APPENDIX A

CHILDREN'S HOSPITAL ASSOCIATION OF TEXAS, et al., Appellees

v.

Alex Michael AZAR, II, in his official capacity, Secretary, Department of Health and Human Services, et al., Appellants

No. 18-5135

United States Court of Appeals
District of Columbia Circuit

Argued April 9, 2019

Decided August 13, 2019

Appeal from the United States District Court for the District of Columbia (No. 1:17-cv-00844)

Tara S. Morrissey, Attorney, United States Department of Justice, argued the cause for the appellants. Mark B. Stern and Samantha L. Chaifetz, Attorneys, Robert P. Charrow, General Counsel, United States Department of Health & Human Services, Janice L. Hoffman, Associate General Counsel, Susan M. Lyons, Deputy Associate General Counsel, and David L. Hoskins, Attorney, were with her on brief.

David B. Salmons, Washington, DC, argued the cause for the appellees. Geraldine E. Edens, Michael E. Kenneally, Washington, DC, and Susan Feigin Harris were with him on brief. Christopher H. Marraro, Washington, DC, entered an appearance.

Daniel G. Jarcho and Michael H. Park, Washington, DC, were on brief for the amicus curiae Children's Hospital Association in support of the appellees and in support of affirmance.

Before: Henderson and Rogers, Circuit Judges, and Sentelle, Senior Circuit Judge.

Karen LeCraft Henderson, Circuit Judge

Under the Medicaid Act (Act), the federal government provides each state funds for distribution to hospitals that serve a disproportionate number of low-income patients. *See* 42 U.S.C. § 1396-1. A state distributes the funds through Disproportionate Share Hospital (DSH) payments. *See id.* § 1396r-4(b), (c). A hospital may not receive a DSH payment that exceeds its "costs incurred" in furnishing hospital services to low-income patients. *Id.* § 1396r-4(g)(1)(A). "Costs incurred" are, *inter alia*, "determined by the Secretary" of the United States Department of Health and Human Services (Secretary). *Id.* In 2017, the Secretary promulgated a regulation defining "costs incurred." Medicaid Program; Disproportionate Share Hospital Payments–Treatment of Third Party Payers in Calculating Uncompensated Care Costs, 82 Fed. Reg. 16,114, 16,122 (Apr. 3, 2017) ("2017 Rule"). The plaintiffs, a group of children's hospitals that receive DSH payments, argue that the regulatory definition is contrary to the Medicaid Act and otherwise arbitrary and capricious. The district court agreed that the definition is inconsistent with the Act and vacated the 2017 Rule.

Children's Hosp. Ass'n of Tex. v. Azar, 300 F. Supp. 3d 190 (D.D.C. 2018). We now reverse.

I. Background

"Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). States implement their own Medicaid plans, subject to the federal government's review and approval. *See* 42 U.S.C. § 1396a. Treating the indigent proves costly even for hospitals that receive Medicaid payments. Indeed, not all hospital services are covered by Medicaid; not all costs associated with covered services are allowed by Medicaid; and Medicaid does not fully reimburse hospitals for all allowable costs associated with covered services. Recognizing this, the Congress authorizes supplemental payments ("DSH payments") to hospitals that serve a disproportionate share of low-income patients ("DSH hospitals"). 42 U.S.C. § 1396a(13)(A)(iv) (requiring that Medicaid payment rates "take into account (in a manner consistent with section 1396r-4 of this title) the situation of hospitals which serve a disproportionate number of low-income patients with special needs"); 42 U.S.C. § 1396r-4 (entitled "Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals"). There is both a state-specific and a hospital-specific limit on DSH payments. The state-specific limit—not at issue in this case—dictates that

all DSH payments to DSH hospitals within a single state must be drawn from the same pool of federal funds. *See* 42 U.S.C. § 1396r-4(f). The hospital-specific limit, which is at issue in this case, dictates that a DSH payment to a single hospital cannot exceed:

> [T]he costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

42 U.S.C. § 1396r-4(g)(1)(A). This sentence—although not the picture of clarity—establishes a few matters clearly. A DSH hospital cannot receive a DSH payment that exceeds its "costs incurred during the year of furnishing hospital services" to Medicaid-eligible and uninsured individuals. The Secretary is assigned the task of determining "costs incurred." And "costs incurred" are "net of payments under this subchapter, other than under this section, and by uninsured patients"; in other words, payments made by Medicaid and uninsured individuals *must be* subtracted out when calculating a hospital's "costs incurred." The dispute here is about whether payments made by Medicare and private insurers *should also be* subtracted out.

In 2003, the Congress enacted legislation requiring states to submit annual reports and independent certified audits regarding their DSH programs. *See* 42 U.S.C. § 1396r-4(j). The reports must identify which hospitals receive DSH payments and the audits must verify that the DSH payments comply with the statutory requirements. *Id.*

In 2008, the Centers for Medicare & Medicaid Services (CMS), using the authority delegated it by the Secretary, promulgated a regulation implementing the reporting and auditing requirements. Medicaid Program; Disproportionate Share Hospital Payments, 73 Fed. Reg. 77,904 (Dec. 19, 2008) ("2008 Rule"). The 2008 Rule provided that each state must report to CMS the cost of each DSH hospital's "Total Medicaid Uncompensated Care." *Id.* at 77,950 (codified at 42 C.F.R. § 447.299(c)(11)). The 2008 Rule did not state whether third-party payments, including payments by Medicare and private insurers, were meant to be included in calculating the amount. *See id.* Three courts of appeals concluded from this silence that the 2008 Rule left uncertain whether these payments should be considered. *See Children's Health Care v. Ctrs. for Medicare & Medicaid Servs.*, 900 F.3d 1022, 1025 (8th Cir. 2018); *Children's Hosp. of the King's Daughters, Inc. v. Azar*, 896 F.3d 615, 621 (4th Cir. 2018); *N.H. Hosp. Ass'n v. Azar*, 887 F.3d 62, 75 (1st Cir. 2018). One court of appeals concluded that the 2008 Rule made clear that these payments *should not* be considered. *See Tenn. Hosp. Ass'n v. Azar*, 908 F.3d 1029, 1043–44 (6th Cir. 2018).

In 2010, CMS posted a Frequently Asked Questions document on its website clarifying that payments made by Medicare and private insurers *should* be included. *See* CMS, *Additional Information on the DSH Reporting and Audit Requirements*, FAQs 33 and 34 (2010), https://www.medicaid.gov/medicaid/finance/downloads/part-1-additional-info-on-dsh-reporting-and-auditing.pdf. A number of hospitals brought suit, arguing that the FAQs posting was invalid because it represented a substantive policy change without notice and an opportunity for public comment. In response, CMS issued a notice of proposed rulemaking and subsequently promulgated the 2017 Rule. The 2017 Rule establishes that payments by Medicare and private insurers are to be included in calculating a hospital's "costs incurred." 82 Fed. Reg. at 16,122 (codified at 42 C.F.R. § 447.299(c)(10)). It provides, *inter alia*, "costs . . . [a]re defined as costs net of third-party payments, including, but not limited to, payments by Medicare and private insurance." *Id.* The Secretary explains that considering payments by Medicare and private insurers "best fulfills the purpose of the DSH statute," is "necessary to ensure that limited DSH resources are allocated to hospitals that have a net financial shortfall in serving Medicaid patients" and "is necessary to facilitate the Congressional directive . . . of limiting the DSH payment to a hospital's uncompensated care costs." *Id.* at 16,116, 16,118. He maintains that the 2017 Rule did not effect a legal change but instead continued the preexisting policy. *Id.* at 16,119.

The plaintiffs are four children's hospitals in Minnesota, Virginia and Washington and an association representing eight children's hospitals in Texas. They claim the 2017 Rule violates the Administrative Procedure Act because it exceeds the Secretary's authority under the Medicaid Act and is the product of arbitrary and capricious reasoning. *See* 5 U.S.C. § 706(2)(A), (C). The district court entered summary judgment for the plaintiffs, holding that the Rule "is inconsistent with the plain language of the Medicaid Act," which "clearly indicates which payments can be subtracted from the total costs incurred during the year by hospitals" and "nowhere mentions subtracting other third-party payments made on behalf of Medicaid-eligible patients from the total costs incurred." *Children's Hosp. Ass'n of Tex.*, 300 F. Supp. 3d at 205, 207. Having held the 2017 Rule invalid under § 706(2)(C) ("*ultra vires*" prohibition), the district court did not reach the plaintiffs' § 706(2)(A) challenge ("arbitrary and capricious" prohibition). *Id.* at 205. The district court ultimately vacated the 2017 Rule and the Secretary timely appealed. *Id.* at 210–11. Our review is *de novo*. *See Ark Initiative v. Tidwell*, 816 F.3d 119, 126–27 (D.C. Cir. 2016).

II. Analysis

A. Exceeds Statutory Authority

The plaintiffs first challenge the Rule as exceeding the Secretary's authority under the Medicaid Act, in violation of 5 U.S.C. § 706(2)(C). The familiar *Chevron* framework guides our review. *See Ass'n of Private*

Sector Colls. & Univs. v. Duncan, 681 F.3d 427, 441 (D.C. Cir. 2012) ("Appellant's claims that various provisions of the challenged regulations are 'in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,' are reviewed under the well-known *Chevron* framework." (citation omitted) (quoting 5 U.S.C. § 706(2)(C))). "Under that framework, we ask whether the statute is ambiguous and, if so, whether the agency's interpretation is reasonable." *King v. Burwell*, ___ U.S. ___, 135 S. Ct. 2480, 2488, 192 L.Ed.2d 483 (2015). "This approach 'is premised on the theory that a statute's ambiguity constitutes an implicit delegation from Congress to the agency to fill in the statutory gaps.'" *Id.* (quoting *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159, 120 S.Ct. 1291, 146 L.Ed.2d 121 (2000)). Because the delegation at issue here is express rather than implied, *see* 42 U.S.C. § 1396r-4(g)(1)(A) ("[T]he costs incurred during the year of furnishing hospital services (*as determined by the Secretary* . . .) . . . ." (emphasis added)); *see also Transitional Hosps. Corp. of La. v. Shalala*, 222 F.3d 1019, 1025 (D.C. Cir. 2000) ("as determined by the Secretary" is "express delegation"), we have no need to search for statutory ambiguity. We skip straight to asking whether the Rule is reasonable. *See Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843–44, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984) ("If Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation. Such legislative regulations are given controlling weight unless they are arbitrary, capricious,

or manifestly contrary to the statute."); *see also Transitional Hosps. Corp. of La.*, 222 F.3d at 1025 (if delegation is express "we are bound to uphold [the Secretary's] determination as long as she exercises [her] discretion in a reasonable way").

The plaintiffs offer four principal reasons the statute does not grant the Secretary authority to require that payments by Medicare and private insurers be considered in calculating a hospital's "costs incurred." *First*, the statute exclusively specifies which payments can be considered. *Second*, the Rule renders superfluous the statute's specification that certain payments must be considered. *Third*, the Congress required consideration of third-party payments in a different statutory provision but not in the relevant provision. *Fourth*, the statute plainly distinguishes costs and payments. We reject all four arguments.[1]

First, we disagree with the plaintiffs' argument that the statute exclusively specifies which payments can be considered in calculating "costs incurred." *See* Plaintiffs' Br. at 58; *Children's Hosp. Ass'n of Tex.*, 300 F. Supp. 3d at 207 ("On its face, the statute clearly indicates which payments can be subtracted from the total costs incurred during the year by hospitals: (1) 'payments under this subchapter,' *i.e.*, payments made by Medicaid; and (2) payments made by uninsured patients. The statute nowhere mentions subtracting other third-party payments made on behalf of

[1] We have also considered and reject the plaintiffs' other arguments.

