June 16, 2022

Chiquita Brooks-Laure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1771-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Hospital Inpatient Prospective Payment System Proposed Rule for FY2023 for Acute Care Hospitals (CMS-1771-P)

Dear Administrator Brooks-LaSure,

On behalf of its 123 member hospitals, the Kansas Hospital Association (KHA) offers the following comments in response to the Centers for Medicare & Medicaid Services' (CMS) proposed payment and policy updates for the Hospital Inpatient Prospective Payment System Proposed Rule for FY 2023 (CMS-1771-P).

KHA would like to thank CMS for its ongoing support for our nation's hospitals, providers, and patients during the COVID-19 public health pandemic. The continued flexibility that CMS has provided to our members so they are best positioned to care for their patients and communities is greatly appreciated. We appreciate the proposal not to penalize hospitals for non-representative performance under the Hospital-Acquired Condition Reduction and Value-Based Purchasing Programs for FY 2023.

Secondly, we thank CMS for proposing a 5% cap on any decrease to a hospital's wage index, though we urge that this be applied in a non-budget neutral way.

KHA has significant concerns over the proposed payment update for IPPS hospitals for FY 2023, which, together with the agency's proposed cuts to DSH payments, cuts to the low-volume hospital adjustments, elimination of the Medicare Dependent Hospital designation, and continued sequestration, Kansas hospitals will see an overall ***decrease*** in IPPS payments by approximately 1%. With inflation at an all-time high, hospitals in Kansas saw an average increase in costs around 11-14% last year. This gap is overwhelming. In order to ensure that Medicare payments for acute care services most accurately reflect the cost of providing hospital care, we urge CMS to implement the changes below.

PAYMENT UPDATE

For FY 2023, CMS proposes a market basket update of 3.1%, less a productivity adjustment of 0.4 percentage points, plus a documentation and coding adjustment of 0.5 percentage points, resulting in an update of 3.2%. This update, as well as the FY 2022 payment update of 2.7%, are woefully inadequate and do not capture the unprecedented inflationary environment. This is because the market basket is a time-lagged estimate that uses historical data to forecast into the future. When historical data is no longer a good predictor of future

changes, the market basket becomes inadequate. Yet, this is essentially what has been done when forecasting the FY 2022 and 2023 market basket and productivity adjustments. Indeed, with more recent data[1], the market basket for FY 2022 is trending toward 4.0%, well above the 2.7% CMS actually implemented last year. Additionally, the latest data also indicate *decreases* in productivity, not gains.[2] KHA urge's CMS to consider the changing health care system dynamics and their effects on hospitals.

Specifically, we urge CMS to 1) implement a retrospective adjustment for FY 2023 to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022; and 2) eliminate the productivity cut for FY 2023.

The current inflationary economy combined with the COVID-19 crisis has put unprecedented pressure on our hospitals. At the same time, we continue to struggle with persistently higher costs and additional downstream challenges that have emerged as a result of the lasting and durable impacts of high inflation and the pandemic.

Specifically, historic inflation has continued and heightened the severe economic instability that the pandemic has wrought on our hospitals. Kansas hospitals have reported paying up to $200 per hour for temporary staffing in nursing, radiology, laboratory, and rehabilitation departments. Basic supply costs such as surgical gloves, blankets, syringes, and blood pressure monitors have increased an average of 25%. Drug costs have skyrocketed during the pandemic. By the end of 2021, total drug expenses were 28% higher than pre-pandemic levels.

Because this high rate of inflation is not projected to abate in the near term, and inflationary pressures are also likely to continue to work their way into wage expectations, it is critical to account for these challenges when considering hospital and health system financial stability in FY 2023 and beyond. **As such, the market basket updates for FY 2022 and FY 2023 are resulting in woefully inadequate reimbursements for our hospital. We ask CMS to implement, for FY 2023, a retrospective adjustment to account for the difference between the market basket adjustment that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022.**

Additionally, we ask that CMS eliminate the productivity cut within the market basket update for FY 2023. The measure of productivity used by CMS is intended to ensure payments more accurately reflect the true cost of providing patient care and effectively assumes the hospital field can mirror productivity gains across the private nonfarm business sector. This is not an accurate assumption. For example, staff and supply shortages have closed units of the hospital. Because of concerns about COVID-19, many patients have delayed or avoided medical care including urgent or emergency care. **We urge CMS to eliminate this cut.**

[1] IHS Global, Inc.'s (IGI's) forecast of the IPPS market basket increase, which uses historical data through third quarter 2021 and fourth quarter 2021 forecast.
[2] U.S. Bureau of Labor Statistics. (May 5, 2022). Productivity and Costs, First Quarter 2022, Preliminary - 2022 Q01 Results. https://www.bls.gov/news.release/pdf/prod2.pdf.

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PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS

KHA opposes CMS's proposal to revert the low-volume hospital qualifying criteria and adjustment back to statutory requirements prior to FY 2011. In Kansas, small rural PPS hospitals are at an extreme financial disadvantage. These hospitals do not qualify for cost-based reimbursement to help with those fluctuations in volume, and they do not have the power to negotiate stronger payer contracts. Because of this, they continue to be at risk for closure.

