Additional Questions for the Record
for Deputy Administrator and Director Daniel Tsai
House Committee on Energy and Commerce, Subcommittee on Health
Hearing on April 30, 2024
"Legislative Proposals to Increase Medicaid Access and Improve Program Integrity"

The Honorable Gus Bilirakis

1. I have been hearing concerns from my constituents about continued degradation of Medicaid rates in the state for some critical healthcare services, like laboratory tests, which are currently benchmarked at about 58 percent of Medicare and have proposed cuts of up to 10 percent in 2024. I am particularly concerned that proposed payment reductions for tests with a high need across Florida may lead to negative impacts on public health and patient care within the state. How can we ensure that Medicaid recipients, including those in my state of Florida, have continued access to essential healthcare services, including clinical laboratory testing, and what is the Centers for Medicaid doing to ensure appropriate payment for providers?

Answer

Ensuring beneficiaries can access covered services is a critical function of the Medicaid program and a top priority of CMS. On April 22, 2024, CMS issued two final rules, *Ensuring Access to Medicaid Services* (Access rule) and *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance and Quality* (Managed Care rule) to advance access to care and quality of care and improve health outcomes for Medicaid beneficiaries across fee-for-service (FFS) and managed care delivery systems. CMS shares your goal to support access to clinical lab testing and other needed services for Medicaid beneficiaries. Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that Medicaid payments be "consistent with efficiency, economy, and quality of care". In meeting these requirements states have flexibility in establishing and updating physician and practitioner payment rates. CMS ensures that states meet their obligation under Medicaid law to provide payment rates that support access to care.

2. Are you at all concerned about the ability of providers in Florida to continue caring for low-income and uninsured patients following the rule change in the 2024 IPPS rule that days of patients for which hospitals are paid from 1115 demonstration-authorized uncompensated or low-income care pools may not be included in the Medicaid fraction?

3. With the rule change in the 2024 IPPS rule that days of patients for which hospitals are paid from 1115 demonstration-authorized uncompensated care pools may not be included in the Medicaid fraction, are you at all concerned that this might have a negative impact on the ability of providers in Florida in caring for these very same low-income and uninsured patients?

4. How do you attempt to rationalize this departure in CMS' long-time interpretation, spanning multiple Administrations, regarding waiver days in the Medicaid fraction utilizing uncompensated or low-income care pools?

Answer 2-4

On February 28, 2023, CMS issued an NPRM, *Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated With Section 1115 Demonstrations in the Medicaid Fraction*, that proposed to explicitly exclude from the

disproportionate patient percentage (DPP) Medicaid fraction numerator the days of patients with uncompensated care costs for which a hospital is paid from an uncompensated/undercompensated care funding pool authorized by a section 1115 demonstration project. In the fiscal year (FY) 2024 Inpatient Prospective Payment System (IPPS) final rule, CMS finalized these changes to the regulation governing the counting of days associated with individuals eligible for certain benefits provided by section 1115 demonstrations in the Medicaid fraction of a hospital's DPP (88 Fed. Reg. 58640).

CMS's overall policy for including section 1115 demonstration days in the DPP Medicaid fraction numerator rested on the presumption that the demonstration provided a package of health insurance benefits that were essentially the same as what a State provided to its Medicaid population. More recently, however, section 1115 demonstrations have been used to authorize funding a limited and narrowly circumscribed set of payments to hospitals. For example, some section 1115 demonstrations include funding for uncompensated/undercompensated care pools that help to offset hospitals' costs for treating uninsured and underinsured individuals. These pools do not extend health insurance to such individuals nor are they similar to the package of health insurance benefits provided to participants in a State's Medicaid program under the State plan. Rather, such funding pools "promote the objectives of Medicaid" as required under section 1115 of the Act, but they do so by providing funds directly to hospitals, rather than providing health insurance to patients. These pools help hospitals that treat the uninsured and underinsured stay financially viable so they can treat Medicaid patients.

By providing hospitals payment based on their uncompensated care costs, the pools directly benefit those providers, and, in turn, albeit less directly, the patients they serve. Unlike demonstrations that expand the group of people who receive health insurance beyond those groups eligible under the State plan and unlike Medicaid itself, however, uncompensated/undercompensated care pools do not provide inpatient health insurance to patients or, like insurance, make payments on behalf of specific, covered individuals. In these ways, payments from these pools serve essentially the same function as Medicaid DSH payments under sections 1902(a)(13)(A)(iv) and 1923 of the Act, which are also title XIX payments to hospitals meant to subsidize the cost of treating the uninsured, underinsured, and low-income patients and that promote the hospitals' financial viability and ability to continue treating Medicaid patients. Notably, as numerous Federal courts across the country have universally held, the patients whose care costs are indirectly offset by such *Medicaid DSH* payments are not "eligible for medical assistance" under the *Medicare DSH* statute and are not included in the DPP Medicaid fraction numerator.

We also note that demonstrations can simultaneously authorize different programs within a single demonstration, thereby creating a group of people the Secretary regards as Medicaid eligible because they receive health insurance through the demonstration, while also creating a separate category of payments that do not provide health insurance to individuals, such as uncompensated/undercompensated care pools for providers.

Nothing in the final policy diminishes or eliminates any benefit low-income patients receive from section 1115 demonstrations, including any "benefit" a patient might receive by having some part of their hospital bill paid for by an uncompensated care pool authorized by a demonstration or by receiving some portion of the cost of their premium paid for with premium assistance authorized by a demonstration; such patient will remain in the same position whether or not a hospital is permitted to include their patient day in the hospital's DPP Medicaid fraction numerator. The policies we finalized merely seek to clarify which days patients provided certain benefits under a Medicaid section 1115 demonstration may also be counted in calculating the Medicare DSH payment adjustment. And because the purpose of the DSH payment adjustment is not to provide as much money as possible to hospitals, but to reflect payment for a hospital's provision of a disproportionate share of care to low-income patients, we believe we have properly considered the effects of the proposal on such patients.