Medicaid-eligible patients from the total costs incurred."). Although the statute establishes that payments by Medicaid and the uninsured *must* be considered, it nowhere states that those are the only payments that *may* be considered. To conclude otherwise, we would have to rely on the interpretive canon *expressio unius est exclusio alterius*, which means "expressing one item of [an] associated group or series excludes another left unmentioned." *Chevron U.S.A. Inc. v. Echazabal*, 536 U.S. 73, 80, 122 S.Ct. 2045, 153 L.Ed.2d 82 (2002) (alteration in original) (quoting *United States v. Vonn*, 535 U.S. 55, 65, 122 S.Ct. 1043, 152 L.Ed.2d 90 (2002)). But that canon has been called a "feeble helper in an administrative setting." *Adirondack Med. Ctr. v. Sebelius*, 740 F.3d 692, 697 (D.C. Cir. 2014) (quoting *Cheney R. Co. v. ICC*, 902 F.2d 66, 69 (C.A.D.C. 1990)). And, in any setting, it "applies only when 'circumstances support[ ] a sensible inference that the term left out must have been meant to be excluded.'" *N.L.R.B. v. SW Gen., Inc.*, ___ U.S. ___, 137 S. Ct. 929, 940, 197 L.Ed.2d 263 (2017) (quoting *Echazabal*, 536 U.S. at 81, 122 S.Ct. 2045); *see also Barnhart v. Peabody Coal Co.*, 537 U.S. 149, 168, 123 S.Ct. 748, 154 L.Ed.2d 653 (2003) ("[W]e do not read the enumeration of one . . . to exclude the other unless it is fair to suppose that Congress considered the unnamed possibility and meant to say no to it."). There is reason to believe the Congress did not intend to exclude Medicare and private insurance payments from consideration. Indeed, the parties agree that the most common sources of payment for treating Medicaid-eligible and uninsured individuals are Medicaid and

the uninsured. The Congress may have wanted to ensure that the most common sources of payment must be considered but at the same time allow the Secretary to decide whether less-common sources of payment should be as well. Especially in light of this plausible alternative explanation, we will not rely on the *expressio unius* canon to find that the statute exclusively specifies which payments can be considered in calculating "costs incurred." *See Indep. Ins. Agents of Am., Inc. v. Hawke*, 211 F.3d 638, 644 (D.C. Cir. 2000) ("[I]f there are other reasonable explanations for an omission in a statute, *expressio unius* may not be a useful tool.").

Second, we disagree with the plaintiffs' argument that the Rule renders superfluous the statute's specification that payments by Medicaid and the uninsured must be considered. *See* Plaintiffs' Br. 41–42; *Children's Hosp. Ass'n of Tex.*, 300 F. Supp. 3d at 207 ("To allow the Secretary to redefine 'costs' to net out a third category of payments—*i.e.*, 'third-party payments, including but not limited to, payments by Medicare and private insurance' . . .—would 'render the Congressional definition of payments in the very same clause superfluous.'" (quoting *Children's Hosp. of the King's Daughters, Inc. v. Price*, 258 F. Supp. 3d 672, 687 (E.D. Va. 2017))); *id.* ("[D]efendants' interpretation of the statute would render portions of the statutory language superfluous."). The statute's specification that two forms of payment *must* be considered removes the Secretary's discretion as to those two forms of payment. But it does nothing to disturb the Secretary's

discretion as to other forms of payment, which *may* be considered. *See Tenn. Hosp. Ass'n*, 908 F.3d at 1038 ("[T]he fact that certain payments must be deducted from costs does not mean that other payments cannot be."); *N.H. Hosp. Ass'n*, 887 F.3d at 66 ("Congress identified two specific sources of payment that must be offset against total costs, but otherwise simply stated that 'costs incurred' are 'as determined by the Secretary.' ").

Third, we reject the plaintiffs' argument that we should infer from the Congress's requiring consideration of third party payments under 42 U.S.C. § 1396r-4(g)(2)(A)—a provision that, before 1995, allowed certain hospitals to receive payments that exceeded their uncompensated costs—that it meant to prohibit consideration of third party payments under § 1396r-4(g)(1)(A). Plaintiffs' Br. 34–35. This argument is based on the so-called "*Russello* presumption—that the presence of a phrase in one provision and its absence in another reveals Congress' design." *City of Columbus v. Ours Garage & Wrecker Serv., Inc.*, 536 U.S. 424, 435–36, 122 S.Ct. 2226, 153 L.Ed.2d 430 (2002) (citing *Russello v. United States*, 464 U.S. 16, 104 S.Ct. 296, 78 L.Ed.2d 17 (1983)). But that presumption "grows weaker with each difference in the formulation of the provisions under inspection." *Id.* at 436, 122 S.Ct. 2226. Because sections (g)(1)(A) and (g)(2)(A) are fundamentally different, we find the plaintiffs' argument unpersuasive. *See Tenn. Hosp. Ass'n*, 908 F.3d at 1039 ("There is no tension, however, in Congress *requiring* third-party payment deductions

in subsection (g)(2)(A) and *allowing* third-party payment deductions in subsection (g)(1)(A). The DSH payments provided for in (g)(2)(A) are above and beyond those mandated by (g)(1)(A); it therefore makes sense for Congress to impose a hard limit on the ceiling of (g)(2)(A) funds—i.e., no more than 200% of the costs of serving Medicaid-eligible patients, less payments from Medicaid, uninsured patients, and 'third party payors'—while giving CMS more discretion to calibrate the appropriate cap on the 'standard' DSH payments discussed in (g)(1)(A).").

Fourth, we disagree with the plaintiffs' argument that the statute plainly distinguishes between costs and payments such that payments can never be considered in calculating "costs incurred." *See* Plaintiffs' Br. at 26, 30, 33, 40, 57. The statute establishes that a hospital's DSH payment cannot exceed its "costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients)." 42 U.S.C. § 1396r-4(g)(1)(A). Both of the parenthetical's adjoining phrases modify "costs incurred"—that is, "costs incurred" are both "as determined by the Secretary" *and* "net of payments under [Medicaid] and by uninsured patients." *Id.* In other words, the statute *requires* that some payments be considered in calculating a hospital's "costs incurred." The argument that the statute separates costs and payments therefore flies in the teeth of the statutory text.

Contrary to the plaintiffs' contention, we believe the 2017 Rule is consistent with the statute's context and purpose, both of which suggest DSH payments are meant to assist those hospitals that need them most by covering only those costs for which DSH hospitals are in fact uncompensated. *See* 42 U.S.C. § 1396r-4(g)(1) (heading of provision at issue: "Amount of adjustment subject to uncompensated costs");[2] 42 U.S.C. § 1396r-4(j)(2)(C) (requiring states to certify that "[o]nly the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in [(g)(1)(A)] are included in the calculation of the hospital-specific limits."); H.R. Rep. No. 103-111, at 211 (in enacting DSH payment limit, Congress noted "some States have made DSH payment[s] . . . to State psychiatric or university hospitals in amounts that exceed the net costs, and in some instances the total costs, of operating the facilities"); *Tenn. Hosp. Ass'n*, 908 F.3d at 1040 ("essence" of Congressional concern in enacting statute was "that hospitals were double dipping by collecting DSH payments to cover costs that had already been reimbursed"). By requiring the inclusion of payments by Medicare and private insurers, the 2017 Rule ensures that DSH payments will go to hospitals that have been compensated least and are thus most in need. Because the 2017 Rule is consistent with the statute, it does not violate § 706(2)(C).

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[2] Headings, although "not commanding," "supply clues" about Congressional intent. *Yates v. United States*, 574 U.S. 528, 135 S. Ct. 1074, 1083, 191 L.Ed.2d 64 (2015).

B. Arbitrary and Capricious

The plaintiffs next challenge the 2017 Rule as the product of arbitrary and capricious reasoning, in violation of 5 U.S.C. § 706(2)(A). A reviewing court "shall . . . hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). An agency rulemaking is arbitrary and capricious "if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43, 103 S.Ct. 2856, 77 L.Ed.2d 443 (1983).

The plaintiffs first contend that "CMS has never acknowledged, let alone justified, its new Rule's departure from the 2008 rule." Plaintiffs' Br. 27–28. We disagree. "Agencies are free to change their existing policies as long as they provide a reasoned explanation for the change." *Encino Motorcars, LLC v. Navarro*, ___ U.S. ___, 136 S. Ct. 2117, 2125, 195 L.Ed.2d 382 (2016). An agency need not provide a more detailed justification for a changed policy than it would for a brand-new policy. *Id.* But it must provide "a reasoned explanation . . . for disregarding facts and circumstances that underlay or were engendered by the prior policy." *Id.* at 2126 (quoting *F.C.C. v. Fox Television Stations, Inc.*, 556

U.S. 502, 516, 129 S.Ct. 1800, 173 L.Ed.2d 738 (2009)). An "unexplained inconsistency" with an earlier position renders a changed policy arbitrary and capricious. *Id.* (quoting *Nat. Cable & Telecomm. Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 981, 125 S.Ct. 2688, 162 L.Ed.2d 820 (2005)).

There is no unexplained inconsistency with an earlier position here. To be clear, we agree with the plaintiffs that the 2017 Rule and the 2008 Rule establish different policies.[3] But it makes no difference. CMS explained why the statute's purposes are better fulfilled by a policy that requires consideration of payments by Medicare and private insurers (the 2017 Rule) than one that does not (the 2008 Rule, as we interpret it):

> In light of the statutory requirement limiting DSH payments on a hospital-specific basis to uncompensated care costs, it is inconsistent with the statute to assist hospitals with costs that have already been compensated by third

[3] The Secretary maintains that the 2017 Rule is consistent with the 2008 Rule and so does not establish a new policy. That argument has been rejected by four courts of appeals, all of which found the 2010 FAQs procedurally invalid because the policy established therein, which is the same policy established by the 2017 Rule, marked a departure from the policy established by the 2008 Rule without notice and an opportunity for public comment. *See Tenn. Hosp. Ass'n*, 908 F.3d at 1043 ("As three circuit courts and several district courts have now held, the payment-deduction policy elucidated in the FAQs and hinted at in the preamble to the 2008 rule seeks to amend, rather than merely clarify, the 2008 regulations." (citing *Children's Health Care*, 900 F.3d at 1026–27; *Children's Hosp. of the King's Daughters*, 896 F.3d at 623; *N.H. Hosp. Ass'n*, 887 F.3d at 74)). We agree with our sister circuits.

> party payments. [The 2017] rule is designed to reiterate the policy and make explicit within the terms of the regulation that all costs and payments associated with dual eligible and individuals with a source of third party coverage must be included in calculating the hospital-specific DSH limit. This policy is necessary to ensure that only actual uncompensated care costs are included in the Medicaid hospital-specific DSH limit. And, because state DSH payments are limited to an annual federal allotment, this policy is also necessary to ensure that limited DSH resources are allocated to hospitals that have a net financial shortfall in serving Medicaid patients.

82 Fed. Reg. at 16,117. This explanation is more than sufficient to survive review under § 706(2)(A).

The plaintiffs also claim that the Secretary has not tied the 2017 Rule to the administrative record. According to their reading, the record shows that CMS reduces DSH payments to the plaintiff hospitals when it considers private insurance payments, notwithstanding "they have among the highest Medicaid inpatient utilization rates in their respective states and the highest net financial shortfalls in serving Medicaid patients." Plaintiffs Br. 65. The plaintiffs claim this outcome is inconsistent with the purpose of the 2017 Rule, which is "to ensure that limited DSH resources are allocated to hospitals that have a net financial shortfall in serving Medicaid patients." 82 Fed. Reg. at 16,117.

