether the patients could have been made eligible for Medicaid under a Medicaid state plan. For FY 2004, CMS further refined this policy to include in the DPP Medicaid fraction inpatient days only for those patients eligible to receive inpatient hospital insurance benefits under the terms of a section 1115 demonstration or under the Medicaid state plan.

However, in 2005, two federal courts ruled that CMS' policy was contrary to statute reasoning that patients in demonstration expansion groups were necessarily "eligible for medical assistance under a state plan" (that is, eligible for Medicaid even if the coverage did not include inpatient hospital benefits), and the Social Security Act (the Act) had always required including their days in the Medicaid fraction. The preamble to the proposed rule indicates that these court decisions were effectively overruled by enactment of section 5002 of the Deficit Reduction Act (DRA) that ratified CMS' earlier policy nullified by the courts.

The statutory language that is the basis for CMS' conclusion is section 1886(d)(5)(F)(vi) of the Act, as added by the DRA:

> In determining [the Medicaid fraction] the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.

CMS argues that this statutory language ratifies its prior policy by being applied retroactively (using the past tense "were eligible under a State plan approved under title XIX").

The proposed rule further indicates that section 5002 of the DRA provided prospective statutory discretion to the Secretary to determine "the extent" to which patients "not so eligible" for Medicaid benefits "may" be "regarded as" eligible "because they receive benefits under a demonstration project approved under title XI" (e.g., the Secretary has the discretion as to when section 1115 waiver days may be included in the numerator of the Medicaid fraction).

At the time of enactment of the DRA, CMS did not believe further changes to its regulations were necessary as the regulations reflected its intent to include patient days of those populations who, under a demonstration project, receive benefits, including inpatient hospital coverage benefits, that are similar to the benefits provided to traditional Medicaid beneficiaries. This would not include circumstances where states extended coverage only for specific services (such as family planning) that do not include insurance coverage for hospital care.

However, several federal courts concluded that CMS' regulations require section 1115 inpatient days to be included in the numerator of the Medicaid fraction where hospitals have received payment from an uncompensated care pool or the patients received premium assistance to purchase health insurance under a section 1115 demonstration program.[1] These courts have concluded that if a hospital received payment for otherwise uncompensated inpatient hospital treatment of a patient, that patient is "eligible for inpatient hospital services" within the meaning of the current regulation.

CMS disagreed with these court decisions and indicates that it never intended to include in the DPP Medicaid fraction numerator days of patients that benefited so indirectly from a demonstration. In response to these court decisions, CMS made proposals in the FY 2022 and FY 2023 IPPS proposed rules to modify its policies consistent with its longstanding view that section 1115 waiver days should only be included in the Medicaid fraction of the DPP where the waiver provides inpatient benefits directly to the patient.

For FY 2022, CMS proposed that only those section 1115 waiver days for expansion populations receiving inpatient benefits directly from Medicaid could be included in the Medicaid fraction.

[1] (Bethesda Health, Inc. v. Azar, 980 F.3d 121 (D.C. Cir. 2020); Forrest General Hospital v. Azar, 926 F.3d 221 (5th Cir. 2019); HealthAlliance Hosps., Inc. v. Azar, 346 F. Supp. 3d 43 (D.D.C. 2018)).

Days of patients who receive premium assistance through a section 1115 demonstration and the days of patients for which hospitals receive payments from an uncompensated or undercompensated care pool created by a section 1115 demonstration would not be included in the DPP Medicaid fraction numerator.

For FY 2023, CMS modified the proposal for those patients receiving premium assistance to purchase health insurance that includes inpatient benefits. Inpatient days for these patients could be included in the Medicaid fraction if the premium assistance receives matching funds under Title XIX, the insurance provides "essential health benefits" as defined under the Affordable Care Act, and the assistance is equal to or greater than 90 percent of the cost of the insurance.

CMS did not finalize either of these proposals but indicated that it would revisit them in future rulemaking.

C. Current Proposal

CMS is making a similar proposal to the one that it did not finalize for FY 2023. The proposed rule indicates that in order for days associated with section 1115 demonstrations to be counted in the DPP Medicaid fraction numerator, the statute requires those days to be for patients who can be "regarded as" eligible for Medicaid. CMS is proposing to modify its regulations to explicitly state that patients may only be "regarded as" eligible for Medicaid if the patient receives health insurance through a section 1115 demonstration where state expenditures to provide the insurance may be matched with federal funds under title XIX (Medicaid).