Reverting the program back will limit the positive payment adjustment to very few hospitals in the country. In 2005, only five hospitals in the country qualified for additional payments. This limited scope was recognized by policymakers under the Affordable Care Act and expanded the low-volume hospital definition as it is today. Currently, fourteen hospitals in Kansas receive low-volume payments that equal $12 million in reimbursement. This would decrease their Medicare reimbursement by an average of 15.4%. The most devastated hospital will see a 28% drop in reimbursement. **KHA urges CMS to continue the enhanced Low-Volume Hospital program.**

MEDICARE-DEPENDENT HOSPITAL PROGRAM EXTENSION

KHA urges CMS to permanently extend the Medicare-Dependent Hospital program. Since many small rural hospitals heavily rely on Medicare reimbursement, which is below the actual costs of care, and these hospitals cannot offset the financial losses with private payer revenue, CMS must continue to reimburse MDHs a hospital-specific payment rate for them to survive. Significant growth in expenses across labor, drugs, and supplies is not sustainable to these hospitals. **KHA urges CMS to stop these cuts to hospitals.**

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

KHA is concerned with CMS' proposal to decrease DSH payments—by approximately $800 million—to hospitals for FY 2023. Medicare DSH payments are a critical component of overall Medicare inpatient payments and help offset the costs of care hospitals incur treating indigent patients. We question the agency's estimate that the uninsured rate will decrease from 9.6% to 9.2% from FY 2022 to FY 2023 when determining DSH payments. In Kansas communities, it is clear that a large increase in the number of the uninsured, not a decrease, will occur as the public health emergency coverage provisions begin to unwind. **We ask that CMS use more recent data and update its estimates of the Medicare DSH amount to more accurately reflect both discharge volume and the uninsured rate. This would yield figures that more accurately reflect changes in discharge volume and health insurance coverage and losses.**

PROMOTING INTEROPERABILITY PROGRAM

Query of Prescription Drug Monitoring Program Measure - KHA supports the reporting of electronic prescribing objective's prescription drug monitoring measures; and supports CMS's exclusion of any hospital or Critical Access Hospital that does not have an internal pharmacy that can accept electronic prescriptions for controlled substances (Schedules II, III and IV) and is not located within ten miles of any pharmacy that accepts

electronic prescriptions for controlled substances at the start of their electronic health record reporting period.

Antimicrobial Use and Resistance (AUR) Measure in the Public Health and Clinical Data Exchange Objective - KHA supports the addition of the AUR measure to this objective to indicate hospitals are in active engagement with the CDC's National Health Care Safety Network (NHSN). **However, for every new measure that is added by CMS to hospitals through NHSN, the IQR program or other quality programs, KHA asks that CMS remove a less-effective measure to reduce provider reporting burden and remove reporting requirements for measures that do not contribute to or are least impactful on improved patient outcomes.**

HOSPITAL QUALITY REPORTING AND VALUE PROGRAMS

CMS proposes to add 10 new measures to the IQR program and to adopt several policies intended to advance health equity and perinatal care. KHA supports initiatives to improve equity and perinatal care. **However, rather than adding new measures without addressing less effective measures that can be removed, KHA requests that CMS provide an analysis of all required measures, in order of impact on improved patient outcomes and remove less effective measures for each new measure added, so that there is a net neutral effect or a reduction in overall provider reporting burden.**

Measure Suppression due to the pandemic - KHA supports the COVID-19 measure suppression policy that CMS has adopted, and appreciates the recognition by CMS that due to long COVID, this impact may continue much longer than the original pandemic. In addition to including patient history of COVID-19 in the 12 months prior to the index hospitalization, KHA asks that CMS continue to monitor this and acknowledge that we do not yet know how long "long COVID" may impact a patient's health status and outcomes.

PSI 90 Minimum Volume Threshold - KHA supports CMS's proposal to increase the minimum threshold for receiving a PSI 90 score to increase measure liability.

Potential Future Inclusion of Health Equity Performance in HRRP - KHA supports the including of evidence-based metrics to measure the impact of efforts to reduce disparities in care. Due to the significant variability of communities across the country, KHA recommends that if benchmarking is pursued, that it not be done using national or state averages, but rather comparing like facilities or communities.

COUNTING DAYS ASSOCIATED WITH SECTION 1115 DEMONSTRATIONS IN THE MEDICAID FRACTION OF MEDICARE DSH ADJUSTMENT

KHA opposes CMS's 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. The Proposed Rule announces CMS's intent to revise its regulations to exclude inpatient days for persons who receive "medical assistance" by means of an uncompensated care pool approved by CMS under a section 1115 demonstration project from the Medicaid fraction of the disproportionate share hospital ("DSH")

calculation. The Proposed Rule is specifically designed to foreclose hospitals from claiming patient days in the Medicaid fraction numerator attributable to patients whom CMS "regarded as" Medicaid eligible when the agency exercised its authority under section 1115 of the Social Security Act to match State funds appropriated to uncompensated care pools to pay for the cost of their inpatient care. *Id.* at 28401-02.