Their argument is doubly flawed. For starters, "Medicaid inpatient utilization rates" are not mentioned

in § 1396r-4(g)(1)(A). *See* 42 U.S.C. § 1396r-4(g)(1)(A). More importantly, the plaintiffs misstate which hospitals suffer a "net financial shortfall." Programs and services a hospital provides that are not paid for by Medicaid are *not* relevant to the shortfall calculation. *See* 42 U.S.C. § 1396r-4(j)(2)(C) ("Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph [(g)(1)(A)] are included in the calculation of the hospital-specific limits under such subsection."). Indeed, the statute does not consider a hospital's *actual costs*; it considers only those costs that Medicaid pays for. *See* 82 Fed. Reg. at 16,118 ("Ancillary programs and services that hospitals provide to patients may be laudable, but they are not paid for by Medicaid because they are not costs associated with furnishing inpatient and outpatient hospital services."). Calculating "net financial shortfall" using only those costs that Medicaid pays for, no hospital that suffers a "net financial shortfall" will be denied a DSH payment. Thus, we disagree with the plaintiffs' argument that the Secretary has failed to tie the Rule to the record. Like their § 706(2)(C) challenge, their § 706(2)(A) challenge fails.

For the foregoing reasons, we reverse the judgment of the district court, reinstate the 2017 Rule and remand the case for further proceedings consistent with this opinion.

So ordered.

APPENDIX B

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

CHILDREN'S HOSPITAL ASSOCIATION OF TEXAS; CHILDREN'S HEALTH CARE d/b/a CHILDREN'S HOSPITAL AND CLINICS OF MINNESOTA; GILLETTE CHILDREN'S SPECIALTY HEALTHCARE; CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS, INC.; and SEATTLE CHILDREN'S HOSPITAL, Plaintiffs, v. THOMAS E. PRICE, in his official capacity, Secretary of Health and Human Services; SEEMA VERMA, in her official capacity, Administrator of the Centers for Medicare and Medicaid Services; and CENTERS FOR MEDICARE AND MEDICAID SERVICES, Defendants.	Civil Action No. 17-844 (EGS)

ORDER

(Filed Mar, 2, 2018)

Upon consideration of plaintiffs' motion for summary judgment, defendants' motion to strike, defendants' cross-motion for summary judgment, the memoranda in support and opposition to these motions, the arguments made by the parties at the hearing on August 1, 2017, the portions of the administrative record submitted by the parties, and for the reasons that will be explained fully in a forthcoming Memorandum Opinion, it is hereby

ORDERED that the defendants' motion to strike, ECF No. 14, is **GRANTED** and the exhibits located at ECF Nos. 12–3, 12–5, 12–7, 12–12, 12–24, 12–26 to 12–28, and 12–30 to 12–38 are stricken from the record; and it is

FURTHER ORDERED that plaintiffs' motion for summary judgment, ECF No. 12, is **GRANTED**; and it is

FURTHER ORDERED that defendants' cross-motion for summary judgment, ECF No. 15, is **DENIED**; and it is

FURTHER ORDERED that plaintiffs' motion for a preliminary injunction, ECF No. 8, is **DENIED** as moot; and it is

FURTHER ORDERED that the final rule, Medicaid Program: Disproportionate Share Hospital Payments – Treatment of Third Party Payers in

Calculating Uncompensated Care Costs, which is published at 82 Fed. Reg. 16114–02, 16117 is hereby **VACATED**; and it is

FURTHER ORDERED that plaintiffs' motion for a hearing, ECF No. 32, is **DENIED** as moot.

Upon posting of the Memorandum Opinion, this Order will be final pursuant to Federal Rule of Civil Procedure 54.

SO ORDERED.

Signed: Emmet G. Sullivan
United States District Judge
March 2, 2018

APPENDIX C

CHILDREN'S HOSPITAL ASSOCIATION OF TEXAS; Children's Health Care d/b/a Children's Hospital and Clinics of Minnesota; Gillette Children's Specialty Healthcare; Children's Hospital of the King's Daughters, Inc.; and Seattle Children's Hospital, Plaintiffs,

v.

Alex AZAR, in his official capacity, Secretary of Health and Human Services; Seema Verma, in her official capacity, Administrator of the Centers for Medicare and Medicaid Services; and Centers for Medicare and Medicaid Services,[1] Defendants.

Civil Action No. 17-844 (EGS)

United States District Court,
District of Columbia.

Signed 03/06/2018

Bridget Springer McCabe, Baker & Hostetler LLP, New York, NY Christopher H. Marraro, Baker & Hostetler LLP, Geraldine E. Edens, Morgan, Lewis & Bockius LLP, Washington, DC, Susan Feigin Harris, Morgan, Lewis & Bockius LLP, Houston, TX, for Plaintiffs.

Steven A. Myers, James C. Luh, U.S. Department of Justice, Washington, DC, for Defendants.

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[1] Pursuant to Federal Rule of Civil Procedure 25(d), the Court substitutes as defendant the Secretary of Health and Human Services, Alex Azar, for former Secretary of Health and Human Services, Thomas E. Price.

MEMORANDUM OPINION

Emmet G. Sullivan, United States District Judge

Medicaid is a federal program that helps to cover the costs of providing medical care to qualified individuals. Some hospitals treat significantly higher percentages of Medicaid-eligible patients than others. Because Medicaid does not generally provide the same level of reimbursement as other types of insurance coverage, such hospitals are often at a financial disadvantage. To rectify this disadvantage, and thereby encourage hospitals to serve Medicaid-eligible patients, Congress has provided for supplemental Medicaid payments to such hospitals. The supplemental payments are subject to limits to ensure that no hospital receives payments that would result in a profit, rather than covering Medicaid-related costs to rectify the disadvantage. This case concerns the method of calculating the limit of these supplemental payments.

Specifically, this lawsuit challenges a final rule that defines how "costs" are to be calculated for purposes of determining the limit on the amount of the supplemental payment a hospital serving a disproportionate share of Medicaid-eligible individuals is entitled to receive. *See* Medicaid Program: Disproportionate Share Hospital Payments—Treatment of Third Party Payers in Calculating Uncompensated Care Costs, 82 Fed. Reg. 16114-02, 16117 (Apr. 3, 2017) ("Final Rule"). Defendants—the Secretary of Health and Human Services ("the Secretary"), Centers for Medicare and Medicaid Services ("CMS"), and the

CMS Administrator—claim that the Medicaid Act permits them to define "costs" in the Final Rule as "costs net of third-party payments, including, but not limited to, payments by Medicare and private insurance." 42 C.F.R. § 447.299(c)(10)(i). Plaintiffs—one children's hospital association, whose members are eight free-standing children's hospitals in the state of Texas, and four other free-standing children's hospitals located in Minnesota, Virginia, and Washington—ask the Court to vacate the Final Rule as contrary to the plain language of the Medicaid Act and as arbitrary and capricious under the Administrative Procedures Act.

Pending before the Court are plaintiffs' combined motion for a preliminary injunction and for summary judgment, defendants' motion to strike exhibits supporting plaintiffs' motion for summary judgment, defendants' motion for summary judgment, and plaintiffs' motion for a status hearing. Upon consideration of the parties' memoranda, the parties' arguments at the motions hearing, the administrative record, the applicable law, and for the following reasons, the Court grants plaintiffs' motion for summary judgment and vacates the Final Rule. The Court further grants defendants' motion to strike, denies defendants' motion for summary judgment, denies plaintiffs' motion for a preliminary injunction, and denies plaintiffs' motion for a status hearing.

I. BACKGROUND

A. The Medicaid Act

Medicaid is a "joint state-federal program in which healthcare providers serve poor or disabled patients and submit claims for government reimbursement." *Universal Health Servs., Inc. v. United States*, ___ U.S. ___, 136 S.Ct. 1989, 1996-97, 195 L.Ed.2d 348 (2016). In addition to serving low-income individuals, Medicaid also provides benefits to children with certain serious illnesses, without regard to family income. *See, e.g.*, 42 U.S.C. § 1396a(a)(10)(A)(i)(II) (children are eligible for Medicaid if they are eligible for Supplemental Security Income ("SSI")); 20 C.F.R. § 416.934(j) (children born weighing less than 1,200 grams are presumptively eligible for SSI).

To encourage states to participate in Medicaid, "[f]ederal and state governments jointly share the cost." *Va. Dep't of Med. Assistance Servs. v. Johnson*, 609 F.Supp.2d 1, 2 (D.D.C. 2009). Participating states administer their own program "pursuant to a state Medicaid plan which must be reviewed and approved by the Secretary of HHS." *Id.*; *see also* 42 U.S.C. § 1396a. Once the Secretary or the Secretary's designee approves a state plan, the state receives federal financial participation to cover part of the costs of its Medicaid program. 42 U.S.C. § 1396b(a)(1). If a state fails to comply with the statutory or regulatory requirements governing Medicaid, the federal government may recoup federal funds from the state. *See id.* §§ 1316(a), (c)-(e).

B. Disproportionate Share Hospitals

In 1981, facing "greater costs . . . associated with the treatment of indigent patients," *D.C. Hosp. Ass'n v. District of Columbia*, 224 F.3d 776, 777 (D.C. Cir. 2000), Congress amended Medicaid to require states to ensure that payments to hospitals "take into account . . . the situation of hospitals which serve a disproportionate number of low-income patients with special needs," 42 U.S.C. § 1396a(13)(A)(iv). This amendment reflected "Congress's concern that [M]edicaid recipients have reasonable access to medical services and that hospitals treating a disproportionate share of poor people receive adequate support from [M]edicaid." *W. Va. Univ. Hosps. v. Casey*, 885 F.2d 11, 23 (3d Cir. 1989).

These payments do not compensate a hospital for providing a particular service to a particular patient; rather, they seek to rectify in part any deficit the hospital may face solely because it treats more Medicaid-eligible patients than most. *See Johnson*, 609 F.Supp.2d at 3 ("The intent was to stabilize the hospitals financially and preserve access to health care services for eligible low-income patients."). Accordingly, the amendment created "payment adjustment[s]" for qualifying hospitals. *See* 42 U.S.C. § 1396r-4(c). Such payments are available to any hospital that treats a disproportionate share of Medicaid patients (a disproportionate-share hospital or "DSH"). *See id.* § 1396r-4(b). In particular, Congress "deemed" hospitals to be DSH hospitals if "the hospital's medicaid inpatient utilization rate . . . is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals

receiving medicaid payments in the State" or if "the hospital's low-income utilization rate . . . exceeds 25 percent." *Id.* § 1396r-4(b)(1).

In 1993, the Medicaid program was amended to limit DSH payments on a hospital-specific basis to assuage concerns that some hospitals were receiving DSH payments in excess of "the net costs, and in some instances the total costs, of operating the facilities." H.R. Rep. No. 103-111, at 211 (1993), *reprinted in* 1993 U.S.C.C.A.N. 278, 538. Congress was particularly concerned by reports that some states were "making DSH payment adjustments to hospitals that d[id] not provide inpatient services to Medicaid beneficiaries" at all. *Id.* Because the very purpose of DSH payments was "to assist those facilities with high volumes of Medicaid patients," Congress wanted to ensure that payments were directed to hospitals that were "unlikely to have large numbers of privately insured patients through which to offset their operating losses on the uninsured." *Id.* To mitigate these concerns, the amendment provided that a DSH payment may not exceed:

> [T]he costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

42 U.S.C. § 1396r-4(g)(1)(A). Thus, for Medicaid patients, the Medicaid Act sets the hospital-specific limit ("HSL") for DSH payments as "the costs incurred during the year of furnishing hospital services" to Medicaid-eligible individuals "as determined by the Secretary and net of payments" under the Medicaid Act (referred to as the "Medicaid shortfall"). *Id.*

C. Auditing and Reporting Requirements

To ensure that DSH payments comply with statutory requirements, the Medicaid Act was again amended in 2003 to require that each state provide an annual report and an audit of its DSH program. *See id.* § 1396r-4(j). The audit must confirm, among other things, that:

> (C) Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in [Section 1396r-4(g)(1)(A)] . . . are included in the calculation of the hospital-specific limits[;]
>
> (D) The State included all payments under this subchapter, including supplemental payments, in the calculation of such hospital-specific limits[; and]
>
> (E) The State has separately documented and retained a record of all of its costs under this subchapter, claimed expenditures under this subchapter, uninsured costs in determining payment adjustments under this section, and any payments made on behalf of the

> uninsured from payment adjustments under this section.