CMS proposes that for a section 1115 inpatient day to be included in the numerator of the Medicaid fraction, the patient must:

1. Receive health insurance authorized by a section 1115 demonstration that provides inpatient hospital benefits; or
2. Buy health insurance with premium assistance provided under a section 1115 demonstration that accounts for 100 percent of the premium cost to the patient, where state expenditures to provide the health insurance or premium assistance is matched with federal funds under title XIX.

Under CMS' proposal, patients whose inpatient hospital costs are paid for with funds from an uncompensated care pool authorized by a section 1115 demonstration are not patients "regarded as" eligible for Medicaid. The days of such patients may not be included in the DPP Medicaid fraction numerator.

The only difference between CMS' proposal for FY 2023 and its current proposal is that CMS is now proposing to require the premium assistance cover 100 percent of the cost of the insurance, rather than 90 percent. Public comments on that aspect of CMS' proposal indicated that it would be burdensome to determine if this threshold percentage was met. CMS' understanding is that any current state waiver that provides premium assistance that includes inpatient hospital benefits cover 100 percent of the cost of the insurance. Therefore, CMS sees this change to the proposal as being consistent with current practice. Further, it believes hospital burden would be

reduced because once the hospital determines the patient became eligible for inpatient benefits through an 1115 waiver that provided premium assistance, it would follow that the waiver provided 100 percent of the cost of the insurance.

D. CMS' Authority and Public Comments

CMS argues that section 1886(d)(5)(F)(vi) of the Act provides clear discretionary authority to determine when section 1115 days may be included in the Medicaid fraction. The proposed rule argues that use of the word "may" and "to the extent and for the period the Secretary determines appropriate" allow the Secretary to determine when section 1115 days may be included in the Medicaid fraction.

Public commenters disagreed with CMS' prior proposals, arguing the statute requires CMS to "regard as" Medicaid eligible those patients with uncompensated care costs for which a hospital is paid from a demonstration funding pool and to count those patients' days in the DPP Medicaid fraction numerator. These commenters assert that uninsured patients "effectively" receive insurance from an uncompensated/undercompensated care pool, and thus, cannot be reasonably distinguished from patients who receive insurance from the Medicaid program.

CMS responds to arguments against its proposal by stating:

- It sees a clear difference between inpatient days where the patient is provided with insurance through an 1115 waiver and where the 1115 waiver compensates the hospitals for uncompensated care. For the former, CMS argues that the patient receives a direct insurance benefit while for the latter the hospital is being compensated for an uninsured patient's costs and the patient is not receiving any health insurance benefit (or at least not directly). The former patient is "regarded" as eligible for Medicaid while the latter is not.
- The Medicare fraction uses SSI and the Medicaid fraction uses Medicaid eligibility as a proxy for low-income patient status. Patients may not necessarily be low-income when their inpatient costs are compensated from an uncompensated care pool.
- Including section 1115 inpatient days from uncompensated care pools in the Medicaid fraction would advantage states with relatively broad uncompensated care pools relative to others that do not, even though the burden of uncompensated care may be no different between the states.

II. Impact

There would be no payment impact in seven states that have section 1115 waivers that explicitly include premium assistance (Arkansas, Massachusetts, Oklahoma, Rhode Island, Tennessee, Utah, and Vermont). Hospitals in six states (Florida, Kansas, Massachusetts, New Mexico, Tennessee, and Texas) would no longer be eligible to report section 1115 inpatient days for patients for which they received payments from uncompensated/undercompensated care pools. In these states, CMS does not have the data to determine the payment impact because the Medicare cost report does not include lines for section 1115 demonstration days separately from other types of days.

However, CMS did use unaudited data on the amounts in dispute from the plaintiffs in the cases referenced above to estimate the potential impact per bed at $2,477. Extrapolating this figure to the number of beds in the above six states would yield annual Trust Fund savings of approximately $348.9 million. However, CMS cautions against extrapolating from these unaudited amounts to Trust Fund savings and indicates the amounts could be higher or lower than its estimates.