# Issue Brief

FEDERAL ISSUE BRIEF

*Analysis provided for MHA by Larry Goldberg, Goldberg Consulting*

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## CMS Issues Final Rule Regarding Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage

The Centers for Medicare & Medicaid Services (CMS) have issued a final rule establishing a policy concerning the treatment of patient days associated with persons enrolled in a Medicare Part C (also known as "Medicare Advantage") plan for purposes of calculating a hospital's disproportionate patient percentage for cost reporting periods starting before fiscal year (FY) 2014 in response to the Supreme Court's ruling in Azar v. Allina Health Services, 139 S. Ct. 1804 (June 3, 2019).

A copy of the 72-page rule is currently available at: https://public-inspection.federalregister.gov/2023-12308.pdf. Publication is scheduled for June 9. The rule would become effective 60-days later.

Section 1886(d)(5)(F) of the Act provides for additional Medicare payments to subsection (d) hospitals that serve a significantly disproportionate number of low-income patients.

CMS says that "Including days associated with patients enrolled in Medicare Part C in the calculation of the Medicare fraction and excluding them from the calculation of the numerator of the Medicaid fraction, does not have any additional costs or benefits relative to the Medicare DSH payments that have already been made because those payments were made under the policy reflected in the fiscal year (FY) 2005 IPPS final rule (prior to it having been vacated). The effect of this final action is to provide certainty as to how Part C days will be treated for DSH calculations for cost years not governed by the FY 2014 IPPS/Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) final rule (referred to as "the FY 2014 IPPS final rule"), resolving any uncertainty that may otherwise continue into the future."

In the FY 2004 IPPS proposed rule, in response to questions about whether patient days associated with patients enrolled in an MA plan should be counted in the Medicare fraction or the Medicaid fraction of the hospital's disproportionate patient percentage (DPP) calculation, CMS proposed that once a beneficiary enrolls in an MA plan, patient days attributable to the beneficiary would not be included in the Medicare fraction of the (DPP). Instead, those patient days would be included in the numerator of the Medicaid fraction, if the patient was also eligible for Medicaid. In the FY 2004 IPPS final rule, CMS did not respond to public comments on this proposal, "due to the volume and nature of the public comments received, and CMS indicated that it would address those comments later in a separate document. In the FY 2005 IPPS proposed rule, CMS stated that it planned to address the FY 2004 comments regarding MA days in the IPPS final rule for FY 2005. After considering comments on this proposal, CMS decided not to implement the policy as proposed."

Instead, in the FY 2005 IPPS final rule (hereinafter referred to as "the FY 2005 IPPS final rule"), CMS determined that, under § 412.106(b)(2)(i) of the regulations, MA patient days should be counted in the Medicare fraction of the DPP calculation.

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After considering the comments received, CMS is finalizing its proposal that a patient enrolled in an MA plan remains entitled to benefits under Medicare Part A and will be counted in the Medicare fraction of the DPP and not counted in the numerator of the Medicaid fraction.

**Comment**

"In the August 2020 proposed rule, we explained that DSH payments made under our proposed policy, which we are finalizing here, would not differ from hospitals' historical DSH payments. We also stated that Medicare DSH payments have already been made under the policy reflected in the proposal (prior to the previous rule which governed the treatment of these days having been vacated by the Court of Appeals, which was affirmed by the Supreme Court's decision). Therefore, the effect of the August 2020 proposed rule being finalized here would be to avoid the consequences of legal ambiguity created by the absence of any properly promulgated regulation that would otherwise continue into the future; the resulting costs, benefits, and transfer impacts are thus highly uncertain."

The majority of this rule is addresses comments received to the August 2020 proposed rule. Many of those comments objected to CMS making a "retroactive ruling," regarding the period before 2014 (October 1, 2013).

CMS provides the following table:

**ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED MEDICARE DSH EXPENDITURES PRIOR TO FY 2014**

| **Category** | **Transfers** |
|---|---|
| Annualized Monetized Transfers | $0 - $0.6 billion |
| From Whom to Whom | Federal Government to Hospitals Receiving Medicare DSH Payments |

Interesting that the range of DSH expenditures prior to 2014 is so large at $600 million.