Id. § 1396r-4(j)(2). Overpayments must be recouped by the state within one year of their discovery or the federal government may reduce its future contribution to that state. *See id.* § 1396b(d)(2)(C)-(D).

In 2005, CMS issued a Notice of Proposed Rulemaking in order to implement the 2003 amendment's auditing and reporting requirements. *See* 70 Fed. Reg. 50262 (Aug. 26, 2005). A final rule was issued on December 19, 2008. *See* 73 Fed. Reg. 77904 (Dec. 19, 2008) ("2008 Rule"). The 2008 Rule made two changes to the applicable provisions of the Code of Federal Regulations.

First, the 2008 Rule required that states begin to submit, on an annual basis, certain information "for each DSH hospital to which the State made a DSH payment in order to permit verification of the appropriateness of such payments." *Id.* at 77950. One such piece of information is the hospital's "total annual uncompensated care costs," which the rule defined as an enumerated set of "costs" less an enumerated set of "payments":

> The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid [fee-for-service] rate payments, Medicaid managed

> care organization payments, supplemental/ enhance Medicaid payments, uninsured revenues, and Section 1011 payments for inpatient and outpatient hospital services.

Id. at 77950; 42 C.F.R. § 447.299(c)(16). The regulation also defined different types of costs and payments. *See* 42 C.F.R. § 447.299(c)(10) (defining total costs for Medicaid-eligible patients as "[t]he total annual costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals"); *id.* § 447.299(c)(14) (defining total costs for uninsured individuals as "the total costs incurred for furnishing . . . services to individuals with no source of third party coverage for the hospital services they receive"); *id.* §§ 447.299(c)(6)-(9) (defining the various Medicaid-related payments); *id.* § 447.299(c)(12) (defining total uninsured revenues as "[t]otal annual payments received by the hospital by or on behalf of individuals with no source of third party coverage for . . . services they receive," exclusive of "payments made by a State or units of local government, for services furnished to indigent patients"); *id.* § 447.299(c)(13) (describing "Section 1011 payments," which are "Federal Section 1011 payments for . . . services provided to Section 1011 eligible aliens with no source of third party coverage").

Second, the 2008 Rule stated that the annual audit "must verify," among other things, that:

> Each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to

> offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures.
>
> . . .
>
> Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share . . . payment limit.

73 Fed. Reg. at 77951; 42 C.F.R. § 455.304(d). To ease the move to the new audit and reporting regime and to avoid subjecting any state to "immediate penalties that would result in the loss of Federal matching dollars," CMS provided for a six-year-long transition. 73 Fed. Reg. at 77906. Accordingly, any audits "from Medicaid State plan rate year 2005 through 2010" would be "used only for the purpose of determining prospective hospital-specific cost limits and the actual DSH payments associated with a particular year," not for "requiring recovery of any overpayments." *Id.* For payments made for all years after 2011, DSH overpayments would be recovered by the state, and the federal share would be returned to the federal government unless

the excess payments "are redistributed by the State to other qualifying hospitals." *Id.*

D. Frequently Asked Questions ("FAQs") 33 and 34

On January 10, 2010, CMS posted answers to FAQs regarding the audit and reporting requirements. *See* A.R. 730-771, Additional Information on the DSH Reporting and Audit Requirements, https://www.medicaid.gov/medicaid/financing-andreimbursement/downloads/part-1-additional-info-on-dsh-reporting-and-auditing.pdf. FAQ 33 asked whether "days, costs, and revenues associated with patients that have both Medicaid and private insurance coverage" would be included in the calculation of the DSH limit. A.R. 747, *id.* at 18. In response, CMS explained that private-insurance payments made on behalf of Medicaid-eligible patients should be included in the calculation of the hospital-specific DSH limit." *Id.* Likewise, FAQ 34 asked "[u]nder what circumstances" would Medicare payments on behalf of patients dually eligible for both Medicare and Medicaid be included in the uncompensated care costs. *Id.* CMS explained that hospitals were required "to take into account" any Medicare payments made on behalf of dually-eligible individuals in calculating a hospital's Medicaid DSH payment. *Id.*

FAQs 33 and 34 were subsequently challenged in multiple courts as an unlawful amendment of the 2008 Final Rule and as inconsistent with the Medicaid Act. Each of the six federal courts to have evaluated FAQs

33 and 34 have entered either a preliminary or permanent injunction prohibiting defendants from reducing a hospital's DSH payment through enforcement of the FAQs. *See, e.g.*, *Texas Children's Hosp. v. Burwell*, 76 F.Supp.3d 224 (D.D.C. 2014) (granting preliminary injunction prohibiting the enforcement of FAQ 33); *New Hampshire Hosp. Ass'n v. Burwell*, No. 15-cv-460, 2017 WL 822094 (D.N.H. Mar. 2, 2017) (permanently enjoining defendants from enforcing FAQs 33 and 34); *Children's Hosp. of the King's Daughters, Inc. v. Price*, 258 F.Supp.3d 672 (E.D. Va. 2017) (granting preliminary injunction prohibiting the enforcement of FAQ 33 against plaintiff); *Tennessee Hosp. Ass'n v. Price*, No. 16-cv-3263, 2017 WL 2703540 (M.D. Tenn. June 21, 2017) (granting plaintiffs' summary judgment and enjoining defendants from applying FAQ 33 to plaintiffs' hospitals); *Children's Health Care v. Centers for Medicare & Medicaid Servs.*, No. 16-cv-4064, 2017 WL 3668758 (D. Minn. June 26, 2017)(permanently enjoining defendants from enforcing FAQ 33); *Missouri Hosp. Ass'n. v. Hargan*, No. 17-cv-4052, 2018 WL 814589 (W.D. Mo. Feb. 9, 2018) (permanently enjoining enforcement of the final rule).

Each of these courts found the FAQs invalid on procedural grounds—i.e., that defendants violated the Administrative Procedure Act ("APA"), 5 U.S.C. § 500 *et seq.*, by failing to properly promulgate the policy embodied in the FAQs in accordance with the notice-and-comment provisions of section 553. Two of these courts also evaluated whether the FAQs violated section 706(2) of the APA because they conflict with the plain

language of the Medicaid Act. *See Children's Hosp. of the King's Daughters*, 2017 WL 2936801, at *8 (finding that the Medicaid statute is "unambiguous" and foreclosed defendants' interpretation as set forth in FAQ 33); *Tennessee Hosp. Ass'n*, 2017 WL 2703540, at *8 ("the Court finds that Defendants' policies set forth in the responses to FAQs 33 and 34 violate the APA because they conflict with the unambiguous language of the Medicaid Act").

E. 2017 Final Rule

On August 15, 2016, defendants published a notice of proposed rulemaking to address the HSL on DSH payments. 81 Fed. Reg. 53980, 53981 (Aug. 15, 2016). Specifically, defendants explained that the new rule was intended to "make clearer . . . an existing interpretation"—which was also embodied in FAQs 33 and 34—that "uncompensated care costs include only those costs for Medicaid eligible individuals that remain after accounting for payments received by hospitals by or on behalf of Medicaid eligible individuals, ***including Medicare and other third party payments*** that compensate the hospitals for care furnished to such individuals." *Id.* (emphasis added). In other words, under the proposed rule, the HSL must be based on the costs for Medicaid-eligible individuals for which a "hospital has not received payment from any source." *Id.*

On April 3, 2017, CMS published the Final Rule entitled "Medicaid Program: Disproportionate Share Hospital Payments—Treatment of Third Party Payers

in Calculating Uncompensated Care Costs." 82 Fed. Reg. 16114-02, 16117 (Apr. 3, 2017). CMS stated that it "received 161 timely comments from state Medicaid agencies, provider associations, providers, and other interested parties" in response to the proposed rule. 82 Fed Reg. 16114, 16117 (Apr. 3, 2017). Defendants identified ten general comment areas in which they received multiple comments, along with nine additional specific comments that did not fit into any of the general areas, and provided responses to those comments. *Id.* at 16117-16120. Many commentators "suggested that CMS' interpretation of the hospital-specific limit" was "inconsistent with the statutory language" of the amendment. *Id.* at 16117. Defendants disagreed, explaining that the statute explicitly gave the Secretary authority to determine the "costs" of providing services, and therefore the Secretary had "discretion to take Medicare and other third party payments into account when determining a hospital's costs for the purpose of calculating Medicaid DSH payments." *Id.* at 16117-18.

Other commentators suggested that the proposed rule should not apply to patients eligible for both Medicaid and another source of insurance ("dual-eligible patients") in cases where Medicaid does not actually pay on behalf of that patient. *Id.* at 16118. According to these commentators, application of the proposed rule to hospitals serving a high number of dual-eligible patients would render those hospitals "ineligible for DSH funds, even though they have substantial losses for Medicaid-paid admissions and for the uninsured."

Id. In response, defendants pointed out that the statutory language referred to those "eligible for medical assistance" and did "not condition eligibility on whether the cost of the service was claimed." *Id.* As such, "all costs and payments associated with Medicaid eligible individuals must be included in the hospital-specific limit calculation, regardless of whether Medicaid made a payment." *Id.* Defendants also stated that the commentators' belief that, under the proposed rule, a hospital could incur substantial losses for treating Medicaid-eligible and uninsured individuals despite receiving a DSH payment was "incorrect." *Id.* Although these hospitals may incur losses for "[a]ncillary programs and services," any "actual uncompensated care costs for furnishing [inpatient and outpatient] hospital services" would be eligible to be covered by DSH payments. The purpose of the rule, according to defendants, was simply to ensure that a DSH payment did not constitute "double pay for costs that ha[d] already been compensated" by, for example, private insurance or Medicare. *Id.*

The Final Rule modifies 42 C.F.R. § 447.299(c)(10) "to make it explicit that 'costs' for purposes of calculating hospital-specific DSH limits are costs net of third-party payments received." *Id.* Specifically, the Final Rule provides:

> (10) Total Cost of Care for Medicaid IP/OP Services. The total annual costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals. The total annual costs

> are determined on a hospital-specific basis, not a service-specific basis. For purposes of this section, costs—
>
> (i) Are defined as ***costs net of third-party payments, including, but not limited to, payments by Medicare and private insurance.***
>
> (ii) Must capture the total burden on the hospital of treating Medicaid eligible patients prior to payment by Medicaid. Thus, costs must be determined in the aggregate and not by estimating the cost of individual patients. For example, if a hospital treats two Medicaid eligible patients at a cost of $2,000 and receives a $500 payment from a third party for each individual, the total cost to the hospital for purposes of this section is $1,000, regardless of whether the third party payment received for one patient exceeds the cost of providing the service to that individual.

Id. at 16122 (emphasis added). The Final Rule became effective June 2, 2017. *Id.* at 16115. Defendants note that, because the Final Rule merely "provid[es] clarification to existing policy," there is "no issue of retroactivity, nor a need for a transition period." *Id.* at 16118.