Regrettably, the Proposed Rule is only the latest instance of a decades-long pattern of CMS's disregard for the structure, text, and purpose of the Medicare DSH provision. Congress enacted the DSH payment adjustment to compensate hospitals that experience higher operating costs due to the treatment of high volumes of lower-income individuals. But ever since the enactment of the IPPS system, CMS "has refused to implement the DSH provision in conformity with the intent behind the statute." *Portland Adventist Medical Ctr. v. Thompson*, 399 F.3d 1091, 1099 (9th Cir. 2005).

The Hospitals are in the State of Kansas, which operates a CMS-approved section 1115 demonstration that implements an uncompensated care pool that covers the cost of inpatient care furnished to uninsured and underinsured individuals. The Proposed Rule, if adopted, would arbitrarily and unlawfully deprive the Hospitals of reimbursement for the substantial costs that they incur in treating these lower-income individuals. We respectfully urge you to refrain from adopting this aspect of your Proposed Rule.[3]

The one common thread in CMS's administration of the DSH provision over the past 20 years has been its consistent efforts to ignore the plain language of the Medicare statute in order to reduce the payments that it makes to hospitals to address the increased costs that are associated with the treatment of lower-income individuals. Yet time after time, Federal courts have ordered CMS to align its policies with Congress's clear commands. Dating back to the early 1990s, CMS adopted a policy to exclude unpaid, but eligible, Medicaid days from the DSH calculation – and reversed course only after four Federal courts ruled the policy was inconsistent with the Medicare statute. *See Cabell Huntington Hosp. v. Shalala*, 101 F.3d 984, 988 (4th Cir. 1996); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996); *Deaconess Health Serv. Corp. v. Shalala*, 83 F.3d 1041, 1041 (8th Cir. 1996); *Jewish Hosp. v. Secretary of Health and Human Servs.*, 19 F.3d 270, 274 (6th Cir. 1994). Even then, CMS refused to make hospitals whole for this error and it took another round of litigation to force the agency to make payment to compensate hospitals for CMS's misapplication of the statute. *See In re Medicare Reimbursement Litigation*, 414 F.3d 7, 12-13 (D.C. Cir. 2005). Fast forward to the present day, and CMS is still at it. To name but one recent example, CMS continues to seek to reduce DSH payments by straining logic to define an individual as "entitled" to benefits under Medicare Part A for purposes of one part of the Medicare fraction of the DSH calculation, but not for the other. *See Empire Health Found. v. Azar*, 958 F.3d 873, 884 (9th Cir. 2020), *cert. granted sub nom. Becerra v. Empire Health Found. for Valley Hosp. Med. Ctr.*, 141 S. Ct. 2883, 210 L. Ed. 2d 990 (2021), and *cert. denied sub nom. Empire Health Found. for Valley Hosp. Med. Ctr. v. Becerra*, 141 S. Ct. 2884, 210 L. Ed. 2d 999 (2021).

[3] The Hospitals reserve the right to submit separate comments on other aspects of the Proposed Rule.

This Proposed Rule is simply the latest iteration of CMS's hostility to Congress's clear instructions to compensate DSH hospitals for their greater costs. Indeed, CMS promulgated a similar proposal in the FY 2022 IPPS proposed rule that attempted to limit hospitals from claiming patient days in the Medicaid fraction numerator only if the demonstration project extended inpatient hospital insurance coverage benefits directly to that patient for that day. *See* 86 Fed. Reg. 25459 (May 10, 2021). In response, Hospitals, other providers, and major hospital associations urged CMS not to adopt its proposed policy based on fundamental flaws in CMS's interpretation of the governing statute and instructive case law. While CMS did not finalize its proposal in the FY 2022 rulemaking cycle, it has now turned a deaf ear to commenters' concerns and has proposed a similarly unlawful proposal for FY 2023.

Tellingly, however, CMS has modified its proposal from FY 2022 to regard certain premium assistance days as Medicaid-eligible. However, the agency provides no reasoned explanation for now regarding premium assistance days (and only certain ones, at that) as Medicaid- eligible while continuing to exclude uncompensated care pool days. As discussed below, the statute requires the inclusion of *all* inpatient days associated with individuals who receive payment of all or part of their inpatient hospital services through a section 1115 waiver. When furnished though a section 1115 waiver, payment for inpatient care is a "benefit" to those individuals. And at the time CMS approved the section 1115 waiver that makes payment for such care, he regarded the population that receives that benefit as Medicaid eligible. The courts have been clear that CMS cannot later exclude from the DSH payment the inpatient days associated with these populations based on the manner in which payment for that care was made. Whether through a traditional fee-for-service model, premium assistance plan, or uncompensated care pool, CMS is providing "medical assistance" to the individuals whose care is covered by these programs – and their days must therefore be counted toward the Medicare DSH payment.

For the reasons stated herein, CMS should recognize the continued vulnerability of its proposal. The Hospitals urge CMS not to adopt this provision of the Proposed Rule to exclude patient days in the Medicaid fraction numerator for patients whose care was covered in part by section 1115 uncompensated care pools.

