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Advancing Health in America

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May 1, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS–1788–P Medicare Program; Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated With Section 1115 Demonstrations in the Medicaid Fraction, (Vol. 88, No. 39), February 28, 2023

Dear Administrator Brooks-LaSure:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 90 that offer health plans, and 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, we thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule regarding the treatment of Medicaid 1115 demonstration days for purposes of the calculation used to determine Medicare Disproportionate Share Hospital (DSH) payments.

The AHA opposes CMS' proposal to limit the inclusion of patient days for patients who are regarded as eligible for Medicaid benefits under a Section 1115 demonstration project for purposes of the Medicare DSH calculation. This proposal could have a devastating impact on access to care for lower-income populations by curtailing much needed resources used to finance health care in historically marginalized communities. This proposed rule is the agency's third attempt in as many years to exclude the counting of days of patients associated with uncompensated care pools from the Medicaid fraction of the Medicare DSH patient percentage. In addition, the agency proposes to limit the counting of patient days to only those patients who purchase health insurance that includes inpatient services through an authorized Medicaid 1115 demonstration premium assistance program where 100%

of the cost of the premium is covered. CMS bases both of these proposed changes on its interpretation of the Medicare statute as it relates to what types of 1115 demonstration project patient days count, for purposes of the Medicaid fraction. **However, the agency's interpretation is contrary to unambiguous statutory language.**

Medicaid Fraction

States have long relied on the authority of the Social Security Act Section 1115(a) to enable more individuals to receive Medicaid benefits without satisfying all statutory Medicaid requirements. To ensure these benefit opportunities, states can request the approval of the Health and Human Services' (HHS) Secretary to waive certain statutory Medicaid requirements for demonstration projects that will promote the objectives of the Medicaid program. Because a component of the Medicare DSH patient percentage includes Medicaid patient days (i.e., the Medicaid fraction), questions have been raised over the years about whether patients provided medical services through a Medicaid 1115 demonstration project could be included in the Medicaid fraction of the Medicare DSH patient percentage. Congress answered those questions in 2005 through a provision of the Deficit Reduction Act:

> "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 [Medicaid], 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."[1]

A plain reading of the statutory phrase "…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," suggests that Congress intended patients receiving benefits under a Medicaid 1115 demonstration be counted in the Medicaid fraction.

Judicial Response Regarding 1115 Demonstration Days

This reading is supported by opinions from several federal courts.[2] For example, in *Forrest General Hospital v. Azar*, the United States Court of Appeals for the Fifth Circuit held, "The governing provisions unambiguously require HHS to include such patient days. By excluding instead of including, HHS committed a fraction infraction—and flouted the law's plain language."[3] It explained, "Once the Secretary authorizes a

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[1] Deficit Reduction Act 2005 PUBLIC LAW 109–171, Sec. 5002.
[2] *HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir. 2020).
[3] *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019) (emphasis added).

demonstration project, no take-backs. The statutory discretion isn't discretion to exclude populations that the Secretary has already authorized and approved for a given period; it's discretion to authorize the inclusion of those populations in the first place."[4]

CMS' current proposal flouts the plain language of the law. The agency proposes to only include those patient days in the Medicare DSH calculation where the patients "receive health insurance through a section 1115 demonstration itself or purchase such insurance with the use of premium assistance provided by a section 1115 demonstration" and state expenditures are matched by Title 19 Medicaid funds.[5] CMS justifies these proposals based on its belief that statute does not grant the secretary such authority to count days of patients who are "not so eligible but who are regarded as such." It explains:

> "<u>We do not believe that either the statute or the DRA permit or require the Secretary to count in the DPP Medicaid fraction numerator days of just any patient who is in any way related to a section 1115 demonstration</u>. Rather, section 1886(d)(5)(F)(vi) of the Act limits including days of expansion group patients to those who may be 'regarded as' eligible for medical assistance under a State plan approved under title XIX.''[6]

But this reading cannot be squared with the text of the statute. As the Fifth Circuit explained, "The statute means that patients who aren't actually Medicaid-eligible still count towards the Medicaid fraction's numerator if they're considered or accounted to be capable of receiving a demonstration project's helpful or useful effects by reason of a demonstration project's authority. There's only one plausible way to read this."[7] The agency may "disagree" with this decision (at 12630), but it is the law in both the Fifth and D.C. Circuits. Any final rule must clarify what the governing legal standards will be in those jurisdictions. And if it decides to follow the court of appeals decisions — as it must — the Administration must explain why it is willing to countenance different legal standards in different parts of the country.