The only other federal court to have adjudicated a challenge to the Final Rule found that it was enacted in excess of defendants' statutory authority under the Medicaid Act. *See Missouri Hosp. Ass'n. v. Hargan*, No. 17-cv-4052, 2018 WL 814589, at *10-12 (W.D. Mo. Feb. 9, 2018). The court held that "42 U.S.C. § 1396r-4(g)(1)(A) is unambiguous that the calculation of a

DSH hospital's HSL does not involve consideration of private insurance or Medicare payments, and a DSH hospital's total uncompensated costs of care for calculating the HSL is reduced only by the total of other Medicaid program payments." 2018 WL 814589, at *12. In so holding, the court found that the context and legislative history of the statute supported plaintiffs' reading of the statute that only Medicaid payments were to be included in the HSL. *Id.* Based on the language of the statute, its context, and its legislative history, the court concluded that, "[w]hile the Secretary may be authorized to define 'costs,'" under the statute, the Secretary's "authority stops short of defining 'payments.'" *Id.*

F. This Lawsuit

The plaintiffs in this case represent twelve not-for-profit children's hospitals located in Texas, Washington, Minnesota, and Virginia. Compl. ¶¶ 13-17, ECF No. 1. The hospitals are "dedicated to the treatment and special needs of children and the advancement of pediatric medicine" and provide care for critically-ill children "regardless of whether their families have health insurance or ability to pay for their care." *Id.* ¶¶ 13-17. As a result, these hospitals each serve a disproportionate number of Medicaid and uninsured patients. *See, e.g.*, *id.* ¶ 13 (the Children's Hospital Association of Texas' "members have among the highest Medicaid utilization rates of all hospitals in the state of Texas"); *id.* ¶ 14 ("Children's Minnesota is federally 'deemed' a DSH hospital entitled to receive

DSH funding under the Medicaid Act."); *id.* ¶ 15 ("Gillette Children's typically serves the highest proportion of patients covered by Medicaid in Minnesota."); *id.* ¶ 16 (Children's Hospital of the King's Daughters "is federally 'deemed' a DSH hospital entitled to receive DSH funding under the Medicaid Act because it serves a disproportionate number of Medicaid and uninsured patients.").

Plaintiffs filed this lawsuit on May 8, 2017. Compl., ECF No. 1. On May 15, 2017, plaintiffs filed a motion for a preliminary injunction requesting the Court to "enjoin[] Defendants—on a nationwide basis—from enforcing, applying, or implementing (or requiring any state to enforce, apply, or implement)" the Final Rule. Mot. for Prelim. Inj., ECF No. 8. On May 23, 2017, in accordance with the Court's May 19, 2017 Order, the parties filed a joint status report in which they agreed that plaintiffs' motion for a preliminary injunction could "be combined with the merits and treated also as a motion for summary judgment." Joint Status Report at 2, ECF No. 11. The Court entered an order consolidating plaintiffs' motion for a preliminary injunction with a determination of the merits under Federal rule of Civil Procedure 65(a)(2) on May 24, 2017. Plaintiffs filed a combined application for a preliminary injunction and summary judgment on June 5, 2017. Pls.' Combined Mem. in Supp. of Appl. for a Prelim. Inj. and for Summ. J. ("Pls.' Mem."), ECF No. 12-1. On June 16, 2017, in addition to filing their combined response to plaintiffs' motion and cross-motion for summary judgment, defendants moved to strike certain

exhibits filed in support of plaintiffs' motion. Defs.' Mot. to Strike, ECF No. 14; Defs.' Mem. in Supp. of Mot. for Summ. J. and Opp. to Pls.' Mot. for Prelim. Inj. and Summ. J. ("Defs.' Opp."), ECF No. 15. The parties' briefing on their cross-motions for summary judgment and defendants' motion to strike was complete on July 12, 2017, and the Court held a hearing on the motions on August 1, 2017. Those motions are now ripe for the Court's considerations. Because the Court's opinion decides the underlying merits, plaintiffs' request for a preliminary injunction is moot.

II. Defendants' Motion to Strike

Plaintiffs attach thirty-six exhibits to their "combined application for a preliminary injunction and for summary judgment," *see* ECF Nos. 12-3 to 12-38, seventeen of which were not "presente[ed] to the agency in the administrative process," *see* Defs.' Mot. Strike at 1, ECF No. 14. These seventeen exhibits consist of (1) declarations from representatives of each plaintiff, *see* ECF Nos. 12-3, 12-5, 12-7, 12-24, 12-26, 12-28, and 12-34; (2) two publications from the Journal of the American Medical Association ("JAMA"), ECF Nos. 12-12 and 12-38; (3) various documents attached to the Declaration of Robert Simon ("Simon Declaration") purporting to explain the relationship between Medicaid cost-reporting principles and inclusion of third-party payments in the HSL calculation, *see* ECF Nos. 12-30, 12-31,12-32, and 12-33; and (4) various documents setting forth facts specific to certain plaintiff-hospitals, *see* ECF Nos. 12-27, 12-35, 12-36, and 12-37.

Defendants move to strike these seventeen exhibits, arguing that judicial review under the APA "is limited to the administrative record, which consists of the materials directly or indirectly considered by the agency decision-makers at the time they made the challenged decision." Defs.' Mot. Strike at 3, ECF No. 14.

"[I]t is black-letter administrative law that in an APA case, a reviewing court 'should have before it neither more nor less information that did the agency when it made its decision.' " *Hill Dermaceuticals, Inc. v. Food & Drug Admin.*, 709 F.3d 44, 47 (D.C. Cir. 2013) (quoting *Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 792 (D.C. Cir. 1984)). This is because, under the APA, the court is confined to reviewing "the whole record or those parts of it cited by a party," 5 U.S.C. § 706, and the administrative record only includes the "materials 'compiled' by the agency that were 'before the agency at the time the decision was made,' " *James Madison Ltd. by Hecht v. Ludwig*, 82 F.3d 1085, 1095 (D.C. Cir. 1996) (citations omitted).

Accordingly, when, as here, plaintiffs seek to place before the court additional materials that the agency did not review in making its decision, a court must exclude such material unless plaintiffs "can demonstrate unusual circumstances justifying departure from th[e] general rule." *Am. Wildlands v. Kempthorne*, 530 F.3d 991, 1002 (D.C. Cir. 2008) (citation omitted). For example, a court may appropriately consider extra-record materials: (1) if the agency deliberately or negligently excluded documents that may have been adverse to its decision; (2) if background information is needed to

determine whether the agency considered all the relevant factors; and (3) in cases where the agency failed to explain the administrative action so as to frustrate judicial review. *Id.*

Plaintiffs make three arguments as to why the Court should consider their proffered extra-record materials: (1) the declarations, and certain exhibits attached to them, should be considered because they support plaintiffs' request for a preliminary injunction and establish plaintiffs' standing, Pls.' Strike Opp. at 4-7, ECF No. 22; (2) that certain paragraphs of the Simon Declaration and all of the exhibits attached to it are proper extra-record evidence because they show that defendants did not adequately explain their decision, *id.* at 7-9; and (3) one JAMA study is included merely to support a "statement of fact" that "put[s] into context the specialized care Plaintiffs provide to Medicaid children" and thus is appropriately before the Court, *id.* at 10. The Court considers each argument in turn.

A. The Court Need Not Consider Extra-Record Materials To Determine Whether Plaintiffs Will Suffer Irreparable Harm Or Have Standing.

Plaintiffs are correct that in APA cases, courts have considered declarations offered to prove that plaintiffs will suffer "irreparable harm" absent a preliminary injunction. *See id.* at 4; *see also*, *e.g.*, *Am. Rivers v. U.S. Army Corps of Eng'rs*, 271 F.Supp.2d 230, 247

(D.D.C. 2003) ("the Court concludes that this case fits squarely within one of our Circuit's stated exceptions for allowing consideration of extra-record declarations in administrative review cases—cases involving preliminary injunctions"). Here, however, plaintiffs concede that consolidation of their motions for preliminary-injunctive relief and summary judgment under Federal Rule of Civil Procedure 65 "effectively moots the Court's consideration of the preliminary injunctive factors because the court will enter judgment on the merits." Pls.' Mem. at 2, ECF No. 12-1. Accordingly, the Court need not determine whether plaintiffs will suffer "irreparable harm" absent an injunction—and, therefore, plaintiffs' extra-record proof of such harm need not be considered.

Whether plaintiffs may supplement the record in order to establish standing is a closer question. *See, e.g.*, *Amfac Resorts, L.L.C. v. U.S. Dep't of the Interior*, 282 F.3d 818, 830 (D.C. Cir. 2002) (stating that those challenging agency action must establish that they have standing and, in so doing, "[t]hey are not confined to the administrative record," but rather, "must support their claim of injury with evidence"); *Chesapeake Climate Action Network v. Export-Import Bank of the U.S.*, 78 F.Supp.3d 208, 217 (D.D.C. 2015) ("Although judicial review of agency action is typically confined to the administrative record, where there is not sufficient evidence of standing in the record because the question was not before the agency, plaintiffs may submit extra-record evidence to establish standing."). Notably, although defendants do not contest standing

here—perhaps because this Court previously found that at least one of the plaintiffs in this case, Seattle Children's Hospital, likely did have standing to challenge defendants' enforcement of FAQ 33, *see Texas Children's*, 76 F.Supp.3d at 238-39—defendants recognize that plaintiffs may be "entitled to make a record on standing for purposes of further review." Defs.' Reply in Supp. Mot. Strike at 3, ECF No. 25. Furthermore, even when no party challenges standing, "federal courts, being courts of limited jurisdiction, must assure themselves of jurisdiction over any controversy they hear." *Noel Canning v. N.L.R.B.*, 705 F.3d 490, 496 (D.C. Cir. 2013).

Here, given that there is no dispute that plaintiffs are subject to the Final Rule, the Court finds that plaintiffs' standing is self-evident and therefore the Court need not consider the declarations attached to plaintiffs' motion. *See Sierra Club v. E.P.A.*, 292 F.3d 895, 899-900 (D.C. Cir. 2002) ("In many if not most cases the petitioner's standing to seek review of administrative action is self-evident; no evidence outside the administrative record is necessary for the court to be sure of it."); *see also Fund For Animals, Inc. v. Norton*, 322 F.3d 728, 733 (D.C. Cir. 2003) (confirming that parties are "not require[d] . . . to file evidentiary submissions in support of standing in every case"). In particular, when, as here, plaintiffs are the "object of the [agency] action (or foregone action) at issue . . . there should be little question that the action or inaction has caused him injury, and that a judgment preventing or requiring the action will redress it." *Id.* (citation and

internal quotation marks omitted). No party contests that the Final Rule, if allowed to stand, could "have the effect of shifting DSH funds from Plaintiffs to other DSH hospitals within each of their respective states." Defs.' Opp. at 31, ECF No. 15. These recoupment decisions—or, going forward, decisions about how to allocate DSH funds—by state Medicaid agencies are inextricably intertwined with defendants' promulgation and enforcement of the Final Rule. *See Texas Children's*, 76 F.Supp.3d at 239 (noting that defendants could "revoke federal financial participation" from states that do not comport with defendants' view of Medicaid's requirements) (citing 42 U.S.C. §§ 1316(a), (c)-(e), 1396a, 1396b). Accordingly, the Court need not consider plaintiffs' proffered declarations in conducting its analysis of the Final Rule.[2]

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[2] This conclusion is buttressed by the fact that plaintiffs' declarations appear to address topics that far exceed the standing inquiry. *See, e.g.*, Declaration of Todd Ostendorf ¶ 5 ("Medicaid currently reimburses Children's Minnesota an average of only $0.65 for every dollar of the cost to provide care to Medicaid patients.") (cited at Pls.' Mem. at 12); Declaration of Stephen Kimmel ¶ 5 ("Cook Child's sustains significant losses treating large numbers of Medicaid patients") (cited at Pls.' Mem. at 32). As another court recently found, "plaintiffs may not smuggle in extra-record evidence relevant to the merits of this APA action by contending that the evidence pertains to standing." *Hispanic Affairs Project v. Acosta*, 263 F.Supp.3d 160, 176 (D.D.C. 2017). This Court agrees. *See also Watersheds Project v. Salazar*, 766 F.Supp.2d 1095, 1104 (D. Mont. 2011) ("The Court believes that the Declarations containing both standing allegations and the extra-record submission should be stricken in full because standing is not in dispute and the extra-record submissions are intermixed with the standing allegations.").