I. The Text of the DSH Provision Unambiguously Requires the Inclusion of Patient Days Attributable to Beneficiaries of Section 1115 Demonstration Projects in the Numerator of the Medicaid Fraction.

The Proposed Rule affects the computation of the Medicaid fraction of the DSH calculation, which sets forth a proxy calculation for a hospital's high-cost patients by measuring how many of the hospital's patient days are attributable to participants in a state Medicaid plan or a state's section 1115 demonstration project. The Medicaid fraction is calculated by determining a fraction that consists of a numerator and a denominator. The numerator is "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 subchapter XIX, but who were not entitled to benefits under part A of this subchapter." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The denominator is "the total number of the hospital's patient days for such period." *Id.* Not every lower-income person receives "medical assistance" – a term of art defined in the Medicaid statute, *see infra* – through a State Medicaid plan, however; CMS has authorized some States instead to provide medical assistance to lower-income individuals

through "section 1115 demonstration projects," a phrase that refers to CMS's authority to waive certain provisions of the Medicaid statute under section 1115 of the Social Security Act.

The specific statutory provision at issue here relates to determining the number of days that are includable in the numerator of the Medicaid fraction under DSH. The DSH provision clarifies that, in determining the number of patient days for patients who were eligible for medical assistance under a State plan, "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 subchapter XI." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

CMS's Proposed Rule attempts to revise 42 C.F.R. § 412.106(b)(4) to define the language "regarded as" "eligible for medical assistance" in section 1886(d)(5)(F)(vi) of the Act to mean patients who receive certain types of health insurance through a section 1115 demonstration itself or purchase such insurance with the use of premium assistance provided by a section 1115 demonstration for which the premium assistance is equal to or greater than 90 percent of the cost of the health insurance. 87 Fed. Reg. 28401-02. Further, the Proposed Rule announces that the Secretary "does not interpret the [Medicare] statute as authorizing the Secretary to 'regard as' Medicaid eligible patients with uncompensated care costs for which a hospital is reimbursed by a section 1115 demonstration-authorized uncompensated care funding pool." *Id*. at 28402. Both statements have the effect of excluding uncompensated care pool days from the numerator of the Medicaid fraction.

CMS's reasoning to support this provision of the Proposed Rule is deeply flawed and contrary to the statute. The Proposed Rule states that CMS "does not believe that [section 1886(d)(5)(F)(vi)] gave the Secretary blanket authority to count in the Medicaid fraction any patient who is in any way related to a section 1115 demonstration." *Id*. at 28400. This statement is imprecise. Uncompensated care pool patients are not just "related" to a section 1115 waiver. These individuals are "patients not so eligible for traditional Medicaid *but regarded as such* because they receive benefits under a demonstration project approved under subchapter XI" and therefore must be counted in the Medicaid fraction under section 1886(d)(5)(F)(vi). *See Bethesda Health, Inc. v. Azar*, 389 F. Supp. 3d 32, 50 (D.D.C. 2019); *aff'd*, 980 F.3d 121 (D.C. Cir. 2020) (finding that Kansas Low Income Pool patients were "regarded as such" under the meaning of section 1886(d)(5)(F)(vi)). The benefit that uncompensated care pool patients receive is medical assistance, and the courts have been explicit that CMS is not just authorized – *but required* – by the statute to include the inpatient days of these individuals in the DSH payment.

CMS is once again reverse engineering the result it wants without regard for what the courts have said the statute requires. For section 1115 demonstrations that authorize the funding of uncompensated care pools to help cover the cost of inpatient care to uninsured and underinsured individuals, the Proposed Rule notes that "such funding pools benefit patients *less directly*" than other demonstration projects that "expand the group of people who receive Medicaid benefits beyond those groups eligible under a State plan," "provide inpatient health insurance," or "make payments on behalf of specific, covered individuals." 87 Fed. Reg. at 28400. Further, CMS believes that it "is not appropriate to include patient days associated with funding pools . . . authorized by section 1115 demonstrations in the Medicaid fraction of the Medicare DSH calculation because

the benefits offered under these demonstrations are not similar to Medicaid benefits under a State plan" and should not be "regarded as" "eligible for medical assistance under a State plan." *Id*. In other words, the Proposed Rule excludes uncompensated care pool patient days from the Medicaid fraction because, according to the Secretary, "uncompensated care pools do not provide inpatient health insurance to patients or, like insurance, make payments on behalf of specific, covered individuals." *Id*. Yet there is no statutory support for CMS's preferences. Congress did not give CMS the discretion to decide which forms of medical assistance are sufficiently direct in order to be counted in the DSH payment. If the section 1115 waiver provides coverage for inpatient care, no matter the specific funding mechanism, then CMS is extending medical assistance to the covered population – a population he necessarily has regarded as Medicaid eligible in order to provide that funding.

