CMS Rulings

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Ruling No.: **CMS-1498-R3** Date: **March 4, 2024**

CMS Rulings are decisions of the Administrator that serve as precedent final opinions and orders.

CMS Rulings are binding on all Centers for Medicare & Medicaid Services (CMS) components, Medicare Administrative Contractors (MACs), the Provider Reimbursement Review Board, the Medicare Geographic Classification Review Board, and Administrative Law Judges of the Social Security Administration who hear Medicare appeals. These decisions promote consistency in application of policy and adjudication of disputes.

This Ruling provides notice that CMS is hereby revoking CMS Ruling 1498-R2 to comply with what the Supreme Court in *Becerra v. Empire Health Foundation, for Valley Hospital Medical Center*, 597 U.S. 424 (2022) (*Empire Health*), has concluded is the Medicare statute's plain meaning. In *Empire Health*, the Supreme Court held that hospital patient days for Medicare beneficiaries for which Medicare does not pay, such as days on which a beneficiary has exhausted their benefits for a spell of illness, are nonetheless days on which beneficiaries are "entitled to benefits under part A" and thus belong in the Medicare fraction of the disproportionate patient percentage used to calculate providers' Medicare disproportionate share hospital (DSH) inpatient prospective payment system (IPPS) payment adjustments. CMS Ruling 1498-R2 allows providers to elect whether to receive Medicare fractions calculated based on "total days" or instead based on "covered days" for cost reporting periods with

discharges pre-dating October 1, 2004. *Empire Health* confirmed that the Medicare statute requires the calculation of Medicare fractions to be based on total days such that the choice permitted under CMS Ruling 1498-R2 of a calculation based on covered days is inconsistent with the Medicare statute, and so the agency hereby withdraws CMS Ruling 1498-R2. This Ruling requires, for each properly pending claim in a DSH appeal or open cost report, including those involving patient discharges pre-dating October 1, 2004, that the agency and MACs calculate or recalculate the provider's Medicare fraction in accordance with the Medicare statute as construed in *Empire Health* – that is, based on total days, not covered days.

MEDICARE PROGRAM

HOSPITAL INSURANCE (PART A)

Hospital Insurance (Part A); Disproportionate Share Hospital Payments: Inclusion of Total Days in the Medicare Fraction.

CITATIONS: Section 1886(d)(5)(F) of the Social Security Act (the Act) (42 U.S.C. 1395ww(d)(5)(F)).

BACKGROUND

Under the IPPS, which is set forth in section 1886(d) of the Act, inpatient hospital services for Medicare patients are paid based on nationally applicable payment rates. In addition, section 1886(d)(5) of the Act provides for various adjustments to the IPPS rates. Under section 1886(d)(5)(F) of the Act, a hospital paid under IPPS may qualify for a DSH payment adjustment if the hospital provides inpatient services for a significantly disproportionate number of low-income patients. One means of determining

a hospital's DSH payment adjustment for a cost reporting period requires the calculation of its "disproportionate patient percentage," which is the sum of two fractions. First, under section 1886(d)(5)(F)(vi)(I) of the Act, the Medicare fraction (also referred to as the Medicare-SSI fraction, SSI fraction, or SSI ratio) is the number of the hospital's patient days for patients who (for such days) were entitled to both benefits under Medicare Part A and supplemental security income (SSI) benefits under Title XVI of the Act, divided by the total number of the hospital's patient days for patients who (for such days) were entitled to Medicare Part A benefits. Second, under section 1886(d)(5)(F)(vi)(II) of the Act, the Medicaid fraction is the number of the hospital's inpatient days for patients who (for such days) were eligible for medical assistance under a State Medicaid plan approved under Title XIX of the Act (42 U.S.C. 1396 et seq.) but who were not entitled to benefits under Medicare Part A, divided by the total number of the hospital's inpatient days. The DSH payment adjustment has been the subject of substantial litigation, including a recent decision by the Supreme Court in *Empire Health*.

Prior to fiscal year (FY) 2005, when we calculated a hospital's DSH adjustment we included in the Medicare fraction only "covered" Medicare patient days – that is, days paid by Medicare (42 CFR 412.106(b)(2)(i) (2003)). The "covered" days approach was based on an interpretation of the statute's parenthetical phrase "(for such days)." The Secretary revisited that approach in a 2004 rulemaking (for more information, we refer readers to the FY 2005 IPPS/LTCH PPS final rule, 69 FR 49098) following a series of judicial decisions rejecting a parallel interpretation of the "(for such days)" language in the statutory definition of the numerator of the Medicaid fraction as counting only patient days actually paid by the Medicaid program. Thus, the "covered days" rule was the relevant Medicare payment policy until it was revised and replaced effective October 1, 2004.