B. The *Esch* Exceptions Do Not Apply.

Plaintiffs invoke *Esch v. Yeutter*, 876 F.2d 976 (D.C. Cir. 1989), to argue that certain paragraphs of the Simon Declaration and all of the exhibits to that declaration are proper extra-record evidence. Pls.' Strike Opp. at 7-9, ECF No. 22. In particular, plaintiffs urge the Court to consider portions of the Simon Declaration because, during the notice-and-comment process, CMS dismissed Mr. Simon's comment "with an explanation that failed to address the issue raised" as to whether the inclusion of third-party payments in the calculation of the hospital-specific limit violates Medicare/Medicaid cost reporting principles. *Id.* at 8. The Court of Appeals for the District of Columbia Circuit ("D.C. Circuit"), however, has "severely limited" the application of *Esch* to allow such extra-record evidence. *Chamber of Commerce v. NLRB*, 118 F.Supp.3d 171, 188 n.12 (D.D.C. 2015). In *Hill Dermaceuticals*, for example, the D.C. Circuit explained that, at most, *Esch* "may be invoked to challenge ***gross procedural deficiencies***—such as where the administrative record itself is ***so deficient as to preclude effective review***." 709 F.3d at 47 (emphases added); *see also American Wildlands v. Kempthorne*, 530 F.3d 991, 1002 (D.C. Cir. 2008) (exception only applies when an agency's failure to adequately explain its actions "frustrates judicial review").

Here, plaintiffs offer no evidence that CMS's decision was so procedurally deficient as to preclude judicial review. Given that courts have repeatedly held that an agency's decision need not "be a model of

analytic precision to survive a challenge," such evidence would need to be provided to justify consideration of the extra-record evidence. *Dickson v. Sec. of Defense*, 68 F.3d 1396, 1404-05 (D.C. Cir. 1995); *see also Camp v. Pitts*, 411 U.S. 138, 143, 93 S.Ct. 1241, 36 L.Ed.2d 106 (1973) (rejecting argument that agency had failed to provide an adequate explanation when agency had provided a "contemporaneous explanation" that simply stated that "a new bank was an uneconomic venture in light of the banking services already available in the surrounding community"; "[t]he explanation may have been curt but it surely indicated the determinative reason for the final action taken").

C. The Court Declines To Consider The 2016 JAMA Study.

Plaintiffs also contend that the Court should consider a 2016 study published in Pediatrics, a JAMA publication, because it supports plaintiffs' argument that free-standing Children's hospitals rely heavily on DSH funding. Pls.' Opp. at 7, 10, ECF No. 22. Defendants maintain that the Court must strike the article because it was "not presented to the agency in the course of the rulemaking process." Defs.' Mot. Strike at 5. The Court agrees, and therefore also strikes the article from the record. *See Hispanic Affairs Project v. Acosta*, 263 F.Supp.3d 160, 179 (D.D.C. 2017) (agreeing that the Court was not permitted to consider "the two referenced news articles" in an exhibit attached to plaintiffs' summary-judgment motion in APA action).

In sum, the Court strikes ECF Nos. 12-3, 12-5, 12-7, 12-12, 12-24, 12-26 to 12-28, and 12-30 to 12-38 from the record.

III. Standard of Review

Although "summary judgment is [the] appropriate procedure" when a party seeks review of an agency action under the APA, the normal standards for summary judgment set forth in Federal Rule of Civil Procedure 56 do not apply. *See Assoc. Builders & Contractors, Inc. v. Shiu*, 30 F.Supp.3d 25, 34 (D.D.C. 2014); *Bimini Superfast Operations LLC v. Winkowski*, 994 F.Supp.2d 106, 119 (D.D.C. 2014). Instead, the court's function is limited to reviewing the administrative record to "determine whether or not as a matter of law the evidence in the administrative record permitted the agency to make the decision it did." *Nicopure Labs, LLC v. Food & Drug Admin.*, 266 F.Supp.3d 360, 379 (D.D.C. 2017).

In reviewing agency action, the court must be "thorough and probing, but if the court finds support for the agency action, it must step back and refrain from assessing the wisdom of the decision unless there has been a 'clear error of judgment.'" *Fund for Animals v. Babbitt*, 903 F.Supp. 96, 105 (D.D.C. 1995) (quoting *Marsh v. Oregon Natural Res. Council*, 490 U.S. 360, 378, 109 S.Ct. 1851, 104 L.Ed.2d 377 (1989)). In its review, a court should consider "whether the agency acted within the scope of its legal authority, whether the agency has explained its decision, whether the facts on which the agency purports to

have relied have some basis in the record, and whether the agency considered the relevant factors." *Id.*

Under the APA, a reviewing court must set aside a challenged agency action that is found to be, *inter alia*, "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right," 5 U.S.C. § 706(2)(C), or "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," *id.* § 706(2)(A). The party challenging the agency action bears the burden of proof. *See Abington Crest Nursing & Rehab. Ctr. v. Sebelius*, 575 F.3d 717, 722 (D.C. Cir. 2009).

IV. Analysis

Plaintiffs challenge the Final Rule on two grounds: (1) defendants acted in excess of their statutory authority under the Medicaid Act; and (2) the Final Rule is arbitrary and capricious because (a) the agency's justification of the Final Rule is contravened by the record evidence, (b) the Final Rule is not a product of reasoned decisionmaking, and (c) the Final Rule is not merely a clarification of existing policy. As set forth below, because the Court finds that the Final Rule is inconsistent with the plain language of the Medicaid Act, the Court need not reach plaintiffs' second argument. *See, e.g.*, *Am. Petroleum Inst. v. S.E.C.*, 953 F.Supp.2d 5, 23 (D.D.C. 2013) ("Because the Court has invalidated the Rule, other APA arguments cannot change the disposition.").

A. The Final Rule is Inconsistent with the Plain Language of the Medicaid Act.

Plaintiffs and defendants both argue that the relevant statutory language is clear and unambiguously compels a decision in their respective favor. Plaintiffs contend that "the DSH provisions of the Medicaid Act are unambiguous that only Medicaid payments are netted out in the Medicaid shortfall component" of the hospital-specific limit. Pls.' Mem. at 16, ECF No. 12-1. Defendants, on the other hand, argue that the Medicaid Act "is unambiguous that only 'uncompensated' costs are to be included" in calculating the hospital-specific limit. Defs.' Opp. at 13, ECF No. 15.

A court's review of whether an agency has acted within its statutory jurisdiction falls under the well-worn framework set out in *Chevron U.S.A., Inc. v. Natural Resources Def. Council, Inc.*, 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). Under *Chevron*'s two-step framework, a reviewing court must first determine "whether Congress has directly spoken to the precise question at issue." *Id.* at 843, 104 S.Ct. 2778. To decide whether Congress has spoken to the precise question, the court must "employ[] traditional tools of statutory construction." *Chevron*, 467 U.S. at 843 n.9, 104 S.Ct. 2778. These tools include "examination of the statute's text, legislative history, and structure, as well as its purpose." *Petit v. U.S. Dep't of Educ.*, 675 F.3d 769, 781 (D.C. Cir. 2012); *see also Pharm. Research & Mfrs. of Am. v. Fed. Trade Comm'n*, 44 F.Supp.3d 95, 112 (D.D.C. 2014) (tools of statutory construction "include evaluation of the plain statutory text at issue,

the purpose and structure of the statute as a whole, while giving effect, if possible, to every clause and word of a statute, and—where appropriate—the drafting history").

Importantly, to prevail under *Chevron* step one, plaintiffs "must show that the statute ***unambiguously*** forecloses the agency's interpretation." *Petit*, 675 F.3d at 781 (citation and internal quotation marks omitted). The statute may foreclose the agency's interpretation if the statute "prescrib[es] a precise course of conduct other than the one chosen by the agency" or if the statute "grant[s] the agency a range of interpretive discretion that the agency has clearly exceeded." *Vill. of Barrington, Ill. v. Surface Transp. Bd.*, 636 F.3d 650, 659 (D.C. Cir. 2011). "[I]f the agency has either violated Congress's precise instructions or exceeded the statute's clear boundaries then, as *Chevron* puts it, 'that is the end of the matter'—the agency's interpretation is unlawful." *Id.* at 660 (quoting *Chevron*, 467 U.S. at 842, 104 S.Ct. 2778). On the other hand, if the statute's "ambiguity has left the agency with a range of possibilities" and if the "agency's interpretation falls ***within*** that range, then the agency will have survived *Chevron* step one." *Id.*

Thus, under *Chevron* step one, the threshold determination—whether the Secretary's determination that the calculation of the hospital-specific limit should include only costs not otherwise reimbursed by private insurers is consistent with the Medicaid Act—turns on whether Congress has directly spoken on the issue. To make this determination, the Court examines the

statutory text, the structure and context of the statute as a whole, and the legislative history in turn.

(1) Statutory Text

The 1993 amendments to Medicaid imposed hospital-specific limits on the amount of payment adjustments received by DSH hospitals. Specifically, the statute makes clear that a DSH payment cannot exceed:

> ***the costs incurred*** during the year of furnishing hospital services (***as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients***) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

42 U.S.C. § 1396r-4(g)(1)(A) (emphases added).

Plaintiffs argue that this section "unambiguously specifies the 'payments' that are to be included in the calculation of a hospital's HSL"—"i.e., Medicaid payments and payments made by or on behalf of uninsured patients." Pls.' Mem. at 16-17, ECF No. 12-1. In other words, because the statutory provision sets forth a formula for calculating a hospital's HSL, and because that formula makes clear what payments can be considered, the Final Rule's inclusion of payments by third parties "contravenes the plain language of the statute." *Id.* at 17. Moreover, plaintiffs claim that the statute

plainly forecloses defendants' attempt to "rewrite" the statutory formula by mandating that third-party payments be subtracted from the "cost" side of the equation. *Id.*

Defendants argue that the heading, which refers only to "uncompensated" costs, along with the language of the audit provision makes clear that "Congress did not intend to treat care that is well compensated as uncompensated." Defs.' Opp. at 13-14, ECF No. 15.

The Court agrees with plaintiffs. On its face, the statute clearly indicates which payments can be subtracted from the total costs incurred during the year by hospitals: (1) "payments under this subchapter," i.e., payments made by Medicaid; and (2) payments made by uninsured patients. The statute nowhere mentions subtracting other third-party payments made on behalf of Medicaid-eligible patients from the total costs incurred. *Id.*

Furthermore, while the statute expressly delegates to the Secretary the authority to determine "costs," the remainder of the statutory text forecloses the reading offered by defendants in the Final Rule. That text, after all, indicates that only payments made by Medicaid and by uninsured patients may be netted out from "costs" to arrive at the hospital-specific limit. To allow the Secretary to redefine "costs" to net out a third category of payments—i.e., "third-party payments, including but not limited to, payments by Medicare and private insurance," 82 Fed. Reg. 16114-02, 16117—would "render the Congressional definition of

'payments' in the very same clause superfluous." *Children's Hosp. of the King's Daughters, Inc. v. Price*, 258 F.Supp.3d 672, 687 (E.D. Va. 2017); *see also New Hampshire Hosp. Ass'n v. Burwell*, No. 15-CV-460-LM, 2016 WL 1048023, at *12 (D.N.H. Mar. 11, 2016) ("The Medicaid Act separately describes the 'payments' that are subtracted from the 'costs' to obtain the Medicaid Shortfall. Congress could not have intended to grant the Secretary the discretion to include other payments within the term "costs," while separately defining payments. If it did, the definition of payments that must be subtracted from costs to determine the Medicaid Shortfall would be surplusage.").

Because the Court must "give effect, if possible, to every clause and word of a statute," *see United States v. Menasche*, 348 U.S. 528, 538-39, 75 S.Ct. 513, 99 L.Ed. 615 (1955), and because defendants' interpretation of the statute would render portions of the statutory language superfluous, the Court rejects defendants' reading of the statute to permit the Secretary to define "costs" to include certain "payments" when "payments" are defined in the statutory language.

(2) Statutory Structure and Context

The fact that Congress specifically provided for subtracting Medicaid payments but not payments by third parties becomes all the more salient upon examination of the subsequent statutory section. That section permits additional DSH payments to certain state-owned hospitals during a transitional period so long as

the state certifies that the additional payments are used for "health services." 42 U.S.C. § 1396r-4(g)(2). In particular, section 1396r-4(g)(2)(A) provides, in relevant part, as follows:

> In determining the amount that is used for [health] services during a year, there shall be excluded any amounts received . . . ***from third party payors*** (not including the State plan under this subchapter) that are used for providing such services during the year.

