

**aSupporting Statement – Part A**

**Medicare Disproportionate Share Hospital (DSH) Payments:  
Counting Days Associated With Section 1115 Demonstrations in the  
Medicaid Fraction**

**Background**

Medicare makes additional payments to hospitals that serve a disproportionate percentage of low-income patients. Eligibility for and the amount of disproportionate share hospital (DSH) payments are generally based on the hospital's geographic designation, the number of beds in the hospital, and the level of the hospital's disproportionate patient percentage (DPP). The DPP is calculated using several factors, including the number of inpatient days associated with individuals eligible for Medicaid. States use section 1115(a) demonstrations to test changes to their Medicaid programs that generally cannot be made using other Medicaid authorities, including to provide health insurance to groups that generally could not or have not been made eligible for "medical assistance under a State plan approved under title XIX" (Medicaid benefits). Under the statute, the patient days of certain patients that receive Medicaid benefits under a section 1115 demonstration may be regarded as eligible for Medicaid for purposes of calculating the Medicare DSH adjustment.

The final rule (CMS-1788-F, RIN 0938-AV17) refines our policy for counting inpatient days associated with patients who are regarded as eligible for medical assistance under a State Medicaid plan to include those who receive health insurance authorized by a section 1115 demonstration or patients who pay for all of the cost of such health insurance with premium assistance authorized by a section 1115 demonstration and such health insurance provides inpatient coverage. The revisions to the regulation are effective for discharges occurring on or after October 1, 2023.

This collection of information request seeks approval for collecting certain information related to individuals eligible for certain 1115 demonstrations which include premium assistance benefits in order to be included in the calculation of the DSH adjustment.

**A. Justification**

**1. Need and Legal Basis**

Section 1886(d)(5)(F) of the Social Security Act (the Act) provides for additional Medicare payments to subsection (d) hospitals that serve a significantly disproportionate number of low-income patients. The regulations implementing the DSH payment adjustment are in 42 CFR 412.106. The statute specifies two methods by which a hospital may qualify for the

## Medicare DSH adjustment.

- Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a Medicare DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to patients with low incomes. This method is commonly referred to as the “Pickle method.”
- The second method for qualifying for the DSH payment adjustment, which is the most common, is based on a complex statutory formula under which the DSH payment adjustment is based on the hospital’s geographic designation, the number of beds in the hospital, and the level of the hospital’s DPP. A hospital’s DPP is the sum of two fractions: The “Medicare fraction” and the “Medicaid fraction.” The Medicare fraction is computed by dividing the number of the hospital’s inpatient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the hospital’s total number of patient days furnished to patients entitled to benefits under Medicare Part A. The Medicaid fraction is computed by dividing the hospital’s number of inpatient days furnished to patients who, for such days, were eligible for Medicaid, but were not entitled to benefits under Medicare Part A, by the hospital’s total number of inpatient days in the same period.

States use demonstrations authorized under section 1115(a) of the Act to test changes to their Medicaid programs that generally cannot be made using other Medicaid authorities, including to provide health insurance to groups that generally could not or have not been made eligible for “medical assistance under a State plan approved under title XIX” (Medicaid benefits). These groups, commonly referred to as expansion populations or expansion waiver groups, are specific, finite groups defined in the demonstration approval letter and special terms and conditions for each demonstration.

In the proposed rule (CMS-1788-P, RIN 0938-AV17), we proposed to refine our policy for counting inpatient days associated with patients who are regarded as eligible for medical assistance under a State Medicaid plan to include those who receive health insurance authorized by a section 1115 demonstration or patients who pay for all of the premium cost of such health insurance with premium assistance authorized by a section 1115 demonstration and such health insurance provides inpatient coverage. We finalized these proposed policy changes in the final rule (CMS-1778-F, RIN 0938-AV17). Specifically, under this finalized policy we revised our regulations at § 412.106(b)(4) to explicitly reflect our interpretation of the language “regarded as” “eligible for medical assistance under a State plan approved under title XIX” in section 1886(d)(5)(F)(vi) of the Act, to mean patients who receive health insurance through a section 1115 demonstration itself or purchase such insurance with the use of premium assistance provided by a section 1115 demonstration. Moreover, of the groups we “regard” as Medicaid eligible, we specified that only the days of those individuals who obtain health insurance that includes inpatient hospital insurance, and if bought with premium assistance, for which the premium assistance is equal to 100 percent of the cost of the premium, will be included in the Medicaid fraction of the DSH calculation, provided the

patient is not also entitled to Medicare Part A. Moreover, we are explicitly excluding from the Medicare DSH Medicaid fraction the days of patients with uncompensated care costs for which a hospital is paid from a funding pool authorized by a section 1115 demonstration project. These changes are effective for discharges occurring on or after October 1, 2023.