We issued CMS Ruling 1498-R on April 28, 2010. CMS Ruling 1498-R set forth our view that the statute required Medicare fractions to be calculated on the basis of "total days," not "covered days,"

and so governed the calculation of the Medicare fraction, notwithstanding the pre-FY 2005 "covered days" rule. On April 22, 2015, we issued CMS Ruling 1498-R2, which modified and amended CMS Ruling 1498-R insofar as it required recalculation of the Medicare fraction for cost reports involving patient discharges prior to October 1, 2004. CMS Ruling 1498-R2 responded to the D.C. Circuit's decision in *Catholic Health Initiatives v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013) (*Catholic Health*), which upheld the Secretary's policy of excluding dual-eligible exhausted coverage days from the numerator of the Medicaid fraction before the Secretary had explicitly addressed that issue through rulemaking. The Secretary excluded such days from the Medicaid fraction because she interpreted the Medicare statute to mean that exhausted benefit and other unpaid Medicare days are attributable to patients "entitled to benefits under part A" and thus excluded from the Medicaid fraction.

The court of appeals held that the "Department's interpretation is the better one," but "is not quite inevitable." (*Catholic Health,*718 F.3d at 920.) Because *Catholic Health* held that the Medicare statute itself did not definitively resolve the issue of whether Medicare beneficiaries remain "entitled to benefits under part A" on patient days for which Medicare does not pay, CMS Ruling 1498-R2 permitted providers to elect whether to receive Medicare-SSI fractions on the basis of "covered days" (consistent with the pre-FY 2005 regulation) or "total days" for FY 2004 and earlier (or, for hospital-specific cost reporting periods, for those periods that included patient discharges occurring before October 1, 2004).

The Supreme Court has since held in *Empire Health* that the statute does definitively resolve the issue of whether Medicare beneficiaries remain entitled to benefits under Part A on patient days for which Medicare does not pay. The Court concluded that the statute "disclose[s] a surprisingly clear meaning," that beneficiaries remain entitled to Part A benefits on such days and thus the Medicare fraction includes total days, not just covered days. (597 U.S. at 434.) The Supreme Court also

definitively resolved the meaning of the parenthetical "(for such days)" in the statutory definition of the Medicare fraction, rejecting the provider's contention that the phrase changed the consistent meaning of "entitled to benefits under Part A" from "meeting Medicare's statutory (age or disability) criteria on the days in question," to "actually receiving Medicare payments." (*Id*. at 440.) The Court determined that the "for such days" parenthetical "instead works as HHS says: hand in hand with the ordinary statutory meaning of 'entitled to [Part A] benefits.'" (*Id.)*

We recognize that hospitals may have anticipated receiving greater Medicare reimbursement for still-open pre-FY 2005 cost reporting periods pursuant to CMS Ruling 1498-R2 in circumstances where the "covered" days limitation would have resulted in a larger DSH adjustment. However, we are obliged to apply the statute as Congress wrote it and in accordance with the statutory meaning that has now been settled by the Supreme Court. Providers whose pending appeals or open cost reports would have been, but for the issuance of this Ruling, subject to CMS Ruling 1498-R2 will have the right to appeal their notices of program reimbursement (NPRs) or revised NPRs that issue and reflect the withdrawal of CMS Ruling 1498-R2.

IMPLEMENTATION OF THIS RULING

CMS Ruling 1498-R2 is hereby withdrawn and may not be relied upon in resolving any open cost report or pending administrative appeals of the Medicare "total" versus "covered" benefit days issue described previously and addressed in *Empire Health*. Instead, for all open or appealed cost reports that would otherwise have fallen within the scope of CMS Ruling 1498-R2, MACs must calculate Medicare fractions based on total days in accordance with the statute and this Ruling.

RULING

It is CMS's Ruling that, for each properly pending appealed or open cost report that would otherwise have been subject to CMS Ruling 1498-R2, the agency and the MACs will calculate or recalculate the provider's DSH adjustment in accordance with the Medicare statute and *Empire Health* – that is, by calculating or recalculating the provider's Medicare fraction based on total days.

It is also CMS' Ruling that, in accordance with 42 CFR 405.1801(a) and 405.1885(c)(1) and (2), this Ruling is not an appropriate basis for reopening any final determination of the Secretary or a MAC or of any decision by a reviewing entity. Accordingly, it is hereby held that the administrative appeals tribunals and MACs may not reopen any determination or decision with respect to the "total" versus "covered" benefit days Medicare-SSI fraction issue.

Dated: March 4, 2024

March 4, 2024 **EFFECTIVE DATE**

This Ruling is effective March 4, 2024.

Dated: March 4, 2024

Chiquita Brooks-LaSure,

Administrator,

Centers for Medicare & Medicaid Services.