42 U.S.C. § 1396r-4(g)(2)(A) (emphasis added).

Thus, while Congress expressly excluded amounts received from third-party payors in section 1396r-4(g)(2)(A), it declined to do so in section 1396r-4(g)(1)(A). That omission is significant. Indeed, it is well-settled that, "[w]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v. United States*, 464 U.S. 16, 23, 104 S.Ct. 296, 78 L.Ed.2d 17 (1983) (citation and internal quotation marks omitted); *see also Jama v. Immigration & Customs Enforcement*, 543 U.S. 335, 341, 125 S.Ct. 694, 160 L.Ed.2d 708 (2005) ("We do not lightly assume that Congress has omitted from its adopted text requirements that it nonetheless intends to apply, and our reluctance is even greater when Congress has shown elsewhere in the same statute that it knows how to make such a requirement manifest."); *D.C. Hosp. Ass'n. v. D.C.*, 224 F.3d 776, 780 (D.C. Cir. 2000) (fact that Congress had specified that only a

State's "direct" payments were to be taken into account in preceding section of statute was compelling evidence that Congress did not intend to limit the computation of payments in such a way under the section at issue, which did not include such a limitation).

To be clear, the fact that Congress specifically excluded payments by third party insurers in subsection (g)(2) does not necessarily demonstrate intent to exclude payments by third party insurers in other subsections. *See, e.g.*, *Waterkeeper All. v. Envtl. Prot. Agency*, 853 F.3d 527, 534-35 (D.C. Cir. 2017) ("The canon of *expressio unius est exclusio alterius* is 'an especially feeble helper in an administrative setting, where Congress is presumed to have left to reasonable agency discretion questions that it has not directly resolved.'") (citation omitted). Indeed, had Congress done nothing more than instruct the Secretary to determine the "costs incurred" by each hospital receiving DSH funds, the Court could reasonably conclude that the Secretary had discretion to determine, consistent with the purpose of the statute, which payments ought to be subtracted in completing that calculation. Here, however, by granting the Secretary discretion to determine "costs," Congress specifically mandated which payments should be subtracted to arrive at the hospital-specific limit. Thus, it is compelling that Congress did not include payments by third-party insurers in subsection (g)(1), despite excluding precisely such payments in the subsection (g)(2).

Defendants attempt to muddy the waters by pointing to other aspects of the statutory structure that they

claim show that Congress intended for the hospital-specific limit to be based on "uncompensated costs." Defs.' Opp. at 13-14. Specifically, defendants point to the heading of section 1396r-4(g)(1)(A)—"Amount of adjustment subject to ***uncompensated*** costs"—and to the audit requirements that require states to certify that "[o]nly the ***uncompensated*** care costs . . . are included in the calculation of the hospital-specific limits" described in § 1396r-4(g)(1)(A)). *See id.* (citing 42 U.S.C. § 1396r-4(g)(1) and § 1396r-4(g)(1)(A)). Neither argument is persuasive.

First, although the heading of the section may "supply cues" as to Congress' intent, *Yates v. United States*, ___ U.S. ___, 135 S.Ct. 1074, 1083, 191 L.Ed.2d 64 (2015), a reviewing court must "place[ ] less weight on captions" than on statutory text, *Lawson v. FMR LLC*, 571 U.S. 429, 134 S.Ct. 1158, 1169, 188 L.Ed.2d 158 (2014). In *Lawson*, the defendant pointed to two statutory headings that read, in relevant part, "Protection for Employees of Publicly Traded Companies" to argue that the statutory provisions were limited to "employees of public companies." *Id.* Rejecting this conclusion, Justice Ginsburg explained that other aspects of the statute made it "apparent" that the statutory headings were "under-inclusive[]." *Id.* Accordingly, the headings were nothing more than "a short-hand reference to the general subject matter of the provision, not meant to take the place of the more detailed provisions of the text." *Id.* (citation and internal quotation marks omitted). So here too. While the heading of the section at issue refers to "uncompensated costs,"

the statutory text indicates precisely which payments Congress intended to be subtracted to derive a hospital's costs. Consequently, the Court will not rely on the provision's heading to alter the plain meaning of the statutory text.

Second, the legislative history belies defendants' argument with respect to the language used in the audit provision. This is because the summary of the law contained in the Conference Report reiterates the statutory definition of uncompensated care costs—i.e., "the costs of providing inpatient and outpatient services to Medicaid and uninsured patients at that hospital, ***less payments received from or on behalf of Medicaid and uninsured patients***." H.R. Conf. Rep. 108-391, 808, reprinted at 2003 U.S.C.C.A.N. 1808, 2160 (emphasis added). Moreover, as plaintiffs point out, the auditor-reporting protocol makes clear that "Medicaid IP/OP hospital costs (including Medicaid managed care costs) must be measured against ***Medicaid IP/OP revenue received*** for such services" in determining the existence of a Medicaid shortfall. Pls.' Mem. at 21 (citing General DSH Audit and Rep. Protocol, CMS-2198-F), ECF No. 12-1. Again, neither the legislative history not the auditor-reporting protocol mention exclusion of third-party payments.

(3) Legislative History

The legislative history accompanying the amendment setting hospital-specific limits demonstrates that Congress intended to ensure hospitals providing

inpatient services to a disproportionate share of "Medicaid and other low-income patients with special needs" were receiving DSH payments. H.R. Rep. No. 103-213, at 211 (1993), *reprinted in* 1993 U.S.C.C.A.N. 378, 538. Congress noted two concerns that prompted the amendment, neither of which are relevant here.

First, Congress was "concerned by reports that some States [we]re making DSH payment adjustments to hospitals that do not provide inpatient services to Medicaid beneficiaries." *Id.* According to the Committee, the purpose of the supplemental payments was "to assist those facilities with high volumes of Medicaid patients in meeting the costs of providing care to the uninsured patients that they serve, since th[ose] facilities [we]re unlikely to have large numbers of privately insured patients through which to offset their operating losses on the uninsured." *Id.* Thus, Congress prohibited states from designating a hospital as a disproportionate-share hospital eligible for supplemental Medicaid funds unless "at least 1 percent of the facility's inpatient days [we]re attributable to Medicaid patients." *Id.* Here, both parties agree that plaintiffs "treat an extremely high percentage of Medicaid patients" and "are deemed DSH hospitals that are eligible to receive DSH payments." Defs.' Opp. at 24; Pls.' Mem. at 23-24.

Second, Congress was also concerned by "reports that some States have made DSH payment adjustments to State psychiatric or university hospitals in amounts that exceed the net costs, and in some instances the total costs, of operating the facilities." H.R.

Rep. No. 103-213, at 211. Those excess Medicaid DSH payments were then "transferred to the State general fund, where they may be used to fund public health or mental health services, to draw down more Federal Medicaid matching funds, or to finance other functions of State government, such as road construction and maintenance." *Id.* at 211-212. Such use of federal Medicaid funds was, according to Congress, "a clear abuse of the program." *Id.* at 212. Here, there is no indication that plaintiffs are transferring DSH funds to "finance other functions of State government"; accordingly, this concern is also irrelevant to the Court's analysis.

B. The Proper Remedy is Vacatur.

Defendants assert that, should the Court find the Final Rule invalid, "the appropriate remedy would be to set aside the Final Rule ***as it applies to Plaintiffs***." Defs.' Opp. at 32 n.11, ECF No. 15. According to defendants, because "'litigation is conducted by and on behalf of the individual named parties only,'" any remedy should be limited to "'provid[ing] complete relief to the plaintiff[s]'" only. *Id.* (quoting *Califano v. Yamasaki*, 442 U.S. 682, 700-701, 99 S.Ct. 2545, 61 L.Ed.2d 176 (1979)).

Under the APA, a court must "hold unlawful and ***set aside*** agency action" that is found to be "in excess of statutory jurisdiction, authority or limitations, or short of statutory right." 5 U.S.C. § 706(2)(C) (emphasis added). Accordingly, "'[w]hen a reviewing court

determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed.'" *Nat'l Min. Ass'n v. U.S. Army Corps of Eng'rs*, 145 F.3d 1399, 1409 (D.C. Cir. 1998) (quoting *Harmon v. Thornburgh*, 878 F.2d 484, 495 n. 21 (D.C. Cir. 1989)). In *National Mining Association*, the district court invalidated a Corps of Engineers regulation and entered an injunction prohibiting the Corps and the Environmental Protection Agency from enforcing the regulation nationwide. 145 F.3d at 1408. The D.C. Circuit upheld that nationwide application, notwithstanding the fact that nonparties to the litigation would specifically be affected. *Id.* at 1409-10.

Defendants argue that vacatur is particularly inappropriate here given that "other federal district judges are considering the questions that are at issue in this case," and an order vacating the Final Rule here "would effectively prevent those other courts from reaching their own decisions." Defs.' Opp. at 32 n.11. But in *National Mining Association*, the D.C. Circuit addressed this very argument, pointing out that a District of Columbia court's "refusal to sustain a broad injunction is likely merely to generate a flood of duplicative litigation" given that venue is often proper in this court for challenges to agency actions. 145 F.3d at 1409. Accordingly, some diminishment in the scope of the "non-acquiescence doctrine" was "an inevitable consequence of the venue rules in combination with the APA's command that rules 'found to be . . . in excess

of statutory jurisdiction' shall be not only 'h[e]ld unlawful but 'set aside.'" *Id.* at 1410.

Defendants further contend that, even if vacatur of an unlawful regulation is the "ordinary result," it need not always be required. Defs.' Summ. J. Reply at 17 n.9, ECF No. 21. The Court agrees that "[a]n inadequately supported rule . . . need not necessarily be vacated." *Allied-Signal, Inc. v. U.S. Nuclear Regulatory Comm'n*, 988 F.2d 146, 150-51 (D.C. Cir. 1993). Rather, "[t]he decision whether to vacate depends on 'the seriousness of the [regulation's] deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of'" vacatur. *Id.* (quoting *International Union, UMW v. FMSHA*, 920 F.2d 960, 967 (D.C. Cir. 1990)); *see also Humane Soc'y of the United States v. Jewell*, 76 F.Supp.3d 69, 136 (D.D.C. 2014) ("The law in this Circuit directs consideration of two principal factors in deciding whether to vacate a flawed agency action: (1) the seriousness of the . . . deficiencies' of the action, that is, how likely it is the [agency] will be able to justify its decision on remand; and (2) the disruptive consequences of vacatur.") (citations and internal quotation marks omitted).

Here, application of these factors militates strongly in favor of vacatur.

First, the Final Rule's deficiency is not merely procedural; rather, as explained above, the Court finds that the agency acted outside of the scope of its statutory authority under the Medicaid Act. Thus, this is not a case where the agency could conceivably "be able

to substantiate its decision on remand." *Allied-Signal*, 988 F.2d at 151. To the contrary, "the agency cannot arrive at the same conclusions reached in the Final Rule because the actions taken were not statutorily authorized." *Humane Soc'y*, 76 F.Supp.3d at 137.

Second, the Court concludes that it is unlikely that vacating the rule would have "disruptive consequences" given that the Final Rule only became effective on June 2, 2017—and given that defendants were already previously enjoined from enforcing the policies underlying the Final Rule as embodied in their FAQs. Accordingly, vacatur of the Final Rule is the appropriate remedy in this matter.

V. CONCLUSION

Accordingly, for the reasons set forth in this Memorandum Opinion, plaintiffs' motion for summary judgment is **GRANTED**, and defendants' motion for summary judgment is **DENIED**. The Final Rule promulgated by CMS, published at 82 Fed. Reg. 16114, 16117, is **VACATED**. Defendants' motion to strike is **GRANTED**. Plaintiffs' motions for a preliminary injunction and for a hearing are **DENIED AS MOOT**. An appropriate Order was entered on March 2, 2018.