This collection of information request describes the changes in burden associated with collecting information from hospitals for certain 1115 demonstrations associated with this policy. Specifically, under this collection of information request, we discuss the burden associated with collecting information related to certain section 1115 demonstrations which provide premium assistance benefits in order to be included in the calculation of the DSH adjustment. CMS has made updates to this collection, as applicable, based on the policies adopted after consideration of public comments in a final rule.

2. Information Users

Hospitals currently collect, and submit to CMS, information related to the number of patient days associated with individuals eligible for Medicaid, including those eligible for certain section 1115 demonstrations. This information is used to calculate a hospital's DPP, and, as applicable, the amount of the hospital's DSH adjustment. Hospitals would collect the information under this collection either through regular communication channels with State Medicaid agencies and State departments of health; or directly from patients in the regular manner in which hospitals obtain payor health information at the point of service. The information will be for the same purposes.

3. Use of Information Technology

Under our finalized policy, the information on whether a patient's insurance premiums are paid for by premium assistance under a section 1115 demonstration that hospitals would collect can be done electronically in part through internet searches and through email with insurers, State Medicaid agencies, and State departments of health. Additional verification will likely occur by hospitals confirming verbally with patients. Under the finalized policy, hospitals only need to submit to CMS aggregate information about total day counts associated with section 1115 demonstrations that provide premium assistance on the S-2 worksheet of their Medicare cost reports.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

CMS requires all hospitals, regardless of size, to complete the cost report, including the information related to section 1115 demonstration days regarded as Medicaid days. CMS collects the form as infrequently as possible (annually) and only those data items necessary to

determine the appropriate reimbursement rates are required.

6. Less Frequent Collection

Hospital cost reports are based on the providers' financial and statistical records, and hospitals attest to the accuracy of the data when submitting their cost reports. A less frequent collection would adversely affect accurate hospital payments.

7. Special Circumstances

There are no special circumstances that would require this information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register/Outside Consultation

The proposed rule (CMS-1788-P, RIN 0938-AV17) solicits comments on the proposed policies. The 60-day Federal Register notice published as part of the proposed rule on February 28, 2023 (88 FR 12623). We received no public comments on the information collection requirements for the proposed policies.

The final rule (CMS-1788-F; RIN 0938-AV17) published on August 28, 2023 (88 FR 58640).

9. Payments/Gifts to Respondents

Information submitted by hospitals under this collection of information request may increase a hospital's DSH adjustment, and ultimately Medicare reimbursement, relative to what it would have been without such information. CMS makes no payments or gifts to respondents for completion of this data collection. CMS issues claims payments for covered services

provided to Medicare beneficiaries. The information collected and reported to CMS is used to determine accurate payments to a hospital.

10. Confidentiality

Confidentiality is not assured for information submitted in cost reports.

11. Sensitive Questions

There are no questions of a sensitive nature.

12. Burden Estimates (Hours & Wages)

The burden associated with this finalized policy is the time for hospitals to determine whether the premium payments for a patient’s insurance are paid for by a section 1115 premium assistance program. We estimate 340 hospitals will be affected by this requirement, which is the total number of Medicare-certified “subsection (d)” hospitals (that is, IPPS hospitals paid under section 1886 of the Act) in the eight states which currently operate approved premium assistance section 1115 demonstrations. We estimate this burden to be \$20,899,060. In addition, we have estimated the additional burden to identify whether any non Medicaid-eligible patients have received premium assistance that covers less than 100 percent of their costs. We estimate that an additional 1.5 minutes is needed for this additional effort for an estimated 56 hospitals. We estimate this burden to be \$479,322.

The estimated total burden is \$21,378,382 (\$20,899,060 + \$479,322) a year as follows:

1,978,141 inquiries a year x 0.25 hours per inquiry x (wages of \$21.13/hour x 2 (fringe benefits) per hour = \$20,899,060 per year; plus an additional 453,689 inquiries x 0.025 hours per x (wages of \$21.13/hour x 2 (fringe benefits) per hour = \$479,322 per year to identify whether any non-Medicaid-eligible patients have received premium assistance that covers less than 100 percent of their costs .