CMS further attempts to bolster its proposal by invoking the discretion afforded the Secretary under the 1886(d)(5)(F)(vi) of the Act. "Even if the statute could be read to permit patient groups whose uncompensated care is paid for from a section 1115 demonstration-authorized funding pool to be 'regarded as' eligible for Medicaid (which the Secretary does not agree the statute permits) … we are proposing to use our discretion under section 1886(d)(5)(F)(vi) of the Act to exclude from the Medicaid fraction the days of patients whose care costs may be reimbursed to the hospitals through uncompensated/undercompensated care pools." *Id*. at 28401.

But as several Federal courts have already made clear, the Secretary only exercises the discretion to decide whether to "regard" individuals who receive "medical assistance" through an 1115 waiver as "Medicaid eligible" *when he approves the waiver itself*. He does not have the discretion to exclude any person who is a recipient of that "medical assistance" once it comes time for CMS to calculate hospitals' Medicare DSH payments. The level of deference that the Secretary reads into the statute has been rejected by each Federal court to examine the statute. *See e.g*., *Forrest Gen. Hosp. v. Azar*, 926 F.3d 221, 233 (5th Cir. 2019) ("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.") Therefore, once the Secretary authorizes a population under a section 1115 waiver demonstration – with "no take backs" allowed – the Secretary has fully and irreversibly exercised his discretion to allow that population to be "regarded as such" because they receive benefits under the demonstration. *Id*.

A. CMS's Proposal Is Foreclosed Under Controlling Case Law

CMS is foreclosed from excluding from the Medicaid fraction inpatient days attributable to uncompensated care pool beneficiaries under section 1115 demonstration projects. As discussed above, Federal courts have already rejected prior attempts to limit the inclusion of section 1115 uncompensated care days in the Medicaid fraction as a violation of the Medicare statute. For instance, in *Forrest General*, the Fifth Circuit concluded that "if the Secretary approves a demonstration project, then we regard patient days involving patients who 'receive benefits under a demonstration project' as if they were patient days attributable to Medicaid-eligible patients (which means those days also go into the numerator)." 926 F.3d at 228. The Fifth Circuit did not mince words:

> "Put bluntly: Certain days just go into the Medicaid fraction's numerator. Which days? Days that a hospital treated Medicaid-eligible patients or – if the Secretary approves a demonstration project – patients regarded as Medicaid eligible because of a demonstration project. This is binary: Patient days are either in or out. If patients underlying a given day were Medicaid-eligible or "receive[d] benefits under a demonstration project," then that day goes into the numerator.

Id. at 228-29. The Fifth Circuit also crystalized what it means to receive a "benefit" in this context: patients under the demonstration project receive a benefit when they are capable of receiving the "helpful or useful effects by reason of a demonstration project's authority." *Id*. at 229. Patients whose care is covered by payments from an uncompensated care pool are recipients of this helpful or useful effect.

Here, CMS's reasons for excluding from the Medicaid fraction patient days attributable to uncompensated care pool beneficiaries are in direct conflict with *Forrest General's* holding. First, the court rejected CMS's notion that uncompensated care pool patient days are not countable in the Medicaid fraction because those patients benefit "less directly" than patients in other demonstration projects. 87 Fed. Reg. at 28401-02. As noted above, *Forrest General* makes clear that patients either receive a benefit, or they don't – there is no middle ground. 926 F.3d at 229. Once the Secretary approves a demonstration project, the statute affords the Secretary no additional authority to limit inclusion of days in the Medicaid fraction based on the Secretary's own notions of the *degree* or *directness* of the benefit to patients under the demonstration project. Furthermore, *Forrest General* instructs that the word "benefit" under the statute has a plain meaning: one must be merely capable of receiving the "helpful or useful effects by reason of the demonstration project's authority." *Id*. There is no room in this definition for CMS to create a hierarchy of "benefits" based upon whether the agency believes those benefits directly or indirectly provide "medical assistance" to individuals. CMS's current proposal to redefine the term "benefit" is nothing more than a means to avoid compensating DSH hospitals for the costs of providing services to low-income patients – in clear violation of the Medicare statute.

For this reason, CMS's position that uncompensated care pool benefits are "not similar to Medicaid benefits under a State plan" and, therefore, should not be "regarded as" "eligible for medical assistance under a State plan" ignores the plain terms of the statute. CMS argues that it is inappropriate to include patient days associated with uncompensated care pools authorized by section 1115 demonstrations in the Medicaid fraction because these pools "do not extend health insurance directly" or "make payments" directly to individuals. 87 Fed. Reg. at 28400. This may be true, but it is also an irrelevant consideration under the statute. The D.C. Circuit rejected this very argument in *Bethesda Health Inc., v. Azar,* 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020), making clear that the statute does not allow the Secretary to limit who is "regarded as" eligible for "medical assistance" simply because uncompensated care pool demonstration projects do not offer the same package of benefits as recipients under a State plan. At bottom, being capable of receiving "inpatient services" under the uncompensated care pool demonstration project alone is enough to be regarded as eligible for "medical assistance" under the statute. CMS cannot imply a broader "benefit package" requirement as an additional mechanism to qualify as "regarded as" "eligible for medical assistance." *Bethesda Health,* 389 F. Supp.

3d at 47 (finding that government's position "informally adds new and limiting phrases to a statute that is already clear when unadorned.").