SO ORDERED.

APPENDIX D

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

CHILDREN'S HOSPITAL ASSOCIATION OF TEXAS; CHILDREN'S HEALTH CARE d/b/a CHILDREN'S HOSPITAL AND CLINICS OF MINNESOTA; GILLETTE CHILDREN'S SPECIALTY HEALTHCARE; CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS, INC.; and SEATTLE CHILDREN'S HOSPITAL, Plaintiffs, v. ALEX AZAR, in his official capacity, Secretary of Health and Human Services; SEEMA VERMA, in her official capacity, Administrator of the Centers for Medicare and Medicaid Services; and CENTERS FOR MEDICARE AND MEDICAID SERVICES, Defendants.	Civil Action No. 17-844 (EGS)

FINAL JUDGMENT

(Filed Mar. 6, 2018)

Pursuant to Federal Rule of Civil Procedure 58 and for the reasons stated in the accompanying Memorandum Opinion docketed this same day, it is hereby

ORDERED that the Clerk shall enter final judgment in favor of plaintiffs and against defendants. This is a final appealable Order. *See* Fed. R. App. P. 4(a).

SO ORDERED.

Signed: Emmet G. Sullivan
United States District Judge
March 6, 2018

APPENDIX E

UNITED STATES DISTRICT COURT
for the
District of Columbia

Children's Hospital Association Of Texas et al *Plaintiff* v. Thomas E. Price et al *Defendant*	)	Civil Action No. CA 147-0844 (EGS)

JUDGMENT IN A CIVIL ACTION

(Filed Mar. 7, 2018)

The court has ordered that *(check one)*:

☐ the plaintiff *(name)* _____ recover from the defendant *(name)* _____ the amount of _____ dollars ($ _____), which includes prejudgment interest at the rate of ____ %, plus postjudgment interest at the rate of ____ %, along with costs.

☐ the plaintiff recover nothing, the action be dismissed on the merits, and the defendant *(name)* _____ recover costs from the plaintiff *(name)* _____

☑ other: Ordered that the Clerk shall enter final judgment in favor of plaintiffs and against defendants. This is a final appealable Order.

This action was *(check one)*:

☐ tried by a jury with Judge _____ presiding, and the jury has rendered a verdict.

☐ tried by Judge _____ without a jury and the above decision was reached.

☑ decided by Judge Emmet G. Sullivan on a motion for

plaintiffs' motion for summary judgment is GRANTED, and defendants' motion for summary judgment is DENIED.

Date: 03/07/2018

ANGELA D. CAESAR, CLERK OF COURT

MARK COATES

Signature of Clerk or Deputy Clerk

APPENDIX F

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 18-5135 **September Term, 2019**

1:17-cv-00844-EGS

Filed On: November 8, 2019

Children's Hospital Association of Texas, et al.,

Appellees

v.

Alex Michael Azar, II, in his official capacity, Secretary, Department of Health and Human Services, et al.,

Appellants

BEFORE: Henderson and Rogers, Circuit Judges; Sentelle, Senior Circuit Judge

ORDER

Upon consideration of appellees' petition for panel rehearing filed on September 27, 2019, and the corrected response thereto, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk
BY: /s/
Ken R. Meadows
Deputy Clerk

APPENDIX G

1. 42 U.S.C. 1396a (2017) provides in pertinent part:

State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * * * *

(13) provide—

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

* * * * *

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1396r-4 of this title) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;

* * * * *

2. 42 U.S.C. 1396r-4 (2017) provides in pertinent part:

Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals

(a) Implementation of requirement

(1) A State plan under this subchapter shall not be considered to meet the requirement of section

1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) of this section which meets the requirements of subsection (d) of this section), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c) of this section.

* * * * *

(b) Hospitals deemed disproportionate share

(1) For purposes of subsection (a)(1) of this section, a hospital which meets the requirements of subsection (d) of this section is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this subchapter in a period (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

* * * * *

(c) Payment adjustment

Subject to subsections (f) and (g) of this section, in order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either—

> (1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1395ww(a)(4) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under section 1395ww(d)(5)(F)(iv) of this title);

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1) of this section) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2) of this section) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in paragraph (b)(3) of this section); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that—

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients,

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a) of this section, the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under

this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) of this section (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1395ww(d)(5)(F)(vi) of this title) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) of this section to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

(d) Requirements to qualify as disproportionate share hospital

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to

provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital—

(i) the inpatients of which are predominantly individuals under 18 years of age; or

(ii) which does not offer nonemergency obstetric services to the general population as of December 22, 1987.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1395ww of this title), in paragraph (1) the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) or (e) of this section unless the hospital has a medicaid inpatient utilization rate (as defined in subsection (b)(2) of this section) of not less than 1 percent.

* * * * *

(g) Limit on amount of payment to hospital

(1) Amount of adjustment subject to uncompensated costs

(A) In general

A payment adjustment during a fiscal year shall not be considered to be consistent

with subsection (c) of this section with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.

(B) Limit to public hospitals during transition period

With respect to payment adjustments during a State fiscal year that begins before January 1, 1995, subparagraph (A) shall apply only to hospitals owned or operated by a State (or by an instrumentality or a unit of government within a State).

(C) Modifications for private hospitals

With respect to hospitals that are not owned or operated by a State (or by an instrumentality or a unit of government within a State), the Secretary may make such modifications to the manner in which the limitation on payment adjustments is applied to such

hospitals as the Secretary considers appropriate.

(2) Additional amount during transition period for certain hospitals with high disproportionate share

(A) In general

In the case of a hospital with high disproportionate share (as defined in subparagraph (B)), a payment adjustment during a State fiscal year that begins before January 1, 1995, shall be considered consistent with subsection (c) of this section if the payment adjustment does not exceed 200 percent of the costs of furnishing hospital services described in paragraph (1)(A) during the year, but only if the Governor of the State certifies to the satisfaction of the Secretary that the hospital's applicable minimum amount is used for health services during the year. In determining the amount that is used for such services during a year, there shall be excluded any amounts received under the Public Health Service Act [42 U.S.C.A. § 201 et seq.], subchapter V of this chapter, subchapter XVIII of this chapter, or from third party payors (not including the State plan under this subchapter) that are used for providing such services during the year.

(B) "Hospital with high disproportionate share" defined

In subparagraph (A), a hospital is a "hospital with high disproportionate share" if—

(i) the hospital is owned or operated by a State (or by an instrumentality or a unit of government within a State); and

(ii) the hospital—

(I) meets the requirement described in subsection (b)(1)(A) of this section, or

(II) has the largest number of inpatient days attributable to individuals entitled to benefits under the State plan of any hospital in such State for the previous State fiscal year.

(C) "Applicable minimum amount" defined

In subparagraph (A), the "applicable minimum amount" for a hospital for a fiscal year is equal to the difference between the amount of the hospital's payment adjustment for the fiscal year and the costs to the hospital of furnishing hospital services described in paragraph (1)(A) during the fiscal year.

* * * * *

(j) Annual reports and other requirements regarding payment adjustments

With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1396b(a)(1) of this title with respect to a payment adjustment made under this section, to do the following:

(1) Report

The State shall submit an annual report that includes the following:

(A) An identification of each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year.

(B) Such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.

(2) Independent certified audit

The State shall annually submit to the Secretary an independent certified audit that verifies each of the following:

(A) The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under this section.

(B) Payments under this section to hospitals that comply with the requirements of subsection (g) of this section.

(C) Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection are included in the calculation of the hospital-specific limits under such subsection.

(D) The State included all payments under this subchapter, including supplemental payments, in the calculation of such hospital-specific limits.

(E) The State has separately documented and retained a record of all of its costs under this subchapter, claimed expenditures under this subchapter, uninsured costs in determining payment adjustments under this section, and any payments made on behalf of the uninsured from payment adjustments under this section.

3. 42 C.F.R. 447.299 (2016) provides in pertinent part:

Reporting requirements.

* * * * *

(c) Beginning with each State's Medicaid State plan rate year 2005, for each Medicaid State plan rate year, the State must submit to CMS, at the same time as it submits the completed audit required under § 455.204, the following information for each DSH hospital to which the State made a DSH payment in order to permit verification of the appropriateness of such payments:

* * * * *

(6) *IP/OP Medicaid fee-for-service (FFS) basic rate payments*. The total annual amount paid to the hospital under the State plan, including Medicaid FFS rate adjustments, but not including DSH payments or supplemental/enhanced Medicaid payments, for inpatient

and outpatient services furnished to Medicaid eligible individuals.

(7) *IP/OP Medicaid managed care organization payments*. The total annual amount paid to the hospital by Medicaid managed care organizations for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals.

(8) *Supplemental/enhanced Medicaid IP/OP payments*. Indicate the total annual amount of supplemental/enhanced Medicaid payments made to the hospital under the State plan. These amounts do not include DSH payments, regular Medicaid FFS rate payments, and Medicaid managed care organization payments.

(9) *Total Medicaid IP/OP Payments*. Provide the total sum of items identified in § 447.299(c)(6), (7) and (8).

(10) *Total Cost of Care for Medicaid IP/OP Services*. The total annual costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals.

(11) *Total Medicaid Uncompensated Care*. The total amount of uncompensated care attributable to Medicaid inpatient and outpatient services. The amount should be the result of subtracting the amount identified in § 447.299(c)(9) from the amount identified in § 447.299(c)(10). The uncompensated care costs of providing Medicaid physician services cannot be included in this amount.

(12) *Uninsured IP/OP revenue*. Total annual payments received by the hospital by or on behalf of individuals with no source of third party coverage for inpatient and outpatient hospital services they receive. This amount does not include payments made by a State or units of local government, for services furnished to indigent patients.

(13) *Total Applicable Section 1011 Payments*. Federal Section 1011 payments for uncompensated inpatient and outpatient hospital services provided to Section 1011 eligible aliens with no source of third party coverage for the inpatient and outpatient hospital services they receive.

(14) *Total cost of IP/OP care for the uninsured*. Indicate the total costs incurred for furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for the hospital services they receive.

(15) *Total uninsured IP/OP uncompensated care costs*. Total annual amount of uncompensated IP/OP care for furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for the hospital services they receive.

(i) The amount should be the result of subtracting paragraphs (c)(12) and (c)(13), from paragraph (c)(14) of this section.

(ii) The uncompensated care costs of providing physician services to the uninsured cannot be included in this amount.

(iii) The uninsured uncompensated amount also cannot include amounts associated with unpaid co-pays or deductibles for individuals with third party coverage for the inpatient and/or outpatient hospital services they receive or any other unreimbursed costs associated with inpatient and/or outpatient hospital services provided to individuals with those services in their third party coverage benefit package.

(iv) The uncompensated care costs do not include bad debt or payer discounts related to services furnished to individuals who have health insurance or other third party payer.

(16) *Total annual uncompensated care costs*. The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and Section 1011 payments for inpatient and outpatient hospital services. This should equal the sum of paragraphs (c)(9),(c)(12), and (c)(13) subtracted from the sum of paragraphs (c)(10) and (c)(14) of this section.

* * * * *

4. 42 C.F.R. 447.299 (2017) provides in pertinent part:

Reporting requirements.

* * * * *

(c)

* * * * *

(10) *Total Cost of Care for Medicaid IP/OP Services*. The total annual costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals. The total annual costs are determined on a hospital-specific basis, not a service-specific basis. For purposes of this section, costs—

(i) Are defined as costs net of third-party payments, including, but not limited to, payments by Medicare and private insurance.

(ii) Must capture the total burden on the hospital of treating Medicaid eligible patients prior to payment by Medicaid. Thus, costs must be determined in the aggregate and not by estimating the cost of individual patients. For example, if a hospital treats two Medicaid eligible patients at a cost of $2,000 and receives a $500 payment from a third party for each individual, the total cost to the hospital for purposes of this section is $1,000, regardless of whether the third party payment received for one patient exceeds the cost of providing the service to that individual.

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