The number of inquiries is based on discharges reported on hospitals’ 2019 cost reports and is calculated by subtracting total FFY 2019 Medicare discharges from total FFY 2019 discharges for all payers for all subsection (d) hospitals in each state with a currently approved premium support demonstration. We used annualized discharges for both Medicare and all payer discharge figures rather than actual discharges, as some hospitals’ cost reports do not provide data for an entire year. We believe that under this policy, hospitals in those states would need to conduct inquiries for all patients with insurance other than Medicare to determine whether a patient’s premiums are paid for by premium assistance provided by a section 1115 demonstration. The estimates difference between all payer annualized discharges and annualized Medicare discharges was 1,978,141 for FFY 2019.

<b>All Discharges, Annualized</b>	<b>Medicare Discharges, Annualized</b>	<b>All Discharges, Annualized Less</b>
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	(FFY2019)	(FFY2019)	Medicare Discharges, Annualized
AR	307,799	104,764	203,035
CT	343,104	101,846	241,258
MA	718,717	265,028	453,689
OK	418,774	137,469	281,305
RI	108,865	27,802	81,063
TN	749,097	211,098	537,999
UT	202,617	43,893	158,724
VT	38,540	17,472	21,068
<b>Total</b>	<b>2,887,513</b>	<b>909,372</b>	<b>1,978,141</b>

We estimate that hospitals will use their existing communication methods that are in place to verify insurance information when collecting the information for this collection. We estimate that verifying section 1115 premium assistance status for non-Medicare for an individual will take, on average, approximately 15 minutes (or 0.25 hours). We believe that information clerks will be making these inquiries. Based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2021) at [https://www.bls.gov/oes/current/oes\\_nat.htm](https://www.bls.gov/oes/current/oes_nat.htm) for Category 43-4199, Information and Record Clerks, All Other, the mean hourly wage for an Information and Record Clerk is \$21.13. We have added 100 percent for fringe and overhead benefits, which calculates to \$42.26 per hour. In addition, we believe hospitals in Massachusetts would need to conduct inquiries for all patients eligible for a section 1115 demonstration with insurance other than Medicare to determine whether those patients have received premium assistance that covers 100 percent of their premium costs. To account for circumstances where additional time may be needed, we estimate this additional verification will take 1.5 minutes per inquiry for the 56 hospitals in Massachusetts, which have an estimated difference between all payer annualized discharges and annualized Medicare discharges of 453,689 for FFY 2019.

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

CMS, through the Medicare Administrative Contractors (MACs), will review and audit the Medicaid days reported on the Medicare cost report, S-2 worksheet for the 340 hospitals that we project will report inpatient days associated with 1115 demonstrations which provide premium assistance benefits. We estimate that one hundred percent of submissions will be audited the first year the information associated with this collection is submitted. We also estimate that it will take 40 hours for MAC staff to process and verify the information submitted by the hospital for each cost report. This time estimate is based on the professional judgment of staff members at the Centers for Medicare & Medicaid Services who work with MAC staff. We estimate the total hourly burden for one year will be 13,600 hours (340 cost

reports x 40 hours per cost report).

MAC auditors will be receiving and processing the Medicaid days information reported on the cost report. Based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2021) at [http://www.bls.gov/oes/current/oes\\_nat.htm#](http://www.bls.gov/oes/current/oes_nat.htm#) for Category 13-2011, accountants and auditors, the mean hourly wage for accounts and auditors is \$40.37. We have added 100 percent for fringe and overhead benefits, which calculates to \$80.74 per hour. We estimate the total annual cost to the Federal government is \$1,098,064 (13,600 hours x \$80.74 per hour).

15. Changes to Burden/Program Changes

This is a new collection associated with a finalized proposal. As detailed above, the burden associated with this finalized policy is the time for hospitals in certain states to determine whether the premium payments for a patient's insurance are paid for by a section 1115 premium assistance program. In the proposal we estimated 310 hospitals in seven states would be affected by this requirement. In this collection request, the estimated number increased to 340 hospitals to include the burden for hospitals in an eighth state, Connecticut, which is also affected by this requirement. The burden is adjusted accordingly. The proposed cost to the Federal Government has also increased due to the additional hospitals and is adjusted accordingly.

16. Publication/Tabulation Dates

The information collected under this policy will not be published. Only aggregate Medicaid days, including section 1115 demonstration days regarded as Medicaid days, are reported on the cost report.

17. Expiration Date

There are no special circumstances regarding the expiration date, which will be determined upon receiving OMB approval.

18. Certification Statement

There are no exceptions to the certification statement.