June 17, 2022 ***e-comment submitted electronically***

The Honorable Chiquita Brooks-LaSure
Administrator
Attn: CMS-1771-P
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: **Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates: Proposed Rule (CMS-1771-P)**

Dear Administrator Brooks-LaSure:

The Tennessee Hospital Association (THA), on behalf of its over 140 healthcare facility members appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) rule, CMS-1771-P. 87 Fed. Reg. 28108 (May 10, 2022) ("Proposed Rule").

The Proposed Rule announces CMS' 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' 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).

Tennessee 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 CMS to refrain from adopting this aspect of your Proposed Rule.**[1]

The one common thread in CMS' 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. Federal courts repeatedly 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' 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).

This Proposed Rule is simply the latest iteration of CMS' 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' 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 commentors' concerns and has proposed a similarly unlawful proposal for FY 2023.

[1] THA submitted separate comments on other aspects of the Proposed Rule.

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, they 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' 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' 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 "do[es] 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' reasoning to support this provision of the Proposed Rule is deeply flawed and contrary to the statute. The Proposed Rule states that CMS "do[es] 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) (emphasis added) (finding that Florida 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 (emphasis added). 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' 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' 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' 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' 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' 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' 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 add[s] 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[2] 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 (emphasis added). 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

[2] *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).

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 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 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' 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' 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 "clarif[ied] our authority to include or exclude expansion populations from the DSH calculation").

But, consistent with its historic hostility to DSH, CMS' 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 (emphasis in original). 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*. (emphasis in original). 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*. (emphasis added).

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 ''[h]ospitals that serve a disproportionate numbers of low-income patients have higher [M]edicare 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. Tennessee 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 "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 (internal quotations omitted).

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

If you or your staff wish to discuss this letter, please contact me at anewell@tha.com.

Sincerely,

Amanda Newell
VP of Financial Policy
Tennessee Hospital Association