The Proposed Rule attempts to sidestep these court decisions by categorizing them as relevant only to its current *regulations*, which CMS now proposes to change. The Proposed Rule indicates: "Recently, courts have decided a series of cases[4] interpreting the current language of the *regulation* at §412.106(b)(4) to require CMS to count in the numerator of the Medicaid fraction patient days for which hospitals have received payment from an uncompensated care pool authorized by a section 1115 demonstration and the days of patients who receive premium assistance under a section 1115 demonstration." 87 Fed. Reg. at 28400. CMS is willfully misreading those decisions. The *Forrest General* court, for example, explicitly stated that the DSH provision in the Medicare *statute* precludes the Secretary from excluding section 1115 uncompensated care pool days once the Secretary has approved the demonstration project. The D.C. Circuit cited *Forrest General* favorable in its opinion in *Bethesda Health*. The Secretary cannot escape the holdings of *Forrest General* and *Bethesda Health* by changing his regulatory language.

B. The Proposed Rule Violates Congress's Statutory Scheme

Even if CMS were correct (which it is not) that *Forrest General's* and *Bethesda Health's* holdings apply only to current regulations, the Proposed Rule still must be rejected under the statute's plain text and understanding of Congress's statutory scheme regarding DSH and Medicaid.

The DSH provision clarifies that, in determining the number of patient days for patients who were eligible for medical assistance under a State plan, "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 subchapter XI." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). These provisions must be read in conjunction with other substantive provisions of the Medicaid statute, which constrain the Secretary's authority to make matching payments to States. That statute authorizes the Secretary to make matching Federal payments only when a State plan provides "medical assistance." And "medical assistance" is a limited and defined term. It means the "payment of part or all of the cost of [statutorily-enumerated categories of] care and services or the care and services themselves … for individuals" who fit within statutorily defined eligibility categories. 42 U.S.C. § 1396d(a). The Secretary cannot use his Medicaid expenditure authority to match a State's expenditures that *do not* meet this definition unless he exercises his authority under section 1115(a)(2) of the Social Security Act. That provision grants him the power to "regard as expenditures under the State plan" such costs that "would not otherwise" be matchable.

Turning back to the Medicare DSH statute, once the Secretary exercises this section 1115 matching authority to "regard" as "medical assistance" payments to hospitals for providing inpatient care to an individual, the

[4] *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 Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018).

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Secretary has "regarded" that individual as eligible for a benefit under the approved demonstration project. Thus, when CMS states in the Proposed Rule that it is inappropriate to regard uncompensated care pool payments as "medical assistance," and the individuals whose care is paid for as "eligible" for "medical assistance," the agency ignores the fact that it *necessarily* did regard them as such when CMS agreed to match those payments using its section 1115 authority. If, as CMS asserts, uncompensated care pool payments do not cover "medical assistance," the Secretary exceeds his authority by matching them in the first place. *See Forrest General*, 926 F.3d at 234 (finding the Secretary's assertion that uncompensated care pools do not provide benefits to individuals "mystifying. If uncompensated care pool patients didn't receive benefits under the pool what did they receive? And under what or whose authority did they receive, well, whatever non-benefits they received? Medical assistance is a benefit. And medical assistance is precisely what uncompensated care pool patients got.").

What the courts understood is that the Medicaid statute does not dictate how States must make "payment" for care and services in order for the payment to be considered "medical assistance." For example, the statute does not specify that this payment must be made through the mechanism of traditional health insurance coverage to be considered "medical assistance." In fact, it does not draw any distinctions as to the form in which that payment is made. 42 U.S.C. § 1396d(a). Therefore, any form of payment that is intended to cover the categories of "care and services" identified in the Medicaid statute constitutes "medical assistance."

Moreover, the Medicaid statute sets forth precisely the categories of care and services that the Secretary can pay for as "medical assistance." As noted, inpatient care is one of those categories. Each of the remaining thirty categories is a type of medical care. 42 U.S.C. § 1396d(a). By contrast, enrollment in a specific type of insurance plan is not. By purporting to add an extra-textual condition that payment be made only in a certain way for medical care, the Proposed Rule arbitrarily excludes from the Medicaid numerator individuals who are eligible to receive medical assistance. Under the plain language of section 1395ww(d)(5)(F)(vi)(II), the inpatient days attributable to that eligible individual must be counted in the numerator of the Medicaid fraction. In other words, when section 1395ww(d)(5)(F)(vi)(II) is read together (as it must be) with the Medicaid statute's definition of "medical assistance," the statute leaves no room for CMS to import the additional requirement that an inpatient stay be paid for through an insurance benefits package that the agency deems "comparable" to "Medicaid state plan benefits." 87 Fed. Reg. at 28400.