Modifications for Premium Assistance Demonstration Days

Despite the unambiguous language of the statute, CMS argues that it will exercise its discretion in interpreting the statute to include only those patient days for purposes of the Medicaid fraction for patients that purchased health insurance through premium

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[4] *Ibid.*
[5] 88 Fed. Reg.12628 (Feb. 28, 2023).
[6] 88 Fed. Reg. 12626 (Feb. 28, 2023).
[7] *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019); *see also Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir. 2020) ("the demonstration project enabled the patient to receive inpatient services, regardless whether the project gave the patient a *right* to these services or allowed the patient to enroll in an insurance plan that provided the services").

assistance that covers 100% of the premium cost which the patient uses to buy health insurance that covers inpatient hospital services.[8] This is a modification from agency's proposal in the fiscal year (FY) 2023 inpatient prospective payment system rule. In that version, CMS proposed requiring that the purchased insurance provide coverage of the Essential Health Benefits (EHBs) and the premium assistance covered at least 90% of the cost of the insurance, rationalizing that EHBs are more consistent with benefits provided to individuals eligible under Medicaid state plans. Based on public comments, the agency acknowledged that the FY 2023 proposal would be burdensome for hospitals with respect to verifying whether a particular insurance program in which an individual was enrolled provided EHB coverage and determining whether a particular premium assistance program covered at least 90% of the cost of the insurance.[9] While acknowledging the burden associated with the prior proposal, CMS ignores the burden they have created for hospitals with this latest proposal. Hospitals would now be required to determine whether a patient is enrolled in coverage for which premium assistance covers 100% of the premium cost. CMS notes that it may be difficult for hospitals to distinguish between patients with premium assistance paid for by Medicaid from patients who are otherwise covered by Medicaid through fee-for-service or managed care. But the agency dismisses this challenge as a burden and essentially argues that hospital will figure it out.[10]

The agency further states that in creating this new requirement for premium assistance programs they rely on the statute's "regarded as eligible" language. But, again, *Forrest General,* and other decisions hold otherwise. The Secretary cannot exclude patient days attributable to 1115 demonstration projects for purposes of the Medicare DSH patient percentage once the secretary approved the same demonstration project for purposes of the Medicaid program. The agency's requirement, for purposes of counting patient days, that the premium assistance must cover 100% of the premium and include inpatient services is what the Fifth Circuit might colorfully call a "take-back"[11] and has no basis in the text of the statute. And no matter how much the agency wishes its novel policy is the one Congress enacted, it was not. CMS therefore has no power to "tailor" legislation to bureaucratic policy goals by rewriting unambiguous statutory terms.[12]

Failure to Assess Impact

Finally, CMS' proposal is fatally flawed because it fails to consider the impact of its policy on low income patients and the hospitals that care for them. CMS clearly identifies in the proposed rule the states that have currently approved 1115

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[8] 88 Fed. Reg.12628 (Feb. 28, 2023).
[9] Ibid.
[10] Ibid.
[11] *Forrest General Hospital v. Azar*, 926 F.3d 221 "Once the Secretary authorizes a demonstration project, no take-backs. The statutory discretion isn't discretion to exclude populations that the Secretary has already authorized and approved for a given period; it's discretion to authorize the inclusion of those populations in the first place."
[12] *Util. Air Regulatory Grp. v. EPA*, 573 U.S. 302, 325 (2014).

demonstration projects that include uncompensated care pools or premium assistance programs. But they fall short in determining what the patient and hospital impact would be for those hospitals in the affected states. For states with premium assistance programs, CMS makes a modest attempt to estimate hospital burden but does not estimate the potential loss of DSH payments. For states with uncompensated care pools, CMS, in fact, states that it cannot estimate the impact because the Medicare cost report does not have information on 1115 demonstration days by hospital.[13] But in reality, the impacts would be devastating to low income individuals and the providers who care for them in many states. For example, Florida's Low-income Pool allotment (uncompensated care pool) is authorized to increase from $1.5 billion to $2.1 billion through state FYs 2026-27.[14] And, for Texas' uncompensated care pool, the estimates for federal FY 2023 to federal FY 2027 are $4.51 billion.[15] Even absent precise information on demonstration days, it is safe to presume that hundreds of millions of dollars of funding for hospitals in these two states alone — and thus hundreds of millions of dollars of care — is at risk. In addition, the agency bases its policy changes on the federal fiscal year and not according to a hospital's cost reporting year, making such changes administratively challenging for hospitals.

340B Hospitals' Impact

Lastly, the agency overlooks another consequence of its actions and that is on 340B hospitals whose eligibility is dependent on meeting the various Medicaid DSH patient percentages prescribed in federal law. Specifically, the reduction of a hospital's DSH patient percentage as a result of this proposal could jeopardize their eligibility for the 340B program. As such, 340B hospitals in 1115 demonstration project states would pay the added penalty of potentially losing their access to drug discounts that allow these very hospitals to stretch the funding they have available to meet the needs of their patients in vulnerable communities.[16] The loss of access to drug discounts provided by the 340B program will only put added pressure on these hospitals as they continue to struggle with increased inflationary cost pressures across all their supplies and services as well as the continuing rise in drug prices.

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[13] 88 Fed. Reg. 12634 (Feb. 28, 2023).
[14] Low Income Pool (LIP) Program (myflorida.com)
[15] June 8, 2022 letter from Lisa Marunyez, CMS Director, Division of System Reform Demonstrations to Stephanie Stephens, Texas State Medicaid Director.
[16] H. Rep. 102-384 (II), 102d Cong., at 12 (1992).

We urge CMS to not move forward with these proposed policy changes and withdraw this proposed rule. Please contact me if you have questions or feel free to have a member of your team contact Molly Collins Offner, AHA's director for policy, at mcollins@aha.org or Shannon Wu, AHA's senior associate director for policy, at (202) 626-2963 or swu@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development