The Proposed Rule fails even to discuss the agency's proposed reading of the statutory term "medical assistance," and this failure is fatal to the proposal. When it approved the section 1115 demonstration projects for Kansas, Florida, Texas, Tennessee, and other states, CMS necessarily determined that the beneficiaries of these projects would receive "medical assistance" as that term is defined in the Medicaid statute. The Medicaid statute (in relevant part) only appropriates funds for CMS to pay States to furnish "medical assistance," 42 U.S.C. § 1396-1, a limitation that applies both to the Federal government's reimbursement of a State's expenditures under a State Medicaid plan and of a State's expenditures under a section 1115 demonstration project. In keeping with this condition in the Federal appropriations statute, section 1115 specifies that, when the Secretary approves a demonstration project, he necessarily has regarded expenditures under the project as expenditures under the state Medicaid plan. *See* 42 U.S.C. § 1315(a)(2)(A) ("the costs of such project which

would not otherwise be included as expenditures under section … 1903 … shall … be regarded as expenditures under the State plan"). In other words, for CMS to exercise its authority to provide matching Federal funds under a demonstration project, it must determine that the project provides "medical assistance" to eligible individuals. Otherwise, it could not lawfully have approved that project or provided the state with matching federal funds. *See Portland Adventist,* 399 F.3d at 1096.

By approving demonstration projects that, for example, provided for innovative forms of payment for medical services such as the compensation of hospitals through an uncompensated care pool, CMS determined (correctly) that this model of payment provides medical assistance for the beneficiaries whom the project is designed to assist. In other words, the agency "regarded" these beneficiaries as eligible for medical assistance under the demonstration project, and the plain language of the statute requires the inclusion of the patient days for these beneficiaries in the numerator of the Medicaid fraction. *See Forrest General,* 926 F.3d at 234 ("Medical assistance is a benefit. And medical assistance is precisely what [uncompensated care pool] patients got.").

Indeed, CMS's departure from its FY 2022 proposed rule to allow some forms of premium assistance days confirms this point. On the one hand, CMS states that it cannot regard as eligible those individuals who receive medical assistance by means of an uncompensated care pool, yet the other hand, CMS concludes that patients receiving premium assistance through a section 1115 demonstration *can be* so regarded. 87 Fed. Reg. at 28400-01. But, as discuss throughout, section 1886(d)(5)(F)(vi) does not afford CMS the discretion to decide whose days are in or out based on the method of payment that CMS uses to provide medical assistance through a section 1115 demonstration project. Rather, the statute "regard[s] as" eligible for medical assistance any patient who "receive[s] benefits under a demonstration project." *See Forrest General,* 926 F.3d at 228-29 (making clear that the "benefit" is the "helpful or useful effects by reason of a demonstration project's authority"); *see also Bethesda Health*, 389 F. Supp. 3d at 50 (stating that "there is no doubt that uninsured and underinsured patients … received benefits under an uncompensated care pool demonstration project and … were 'regarded as eligible'" under section 1886(d)(5)(F)(vi)). And the court in *HealthAlliance* did not condition its holding on the structure of the insurance product funded by the Massachusetts section 1115 waiver's premium assistance program, or on how much of the premium such assistance actually covered. On the contrary, the only consideration the court said was material was whether such individuals were eligible for inpatient hospital services covered by that assistance. 346 F. Supp. 3d 60.

Inpatient services covered by either premium assistance or an uncompensated care pool, when funded through an approved section 1115 waiver, are a "benefit" in either case because both achieve the same end for the individual patient – payment for inpatient care. CMS's attempt to now consider premium assistance itself the "benefit" misses the point entirely. The benefit is the inpatient care that such premium assistance covers. Uncompensated care pools extend the exact same benefit. The statute therefore compels the inclusion of both types of inpatient days in the Medicare DSH calculation. CMS is drawing unlawful distinctions without meaningful differences in order to achieve the agency's desired policy result.

C. The Secretary Lacks Discretion to Exclude Patient Days in the Medicaid Fraction Numerator for Approved Section 1115 Demonstration Projects

We recognize that CMS proposes to read the DSH provision as conferring it with unlimited discretion to decide whether, or to what extent, to include patient days attributable to beneficiaries of section 1115 demonstration projects in the numerator of the Medicaid fraction. *See* 87 Fed. Reg. at 28399-400 (reasoning that 2005 amendments to the statute "clarified our authority to include or exclude expansion populations from the DSH calculation").

But, consistent with its historic hostility to DSH, CMS's misreading of the statute is driven by the agency's effort to avoid compensating DSH hospitals for the costs of providing services to low-income patients. The statute does indeed confer the agency with discretion as to whether to *approve* a demonstration project, but that discretion is limited. Once the agency has approved a project, it necessarily has "regarded" an individual who receives benefits under that project as eligible for "medical assistance" within the meaning of the Medicaid statute, as that individual is capable of receiving medical assistance under the project in the form of payment for his or her medical care. The statute's otherwise broad grant of discretion does not extend so far as to permit the agency to disregard the statutory definition of "medical assistance" as payment, in whatever form, for medical care.

Indeed, the Secretary has attempted to make this same argument regarding his discretion under the statute only to have that argument squarely rejected in *Forrest General*. There, the Secretary argued that he had the discretion to exclude uncompensated care pool days from the Medicaid fraction's numerator because the statute says that "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." *Forrest General*, 926 F.3d at 233. The Fifth Circuit responded to this argument as "true, but not quite on point. The Secretary *may* exercise discretion, and the Secretary *did* exercise that discretion when he authorized the uncompensated care pool demonstration." *Id*. The Fifth Circuit summed up the extent of the Secretary's discretion on this score: "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." *Id*.

And nor does the statute give CMS the discretion to count only those section 1115 patients it ranks higher in its benefit hierarchy – or to invent new benefits altogether. As discussed above, the Medicaid statute enumerates the 31 types of "care and services" that the Secretary may consider "medical assistance" and fund with matching payments. *See* 42 U.S.C. 1396d(a)(xvii)(1)-(31). While CMS is superficially correct that the statute does not require the agency to count every individual "who is in any way related to a section 1115 demonstration," 87 Fed. Reg. at 28400, the Secretary can only count those individuals who are regarded as eligible because they receive "medical assistance" under a section 1115 demonstration. CMS recounts its decision to only include the days of individuals who receive inpatient hospital services under a section 1115 demonstration and not the days of individuals who receive other defined forms of medical assistance such as family planning services. *Id*. at

28399. But the common thread in those prior rulemakings is that CMS decided to include in the Medicaid fraction days associated with individuals who receive a particular form of medical assistance under a section 1115 demonstration. The thread comes undone here where CMS now proposes to include individuals on the basis of a "benefit" – enrollment in a particular form of health insurance – that *is not an enumerated form of medical assistance*. This extra-textual "benefit" is no benefit at all under either the Medicaid or Medicare statutes. The benefit is the medical assistance for care and services that the Secretary funds through a section 1115 demonstration project. *Forrest General*, 926 F.3d at 234. CMS may not be required to include in the DSH payment all individuals who receive any of the 31 forms of medical assistance defined in the statute. But the agency does not have the authority to include individuals based on something that falls outside the definition of medical assistance altogether.

II. The Proposed Rule Cannot Be Reconciled with the Congressional Purpose in Favor of Compensating Hospitals for Treating Lower-Income Patients.

The Proposed Rule not only disregards the statutory text and statutory scheme, it also runs directly counter to Congress's purposes in enacting the DSH provision. That provision reflects Congress's recognition that ''hospitals that serve a disproportionate numbers of low-income patients have higher Medicare costs per case,'' H.R. Rep. No. 99-241, pt. 1, at 16 (1985), and that those higher costs would not otherwise be compensated by the IPPS payment formula. We do not understand CMS to dispute this point; to the contrary, in the Proposed Rule itself, the agency recognizes that the purpose of the DSH adjustment is to "recognize the higher costs to hospitals of treating low-income individuals covered under Medicaid." 87 Fed. Reg. at 28399. Yet, despite paying this lip service to the Congressional goal, CMS fails entirely to explain how it believes that the Proposed Rule could promote this purpose. For this reason alone, the Proposed Rule's analysis of the statute is fatally incomplete. *See United States v. Cordova*, 806 F.3d 1085, 1099 (D.C. Cir. 2015) ("we must avoid an interpretation that undermines congressional purpose considered as a whole when alternative interpretations consistent with the legislative purpose are available").

The Medicaid statute defines "medical assistance" as the payment for medical care and services, and it enumerates the categories of care and services for which the Secretary may make that payment. It does not draw any distinctions as to the form in which that payment is made. 42 U.S.C. § 1396d(a). Thus, there is no reason to believe that the Hospitals do not incur disproportionate costs for treating the beneficiaries of an uncompensated care pool, and courts have rejected the notion that hospitals that provide care to beneficiaries covered by section 1115 uncompensated care pool demonstration projects are any less entitled to receive reimbursement for their costs. *See Forrest General*, 926 F.3d at 228; *Bethesda Health*, 389 F. Supp. 3d at 47. The Hospitals should receive appropriate compensation for these costs because they are the costs associated with furnishing medical assistance to eligible individuals.

Finally, and at all events, if CMS were to proceed with its revisions to its regulation, it should at the very least specify that its policy applies only to future demonstration projects and not those that are currently approved by the Secretary. For beneficiaries under existing Medicaid demonstration projects, as noted, the agency has already necessarily made the finding, as the time that it approved the project, that these beneficiaries are

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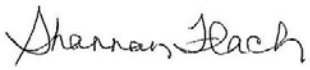
"regarded" as eligible for medical assistance. Hospitals in States with demonstration projects that incorporate uncompensated care pools have acted in reliance on the statute's promise of DSH funding to pay for the treatment of these beneficiaries. The agency should not upset these settled expectations lightly. Even if it were to be assume that CMS has the discretion to redefine the numerator of the Medicaid fraction, then, "such discretion must be exercised prospectively, not after a demonstration project has already been fully approved and implemented and the bill comes due." *Bethesda Health,* 389 F. Supp. 3d at 52.

For these reasons, the Hospitals appreciate the opportunity to offer these comments. **KHA urges you not to finalize your proposal to revise the DSH regulations in a manner that would deny the Hospitals the compensation that they need for the provision of inpatient care to lower-income individuals.**

KHA appreciates your consideration of these issues. We urge CMS to implement the changes outlined above in the FY 2023 final rule in order to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care.

Sincerely,



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